Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight

June 2015
To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly


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Foreword

The UN Convention was adopted in 2006, came into force and was ratified by Australia in 2008. Much has been said and written since then about protecting people with disabilities from abuse and violence – including reports from the Public Advocate, the Disability Services Commissioner, the Victorian Equal Opportunity and Human Rights Commission, and my own office, to name a few.

Yet the problem persists. Cases of abuse continue to shock the public, and the Public Advocate says that the reported cases are “just the tip of the iceberg”. There is widespread agreement that abuse of people with a disability is an unconscionable violation of their human rights, yet it continues to happen.

This investigation was launched in December 2014, prompted by revelations in the media and concerns in the sector about the capacity and capability of the oversight systems in place. It aims in large part, to identify what is broken, and what can be done to fix it. A Victorian parliamentary inquiry has also been announced, which will be informed by the outcomes of this investigation.

In announcing the investigation, I invited submissions from interested parties, including individuals, families and workers in the disability sector with experience of reporting abuse. I received 78 submissions, from organisations and individuals, many of them invaluable in shaping my understanding of the extent of the problems. I would like to thank all of those who gave their time and effort in assisting our investigation.

The submissions gave us powerful evidence of the very real problems people have faced in reporting abuse, and the inability of the system to address them.

The overwhelming conclusion of this investigation is that despite areas of good practice, oversight arrangements in Victoria are fragmented, complicated and confusing, even to those who work in the field. As a result there is a lack of ownership of the problem and little clarity about who is responsible for what. In some areas there are overlapping responsibilities between agencies and no clear understanding of the boundaries. In others there are legislative barriers to sharing information or jurisdictional gaps. Thus problems are regularly raised – including by many well-meaning players in the system – but rarely fixed.

This means that the system is fundamentally failing to deliver protection in a coherent and consistent way. If these arrangements are confusing to people well versed in the system, how much more confusing they must be to the public, including people with disabilities.
Whether or not they ever have the need to report abuse, it is vital that everyone has confidence in the systems that exist to protect them. Yet reports and research consistently show that many people with a disability will not report abuse, for fear they will either not be believed, that nothing will happen, or that they will suffer repercussions. If no single agency carries overall responsibility for building people’s confidence, including in fair and robust outcomes, this sorry state of affairs will continue.

A person’s vulnerability should dictate the protections afforded them and the nature of the allegation should determine the response to it – not which service provider they happen to access.

In examining Victoria’s oversight systems I was mindful that the picture being painted in submissions and subsequent evidence was not wholly bleak. There is a widely accepted view that Victoria has one of the strongest oversight regimes in Australia, even if there are still gaps and deficiencies. This report therefore seeks to capture what works, as well as what needs to be fixed, both to inform the current system and any new one that may be introduced with the NDIS.

Victoria has a unique protection for people with disabilities under its Charter of Human Rights and Responsibilities. This must not be lost.

The impending introduction of the National Disability Insurance Scheme (NDIS) means that looking at oversight systems was a priority. The concerns of the disability community are exacerbated by worries about what safeguards will exist when responsibilities currently held by the states pass to the Commonwealth.

This investigation is therefore being done in two phases. This report examines the effectiveness of the current oversight systems, and Phase 2 which will conclude later this year, will look in greater depth at the process for reporting and investigating abuse, drawing on the experience of individual cases.

I make recommendations in principle in this report, bearing in mind the introduction of the NDIS. They focus on two key areas: the need for a single independent oversight body for the disability sector, and building the role of advocacy to empower the disempowered. Together, they should make a formidable difference, and should be the bedrock of any new national safeguarding system.

Doing nothing while waiting for a national scheme is not an option. All too often in past years we have seen reports result in reviews which simply confirm the existence of the problem. For the sake of people with disabilities, Victoria cannot afford to wait any longer to fix this.

Deborah Glass
Ombudsman
Executive summary

The investigation

1. Through 2014 it was apparent that people in the community were becoming concerned at the abuse of people with disability within the care arrangements that are supposed to protect them. This concern reached a crescendo with media coverage in November 2014 detailing allegations concerning one of Victoria’s best-known providers of disability services, Yooralla.

2. Data from the Disability Services Commissioner (DSC), the Office of the Public Advocate (OPA) and my own office was also showing continuing issues with the way incidents of abuse were reported and handled. The data raised concerns of delay, lack of awareness and co-ordination, poor investigation and poor communication with clients and families.

3. As a result of community concerns and the above evidence, I decided to investigate the adequacy of the processes for reporting and investigating allegations of abuse in the disability sector in Victoria. While many of the concerns raised in the media focussed on allegations of abuse in supported accommodation provided by Yooralla and other funded providers, this investigation is not specifically into Yooralla. It is focussed on the process of abuse reporting and investigation across the disability sector – a wide and complex landscape.

4. My investigation is being undertaken in two phases so I could prioritise the issues relevant to imminent decisions about the shape of the NDIS and the current Victorian Parliamentary Inquiry by the Family and Community Development Committee.

5. Accordingly this report examines the effectiveness of the statutory oversight mechanisms that are used for reviewing incidents and reporting on deficiencies in how incidents are managed. This includes the work of:

   - the Department of Health and Human Services (DHHS or the department)
   - the DSC
   - the Senior Practitioner
   - OPA
   - Community Visitors
   - Authorised Officers under the Supported Residential Services (Private Proprietors) Act 2010
   - the Transport Accident Commission (TAC).

6. Phase 2 of my investigation will examine incident reporting and management in more detail. I expect to table that report later this year.

A complex landscape in transition

7. The disability services landscape is complex. It is estimated that around 1 million people in Victoria have a disability including a smaller cohort of around 338,200 who have a ‘profound’ or ‘severe’ disability. The needs of people with disability can therefore range from requiring minimal or no support to live independently through to those who need full-time care and specialist intervention services.

8. The service system that has evolved in response to this diverse population reflects its complexity. Services have been established under a variety of legislative arrangements, at different points in history, based on various funding models, and delivered by combinations of for-profit, not-for-profit and government providers who are in turn subject to a mixture of oversight and accountability mechanisms. They include:

   - services provided directly by government through DHHS

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1 Australian Bureau of Statistics, Disability, aging and carers, Australia state tables for Victoria, Cat. no. 4330.0, ABS, Canberra, 2011.
services (including residential, respite and day services) provided by community service organisations (CSOs) or other providers and funded by DHHS
• services provided by private providers registered as Supported Residential Services (SRS) and regulated by DHHS
• services provided or funded by the TAC
• other services outside the scope of this investigation, including Commonwealth disability pension funding, and the Home and Community Care program, which involves a complex mix of state and federal funding as well as private providers.

9. The disability services system stands on the cusp of a generational change with the introduction of the NDIS. To be progressively implemented between July 2016 and July 2019, the NDIS will largely replace the system that my investigation is examining. As a national scheme, it is expected to provide a uniform framework for much of the disability service system.

10. Earlier this year the National Disability Insurance Agency issued a consultation paper on the quality and safeguarding framework proposed under the NDIS. The paper sets out two key risks: the risk of receiving poor quality support services, and the risk of being harmed in some way. Decisions about the framework are expected at a national level later this year. Much of the evidence and many of the conclusions in this report are relevant to this discussion.

11. My investigation has found areas of good practice that Victoria can build upon, including:
• a Disability Services Commissioner, independent of service providers, as a complaint body for people with disability, their carers and supporters
• the Community Visitors program of volunteers who visit supported accommodation, provide an important protection at a minimal cost, and actively foster the social inclusion of people with disability in the community
• the Senior Practitioner, an important source of professional expertise both to the DSC and in managing restrictive interventions and compulsory treatment by service providers
• the Public Advocate, who provides a vital role in protecting the interests of vulnerable people as a guardian and advocate of last resort
• the TAC’s system of welfare checks by Support Coordinators, both in homes and supported accommodation.

12. However, my investigation has identified serious issues which limit the effectiveness of the current system of oversight and accountability. Some of these are inconsistencies that arise from the mishmash of legislative, financial and service delivery arrangements present within the system – put simply, the same problem is dealt with differently in different parts of the service system. Other issues relate to the performance of the system itself and instances where it is not doing what the community would reasonably expect it to do.
13. The response to an allegation that a person with disability has been abused in Victoria is not determined by the nature of the abuse or the vulnerability of the victim; instead, it is determined by the institutional arrangements governing the service within which the abuse occurred or which agency took the complaint. Thus the focus of the response is not on the individual but the process. These same anomalies also dictate the reach of the mechanisms in place to ensure the safety of some of Victoria’s most vulnerable people. For instance:

- Serious incidents in SRS are not subject to DHHS incident reporting or review procedures, despite this being a routine response for services operated by the department or providers funded by the department.
- Incident reports concerning allegations of assault are provided to the DSC if the perpetrator is an employee of DHHS or a funded provider but not if they are a fellow resident, or if the incident occurred in an SRS.
- Some funded providers follow the Public Advocate’s guidelines for responding to incidents of violence, neglect and abuse while SRS, other providers or DHHS operated services do not.
- Community Visitors can inspect SRS or accommodation provided by DHHS or CSOs but not day services or TAC accommodation.

14. As well as the inconsistencies arising from current service delivery arrangements, there are also a number of elements not functioning as they should, as well as significant gaps in coverage. In summary:

- There is no independent review of all serious incidents despite this being critical to ensuring that the department and funded agencies are meeting their obligations under the Charter of Human Rights and Responsibilities Act 2006.
- Departmental guidance on investigating serious misconduct does not apply to funded providers, which adopt a variety of separate approaches.
- While the law is intended to balance the public interest in the free flow of information with the public interest in protecting the privacy of personal information in the public sector, some parts of the system are either constrained or consider themselves to be constrained from sharing information.
- The Disability Worker Exclusion Scheme has limited reach and no legislative backing.
- There is a critical role for advocates to assist people with disability; however, there is limited appreciation of the importance of this role, manifest in its modest funding, as well as an inherent conflict in advocacy services being funded by the department upon whom the recipients of the service rely.
- There is also a tension between the roles of the department, particularly its dual functions as both funder/provider of services and regulator.

15. There are also a variety of issues specific to individual agencies that I have addressed in the relevant chapters.

2 Sec 5, Privacy and Data Protection Act 2014 (Vic).
Where to from here?

16. At a systemic level, Victoria's fragmented model of oversight and accountability needs to be transformed into a model that ensures allegations of abuse receive a comprehensive response that is independent from the service system within which the abuse occurs. A person's vulnerability should dictate the protections afforded them and the nature of the allegation should determine the response to it - not which service provider they happen to access.

17. This transformation requires:

• a model that provides a consistent response to serious incidents regardless of service provider
• mandatory reporting of serious incidents by service providers
• a single point of accountability for receiving these reports and complaints, investigating or overseeing investigations as appropriate, and analysing them to identify learnings and systemic improvements. It should also have a key guidance and education role for the disability sector and service users, promoting complaints and good practice, and providing training to agencies, the public and people with disability.

These arrangements would boost accountability and scrutiny within the disability services system.

18. A safer system for people with disability also requires that every voice can be heard. While many people with disability can speak out for themselves when their care is unsatisfactory, and should be encouraged to do so, those who cannot are especially vulnerable. Victoria therefore requires a robust system of advocacy to ensure that those who need support to speak up when something is not right are able to access that support.

19. Advocacy services, and the funding of advocacy, should be independent of all agencies involved in funding, regulating, or providing services to ensure they can be truly fearless when standing up for the vulnerable.

20. The strengths and weaknesses of the Victorian system provide lessons for a national safeguarding framework. The NDIS represents an opportunity to fundamentally rethink the systems of oversight and accountability applicable to the disability services system. I have also made recommendations for the consideration of the Victorian Parliamentary Inquiry, being conducted by the Family and Community Development Committee, as it considers what ought to be done at a structural level pending the full roll out of the NDIS.

21. Finally, the generational leap promised by the NDIS must both build on the strengths and improve on the weaknesses of the current system. Victorians with a disability should not be left to rely on a weaker system with less oversight than the one currently in place.
Scope and methodology

22. In settling the scope of my investigation, I considered:
   - feedback from the submissions process
   - the role the agencies and/or services play in supporting people with disability
   - the timing of the consultation and roll-out of the NDIS
   - concerns identified in meetings with individuals and advocacy organisations
   - information published in the reports of the DSC and OPA.

Terms of Reference

Phase 1
The investigation will consider:
1. the effectiveness of the statutory oversight mechanisms in reviewing incidents and reporting on deficiencies. This includes the work of:
   - the Department of Health and Human Services
   - the Disability Services Commissioner
   - the Senior Practitioner – Disability, Office of Professional Practice
   - Office of Public Advocate and Community Visitors
   - Authorised Officers
   - the Transport Accident Commission/WorkSafe.
2. Any gaps in statutory oversight.

Phase 2
The second phase of the investigation will look more specifically at incident reporting under relevant legislation including the:
   - Disability Act 2006
   - Supported Residential Services (Private Proprietors) Act 2010

3. The management of incidents that occur involving a registered disability service provider for the purposes of the Disability Act including:
   - accommodation
   - day service programs
   - respite
   - advocacy
   - individual support.

4. The management of incidents involving a supported residential service under the Supported Residential Services (Private Proprietors) Act.

5. The management of incidents that occur involving severely disabled workers or compensable clients of the TAC or WorkSafe for the purposes of the Transport Accident Act and Workplace Injury, Rehabilitation and Compensation Act.

Scope

23. Some agencies and services are outside the scope of this investigation:
   - agencies with specific responsibility for the management of children with a disability under the Child Protection Program
   - the management of people with disability in Victorian education facilities
   - mental health service providers working under the Mental Health Act 2014. A person with a mental illness living in an SRS will be considered as part of this investigation, however a health service provider under the Mental Health Act will not
• the Home and Community Care (HACC) program – providing services direct to a person’s home and usually managed by local councils. There is a complex mix of state and federal funding as well as private service providers operating under HACC.

24. In addition, I do not have jurisdiction over Victoria Police. Consequently, I have not directly looked at how Victoria Police deals with reports of abuse about people with disability.

25. Wider issues that are not included in the scope of the investigation will be kept under review by my office – particularly in light of any ongoing complaints – and may become the subject of a future investigation.

**Approach**

26. My investigation involved:

• analysing information received as part of the submissions process

• meetings and interviews with a number of disability clients, their parents and families

• briefings with representatives from the department, the DSC and the TAC

• meetings with the Community Visitor Regional Convenors

• consulting with a number of disability groups, advocacy organisations, peak bodies and community groups

• attendance at disability events, including the Victorian Advocacy League for Individuals with Disability (VALID) ‘Having A Say’ 2015 Conference and several VALID self-advocacy network meetings

• interviewing key people from various oversight bodies

• examining extensive documentation and material obtained from the department, the DSC, OPA and the TAC

• considering and reviewing relevant legislation, policies, procedures, instructions and standards.

27. I am reporting my opinion and the reasons to the Minister and the Secretary of DHHS under section 23 (1) (g) of the Ombudsman Act 1973. The administrative action to which the investigation relates is the effectiveness of decision making processes of the department, the DSC, OPA, Community Visitors and the TAC as they relate to incidents of alleged abuse against people with disability.

28. In accordance with section 25A(3) of the Ombudsman Act I advise that any persons who are identifiable, or may be identifiable from the information in this report, are not the subject of any adverse comment or opinion. They are named or identified in this report as:

• I am satisfied that it is necessary or desirable to do so in the public interest

• I am satisfied that identifying those persons will not cause unreasonable damage to those persons’ reputations, safety or wellbeing.

**Considerations**

29. In conducting this investigation I am mindful of several other activities which have a bearing on the timing and scope of my investigation, including both state and federal inquiries into abuse in the disability sector, as well as the rollout of the NDIS.
30. On 5 May 2015, the Victorian Government announced the terms of reference of the Parliamentary Inquiry by the Family and Community Development Committee into systemic failures in Victoria’s disability service system. The Inquiry’s Terms of Reference state:

   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.

31. The Inquiry is to be conducted in two stages, with Stage 1:

   ... [to] 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 ...^4.

32. Stage 2 of the Inquiry will:

   ... 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 ...^5.

33. The Terms of Reference acknowledge my current investigation into disability abuse reporting and state that the inquiry will ‘work cooperatively with the Ombudsman to avoid unnecessary duplication’^6.

34. The Committee is required to provide an interim report on Stage 1 by no later than 31 July 2015. A final report is required by no later than 1 March 2016.

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3 Victorian Parliamentary Inquiry into Abuse in Disability Services, Terms of Reference, Received from the Legislative Assembly on 5 May 2015.
4 ibid.
5 ibid.
6 ibid.

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35. The Commonwealth Senate Community Affairs References Committee is also conducting an inquiry into violence, abuse and neglect against people with disability in institutional and residential settings. The Senate Inquiry recently called for submissions and has commenced a number of public hearings. The Senate Inquiry has until 16 September 2015 to complete its report.
36. Around one million Victorians or 18.4 per cent of the population\(^7\) have a disability\(^8\).

37. In 2011, the Australian Bureau of Statistics identified that 338,200 people in Victoria had a ‘profound’ or ‘severe’ disability\(^9\). Of these:
   - 196,200\(^10\) are over the age of 60 years\(^11\) and are likely to reside or be receiving services in the aged care sector or through the Home and Community Care Program (HACC)\(^12\)
   - 36,500\(^13\) are under the age of 15 years and are likely to reside or be receiving services in the child protection sector
   - 300,000\(^14\) are older people and people with disability living in their own residence, and receiving funding under HACC.

38. The landscape of disability in Victoria is complex, but it is dominated by DHHS, which has a legislative responsibility under the Disability Act to promote the rights of people accessing disability services and to support the provision of quality disability support services.

39. Through the department, the state provides, funds, and/or regulates the vast majority of services in the sector. The Commonwealth also supports people with disability through the Disability Support Pension.

40. Like all Victorians, people with disability live, work and play in a wide variety of settings. Arrangements, supports and responses are as wide as the breadth of disability, and many rely heavily on family and unpaid care. People with disability may live at home, in supported accommodation such as a group home with other residents with disability, in a SRS\(^15\) or in Commonwealth-funded facilities. They work in a range of programs designed for people with disability or in the community, and many also access day services and other support. These services are provided either direct by the department (in Disability Accommodation Services (DAS)) or through CSOs.

41. These elements broadly make up the state funded disability sector:
   - 14,593 people receiving an Individual Support Package – financial support to people with disability so they can purchase services suited to their needs
   - 5,041 supported accommodation beds, including:
     - 52 per cent of funding – provided by the department
     - 48 per cent of funding – services provided by CSOs and funded by the department
   - 5,400 beds in 141 SRS – 91 per cent of residents reported as having a disability
   - approximately 1,400 severely injured clients of the TAC and WorkSafe Victoria

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\(^7\) The Office of Disability Victoria
\(^10\) ibid.
\(^11\) ibid.
\(^12\) The HACC program is designed to support people whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care.
\(^13\) ibid, above n 1.
\(^15\) An SRS is a privately owned residential service where accommodation and personal support are provided or offered to residents for a fee.
• 93 facility-based respite services
• 296 funded organisations that deliver disability services
• 1,701 disability advocacy clients.

There is considerable overlap between these services and funding streams, so people may be clients of a number of service providers under different systems.

42. In addition, there are 4,617 people waiting for services on the state Disability Support Register:
• 1,496 waiting for accommodation
• 3,121 waiting on support to live in the community.

Where people live

DAS and CSO accommodation

43. The vast majority of Victorians with a disability live at home; however, there are over 5,000 people with disability living in state funded accommodation. This is divided into two sectors:
• DHHS which accounts for around 52 per cent
• facilities run by CSOs (two of the largest being Scope and Yooralla) to deliver disability services for the remaining 48 per cent.

The TAC

44. The TAC is responsible for the management of seriously injured accident victims under the transport accident and workers compensation (WorkSafe) schemes, including the funding of supported accommodation.

SRS

45. There are an estimated 4,275 SRS residents in Victoria, with just over half (2,308) living in pension-level facilities.

46. The number of people with disability living in SRS is very high. The 2013 Census of Supported Residential Services (SRS) in Victoria found that:
• 96 per cent of residents living in pension-level SRS have a disability
• pension-level residents are significantly more likely to have a psychiatric disability (59 per cent)
• the incidence of people with aged related frailty, disability, and drug and alcohol problems increased significantly between the 2008 and 2013 census.

Other types of support

Individual support

47. An Individual Support Package (ISP) is an allocation of funding to a person with disability to assist in the purchase of supports that will best meet their needs and achieve their goals. Planning for an ISP will also take into consideration the needs of family members or carers to maintain the caring relationship.

Day services and respite

48. Day services provide activities for people to support their community and social participation, and can include skill development and recreation. Day services can be purchased through ISP funding.

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17 Sec 10, Disability Act 2006 (Vic).
19 ibid
49. Respite is when carers take a time-limited break while someone else supports the person with disability.

50. Day services, respite and other support services are funded by the department.

Service standards

Disability services

51. The department has responsibility for developing policies and practices to address complaints and reports of incidents in DAS, CSOs and SRS. For DAS and CSOs, this includes:

• implementing a systemic approach to reviewing incidents
• reviewing and analysing individual and aggregate incident information over time to identify lessons and practice implications
• providing guidance on investigation processes
• investigating staff conduct (only employees of the department, not CSOs)
• Disability Worker Exclusion Scheme – individuals who pose a threat to the health, safety or welfare of people with disability are excluded from working in disability residential services.

SRS and Authorised Officers

52. The department also has responsibility for the regulation of SRS under the SRS Act and Regulations.

53. Authorised officers are appointed by the Secretary of the department to monitor the compliance of SRS with the minimum service standards and ensure quality care and accommodation is provided to residents.

As part of their compliance with state regulations, SRS proprietors are required to notify the department of ‘prescribed reportable incidents’.

The TAC

54. In its role as a funder of disability services, the TAC has a responsibility under the Transport Accident Act 1986 and the Workplace Injury Rehabilitation and Compensation Act 2013 to ensure that adequate and appropriate safeguards are in place to ensure the safety and wellbeing of its clients.

External oversight

55. Victoria’s safeguarding framework for people with disability includes:

• the DSC
• OPA
• volunteer Community Visitors
• a Senior Practitioner, based in the department.

56. In its submission to my office dated 12 February 2015, National Disability Services Victoria (NDSV), the peak body for non-government disability service providers, commented on the strength of Victoria’s existing safeguarding framework:

This framework includes some valuable elements that have helped position Victoria as being a national leader in terms of safeguarding ...

There is room for systemic improvement in Victoria, prior to a new set of national safeguarding arrangements being developed. The current array of initiatives and structures do not form a comprehensive framework for safeguarding, and do not incorporate sufficient emphasis and investment in prevention, and driving best practice responses to allegations of abuse.
57. In 2012-13, thousands of incidents involving people with disability were reported to the department, the DSC, OPA, Community Visitors and the TAC. There is no single agency responsible for dealing with incident reports involving people with disability.

The Disability Services Commissioner

58. The DSC 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.

59. Since June 2012, the DSC has been responsible for independently reviewing incident reports to the department from disability service providers about allegations of staff-to-client assault or unexplained injury.

The Office of the Public Advocate

60. The Public Advocate is established under the Guardianship and Administration Act 1986 and appointed by the Governor in Council to promote and protect the rights of people with disability in Victoria. The Public Advocate acts as the adult guardian of last resort for people with disability, with responsibilities including advocacy and the Community Visitors Program.

61. OPA reports to the Victorian Parliament but sits within the Department of Justice and Regulation.

Community Visitors

62. Community Visitors are volunteers appointed by the Governor in Council. They are able to visit premises where disability residential services are provided, and inquire into various matters relating to service delivery, including whether the rights of people with disability are being upheld.

63. Community Visitors monitor and report on the adequacy of the services provided, in the interests of residents and patients. This includes raising concerns about the treatment of residents with staff and management from the facilities.

Senior Practitioner

64. 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.

65. The position is physically located and administratively placed within the Office of Professional Practice, in the department.

66. The Senior Practitioner reviews some incident reports from disability service providers about allegations of staff-to-client assault involving a serious outcome, and provides clinical advice to the DSC.

24 Sec 14(1), Disability Act 2006 (Vic).
25 Sec 16(a)-(q), Disability Act 2006 (Vic).
26 Schedule 3, Sec 1(1), Guardianship and Administration Act 1986 (Vic).
27 This includes disability services, supported residential services and mental health prescribed premises, operating under the Disability Act 2006, the Supported Residential Services (Private Proprietors) Act 2010 and the Mental Health Act 2014.
28 Sec 23(c), Disability Act 2006 (Vic).
29 Sec 23(2)(a), Disability Act 2006 (Vic).
Victorian Ombudsman

67. The Ombudsman has jurisdiction over each of the oversight bodies in the disability landscape, however receives few complaints about people with disability. While the Ombudsman has a clear jurisdiction to deal with allegations in state-run facilities, the jurisdiction to deal with allegations elsewhere, for example in funded providers, is far less clear and needs to be considered on a case-by-case basis.

Victoria Police

68. The role of Victoria Police is to investigate allegations of abuse which may amount to a criminal offence and to make decisions about whether reported matters proceed to court for action against alleged offenders.

69. As my jurisdiction does not extend to Victoria Police, I have not directly looked at how Victoria Police deals with reports of abuse about people with disability. However, in response to my call for submissions and in my consultation with the disability sector, a number of people raised concerns about Victoria Police’s handling of abuse involving people with disability. These included:

- inadequate supports for people with disability to navigate police processes and the justice system
- intimidating and complex procedures
- failure by police to pursue investigations.

70. In July 2014, the Commissioner for the Victorian Equal Opportunity and Human Rights Commission, published her report titled, Beyond Doubt30, which looked at the experiences of people with disability reporting crime. The Commissioner found that ‘when it comes to people with disability trying to report crimes committed against them, Victoria Police are falling short31’.

The National Disability Insurance Scheme

71. The NDIS was launched in July 2013, and is described as ‘a new way of providing individualised support for eligible people with permanent and significant disability, their families and carers’32. It is intended to give people with disability greater flexibility and control over how, when and where required supports are provided. The NDIS is currently being trialled in most states and territories and will be progressively implemented throughout Australia between July 2016 and July 2019, with the exception of Western Australia.

72. Under the NDIS, people with a permanent and significant disability affecting their ability to participate in everyday activities, will be entitled to seek supports as part of the NDIS.

73. Earlier this year, the National Disability Insurance Agency (NDIA) issued a consultation paper on the quality and safeguarding framework proposed under the NDIS scheme33. The NDIS quality and safeguarding framework is expected to eventually replace the existing state-based safeguards, although the extent of this is as yet unclear.

74. The NDIS consultation paper states that the objectives of the quality and safeguarding framework are ‘to advance the rights of people with disability and minimise the risk of harm, while maximising the choice and control they have over their lives’.

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31 Victorian Equal Opportunity and Human Rights Commission, Media release: Justice system ill equipped to meet the needs of people with disabilities, 20 July 2014.
75. The consultation paper sets out an approach to address two key risks:
   • that people with disability may receive poor quality support services which do not help them achieve their goals
   • that people with disability could be harmed in some way.

76. Decisions about the framework are expected at a national level later this year.

**Charter of Human Rights**

77. Victoria is the only state in Australia with a legislative charter of human rights, being the *Charter of Human Rights and Responsibilities Act 2006* (the Charter). The introduction of the Charter amended the Ombudsman Act to provide me with the express function to enquire into or investigate whether an administrative action is incompatible with a human right set out in the Charter.

78. Under the Charter, it is unlawful for a public authority to act in a way that is incompatible with a human right, or in making a decision, to fail to give proper consideration to a relevant human right. Significantly, for people with disability, the Charter promotes and protects the right to:
   • recognition and equality before the law
   • protection from torture and cruel, inhuman or degrading treatment
   • privacy and reputation
   • freedom of expression
   • cultural rights
   • liberty and security of person.

79. 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.
The effectiveness of statutory oversight

80. The following chapters of my report examine the effectiveness of each of the current statutory oversight mechanisms responsible for reviewing incidents and reporting on deficiencies. This includes:

- Department of Health and Human Services
- the TAC and WorkSafe
- the DSC
- OPA
- Community Visitors.

81. Figure 1 shows the complexity of making a complaint about disability services in Victoria.

Figure 1: Disability Act complaint pathways in Victoria
The role of the department

82. 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 as set out below.

83. The majority of state-funded and regulated services and providers are overseen by the department under either the Disability Act or the SRS Act. The department’s specific responsibilities vary depending on whether people are receiving services governed by the Disability Act or the SRS Act. Approaches to incident reporting, responding to and investigating incidents also differ significantly.

84. In January 2015 the previous Department of Human Services and Department of Health were merged to create DHHS. The merger into one department is intended to integrate health and human services policies. Although work is underway to achieve this, the historic reporting lines still prevail and there is little apparent integration of policy or practice as yet.

Disability Act

85. The department is responsible for administering the Disability Act 2006 in accordance with the objectives and principles of the Act. The principles of the Act state that people with a disability have the same rights and responsibilities as other members of the community. Other principles include:

> Persons with disability have the same right as other members of the community to -
> (a) respect for their human worth and dignity as individuals;
> (b) live free from abuse, neglect or exploitation.

86. Under the Disability Act, the role and functions of the department include:

- developing policy
- determining priorities for policy development, resource allocation and the provision of disability services
- planning, developing, providing and funding or purchasing comprehensive services, programs and initiatives for persons with a disability
- collecting and analysing data
- advancing the inclusion and participation of persons with disability in the community
- monitoring evaluating and reviewing disability services
- promoting the quality of disability services.

87. The department operates two residential institutions, Colanda and Sandhurst.

88. The department also provides funding to CSOs 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

89. Throughout this report, references to ‘disability service providers’ covers services delivered by the department, CSOs and private providers under the Disability Act.

SRS Act

90. The objective of the SRS Act is to protect the safety and wellbeing of residents living in private supported residential services.

34 Sec 8(1)(d), Disability Act 2006 (Vic).
35 Sec 5(1), Disability Act 2006 (Vic).
36 Sec 5(2), Disability Act 2006 (Vic).
37 Sec 8, Disability Act 2006 (Vic).
38 Sec 86 (2), Disability Act 2006 (Vic).
The SRS Act provides for accommodation and prescribed standards in SRS, with which a proprietor must comply or face a penalty.  

For SRS the department's functions include:  
- developing policies and guidelines for the accommodation and personal support provided by SRS  
- encouraging safety and improvement in the quality of accommodation and personal support provided by SRS  
- collecting, analysing and using data.

All SRS facilities are privately owned and operated. The department does not operate any SRS, and provides minimal funding.

**Advocacy**

The department funds 24 advocacy organisations and two resource units to assist people with disability. In its 2013-14 Annual Report, the department stated there are 1,701 advocacy clients in Victoria and the cost of this advocacy is $4.8 million. This includes systemic and individual advocacy, with individual advocacy allocated $1.59 million.

**Regulation**

**Under the Disability Act**

Under the Act, the department has a regulatory role in relation to the disability services it provides directly, as well as those it funds through CSOs.

The department is responsible for:  
- registering all disability service providers  
- monitoring standards as determined by the Minister  
- setting and monitoring performance measures  
- independently monitoring compliance.

96. The department has responsibility for managing the Disability Support Register - a database of all people with a need for disability funding.

97. It also administers ISPs which are provided to people with disability who are then able to purchase services to suit their needs.

98. The department’s Human Services Standards apply to all department-funded agencies that provide services to clients, including disability services and registered service providers.

**Compliance**

Compliance with the standards is monitored by the Secretary of the department, and most disability service providers are required to select a department-endorsed independent review body to evaluate service practices against the standards every three years.

Failing to resolve compliance issues can lead to the service provider’s payments being halted, the contract terminated or the committee of management of the disability service provider removed.

The department states that it also ensures funded agencies comply with mandatory policies through its contract management functions, such as annual review of organisations and service reviews where necessary.

**Under the SRS Act**

Under the SRS Regulations there is a commitment to:  
- ensure that residents live in an environment free from verbal, emotional, sexual or physical abuse, harassment exploitation or neglect.

42 Department of Health and Human Services, Human Services Standards Policy, May 2015.  
43 ibid, page 5.  
44 Sec 98(2), Disability Act 2006 (Vic).  
45 There may be some exceptions to this requirement for funded agencies that receive less than $100,000 in funding from the department or where the service is subject to a departmentally approved accreditation process for another government department.  
46 Sec 100(2)(a), Disability Act 2006 (Vic).  
47 Sec 100(2)(b), Disability Act 2006 (Vic).  
48 Sec 100(2)(c), Disability Act 2006 (Vic).  
49 Schedule 9, Standard 31, Supported Residential Services (Private Proprietors) Regulations 2012 (Vic).
103. The department has responsibility for developing the regulatory framework, policies, and practice guidelines. It also has carriage of regulatory compliance and enforcement and these functions are carried out by the department at the area, regional and central levels.

104. The department’s Supported Residential Services Regulatory Practice Framework (the framework) provides “a risk-based approach” to compliance:

The SRS Program’s aim is to ensure that at all times effective action is taken in response to any significant identified risk to residents, through assessing the seriousness of the breach and considering penalties that may apply.

105. The framework also states that non-compliance is measured:

... by making an assessment of the identified risk the non-compliance carries and the likelihood it will occur, combined with the impact the identified risk would have on residents if it did occur.

106. The framework describes the elements of the department’s targeted regulatory approach as:

• resident focus: achieving good outcomes for residents and protecting their wellbeing and safety
• support to comply: working with proprietors to identify risks, meet minimum standards and improve practices
• monitor compliance: risk based approach with resources targeted at areas if non-compliance
• enforcement.

Compliance

107. Compliance is monitored by Authorised Officers of the department through a range of inspection activity:

• Targeted Compliance Reviews (TCR) – scheduled, planned inspections
• compliance inspections – to follow up and check progress of any issues that have been identified and notified by the proprietor
• complaint inspections – to investigate a complaint made by or on behalf of a resident or by a member of the community
• other inspections – in response to an incident, to investigate a new non-compliance issue or in response to a notification from Community Visitors.

108. Where non-compliance occurs, a risk assessment should be conducted by the department. In determining appropriate enforcement actions, the department can consider a range of matters including the risk to residents’ wellbeing and safety.

Departmental structure

109. There are a number of areas within the department with responsibility for matters arising under both the Disability and SRS Acts, as shown in figures 2 and 3.

110. State-wide, the delivery of disability services is divided into four divisions (North, South, East and West) and seventeen local areas. The Deputy Secretary of each operational Division reports to the Deputy Secretary of the Service Design and Operations Division.

111. In addition, the department’s Regulation, Health Protection and Emergency Management Group is responsible for monitoring the performance of both the department and CSOs.

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50 Department of Health, Supported residential services regulatory practice framework, January 2013.
51 ibid, 3.
52 ibid, 4.
53 ibid, 5.
Figure 2: Departmental structure under the Disability Act

DHHS Division
Service Design and Operations

- Youth and Disability
- Funded advocacy groups
- DHHS Division
- Service Design and Operations
- Office of Professional Practice
  Senior Practitioner
- Service Improvement and Support
- DHHS Division
- Service Design and Operations
- Human Services Design and Development
- Regulation, Health Protection and Emergency Management
- Performance, regulation and reporting; accreditation and auditing

Figure 3: Departmental structure under the SRS Act

DHHS Division
Mental Health, Wellbeing, Social Capital and Ageing
Policy and regulation: registration, education and monitoring

Monitoring and Regulatory Oversight

- Monitoring and Regulatory Oversight
- East Division
  Hume and Southern
- South Division
  South and East Metro and Gippsland
- North Division
  North and West Metro and Loddon
- West Division
  North and West Metro, Grampians and Barwon South

SRS SRS SRS SRS
Monitoring of services for Disability Act clients

112. Reporting and managing incidents and complaints that arise as a result of service provision is fundamental to the oversight systems for people with disability. As a result, this section focuses on how the department responds in these circumstances.

113. The department’s incident oversight and management system includes:
- incident reporting
- Quality of Support Reviews – triggered by two types of events: staff-to-client assault or unexplained injury
- adverse event reviews – triggered by a wide range of issues that lead to negative outcomes for individuals.

Incident reporting

114. All ‘critical incidents’ (defined as ‘incidents or alleged incidents that involve or impact upon clients during service delivery’) must be reported to the department by all disability service providers. This is an obligation under the department’s funded agency service agreement which also applies to the services delivered by the department.

115. All service providers are required to adhere to the department’s Critical Client Incident Management Instruction. The Instruction also provides guidance on how to complete an incident report and categorise an incident.

116. There are eight parts to the Incident Report form, each requiring review and sign-off from various levels of staff and management, who are also required to tick various boxes and provide information to indicate that certain action has been taken, or is required to be taken, for example, reporting an incident to the police.

117. Parts one to four are completed by the most senior staff member to witness the incident. Part five is completed by a delegated management representative who is also required to fax the report to the department’s designated divisional office.

118. This is a paper-based reporting process. Incidents cannot be emailed and are manually entered into an electronic system once received by the department.

119. Parts six to eight of the incident report are for internal department review and are completed by the Area Team Leader, the Area Manager and the Area Director.

120. Once the incident report is completed, the report must not be changed or altered in any way. According to the Instruction, ‘if another witness or individual disagrees with the content of the report the alternative views must be put in writing as a file note and attached to the completed client incident report’.

54 Reviews into unexplained injury at the discretion of departmental staff.
56 ibid.
58 The Critical Client Incident Report form describes this as House Supervisor/Coordinator, line manager, CEO or agency manager.
60 ibid, page 12.
61 ibid.
121. The Area Team Leader is required to quality check the report, ensure that there has been an appropriate response and identify any program management failures or follow up action required. The Area Manager should identify whether the DSC should be informed. The Area Director decides whether a Quality of Support Review is recommended.

122. In response to my draft report, the department stated:

Client Incident Reports that involve allegations of the assault of a client by a staff member, death of a client, unexplained injury or involves a very high impact on the client or a member of the public are also provided to the divisional Deputy Secretary for review and sign off.

123. Figure 4 illustrates the incident reporting and response process.

Figure 4: Department incident reporting and response process

- Incident occurs
- Respond to immediate needs of the individual involved
- The most senior staff member present or the staff member to whom the incident was disclosed, records the incident using the Department of Health and Human Services Client Incident Report form (parts 1–4)
- The delegated management representative records a summary of the incident, the response to the incident and action to prevent recurrence (part 5)
- The completed Department of Health and Human Services Client Incident Report is faxed to the designated divisional office
- Client incident report is entered into client incident register
- The report is placed in the client file

Assault is reported to police where appropriate

Refer to Responding to allegations of physical or sexual assault

124. Reportable incidents are classified as either Category One or Category Two\(^{63}\). A Category One incident is ‘an incident that has resulted in a serious outcome, such as client death or severe trauma’\(^{64}\). A Category Two incident is an incident that ‘threatens the health, safety and/or wellbeing of clients or staff’\(^{65}\).

125. The incident type categorisation table\(^{66}\) describes 27 different incident types, some of which are further divided into subcategories, giving a total of 41 different incident types.

126. In categorising an incident, staff are instructed to ‘choose the incident type with the definition that best describes what happened in the incident’\(^{67}\) and ‘give consideration to the actual impact or apparent outcome for the client and the likelihood of a recurrence’\(^{68}\).

127. Considerations when reporting an incident must include whether the client was hurt, if the client is at risk, as well as changes that ought to be made in service delivery following the incident to ensure the client’s wellbeing.

128. Incidents categorised as staff-to-client assault, and some incidents of unexplained injury, are subject to a Quality of Support Review. These categories of incident are also reviewed by the DSC.

129. The information Table 1 below from the department shows the number and category of incidents reported by disability service providers between 2010 and 2014.

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Category One</th>
<th>Category Two</th>
<th>Category Three</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,274</td>
<td>8,525</td>
<td>9,911</td>
<td>19,710</td>
</tr>
<tr>
<td>2011</td>
<td>1,776</td>
<td>10,669</td>
<td>8,206</td>
<td>20,651</td>
</tr>
<tr>
<td>2012</td>
<td>1,727</td>
<td>9,064</td>
<td>43</td>
<td>10,834</td>
</tr>
<tr>
<td>2013</td>
<td>1,837</td>
<td>10,309</td>
<td>5</td>
<td>12,151</td>
</tr>
<tr>
<td>2014</td>
<td>2,120</td>
<td>11,141</td>
<td>1</td>
<td>13,262</td>
</tr>
<tr>
<td>Total</td>
<td>8,734</td>
<td>49,708</td>
<td>18,166</td>
<td>76,608</td>
</tr>
</tbody>
</table>

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63 Previous incident reporting instructions included a requirement to report Category Three incidents. This is not required in the current instruction, however staff in accommodation services are required to maintain a ‘Non-Critical Client Event Log’ of incidents for each client.


65 ibid, page 10.

66 ibid.

67 ibid, page 16.

68 ibid.
130. The drop in total reports after 2011 is the result of the change in practice which no longer required reports of Category Three incidents.

131. The department’s website provides the information in Table 2 for Category One incidents in the 2013-14 financial year.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client death</td>
<td>84</td>
</tr>
<tr>
<td>Assault</td>
<td>410</td>
</tr>
<tr>
<td>Behaviour</td>
<td>121</td>
</tr>
<tr>
<td>Other incident types</td>
<td>1,305</td>
</tr>
</tbody>
</table>

132. The following case studies provide examples of the subjective nature of the current categorisation model.

**Case study**

A client of a department-managed group home was being changed by a male staff member on her bed. She had soiled herself and her incontinence pad required changing. During the change, she reached down and touched the faeces. When the staff member attempted to stop the client touching her face, the client attempted to bite him. In response to this, the staff member let go of the client and the client rolled off of her bed and onto the floor, hitting a chest of drawers. The fall resulted in a small laceration to the client’s elbow.

The incident was reported by the staff member involved as a Category Two “Behaviour – Disruptive”, described as ‘Client actions that cause disorder, are intrusive and/or offensive to others’.

A service provider reported that they received a phone call from staff providing individual support advising them that a client had been sexually assaulted the previous night. The reporter of the incident attended the property of the client and was provided details of the incident including that an individual had entered the client’s home and sexually assaulted him before leaving. The client advised the reporter that he contacted police and that police had attended his home.

A separate incident report for this was provided by a different support worker. Both reporters categorised the incident as Category Two “Behaviour – Sexual”, described as “Sexually orientated actions by client in inappropriate circumstances”.

Categorising the incident as sexual behaviour could understate the seriousness of the incident which could have been reported as a Category One Sexual Assault – Indecent, described as “Unwanted sexual actions which are forced upon a person against their will, through the use of physical force, intimidation and/or coercion.”

There were also a number of discrepancies between the reports including:
- The date and time of the incident
- Whether the client was injured – one writer said the client was a ‘victim’ and was ‘injured’; the other writer said the client was a ‘participant’ and not injured
- The relationship between the client and the perpetrator of the alleged sexual assault – one writer said the perpetrator was known to the client; the other writer said the client was not known to the client.

The incident was not subject to a Quality of Support Review or referral to the DSC.
133. In response to my draft report, the department stated that ‘all incident reports are reviewed by Divisions’.

**Responding to an incident**

134. Guidance for service providers in responding to an incident of physical or sexual assault is provided in the department’s *Responding to allegations of physical or sexual assault*[^69]. This document outlines the key considerations for staff, such as how to address the immediate needs of a client, how to report to police, and how to connect a client to other supports such as counselling or advocacy.

135. Guidance is also provided in the department’s *Residential Services Practices Manual*. There are no departmental documents specifically directing staff on how to address the needs of clients after an incident other than incidents of physical or sexual assault.

136. When asked about whether there is a client focus in the current reporting system, the Assistant Director, Service Outcomes said that:

> ... there have been attempts to strengthen instructions and strengthen guidance to consider the service user or the client. I think that the greater focus is on reporting, rather than reflecting on the client. I think that everything we do in Human Services needs to have a stronger focus on the experience of the service user, but that means a very big shift ... it’s not just the instructions and the guidance... it’s a fundamental shift in the way we do our business...it’s a fundamental shift in the way we move [our thinking] from client and service provider to people with a disability and, giving as much control as we possibly can to that individual ...

**Analysis of incident reporting**

137. Phase 2 of my report will look more closely at the management of incident reports. However, for the purposes of phase 1 of my investigation, my officers undertook a preliminary review of 410 incident reports.

138. Their review identified a number of issues with the current incident reporting system, including that the department is not consistent in its review and response to incident reports. The current incident categorisation model is confusing and can result in incorrect categorisation of incidents. Examples include:

- “dangerous behaviour” and “disruptive behaviour”; both categories may result in threats to the safety of others
- “disruptive behaviour” or “dangerous behaviour” instead of “physical assault” which also involve a threat to cause harm
- “behaviour – sexual” and “sexual assault – indecent”.

139. At interview, the State Manager of NDSV commented on the department’s incident reporting system:

> ... the major gap ... [in navigating the complaints systems] that service providers tell us is ... probably the relationship with DHS, and, what the expectations are of the department when it comes to reporting incidents ... there is a sense from service providers ... that a lot of the department’s reporting requirements are pretty transactional, so you report [a] category One incident in, there’s not a lot of feedback ... whether that leads to any sort of practice change and meaningful feedback from the department to service providers is unclear. Service providers will have their own... practice review exercises ... in the wake of an incident but that sort of relationship with the department seems to be pretty fragmented and [there] doesn’t seem to be a lot of feedback mechanisms that come through ... post-reporting.

[^69]: Department of Health and Human Services, Responding to allegations of physical or sexual assault: Technical update, 2014.
At interview the Public Advocate described her experience of the difference between incident reporting in department accommodation and CSOs (funded providers). She said:

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...

Reports commissioned by the department

In June 2014, the department commissioned KPMG to conduct a review of its Critical Client Incident Response and Management (CCIRM) framework. KPMG's final report, which was completed in December 2014, made the following key findings:


[the department] is failing to meet the stated aims of the [critical client incident management] framework and to adequately minimise risks arising from critical incidents. The department is currently performing case-by-case management and oversight of around 33,000 critical incident reports per year, many of which relate to routine matters that are reflective of complex client needs and service delivery challenges rather than being genuinely critical incidents.

Significant, disproportionate resource input is devoted to administration of the system... [which is] driven by unrealistic expectations about the ability to predict incidents and prevent their occurrence.

The KPMG report noted that since 2006, there have been five separate reports or inquiries concerning various aspects of the department’s management of incident reporting. These included three reports by my office, one inquiry by the DSC and a report by the Victorian Auditor-General’s Office. The KPMG report notes that all the reports had findings about the department’s CCIRM framework, “consistently questioning its rigour and effectiveness”71.


The KPMG report makes 21 recommendations including that the department:

- establish a clear minimum standard in the CCIRM Instruction for an appropriate and immediate response to a critical incident that describes the main activities and responsibilities to be discharged72
- strengthen oversight ... and workforce capability ... to ensure funded agencies and [department-delivered] services adequately discharge their obligation to appropriately manage responses to critical incidents73
- revise the current categorisation model74...

When asked by my officers at interview about the effectiveness of the current CCIRM framework, the Assistant Director, Service Outcomes said:

I think we [the department] are very good at reporting incidents ... it is a point in time assessment or documentation of a response. And again, I think we do well to document the response. What it doesn’t do is provide an end to end learning opportunity. It doesn’t inform prevention as much as it needs to ... it has become a reporting system rather than a responding system or a management system ... I think its strengths are in its reporting, not its management.

When asked about the current status of the KPMG report’s recommendations, the Assistant Director, Service Outcomes stated that:

The recommendations that KPMG are making are fairly significant changes ... I think that the greatest benefit for us is a shift in, really a focus in practice, and practice improvement in relation to both ... identification and reporting, and our response to a particular incident.

72 ibid, Recommendation 7, page 8.
73 ibid, Recommendation 6, page 8.
74 ibid, Recommendation 9, page 9.

the department of health and human services 29
146. In response to my draft report, the department stated:

... that it is currently considering the recommendations of the KPMG review in the context of the newly created Department of Health and Human Services and will commence implementation of reforms to its critical client incident reporting and management system shortly.

The KPMG review relates to programs overseen by the former Department of Human Services and implementation requires further work to be undertaken to consider the needs of similar programs and client groups of the former Department of Health.

**Quality of Support Reviews**

147. For all incidents of staff-to-client assault, a Quality of Service Review (QoSR) is mandatory. Department staff are also encouraged to consider a QoSR for incidents relating to unexplained injury. The objective of the QoSR is to ‘review the actions of the service provider’.

148. QoSR reports are required to be endorsed by the Client Outcomes and Service Improvement Director in the department, and provided to the divisional Deputy Secretary within 60 working days.

149. A QoSR can involve the review of client’s rights and outcomes, staff action and wider systemic issues.

150. A central aspect of the QoSR is an action plan, which requires the identification of actions to be undertaken by the service provider to improve its practices. The implementation of an action plan is the responsibility of the Area Director for both DAS and CSOs.

151. The QoSR process requires that at the completion of a review, the client and their family or advocate is advised of the outcome within five working days.

152. A QoSR is not required for other types of incidents, therefore reviews are not routinely carried out in relation to all allegations of abuse, for example, client to client assault.

**Analysis of Quality of Support Reviews**

153. My officers requested from the department copies of all QoSR undertaken in 2012, 2013 and 2014 and received 478.

154. My officers reviewed a sample of 171 QoSR completed by the department for the period 1 July 2014 – 30 December 2014 and found:

- significant time delays between the date an incident occurs and the completion of a QoSR: 71 per cent of the QoSR considered were completed outside the required 60 days
- areas of further action recommended in the QoSR were not followed up to ensure completion, despite being necessary to address client safety and wellbeing
- the divisions were not using the same QoSR template, for example, reviews from one division did not include a section for following up identified actions.

155. The following case study illustrates a number of issues with QoSR, including:

- the inadequacy of a desktop review
- the delay in reporting the incident to the police and to the department and
- that the client was not interviewed nor was any independent support arranged for her.
Case study

A staff member of a group home managed by a CSO reported that he was dressing a client when she took hold of his hand and tried to bite him. He reported that his immediate reaction was to pull his hand away but the client had a very strong hold so he hit her to the side of her head and she immediately let go.

The client is an older woman with multiple disabilities and medical conditions including cerebral palsy, intellectual disability, and epilepsy. The report noted that she required full support with all aspects of her life and has no family involvement.

The Quality of Support Review for this incident was conducted as a desk-top review using information received from the incident report and by email from the service provider reporting the incident.

The review identified that:

• the incident report was received by the department 13 days after the date the incident occurred. The service provider stated that this was because the staff member reporting the incident initially reported it as a non-critical incident and that this was identified by management three days after the incident occurred
• staff member was stood down and, following an internal investigation, issued with a formal warning and advised that they would be relocated to work in another service where supervision was available
• the client was not interviewed as part of the investigation because of “[her] cognitive ability and inability to articulate the event and timeframe”. The service provider reported that “the client received debriefing and support from coordinators who have worked with her for years”
• the matter was reported to police the day before it was reported to the department. According to the QoSR, the police stated that ‘if there was no CCTV, witness or injury and the person [was] unable to explain what occurred or make a statement, no investigation could occur’, and that ‘... based on information, the person with disability initiated the incident by attempting to bite and it would be considered in a court of law as self-defence’.

The review report did not identify who was responsible for implementing the action items or if any of them have been implemented. A number of actions were identified in the QoSR but there was nothing to indicate whether any of these had been implemented.

156. In his 2011 report to the Minister entitled Inquiry into the Department of Human Services (DHS) Quality of Support Review processes for staff-to-client assaults in DHS disability services, the DSC focussed on how QoSR address:

• the immediate and ongoing responses to ensure client safety and well being
• processes to ensure clients are supported following an alleged assault
• other relevant issues identified in the course of the inquiry including those which would assist in reducing the incidence of staff-to-client assaults80.

157. The DSC inquiry made 21 recommendations to improve the QoSR system which were accepted by the department. The recommendations included:

- developing Practice Guidelines
- ensuring a client-centred focus during the QoSR process
- reviewing current monitoring and compliance of incident reports
- redesigning the QoSR process to clearly articulate its objectives and the responsibilities of key parties.

158. My officers requested information from the department about what steps it had taken in response to these recommendations. The department advised that:

- eight recommendations were implemented
- nine recommendations were implemented but a further quality improvement was identified
- four recommendations were yet to be implemented.

159. Those yet to be implemented are awaiting the department’s release of the Quality of Support Review Practice Guidance (the practice guidance) initially planned for March 2015 and now June 2015.

160. In his most recent advice to the department regarding incident reports from the period 1 July–31 December 2014, the DSC observed an increase in the number of QoSR not completed within the prescribed timeframe of 60 days. The Commissioner also had concerns about a number of the issues he had raised in his 2011 Inquiry:

- police engagement and responsiveness to allegations of assault
- families declining to pursue further police action
- level of Independent Third Party usage
- service providers not understanding reporting requirements.

161. When asked at interview about the effectiveness of the QoSR, the Commissioner stated:

it seems extraordinary that the time taken to undertake Quality of Support Reviews can seem so breathtakingly past the event as to question the relevance of it being vaguely contemporary at the time of its delivery ... but it’s their [the department’s] system.

162. My officers have reviewed the proposed practice guidance. In principle, it appears to improve the QoSR process by:

- increasing accountability of staff
- adding an additional layer of investigation for particularly complex or unresolved matters
- requiring that all reviews be signed off by the Divisional Deputy Secretary only after identified follow up actions are complete.

163. The success of the practice guidance will be reliant on the department’s implementation and consistent compliance.

Adverse event reviews

164. The department also conducts reviews of ‘adverse events’. Its Promoting Better Outcomes – Systemic Improvement policy: Managing and reviewing adverse events describes an adverse event as one that ‘leads to negative consequences for individuals and/or groups directly or indirectly attributable to the disability service provision’.

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81 Department of Human Services, Disability Services, Promoting Better Outcomes – Systemic Improvement Policy: Managing and reviewing adverse events, July 2012.
82 Ibid, page 3.
165. The policy states that:

... for the purpose of ... [the policy] document an adverse event is an overarching term used to cover a collective group of events and includes an incident, issue or event identified in a complaint or by a notification in relation to the provision of services or supports by a disability service provider.

166. An adverse event review may be identified or triggered by:

• a person affected by the event
• carers, family members, advocates, friends or visitors to the service
• a staff member present at the time or after the event
• expressed dissatisfaction with the service or support care provided
• the Critical Client Incident Management system
• a complaint, or group of complaints.

167. Adverse event management is the responsibility of all disability service providers including departmental staff and CSOs. Events are to be first managed at the local level and can be escalated to the department’s central office if the matter is systemic in nature or cannot be resolved.

168. According to the policy, the department’s central office has overall responsibility for the management of the review and its compliance with the policy. Departmental divisional managers are required to ensure processes are in place to assess and review an adverse event, quality manage the review and commit to improvements in policy and procedure.

169. An adverse event review adopts “risk and root cause analysis” to identify how often a specified adverse event occurs, its consequences, and the factors that contributed to the event so as to prevent recurrence.

**Analysis of adverse events**

170. My officers requested the number of all adverse event reviews completed since 2011 and copies of all reports completed in 2014 and 2015 so far.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of reviews completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>3</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
</tr>
</tbody>
</table>

171. As shown in Table 3, these numbers are very low, given the range of triggers for an adverse event review.

172. Between January 2013 and December 2014 the department received eight notifications from the National Disability and Abuse Hotline and, between July 2013 and December 2014, eight notifications from OPA. Despite this, only two reviews were conducted over this period.

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84 Ibid, page 3.
85 Ibid, page 2.
88 Ibid, page 5.
173. In response to my draft report, the department stated:

All notifications from the National Disability and Abuse Hotline were investigated and they were not classified and counted as Adverse Event Reviews. The investigations of the Hotline complaints were co-ordinated by the relevant operational Divisions and investigation outcomes were communicated to central office and the complainant.

Notifications from the OPA between July 2013 and December 2014 were responded to by the department under the ‘Notification Protocol for serious and/or unresolved issues’, agreed between the OPA and the former Department of Human Services.

174. At interview, the Assistant Director, Service Outcomes was asked about the adverse events policy used by the department. She said:

The adverse events policy gives us a good method or framework to understand an incident or an event ... some of the language [within the document] we use is very outdated because it’s an older document ... There [are] some technical updates ... [the department] need[s] to make to it ... I think we need greater clarity about when you use it and how you use it ...

External investigations

175. The department has the ability to contract external investigators to review or investigate an incident under certain circumstances. For example, the department may contract a forensic investigator or an external consultant in instances where special expertise or particular skill is required.

176. The department does not have any policy or guideline for when an external investigator should be engaged.

177. My officers reviewed a number of external investigations that illustrated the confusion that exists around the use of external investigation. For example:

A Review of Category 1 and 2 Incident Reports involving a client attending a day program was conducted by an external investigator engaged by the department. The review investigated a number of incidents including alleged staff-to-client assault. The investigator found a number of concerning issues including failure of the day program to report physical restraint incidents and ‘serious concerns about staff and management practices’ at the day program. The final report recommended that the issues investigated be referred to the Disability Services Commissioner for immediate action. This recommendation was received by the department in February 2013.

In October 2013, the department engaged another external investigator to review the effectiveness of the day program in meeting the needs of all of its clients.

178. The department responded to my draft report by stating:

... it is common practice that investigation of a client specific matter may lead to a whole of service review (as part of the department’s agency management functions) and that may be the case in this example.

179. At interview, the Assistant Director, Service Outcomes noted that the department’s Children, Youth and Families unit have a Quality of Care process, which is an ‘investigation framework’ based on a determination of whether abuse occurred and substantiating the abuse. This is unlike the Quality of Support Review process which is a review of actions taken in response to the allegation at the time of the incident and the period immediately following.
180. At interview, when asked how often an external investigator is engaged by the department, the department’s Assistant Director, Residential Services and Complex Support said that ‘I don’t often … engage an external contractor’ unless the department is ‘really short of staff’.

181. How external investigations are to be conducted in CSOs is also unclear. The Assistant Director, Residential Services and Complex Support said that following an incident of concern, the department may engage in negotiation with a CSO about the need for an investigation, including whether the department is likely to financially assist. She said that there is ‘no hard and fast rule’ about the department’s assistance or funding of external investigation.

182. My officers examined nine QoSR conducted by the department’s East division between June 2012 and November 2012. The reviews related to incidents of staff-to-client sexual and physical assault that occurred in group homes managed by a large funded agency.

183. The funded agency engaged external consultants to investigate five of the nine incidents. It was not clear to my officers why some incidents were subject to external scrutiny and others were not. All of the incidents included allegations of serious assault and all involved vulnerable residents.

184. It was also unclear whether the funded agency shared the findings of the external investigations with the department. For example, one review noted as an action that the [funded agency] “consider sharing with the [departmental officer] the investigation report to increase departmental understanding of the complexities the [funded agency] face in improving the practice of supporting residents and timely incident reporting”.

185. At interview, my officers asked the State Manager NDSV about the engagement of external investigators by CSOs. He said:

Some providers will take initiative and appoint their own external person, they’ll stand the worker down, they will run the investigation or the department will appoint someone to do the same thing. ... there have been some concerns from providers about the length of those investigations and how long they need to stand a worker down for, because there is a financial implication with that, to pay someone who’s been stood down and then employ someone to provide that backfill ...

Misconduct investigations

Departmental staff

186. The department’s Managing Performance and Conduct in Disability Services (MPC) Policy, provides a comprehensive process for managing department employees who are alleged to have performed unsatisfactorily, or engaged in general or serious misconduct. The policy provides a number of possible outcomes at the completion of each review, from recommending counselling to possible termination of employment.

89 Department of Health and Human Services, Managing Performance and Conduct in Disability Services (MPC) Policy, 5 February 2015.
187. The department’s Ethical Standards Unit investigates allegations of serious misconduct of departmental staff and reports its findings to a duly authorised officer. The Ethical Standards Unit may consult an external reviewer in instances where specialist expertise is required or where the Ethical Standards Unit does not have capacity to conduct a review.

188. At interview, when asked about the role of the Ethical Standards Unit, the Assistant Director, Residential Services and Complex Support said ‘their brief is to do the investigation in an objective and independent way’.

**CSO staff**

189. The department’s MPC policy applies only to departmental staff. When asked whether CSOs have a similar process for review of staff misconduct, the Assistant Director, Residential Services and Complex Support said:

> probably not ... and it probably varies quite a fair bit ...

190. CSOs are however under an obligation pursuant to section 3.1(c) of their service agreement with the department to:

> ... demonstrate a commitment to ethical practices and behaviours, and make sure that ethical practices are implemented and ethical behaviours are promoted through appropriate staff training and monitoring.

191. At interview, the department’s Assistant Director, Service Outcomes when asked by my officers whether the department had considered expanding the role of the Ethical Standards Unit to cover CSOs stated:

> When we developed the disability exclusion scheme and when a decision was made to construct that scheme around policy and draw on the existing employment arrangements ... we were relying on the quality of the construction of the allegations, allegations of serious misconduct, and investigation of that serious misconduct ... We were concerned ... if that was not a strong investigation, and a robust investigation, that person would not be terminated and therefore would not be referred to DWES [Disability Worker Exclusion Scheme] and it was seen as one of the greatest risks ... 

> ... we certainly have explored ways in which, and considered ways in which the organisation ... might consider a central approach to the investigation of serious misconduct ... The Ethical Standards Unit is one of those options.

> ... I think it becomes quite complicated when you’re talking about employment contracts between a community service organisation and the individual. So, it hasn’t been explored much further ...
Disability Worker Exclusion Scheme

192. In September 2014, the department introduced the Disability Worker Exclusion Scheme (DWES) as a way to ‘collect, store and use information about people who are deemed unsuitable to work with clients in disability residential services’.

Workers who meet the criteria and are considered unsuitable are placed on the Disability Worker Exclusion Scheme List. The scheme requires service providers to notify the department if they become aware that a worker satisfies the criteria and should be placed on the list, and to check prospective employees against the list.

193. According to the Assistant Director, Service Outcomes, consideration of whether a worker will be placed on the DWES list occurs at the end of any departmental disciplinary process by the Director, who must:

- rely on the investigation into the allegations of misconduct and the provision of the evidence obtained during the discipline investigation to make the assessment.

194. The department has identified significant impediments to the effective operation of DWES, such as the inability to refer an employee unless it can be proven that serious misconduct has occurred, which requires a high standard of proof under employment law. It also identified conflict that exists between its obligations under its industrial agreement and its obligations under the Protected Disclosure Act.

195. The DWES only applies to staff who work in residential services registered under the Disability Act. It does not apply to staff who work in SRS or in other types of disability services such as day programs or individual support.

196. At interview the State Manager of NDSV said he thought the DWES was a ‘welcome step in the right direction’; however he noted that as it only applies to residential services, there are still a number of gaps in the system. He said that DWES should be extended, at least until a national arrangement is made under the NDIS, and apply to all services. He also suggested that DWES would be strengthened if legislated, and would enable appropriate natural justice provisions for workers.

197. This view was also put by the Public Advocate who said that ‘there was a place for some kind of scheme but it needs to be in legislation’. She expressed concern about a lack of natural justice for staff and said:

- It’s weaker than the Working with Children Scheme which is based in legislation.
- I don’t know what the natural justice principles are for a staff member that is excluded, but I think it’s terribly weak and I think it will falter because it is so weak.

Monitoring of services for SRS clients

Incident reporting

198. The SRS Act requires a proprietor to keep records of any ‘prescribed incidents’ that occur in the SRS. These are defined in the SRS Regulations as ‘any event that threatens the safety of a resident or staff’.

These can range from more minor incidents right through to serious injury of a resident.

199. Different SRS keep these records in different ways. It is however a requirement to make them available to Community Visitors.

94 Department of Human Services, Disability Worker Exclusion Scheme management instruction, 29 September 2014, page 1.
95 ibid, page 3.
96 Regs 44 and 45, Supported Residential Services (Private Proprietors) Regulations 2012 (Vic).
200. The Regulations requires proprietors to notify the department of certain prescribed reportable incidents. These are:

- the unexpected death of a resident
- a serious injury of a resident
- a fire or other emergency event
- an alleged serious assault, either sexual or physical.

201. SRS proprietors must notify the department of any incidents which fall into these categories by the end of the next business day.

202. While notifying the department is mandatory, the SRS Act is silent on how this should be done. Typically, the SRS proprietor phones an Authorised Officer in the department to report an incident.

203. The Authorised Officer:

- completes a form that captures details about the incident and the proprietor’s response to it which is then filed
- records basic information about the incident.

204. Records provided by the department for prescribed reportable incidents showed only:

- the name of the SRS and the dates on which the incident occurred and was notified to the department
- the region in which the SRS is located
- the type of incident – one of the four prescribed reportable incident types.

205. In response to my draft report the department stated:

We note that in addition to the department’s SRS CRAMS database capturing the basic raw data ascribed in the dot points ... [above], the details of incidents and follow up actions by authorised officers are also stored in the database. Sufficient information is recorded in CRAMS to ensure the details can be linked to the records kept at the SRS so appropriate follow up responses occur.

206. Until April 2014, when a notification of a reportable incident was received, an Authorised Officer was required to complete a Category One incident report, in accordance with the Department of Health incident reporting instruction\(^97\).

207. In April 2014, the department reviewed this requirement and implemented a policy that reduced the role of Authorised Officers in the incident reporting process.

208. The reason for these changes is detailed in a factsheet for SRS authorised officers and Regional Directors, which states:

Given the legislative framework governing SRS proprietors, and the absence of a direct funding relationship between DH [Department of Health] and SRS proprietors, the Incident Management Governance Group and the Director, Ageing and Aged Care have agreed that SRS should be removed from the scope of the incident reporting instruction\(^98\).

209. The focus of the department’s monitoring of incidents in SRS is on the proprietor’s compliance with process rather than client wellbeing.

\(^{97}\) Department of Health, *Incident reporting instruction*, Updated May 2013.

\(^{98}\) *ibid.*
210. At interview with my officers, a manager in the department’s SRS program said that the policy change was ‘a bright ray of sunshine’, as now Authorised Officers only complete an incident report for the most serious matters that have to ‘go up’ to the Minister or the Secretary.

211. The manager also said:

> When we receive it [notification from the proprietor] we fill in … [the] document … we check that they’ve done the processes that are required and we review them from time to time.

212. In response to my draft report, the department stated:

> … the expectation of the department is that in addition to ‘routine review’ each individual incident will be interrogated and analysed as soon as the notification has been received and responded to in accordance with published guidelines. Prescribed reportable incidents are subject to interrogation and analysis by both the regional and central office staff when they occur to determine what could be done better and by whom to avoid, prevent, manage and respond to the incident …

**Serious Incidents**

213. My investigation examined the department’s policies, procedures and practice guidelines for Authorised Officers in responding to and reporting incidents – an incident involving a serious outcome such as a client death or severe trauma.

214. At interview with my officers, a manager in the department’s SRS program described the role of the Authorised Officer as taking information from the SRS, discussing it, but not to arrange supports for the person involved in the incident.

215. In response to my draft report, the department stated:

> While it is correct that Authorised Officers do not directly provide supports for the person involved in the incident, they will provide advice and guidance and undertake with their regional manager to facilitate the provision of adequate support.

The role of responding to serious incidents lies primarily with the proprietor and ongoing guidance and advice is issued regularly as well as specific training is incorporated into the LASA [Leading Age Services Australia] proprietor /staff training programme. Authorised officers have specific and regular guidance and advice about management of serious incident notification and take direction from regional directors and regional SRS managers when serious incidents occur.

216. The department’s guideline, *Responding to allegations of sexual assault in supported residential services*\(^99\) refers to a standard procedure in place for responding to allegations of sexual assault that includes the Authorised Officer contacting the facility to ensure the proprietor has undertaken appropriate actions in response to an incident. My investigation has found that there is currently no specific training provided to Authorised Officers on responding to serious incidents.

217. The guideline states that Authorised Officers will visit the SRS on two occasions including to ‘conduct a follow up visit to monitor compliance and implementation of quality improvement strategies’.

218. In practice, Authorised Officers do not always visit an SRS in response to an alleged sexual assault. At interview, a manager in the SRS program said that:

> … prior to the implementation of the [SRS] Act, AOs [Authorised Officers] would visit the SRS after an incident, view relevant documentation and spend some time working with [the proprietor]. Now it is an office-based exercise, unless it is an incredibly serious incident.

> … any sexual assault I would deal with is an incredibly serious incident, but [that] doesn’t necessarily mean we will go out [to the SRS]. Because if we feel the proprietor is making the correct responses and got everybody else involved … we probably wouldn’t go out.

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99 Department of Health and Human Services, *Responding to allegations of sexual assault in supported residential services*, October 2012.
**Incident review**

219. The department does not routinely review prescribed reportable incidents received from SRS.

220. My officers reviewed the department’s records for 134 notifications submitted by SRS proprietors from 1 July 2012 to 31 December 2014. The records do not contain a description of the incident or any detail about who was involved.

221. The review conducted by my officers identified that:

- 72 (54 per cent) of the notifications were about serious sexual assault, serious physical assault or serious injury to a resident
- 41 (31 per cent) were about the unexpected death of a resident
- 18 (14 per cent) were about a fire or other emergency (including one incident relating to a missing person).

222. Sixty-five notifications were recorded as having occurred prior to April 2014 but had no corresponding Category One incident reports written by an Authorised Officer, as was required at that time.

223. Review by my officers of 22 incident reports written by Authorised Officers prior to April 2014, revealed that 11 of the reported incidents involved people who were identified as clients of either a disability service (including the department) or a mental health service, or people living in an SRS. Incident types included rape, indecent sexual assault, death, physical assault, missing persons, and fire.

224. When asked at interview how often incident report information is reviewed, a manager in the SRS program told my officers:

> ... we don’t get that many incidents, which is one of the problems we have with reviewing.

... Ideally, it [a review of incidents] would be done at least every year but it hasn’t been [done] ... partly because we don’t have that many incidents to review.

225. The manager was also asked how effective he felt the department’s oversight of serious incidents in SRS was. He said:

> The ones we know about – quite good. We don’t know what we don’t know.

226. My officers reviewed a number of complaints received by the department, which included allegations of apparent abuse and neglect that in a funded disability service would be reported to the department as an incident and, depending on the circumstances, investigated. These complaints have been made by a diverse range of complainants including department staff, police officers, clergy and members of the public. For example:

- a health practitioner complained to the department that he witnessed an SRS staff member “screaming” at his client, a resident of the SRS, to “shut up”. On investigation, the Authorised Officer found the complaint substantiated. The proprietor agreed the behaviour was unacceptable and undertook to ensure that the staff member would “engage with residents in a respectful, supportive and courteous manner”
- a medical practitioner complained that, among other things, an injection his patient was to receive was a week overdue and that the dose listed on the (medication) record was incorrect
- a police officer complained that they had serious concerns about the ability of staff and management (of an SRS) to safely manage the residents. Another complaint, relating to the same SRS, was received from a departmental officer on behalf a client, alleging that they had been subjected to threats of violence from another resident, that they feared for their safety and the staff at the SRS staff do not intervene.
A number of complaints suggested human rights breaches were occurring, such as locking residents in their rooms, lack of privacy or the constant threat or fear of eviction. The structure of the complaint database does not adequately capture these human rights issues and therefore breaches are not readily identifiable. For example, one complainant raised concerns that a woman with dementia, who was known to “wander”, was locked in her room from evening to the following morning by a staff member, who tied a rope from her bedroom door to the hand rail outside her room. The complainant said that there were other witnesses to this.

At interview, the department’s Director, Ageing and Aged Care told my officers that the incident reporting system is now being reviewed again because of the recent establishment of the new department. When asked how well the current system ensures the safety and wellbeing of residents in SRS, she said:

Well, an incident reporting system is what it is. It’s reporting an incident that’s occurred, obviously, but it follows through the incident …

… so it’s about managing the incident … and about any follow-up action that’s required e.g. move someone. AOs [Authorised Officers] will ensure that’s occurring, support [the] proprietor if that’s what’s needed or if there’s reason to sanction the proprietor that may occur as well.

SRS enforcement and compliance

Targeted Compliance Reviews

Targeted Compliance Reviews (TCRs) are a key part of the department’s inspection activity of SRS. They are described as ‘a regulatory tool used to monitor and assess a proprietor’s compliance with the law and target specific areas of the Act or regulations”100.

The department has an annual program of TCRs, with each review covering one or more areas of the legislation. The number of TCRs an SRS is subject to each year varies depending on its level of risk. All SRS are required to undergo a minimum of two TCRs per year, medium risk SRS are required to undergo three and those classified as high risk, four.

An SRS can be subject to several inspections each year, over and above its TCRs, depending on the number of complaints received, notifications from Community Visitors and any follow-up inspections.

My officers reviewed the department’s records for inspections, complaints, notifications and actions for four SRS classified as high risk and noted the following issues:

- an SRS in the Gippsland region underwent 21 inspections in a 28 month period. Seventeen of these inspections found the proprietor non-compliant with many of the accommodation and support standards, including those relating to medication, staffing, care plans, and incident reporting. In spite of the high level of non-compliance by the SRS, no enforcement action was taken by the department against the SRS proprietor
- in the Eastern Metropolitan region, an SRS was subject to 11 inspections in an eight month period. The SRS was non-compliant in eight of the inspections. Areas of non-compliance included medication, quality of food, staffing and emergency management. No compliance actions were taken by the department in relation to this SRS

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100 Department of Health and Human Services, Guide for authorised officers conducting inspections of supported residential services, January 2013.
• forty-five inspections were carried out in a 30 month period for an SRS in the Western Metropolitan Region. Fifteen inspections found the proprietor to be non-compliant. Two inspections found that serious incidents had occurred but no incident reports were found to support the events. Other non-compliance identified during the inspections related to the actions of the manager and other staff, a hazardous environment, medication errors, staffing requirements, and incident reporting. No enforcement actions were taken by the department in relation to this SRS.

• in the Northern Metropolitan Region, 24 inspections were carried out in an SRS over a 25 month period. The SRS was identified as non-compliant in 14 of these inspections. An inspection in February 2014 identified numerous areas of non-compliance including issues with the management and administration of medication. The inspection record notes that a compliance instruction was issued at this time and six follow-up inspections were carried out to monitor the proprietor’s response to the instruction. On the sixth inspection the proprietor was found to be compliant. Just over a month later, another inspection was conducted and the proprietor was again non-compliant with medication requirements, staff rostering and environmental conditions. Another compliance instruction was issued by the department to which the proprietor of the SRS failed to respond.

233. The department has developed a TCR schedule for all SRS through until the end of 2015 and identified which areas of the legislation and regulations will be covered in each review.

234. However there is currently no date scheduled for the TCR that covers protection from abuse (Standard 3). The schedule that includes this standard is referred to as ‘Lifestyle’ with a notation that it is ‘timetabled for completion by December 2015’.

235. At interview, a DHHS manager in the SRS program was asked his views on the scheduling of ‘protection from abuse’ so late in the TCR schedule, and two and a half years after the implementation of the SRS Act. He said:

   It’s not one I’m comfortable with, and it’s certainly been the basis of several conversations. ... I guess I can speak for the authorised officers in our region, and certainly some of the authorised officers in other regions too, we are concerned about certainly the physical environment and support to residents ...

236. The Manager also said this issue has been raised with the department’s Central Office several times and its response had been:

   That they’re developing the TCRs [Targeted Compliance Reviews] basically. And that TCRs are being developed based on their priorities and they’ll get to it.

**Enforcement**

237. Section 134 (1) of the Act empowers an authorised officer to enter any premises they believe is a registered SRS for the purposes of:

   • monitoring compliance with the Act or regulations
   • investigating a possible contravention of the Act or regulations.
238. The Act provides for a range of statutory enforcement options:

- infringements\(^{101}\)
- undertakings\(^{102}\)
- compliance notices\(^{103}\)
- censure in Parliament\(^{104}\)
- suspension of admissions\(^{105}\)
- revocation of registration\(^{106}\).

239. In addition to statutory enforcement options the department has developed the following administrative options to address non-compliance:

- verbal directions to the proprietor to rectify non-compliance
- an inspection report to the proprietor containing compliance instructions requesting rectification of non-compliance within a specified timeframe\(^{107}\).

240. In my April 2015 report, *Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service*\(^{108}\), I identified concerns about the department’s delay in implementing processes to enable them to issue infringement notices. I commented on the department’s failure to issue infringement notices to the SRS proprietor for repeated non-compliance and its lack of enforcement capability:

> ... nearly three years since the commencement of the SRS Act, and over 24 years since the commencement of the Health Services Act, the department has never issued an infringement notice to an SRS proprietor, despite having the legal power to do so.

241. When asked at interview what enforcement action the department had taken since the implementation of the SRS Act, a manager in the SRS program said:

> Since the new legislation ... we have used compliance instructions ... there’s been one suspension of [SRS] admissions ...

> ... the process for infringement notices hasn’t been approved yet, so we haven’t been able to do that [issue infringements], we’ve had no prosecutions in [the region], we’ve had no undertakings or compliance notices provided in [the region].

The compliance notice and undertakings, although the documentation hasn’t been decided ... or the processes ... I feel confident that if we had one we’d probably be able to do that and similarly with prosecutions we’d be able to do it.

242. The Manager was asked why the department was using compliance instructions\(^{109}\) when there were statutory enforcement options available under the SRS Act. He said:

> The compliance notice ... requires that there have been steps put in place to draw this to your attention. That you’ve done something about it. ... I mean to have a notice put up in your SRS for all and asunder [sic] to see that you’re not complying, is some way down the track of saying that you’ve been a been a naughty person, so there has to be some sort of information to say what the problem has been beforehand.

243. The Manager also said that if infringement notices were in place he would use them and that they would be very effective. He likened the effectiveness of an infringement notice to that of a speeding fine:

> If you’re ten kilometres over the speed limit, and the police have to prosecute you every time you do that, it’s incredibly onerous on everybody involved and incredibly expensive but if they give you a speeding fine ... if you get enough speeding fines you’ll stop doing it – same thing with an infringement notice ...

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102 ibid, Sec 156.
103 ibid, Sec 160.
104 ibid, Sec 166.
105 ibid, Sec 167.
106 ibid, Sec 168.
244. With the exception of one SRS where admissions were suspended, the department has not used any of the statutory enforcement powers available to it under the Act to enforce compliance by SRS. The only other enforcement action taken by Authorised Officers has been the issuing of compliance instructions.

245. The use of enforcement powers by Authorised Officers will be examined in greater detail in the second phase of my investigation.

People with disability living in SRS

246. There is considerable overlap between clients under the Disability Act and residents of SRS. How many people are covered by both is not clear. At interview the department Assistant Director, Service Outcomes said the department should be able to provide this information, but it would be a manual exercise and that, ‘we’ll struggle to get [that] information’.

247. The following case studies illustrate the circumstances of some vulnerable people with disability living in SRS and the lack of co-ordination between the two systems.

Case study: Mr E’s story

Mr E has multiple disabilities, uses a wheelchair and requires daily assistance with his personal care needs, such as dressing and toileting. He receives support services through a disability agency. Until a few years ago Mr E lived independently in a public housing unit but, when his support needs changed, he moved into an SRS.

When Mr E spoke to my officers he was extremely distressed. He told them that, late last year, he had been physically assaulted by another resident, who punched him in the face in an unprovoked attack. This resident, and others, according to Mr E bully and harass him, and he said that the proprietor of the SRS could do nothing about it. He said that the resident who assaulted him ‘tells him off every morning and it makes him feel sad’ and that ‘[this resident] calls people morons and staff don’t do anything to him – they don’t even tell him off’.

There have been two other incidents this year, one in which Mr E hit the resident who had assaulted him. Mr E said that he didn’t mean to hit the other man, but the man was wearing his shirt and bullying him. In the other incident, a different resident told Mr E that he should go to a nursing home, which Mr E found very hurtful.

Mr E said that he does not feel safe. He said that he wants to leave as he ‘can’t take it anymore’ and that there were ‘fights, fights, fights all the time [at the SRS]’.

Enquiries with the department revealed that it had no record of the incidents involving Mr E. The department has since agreed to conduct an inspection of the SRS where Mr E is living.

Mr E has been on the DHHS Disability Support Register for three years and has lodged applications to move to other supported accommodation and to increase his ISP funding. At the time of speaking with my officers, Mr E said that he had not received an update on the status of these applications.

Mr E’s advocate recently informed my officers that the department approved Mr E’s application for increased ISP funding. This will provide him additional support with personal care and enable him to get out into the community and take part in a number of different activities.
Case study: Ms J’s story

Ms J is an older woman who has lived in the same SRS for nine years. She has intellectual disability, is unable to communicate verbally and is dependent on SRS staff for her personal care needs.

Late last year, Ms J was found semi-naked crawling out of another resident’s room. The Police had concerns about Ms J’s capacity to consent to a medical examination, so applied to the Victorian Civil and Administrative Tribunal (VCAT) for a temporary guardianship order. VCAT granted the application and the Public Advocate was appointed as guardian with specific authority in relation to health and examination issues for Ms J.

Staff of the SRS responded appropriately to the incident and supported Ms J. Police found considerable evidence of an indecent assault and charges were laid against the alleged perpetrator.

Ms J’s story demonstrates the extreme vulnerability of some people who live in SRS. She has no one in her life, other than SRS staff, to look after her interests. While the current staff at the SRS were described by the Public Advocate as very protective of her, she is dependent on their continued goodwill for her safety and wellbeing.

While Ms J is also a client of DHHS disability services, it is not clear how someone in her circumstances came to be living in an SRS, and how she has continued to do so for nine years.

During its guardianship, OPA contacted the department about Ms J’s situation. The department is currently exploring alternative accommodation options for Ms J.

248. My officers discussed Ms J’s case with the department’s Assistant Director, Service Outcomes, who expressed concern at her situation and undertook to follow-up with the relevant Deputy Secretary. She also said that:

Legislation requires us to undertake case plan reviews every three years of people that have been in receipt of disability services; so the system, the structure, would be that we should be contacting [Ms J] and … having the conversation with her or people around her, around whether a case plan review is required.

…

This does identify (that) whilst the legislation, and there is a very clear planning policy that talks about what should be done and when, this is an example where the policy is not being applied.

249. Mr E and Ms J’s stories provide useful insight into how people with varying abilities and levels of support may experience the NDIS. For example, Mr E would most likely be well-placed to take full advantage of the new approach: with the assistance of people who know him well he could meaningfully plan his supports, make considered and informed choices about purchasing them and exercise full control of his own resources.

250. The NDIS experience for Ms J, on the other hand, may be different. She lacks the capacity to make decisions for herself, is unable to communicate her wishes and has no one independent in her life to speak on her behalf. She should benefit from the freedom to choose her own supports under the NDIS, but will need considerable assistance to do this in a meaningful way.
Advocacy services

251. It is a requirement under the Disability Act that disability services should:

... be designed and administered in a manner so as to ensure that persons with a disability have access to advocacy support where necessary to enable adequate decision making about the services they receive.\(^\text{10}\)

252. According to the department, ‘the need for advocacy can be identified in a number of ways’ and ‘provided when requested by people with a disability’. The department suggests that ‘family or carers might also request advocacy support, when appropriate’\(^\text{11}\).

253. The department highlights the need to consider an advocate for a client in its Responding to Allegations of Physical and Sexual Assault guideline. The guideline requires staff to consider the client’s ‘ongoing safety’ including, with the client’s consent, whether a key support person or advocate should be engaged following a physical or sexual assault allegation.\(^\text{12}\).

254. When asked about the department’s expectation of service providers to support clients who have a lack of support or have profound disability, the department’s Assistant Director, Service Outcomes has said:

If we are talking about people that are not connected to anyone other than their service provider, that to me is an immediate trigger for independent and external support. So, whether it’s the use of an advocacy organisation or a more formal … guardianship arrangement, or even advocacy through OPA … when you’re talking about a victim who has no one other than the system in their life, it is a trigger for … independent oversight …

255. The lack of assessment into a client’s need for advocacy or support in both the department’s incident report and the Quality of Support Review process was raised with the department’s Assistant Director, Service Outcomes who agreed and said:

I think you’re right, there’s nothing there.

256. When asked about what happens to a client if self-advocacy is not realistic, the Assistant Director, Residential Services and Complex Support stated:

If we feel that the person is really isolated, and by default we are the service provider, we can’t be the advocate of the person either, there’s a conflict of interest … so we do often think about what other avenue there might be to make sure there is someone representing the person … Community Visitors is a good source. We also at times have [referred] them to VALID [Victorian Advocacy League for Individuals with Disabilities] to actually ask them to appoint an advocate for the person…We try [ways] to make sure there is a person…that can actually support the person or advocate the person…

257. When asked if this is required across the CSO sector, the Assistant Director, Residential Services and Complex Support said:

No because I think sometimes we [need to] be a bit mindful that … because [of] the disperse environment of the group home you can’t leave every decision to the staff … and I would expect that decision, or those judgment [calls] need to be made at the operational [management level] or above…because the staff might feel [it is] quite convenient to say ‘actually you don’t’ [need advocacy]…

258. There is currently limited funding for advocacy, with many advocates unable to provide advocacy services when called upon. Of the $4.8 million provided for advocacy, only $1.59 million is allocated to supporting individuals.\(^\text{13}\).

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\(^{10}\) Sec 5(3)(p), Disability Act 2006 (Vic).


\(^{12}\) Department of Health and Human Services, Responding to allegations of physical or sexual assault. Technical update, 2014, page 12.

\(^{13}\) Email correspondence from DHHS 5 June 2015.
259. In a submission to my office, an advocacy agency advised:

[The agency] was funded a small amount by the [former] DHS of $30,000 per year for two years … to provide accessible information and face to face training to residents which provided many with an opportunity to discuss abuse with advocates.

Unfortunately the funding was of a one off nature and we have not been refunded … There are 1000 shared supported accommodation homes with around 6000 residents and we were only able to visit 86 houses. In doing so 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.

260. In its submission to the Inquiry into Social Inclusion of Victorians with a DisabilityVALID stated:

Because of the limited supply of independent advocacy, individual advocacy, including VALID’s, has tended to become focused on reacting to situations of crisis or high need, and has become less available to people who need advocacy support in their day-to-day lives.

261. In anticipation of the NDIS, the Productivity Commission report Disability Care and Support states:

Advocacy plays an important role in the disability system. 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. These functions should lie outside the NDIS, reflecting the potential conflict of interest that would arise were the NDIS to fund advocacy bodies whose role was to challenge the disability system overseen by NDIS.

Leadership

262. The department has a responsibility as a leader in the sector. Concerns have been raised however, in submissions to this investigation, as to the department’s commitment to two areas of leadership and policy: prevention of abuse, and working to develop interagency guidelines.

Prevention of abuse

263. A number of submissions received by my office raised the need to strengthen abuse prevention as a critical consideration in the overall safety and wellbeing of people with disability. One submission stated the department’s current methods for responding to abuse is ‘reactive not preventative’.

264. At interview, the Public Advocate stated that:

... there is an absolute failure of leadership in the department ... to develop a preventative program.

265. Another submission received by my office said:

We are not aware of any disability service provider in Victoria that has as a part of their system of governance and management an active, measurable and accountable approach to risk prevention ... legislative intervention is warranted to require disability service providers to ensure they implement a proactive system of abuse prevention that has real, measurable and enforceable standards.


266. The department does not have a coordinated approach to the prevention of abuse. To address this gap, NDSV developed the Zero Tolerance project. In its submission\textsuperscript{116} to my investigation, NDSV stated that the project developed:

[a] ... comprehensive framework which provides a platform for the non-government sector to support broader safeguarding approaches for people with disability, and which identifies specific strategies for service providers to improve prevention, early intervention and responses to abuse, neglect and violence experienced by people with disability.

267. The framework provides an 'evidence-based curriculum' for providers to prompt improved approaches to abuse and covers the following areas:

- 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.

268. In its submission, NDSV also said that:

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.

269. At interview, when asked about the department's role in prevention, the Assistant Director, Service Outcomes said:

I think we work in partnership with NDSV ...with some of the zero tolerance work ... I think we absolutely have a role, I think we need to be more aligned and make sure that there is not duplication of effort.

**Interagency guidelines**

270. Other than the specific guidance on incidents of physical and sexual assault, the department does not have any guidelines for agencies responding to incidents of other forms of abuse. To address this gap, OPA developed the *Interagency Guideline for Addressing Violence, Neglect and Abuse* (IGUANA).

271. The development of IGUANA followed the Public Advocate's call in the 2011-12 Community Visitor annual report for the department to introduce a comprehensive abuse prevention program to 'create safer environments and to transform a culture that tolerates violence and abuse'.

272. According to OPA's website, IGUANA provides assistance to service providers in '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'\textsuperscript{117}.

273. In the *Community Visitors Annual Report 2012-13*, the Public Advocate reported on the launch of IGUANA. All three Community Visitor Boards recommended that the department endorse the guideline and encourage all funded agencies to adopt it.

274. Over 30 funded agencies and NDSV have endorsed IGUANA. However, the department has not endorsed it.

\textsuperscript{116} National Disability Services Victoria submission, 12 February 2015, page 5.

\textsuperscript{117} The Office of the Public Advocate, *The Interagency Guideline for Addressing Violence, Neglect and Abuse*, 2013.
275. At interview, when asked why the department has not adopted IGUANA, the Public Advocate said:

I’ve never had a satisfactory explanation [from the department] ... For me it’s not [about] that [IGUANA] document so much as the principle, where is the leadership in the department in issuing guidelines? It’s not my role to issue guidelines, the only reason I did it is because there is nothing from the department to assist agencies.

276. At interview the department’s Assistant Director, Service Outcomes told my officers that IGUANA presented challenges for the department because of:

... the alignment to [the department’s] own policies and procedures ... and some question ... around the government or the department supporting a document that it ... hasn’t developed itself ...

277. In response to my officers asking if the department could adopt areas of IGUANA, the Assistant Director stated that:

Most of IGUANA ... [is a] very sound document and ... [the department] support[s] [it] ... we have to work with our health colleagues ... still working through process of trying to support IGUANA.

278. Subsequent to the interview the Assistant Director, Service Outcomes provided my officers with further information stating that, while the department’s existing instructions to service providers on responding to allegations of physical or sexual assault were closely aligned with IGUANA, there are areas of incompatibility between the documents that prevent the department from fully endorsing IGUANA.

279. The department responded to my draft report by stating that:

... its existing requirements and policies provide a more comprehensive approach than the IGUANA guidelines. As a result, the department has not endorsed IGUANA in relation to disability services. In particular there are concerns that the IGUANA guidelines do not meet departmental requirements and policies regarding:

- 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 and
- existing departmental discipline procedures consistent with relevant industrial instruments.
The role of the TAC

280. The TAC is a Victorian Government owned organisation, established under the Transport Accident Act 1986, responsible for the payment of treatment and support services for people injured in transport accidents. For severely injured clients, this includes medical, rehabilitation and disability services. For example, accommodation support services, respite care, nursing and attendant care.

281. Under the Workplace Injury Rehabilitation and Compensation Act 2013, the TAC is also responsible for the management of catastrophically injured clients, who have been injured in workplace accidents on behalf of WorkSafe Victoria.

282. The TAC actively manages approximately 1,400 severely injured TAC and WorkSafe clients who are receiving funding for disability services.

283. Severely injured clients of the TAC live in a variety of settings. Depending on the level of support and care required, TAC clients may choose to live at home, in supported accommodation services such as a department-run group home, or an SRS. The TAC also has approximately nine clients receiving shared supported services funded by the TAC while living in purpose-built homes funded by the Residential Independence Pty Ltd (RIPL) project, a wholly owned subsidiary of the TAC.

284. The TAC has a role in ensuring that clients in each setting are safe and that there are systems in place for reporting and responding to any concerns.

285. For seriously injured clients managed by the TAC, the NDIS is not expected to significantly alter existing funding arrangements. The TAC will continue to be responsible for the funding of compensation, services and benefits to seriously injured transport accident and workplace injury victims.

Disability legislation not applicable to the TAC

286. Under the Disability Act 2006, the definition of ‘disability service provider’ does not extend to services and supports funded by the TAC. This means that TAC clients are not generally covered by the principles or protections of the Disability Act. For example, the Disability Act and the National Disability Insurance Scheme Act 2013 (C’th) require service provider registration standards and a process for the renewal or revocation of a service provider’s registration. The Transport Accident Act does not require these for TAC service providers.

Differences in protection

287. In a submission to my office dated 14 February 2015, a lawyer with experience in personal injury matters commented on the different legislative rights and protections which apply to TAC and WorkSafe clients compared to those under the Disability Act:

It seems unfortunate that the legislative protections and enforcement powers that are contained in the DA Act [Disability Act 2006] and, relevantly in the more recent SRS (PP) Act [Supported Residential Services (Private Proprietors) Act 2010], are not replicated in the TA [Transport Accident Act 1986] or WPIR [Workplace Injury Rehabilitation and Compensation Act 2013] Acts.
... it is possible that a cohort of compensable TAC and WSV (WorkSafe Victoria) clients ... who may be properly concerned about abuse, will be left out on a limb and disconnected from the legislative powers and protections available to disabled people funded by DHS [now DHHS] and the NDIS.

288. There are two key gaps in the current legislative framework for seriously injured clients managed by the TAC: lack of access to the DSC and lack of access to Community Visitors.

Access to the Disability Services Commissioner

289. For disability clients receiving services under the Disability Act, there is a right to make a complaint about a disability service provider to the DSC\textsuperscript{121}. However, the DSC has long held the view that it does not have jurisdiction to receive complaints from TAC and WorkSafe clients. Up until May this year, the DSC website\textsuperscript{122} listed complaints about the TAC as being outside its jurisdiction.

290. At interview on 7 April 2015, the Commissioner gave an example of a group home accommodating clients of both the department and the TAC, where only department clients in the group home have the right to make a complaint to the DSC.

291. To address this, the TAC and the DSC signed a Communication Protocol on 11 May 2015, outlining how TAC clients may access the DSC complaints resolution process in respect of disability service providers who are funded by the TAC to provide a service to TAC clients.

Access to Community Visitors

292. While Community Visitors are able to visit TAC clients residing in supported accommodation, such as a department group home or an SRS, there is no capacity for the TAC to receive reports from Community Visitors about the welfare of their clients. These reports are either provided to the department or the facility.

293. This is because the role of the Community Visitors under the Disability Act\textsuperscript{123} is to liaise with staff and management of the ‘disability service provider’ about any issues or concerns. As the TAC is not a ‘disability service provider’ under the Disability Act it is not entitled to receive Community Visitor reports or information about TAC clients.

294. At interview, the TAC Head of Claims was asked about Community Visitor reports concerning TAC clients. He said:

That’s a gap [in oversight]. That is one of the areas we have been talking to them [OPA] about that possibility [of sharing information] but haven’t made that breakthrough …

295. Community Visitors also do not have the power to visit TAC clients who receive shared supported services funded by the TAC while living in homes that are built and paid for by the RIPL project.

296. At interview, the Public Advocate was asked about Community Visitors visiting TAC clients in RIPL supported accommodation. She said:

... basically nothing is in place [for TAC clients living in RIPL accommodation] and Community Visitors have raised this over time … It makes perfect sense that all of the oversight mechanisms should be extended to TAC houses.

\textsuperscript{121} Sec 109, \
\textsuperscript{122} <odsc.vic.gov.au/issues-we-cannot-deal-with> viewed on 27 April 2015. 
\textsuperscript{123} Sec 130, Disability Act 2006 (Vic).
TAC registration of service providers

297. In the absence of service provider registration, renewal and revocation provisions in the Transport Accident Act, the TAC has developed its own service provider requirements, policies, procedures, agreements and registration model to address these matters.

298. Up until September 2014, the TAC’s funding of disability services, such as supported accommodation and attendant care, had been provided in the main by contracted service providers as part of the TAC Disability Services Agreement.

299. From 28 September 2014, the TAC has been introducing a new service provider registration model, with service providers required to meet new mandatory criteria as part of a registration process. Its aim is to have all provider registrations completed by September 2016.

300. At interview, the TAC Head of Claims commented on the change to a service provider registration model. He said:

A registration process seems to be the way that the rest of the industry is going. It gives you more flexibility.

301. As part of the TAC’s registration requirements, the TAC has set a number of conditions with which service providers must comply. The registration requirements cover a range of areas such as:

- provider conduct
- service delivery
- standard of accommodation
- incident reporting and complaints
- confidentiality and privacy
- audits and reviews.

302. To be registered, service providers must demonstrate amongst other things financial viability, experience in service provision and appropriate staffing standards.

303. In setting these requirements, the TAC has reviewed the requirements of the department and the NDIS to ensure that TAC standards are aligned with the department and the NDIS requirements.

304. In August 2014, the TAC commissioned its internal auditors, PricewaterhouseCoopers (PwC) to conduct a review of the TAC’s management of vulnerable clients. The PwC Review examined the TAC’s provider registration process amongst other things, and identified opportunities to strengthen the TAC quality assurance process. In particular, PwC found that the provider registration process could seek more specific information from providers about service quality and client safeguards, for example, the number of reported incidents per year and the average experience of staff.

305. PwC also found that once service providers are registered, the TAC has limited processes in place to monitor compliance with the registration requirements.

306. In response the TAC has agreed to:

- expand provider registration criteria and verification
- improve compliance monitoring with registration criteria
- strengthen criteria and process for deregistration of providers
- implement continuous quality assurance and improvement programs with providers.

307. My investigation identified that where the department or a department-funded organisation is providing services to TAC clients, for example supported accommodation, department standards prevail. At interview, the TAC Manager, Care Assurance stated the TAC relies on the service provider’s compliance with department standards, given their alignment with TAC standards.

Monitoring and compliance

308. The TAC is responsible for conducting any reviews, audits or investigations of its registered disability service providers.

309. The PwC Review made a recommendation to conduct regular visits to assess the quality of service provided to TAC clients including the qualifications of staff, and compliance with standards like building codes and food safety regulations. At interview, the TAC Head of Claims said:

... before the end of this calendar year those reviews [with service providers] will be up and running under this new criteria and ... those provider visits will be embedded as an ongoing requirement of the system we have.

310. While there are no specific powers under the Transport Accident Act for the TAC to revoke a service provider’s registration, the registration process allows for revocation of registration where there are identified concerns about services provided.

Effectiveness of TAC oversight

Incident reporting

311. The TAC’s Provider Registration Requirements For Provision Of Disability Services require complaint handling and dispute resolution processes. Registered providers are required to notify the TAC of a ‘serious incident’ within one business day. A ‘serious incident’ means:

- the death of or serious injury to a client
- allegations of or actual sexual or physical assault of a client
- significant damage to property
- serious injury to another person caused by a client.

312. There are some parallels between the TAC management of incidents and the way the department approaches it. Serious incidents are those which in the department’s processes would require reporting under the department’s Critical Client Incident Management Instruction. Service providers also generally use the department’s Client Incident Report Form when reporting incidents to the TAC.

313. TAC Incident reports are reviewed by the Health and Disability Strategy Group (HDSG) to determine whether any follow up action is required. For example, where concerns have been raised about the safety of a TAC client in supported accommodation this may involve the HDSG conducting its own enquiries/investigations or meeting with the service provider and ensuring that concerns are appropriately addressed.

314. My investigators reviewed incident reports involving TAC clients over the past two years. They found that overall the TAC had taken action in a timely manner to follow up any identified concerns or issues arising from the incidents with either the service provider and/or the client.

315. However, with TAC clients living in a variety of residential settings and subject to complex funding arrangements, this can sometimes lead to confusion for service providers about who should receive an incident report. In one recent case involving a TAC client in receipt of dual funding from the TAC and the department, the service provider only notified the department of the incident and not the TAC as required. The TAC identified this oversight and has since obtained a copy of the incident report.

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125 TAC Provider Registration Requirements For Provisions of Disability Services.

126 ibid.


128 A shared TAC and WorkSafe service responsible for managing the relationship with health and disability service providers.
Response to PwC Review

316. As noted above, the TAC commissioned PwC to conduct a review of the TAC’s management of vulnerable clients in 2014. At interview, the Head of TAC Claims was asked about the extent of the PwC Review. He said:

We were saying [to PwC] look at the whole spectrum ... If we [the TAC] were best practice in every area what would that look like. And then rate us against that.

317. PwC identified the following key areas where TAC processes could be improved and strengthened.

1. Client Risk Assessment
2. Provider registration & quality assurance processes
3. Information sharing with the DHS and DSC
4. Provider Management and Performance processes
5. TAC complaints processes.

318. In response, the TAC established its own taskforce to identify its most vulnerable clients and ensure their safety through welfare checks. This included a review of the TAC client risk assessment process and consideration of the criteria used for the identification of clients at potential risk.

319. The TAC considered that its Support Coordinators were best placed to conduct the welfare checks, given their role and established relationship with TAC clients. This involves visiting the most vulnerable TAC clients at their residence to assess overall level of risk and to report any safety concerns. TAC Support Coordinators are responsible for working with clients and their team of health professionals to establish an individualised ‘independence plan’ containing both short and long-term goals for each client\textsuperscript{129}.

320. The independence plan details the services and supports necessary to assist the TAC client to achieve their goals. Depending on the client and their goals, the plan is reviewed and updated every six to 12 months\textsuperscript{130}.

321. At interview, the TAC Manager, Care Assurance was asked about the welfare checks conducted on vulnerable clients by TAC Support Coordinators. She said:

It’s not just going out and identifying ... [abuse] it’s about education — what is good care, what [support and care] you can expect and what is not acceptable. And that our tolerance is zero tolerance [to abuse].

322. In response to my draft report, the TAC Chief Executive Officer also stated:

The TAC [as at 9 June 2015] has completed approximately 79 welfare checks out of 275 of its most vulnerable clients and taken action to address any identified safety concerns. The TAC anticipates undertaking welfare checks for the balance of the TAC vulnerable clients by December 2015.

TAC complaints process

323. In response to my officer’s request for information about the number of complaints received by the TAC for 2012-13 and 2013-14 involving alleged client abuse, neglect, or quality of care concerns, the TAC provided three separate registers, containing 33 complaints.

324. At interview, the TAC Head of Claims said:

We recognised that we had three separate areas of registers and complaints, at different levels, and there wasn’t a really strong coordination and governance around ... [complaints].

\textsuperscript{129} TAC, The Independence Plan – Information for providers, 2015.

\textsuperscript{130} ibid.
325. While TAC clients can also raise concerns about alleged abuse, neglect or quality direct with the TAC, the PwC Review considered that the TAC complaints process was ‘reactive’ and was failing to ‘actively encourage complaints and feedback for continuous improvement’.

326. In response to the PwC Review, the TAC committed to:

- strengthening its complaints process in order to respond rapidly to serious incidents and identify systemic problems
- developing a governance process for management of data to support continuous improvement of the framework.

327. At interview, the TAC Head of Claims said:

We [now] have one register which captures all those [matters], whether they are just an issue raised or just a potential issue, or a formal complaint that has been investigated.

328. The TAC Head of Claims also said the register is now reviewed on a weekly basis by key managers across the TAC and then escalated to him fortnightly to review the actions taken.

329. TAC staff have also received updated training about how to capture complaints and concerns. The ‘Reporting of Concerns’ training program for TAC Support Coordinators, implemented in November 2014, also seeks to ensure that TAC staff are made aware of the requirement to identify trends before serious incidents occur, and to record them in a consistent way.

330. There are still issues to address. In one submission received by my office, concerns were raised about the TAC’s website not clearly articulating the process for a person wishing to report abuse or quality of care issues to the TAC, particularly where the person requires immediate support or assistance to ensure their safety.

331. In response to my draft report, the TAC Chief Executive Officer stated:

As part of its ‘Safeguards of Clients at Risk’ project, the TAC is taking steps to design and implement effective communication channels to receive reports of abuse or quality of care issues, including updates to the TAC website, communication with clients and service providers and establishing a dedicated telephone service within the TAC to receive reports of abuse.

332. Information sharing

332. At interview, the TAC Head of Claims said that the sharing of interagency information had been a challenge in the past for the TAC due to restrictions in the legislation.

333. To address this, the TAC has been working towards establishing an information sharing protocol with the department for some time. In response to my officers’ request for information, the TAC Head of Claims in a letter dated 17 April 2015 stated:

A protocol has been drafted and has been with DHHS for the past several months for review by their legal area.

334. In response to my draft report, the TAC Chief Executive Officer also stated:

This protocol remains with the DHHS legal area in draft for review. Pursuing this agreement remains a priority for the TAC and will be pursued as part of the Safeguarding Clients at Risk project.
335. In response to my draft report, the department stated:

The department’s Legal Services Branch has no record of receiving either a draft protocol or request to review a draft protocol relating to information sharing between the department and TAC.

336. As mentioned earlier, the TAC has recently established a Communication Protocol with the DSC, including the ability to share information between these agencies.

337. In responding to my draft report, the TAC Chief Executive Officer also stated:

The Communication Protocol between the TAC and DSC provides for the TAC and DSC to meet three times per year to share information, discuss systemic issues and other matters relevant to disability service providers, as well as exchanging relevant data where not prevented by law to do so.

338. In the absence of information sharing protocols between the TAC, the department and Community Visitors, there is a risk that the TAC and the department and Community Visitors may remain unaware of each other’s intelligence regarding service providers who have been found to have acted improperly or not met required standards.
Disability Services Commissioner

The role of the DSC

339. The DSC 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.

340. The functions of the DSC are described in the Disability Act and include:

- resolving complaints
- developing programs for people in the handling of complaints
- providing education and information about complaints relating to disability services
- providing training about the prevention and resolution of complaints relating to disability services.

341. In addition, a disability service provider must report annually to the DSC about the number and type of complaints it receives and the outcome of complaints.

342. A complaint can be made to the DSC if it: arises out of the provision of services by a disability service provider, contracted service provider or funded service provider; or is that one of these service providers has acted unreasonably by not properly investigating, or not responding properly to a complaint.

343. In 2013-14, issues raised in complaints to the DSC included:

- service delivery and quality standards, including concerns relating to physical and psychological health and safety
- communication and relationships
- policies and procedures
- service access and compatibility
- workforce and staff, including inappropriate behaviour or attitudes by staff.

344. In 2013-14, the DSC reported that of the complaints received via the reporting tool, 39 per cent were staff-related issues and of that six per cent were about discrimination, abuse, neglect, intimidation, assault or bullying. The DSC advised my office that of the complaints it received directly in 2013-14, five enquiries or complaints raised allegations of sexual assault and 20 raised allegations of physical assault.

345. Parents, guardians and other family members of a person with disability are the highest source of complaints to the DSC at 48 per cent, followed by the client themselves at 29 per cent.

346. The DSC has three methods of complaint resolution: assessment, conciliation and investigation.

131 Sec 14(1), Disability Act 2006 (Vic).
132 ibid, Sec 16(a)-(q).
133 ibid, Sec 16(k).
134 ibid, Sec 16(n).
135 ibid, Sec 16(o).
136 ibid, Sec 105.
137 ibid, Sec 109.
139 ibid, page 26.
140 ibid, page 13.
141 ibid, page 21.
Table 4: DSC methods of complaint resolution

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<td>• After an assessment or unsuccessful conciliation, matters may be referred to investigation</td>
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<tr>
<td></td>
<td></td>
<td>• As little formality as possible</td>
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<td></td>
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<td>• Must decide what action to take to remedy the complaint.</td>
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</tbody>
</table>

347. During the complaints process, the Disability Act emphasises a need for informality wherever possible\(^{142}\). At interview with my office, the DSC said:

The Act emphasises the need for informality ... that expectation was informed by the view and appreciation of the then policy makers around the difference of dealing with complaints from people with a disability to dealing with complaints from just about anybody else. It was also a particular appreciation that ... people receiving a disability service would almost certainly be characterised by a life-long association or relationship with the providers ... that impacts on them differently than any other complaints function ...

348. Also central to the DSC’s complaints approach is ‘flexible assessment and complaint resolution processes which are adapted to the particular needs of people with a disability and circumstances of the complaint’\(^{143}\).

349. The DSC practice model can be seen as a form of alternative dispute resolution (ADR). ADR ‘usually describes dispute resolution where an independent person helps people in a dispute try and sort out the issues between them’\(^{144}\).

Effectiveness of the DSC

Assessment

**DSC responsibility**

350. The DSC is required to assess a complaint within 90 days\(^{145}\), unless a longer period is considered reasonable. During the assessment phase, the DSC may seek to resolve the complaint informally\(^{146}\).

351. The DSC may invite a complainant or disability service provider to discuss the complaint in person at an assessment conference, or request documents to aid in its assessment of the salient features of the complaint\(^{147}\). At the end of the preliminary assessment period, the DSC must advise the complainant whether he will consider the complaint further\(^{148}\). The DSC may then refer the matter for conciliation\(^{149}\) or investigation\(^{150}\).

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142 Secs 113(3), 116(2), 118(3)(b), and 118(8), Disability Act 2006 (Vic).
143 Victorian Disability Services Commissioner, Submission No DR820 to Productivity Commission, Disability Care and Support Inquiry, 2 May 2011, page 4.
145 Sec 113(1) and 113(4), Disability Act 2006 (Vic).
146 ibid, Sec 115(3).
147 ibid, Sec 115(2).
148 ibid, Sec 115.
149 ibid, Sec 116.
150 ibid, Sec 118.
DSC practice

352. In 2013-14, 150 complaints were closed by the DSC\(^{151}\) and 141 resolved informally\(^{152}\). The assessment phase is where the majority of complaints to the DSC are resolved. My officers reviewed 22 jurisdictional assessment files closed by the DSC in 2014 that related to concerns about the physical and psychological health and safety of clients of disability services. The review showed that the focus of the assessment process is to resolve complaints informally, quickly and effectively.

353. My investigation found that the assessment process is effective in cases involving issues such as insufficient communication, fees and charges, or access to services. This is because the nature of these complaints indicate that informal mechanisms, such as assessment or conciliation, are often a preferred method of dispute resolution.

354. This investigation identified a number of assessments where the substance of the complaint related to the department’s or provider’s handling of allegations of abuse. Some of these assessments included:

- the department’s response to an alleged sexual assault by a 14 year old living in a group home with adults
- concerns raised by a parent about the safety of their child who was allegedly sexually assaulted by a fellow resident in a group home
- an allegation that a bus driver assaulted a client and complaint about the inadequate response by the service provider.

Conciliation

DSC responsibility

355. The purpose of conciliation is to encourage the settlement of a complaint by arranging facilitated informal discussions and if possible, assisting the service provider and the complainant to reach agreement\(^{153}\).

356. The DSC’s Guideline for deciding if a complaint is suitable for conciliation\(^{154}\), states that suitability for conciliation will be reviewed in terms of the substance of the complaint and the people involved. Specifically, the guideline asks the DSC Resolution Officer to consider:

- the history of the dispute, distrust or litigation
- whether the facts of the complaint are in dispute
- whether the issues need some other process
- hostility between the parties.

357. Once an agreement has been reached – by either informal resolution between the parties during the assessment or conciliation phase – the DSC will capture the terms of the agreement and the complaint will be finalised.

358. Alternatively, a complaint can be closed if it cannot be conciliated, no further action is warranted or it is reasonable to stop dealing with the complaint\(^{155}\).

359. The DSC information sheet on investigating a complaint\(^{156}\) states that a matter will be referred to investigation if it is not suitable for conciliation at the time, or conciliation has been tried and has not worked.

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\(^{152}\) Pursuant to section 113 of the Disability Act 2006 (Vic).

\(^{153}\) Sec 116(2), Disability Act 2006 (Vic).

\(^{154}\) Victorian Disability Services Commissioner, Guideline for deciding if a complaint is suitable for conciliation under Section 116(1)(b) of the Disability Act 2006, September 2014.

\(^{155}\) Sec 117(1), Disability Act 2006 (Vic).

**DSC practice**

360. In 2013-14, three new complaints were accepted and referred to conciliation and nine conciliation files (some carried over from the previous years) were closed\(^{157}\) by the DSC.

361. My officers reviewed seven of the DSC conciliation files closed in 2014 and so far in 2015 and identified issues in relation to the suitability of matters being referred to conciliation, and the duration of conciliation. For example:

- 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.

**Investigation**

**DSC responsibility**

362. During an investigation, the DSC must decide what action should be taken to remedy the complaint\(^{158}\). At the conclusion of an investigation, the DSC must issue a Notice of Decision to the complainant and service provider\(^{159}\). A Notice of Decision allows the DSC to name a disability service provider who has unreasonably failed to take action\(^{160}\).

363. The DSC does not have any internal policies, procedures or practice guides on conducting an investigation. In response to my draft report the DSC said that it uses its external resources to guide its practice including:

- Fact sheet: Investigating a complaint

364. These documents are designed to guide service providers and do not refer explicitly to the DSC’s internal practice or statutory investigation powers.

365. The DSC relies on people bringing complaints to its office and cannot undertake an investigation on its own motion.

**DSC practice**

366. The DSC has not completed an investigation since 2010. When asked at a previous interview in May 2014 by my office about how often the DSC uses its formal powers the Commissioner said:

> Sparingly, as I have taken what I would describe as a journeymen approach, an educative approach to change the thinking of the sector ... [the legislation] is unambiguously rights based so my view was I could wander around with a stick or behave in a threatening way but would it cause sustainable change? No, not really, people will react to being hit with a stick but it won’t drive change that stays.

367. Submissions from and consultations with the disability sector for this investigation have raised questions about the DSC’s reluctance to use investigation powers. For example:

- an academic said ‘the DSC has not been as strong as it could have potentially been. He is trying to be nice to everybody’

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\(^{158}\) Sec 118(4), Disability Act 2006 (Vic).

\(^{159}\) ibid, Sec 119(1).

\(^{160}\) ibid, Sec 19(2).
• an advocate said ‘unless you show that you have got teeth you will not be respected, you will not create the culture that will bring about change ... Where they have got it wrong is that they have not investigated to the extent that they should have’

• a legal service said ‘[they] would never send clients to [the] DSC concerning allegations of abuse as nothing gets dealt with effectively’ ... ‘[The DSC] is inadequate and fails to use powers of investigation’

• an advocate said ‘we believe that the Disability Services Commissioner should be taking a stronger stand against abuse and neglect … The Office seems to focus too heavily on conciliation and mediation rather than undertaking serious investigations into misconduct, abuse and neglect’.

368. When asked at interview with my officers about his reluctance to use investigation powers, the Commissioner said:

... simple rule, if the facts of the matter were not evident to me [during the assessment stage], that would be a reason to conduct an investigation.

... if we are satisfied that we have all of the information before us, nothing will be served by conducting an investigation to establish the same knowledge.

... [being] mindful and sensitive to the cohort of people who bring issues to us, investigating has a particular menacing meaning for many folks ...

**Decline in conciliations and investigations**

369. There has been a decline in the number of conciliations and investigations completed since the DSC’s inception in 2007.

370. In response to my draft report the DSC said:

Informality is a key aspect of the legislation, not just a view of the DSC. This also links to the ADR approach and success of the office to resolve issues informally... The investigation numbers reflect a refinement of our practice and process. Conciliation and investigation is not a KPI [key performance indicator] but rather assessed on [an] individual situation. To suggest otherwise would be to suggest removal of the powers of the Commissioner to have discretion of this individual assessment.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Number of jurisdictional complaints assessed</th>
<th>Number of matters referred to conciliation</th>
<th>Number of matters referred to investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>114</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>2008-09</td>
<td>117</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2009-10</td>
<td>107</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2010-11</td>
<td>138</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>2011-12</td>
<td>121</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>2012-13</td>
<td>160</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>2013-14</td>
<td>144</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
An advocate spoke to my officers and raised concerns about the management of a complaint made to the DSC about alleged abuse and breach of human rights. This involved the failure of the DSC to use its formal powers to investigate the complaint, in light of the systemic concerns the complaint raised. The facts are set out below.

Case study: Child A’s story

Background

Child A is a 13 year old residing in accommodation designed to be transitional for young adults up to the age of 18 years (the House). Child A has significant autistic traits and a moderate level of intellectual disability.

Child A was formally matched to the House through the processes of the department’s Vacancy Management Unit (VMU). At the time the House had four adult occupants.

In meetings between the VMU and the supported accommodation provider responsible for the House, Child A’s suitability for the House was discussed. In both meetings the provider raised concerns about Child A being targeted by co-residents.

The provider confirmed with Child A’s school that he does not display protective behaviours.

Child A moved to the House with two of the four previous adult residents. In a site inspection conducted by my office, house staff advised that planning to transition the remaining two adult residents into long term adult accommodation had commenced two years ago for one resident and four years ago for the other resident.

A short period after moving into the House, Child A was involved in a number of incidents including:

- on 15 October 2014, Child A was hurt by one co-resident. Staff described in an incident report that the co-resident ‘showed intent to punch [Child A]’ and later scratched Child A across the face
- on 14 November 2014, the same co-resident ‘closed [his/her] hand into a fist and hit [Child A] in the right eye’
- on 16 November 2014, Child A displayed dangerous behaviour which escalated to the point that the provider called Police and Child A was hospitalised
- on 17 November 2014, a family member of Child A complained to the DSC about the suitability of the placement. Specifically, the family member was concerned about Child A’s safety in the house
- in December 2014, Child A was returned to the house and separated by a locked door from his co-residents.

Disability Services Commissioner

In response to the family member’s complaint to the DSC about the placement decision, the DSC undertook a preliminary assessment and determined that all available housing and resources had been considered in determining the accommodation as the most suitable option to support Child A, and closed the complaint. Part of the DSC’s consideration was that Child A was now separated from the co-residents.
372. When asked at interview about his view on the placement of children with adults in group homes, the Commissioner stated ‘there is no case for the placement of children with adults’, but that he cannot direct the department to remove a child.

373. The DSC’s assessment should have raised questions about the department’s Vacancy Management Unit practice of placing children with adults.

374. In response to my draft report the DSC said:

   The DSC did consider this issue as reflected in the assessment. Broadly, the case goes to [the] issue of complex needs and families unable to provide day-to-day caregiving. These are complex matters that involve the resource of the family, department and services. No clear, one-response solution to this in Victoria.

375. The assessment required further exploration of Child A’s original placement and this would have been inappropriate under a conciliation model due to the nature of the complaint and parties to it.

376. As Child A’s complaint raised significant concerns for my office including a potential breach of human rights\(^\text{161}\), I have notified the Secretary of the department and the Minister of my intention to conduct a separate investigation into the department’s placement of Child A.

DSC response to allegations of physical or sexual assault

377. In 2013-14, there were 12 enquiries and 13 complaints to the DSC that included allegations of assault.

378. In response to these enquiries:

   - the DSC contacted the service provider to discuss concerns and obtain information
   - the caller was anonymous and did not want to provide details
   - the caller considered making a complaint, follow-up calls were made but the caller did not progress to make a complaint
   - advice about possible further actions were provided.

379. In response to the 13 complaints lodged:

   - the DSC took action on 11 complaints, four matters were partially resolved and seven matters were resolved
   - one matter was unable to be resolved as the complaint was withdrawn
   - one matter was unable to be resolved as it was being considered by a court, board or tribunal.

Review of incident reports

DSC responsibility

380. In response to my predecessor’s report of March 2011, Assault of a Disability Services Client by Department of Human Services Staff, the DSC received a referral in July 2011 from the former Minister of Community Services to inquire into the adequacy of the Quality of Support Review process and related matters concerning staff-to-client assaults in disability services provided by the department (the Inquiry\(^\text{162}\)).

\(^{161}\) Sec 17, Charter of Human Rights and Responsibilities Act 2006 (Vic).

381. The Inquiry ‘found no compelling evidence that the quality or compliance in incident reporting was being systemically monitored’\(^{163}\). As a result the Protocol for Incident Report Reviews between: The Disability Services Commissioner and the Department of Human Services April 2014 (the Protocol) was created and implemented. The Protocol allows the DSC to monitor and review Category One incident reports relating to staff-to-client assault or unexplained injury only. It does not allow the Commissioner to review all Category One incident reports and excludes a number of areas including:

- dangerous behaviour
- sexual behaviour or sexual exploitation
- client-to-client physical or sexual assault
- death
- injury (where the cause is known).

382. There is no other independent oversight body monitoring or receiving these Category One incident reports in Victoria.

**DSC practice and experience**

383. The Protocol between DSC and the department in relation to the review of Category One incident reports (staff-to-client assault and unexplained injury) outlines the purpose of the review and the steps the DSC will take in undertaking it.

384. Since the Protocol started on 1 June 2012, the DSC has reviewed 719 incidents of staff-to-client assault and unexplained injury, and provided six Notices of Advice to the Secretary of the department on issues identified during his review\(^{164}\).

385. Notices of Advice were provided by the DSC to the department on a quarterly basis until June 2013 when the department requested six-monthly notices. Table 6 shows the number of incident reports reviewed in each reporting period.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of incidents reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July – 31 December 2014</td>
<td>169</td>
</tr>
<tr>
<td>1 January – 30 June 2014</td>
<td>142</td>
</tr>
<tr>
<td>1 July – 31 December 2013</td>
<td>115</td>
</tr>
<tr>
<td>30 April – 30 June 2013</td>
<td>73</td>
</tr>
<tr>
<td>1 November 2012 – 30 March 2013</td>
<td>121</td>
</tr>
<tr>
<td>1 June – 30 October 2012</td>
<td>99</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>719</strong></td>
</tr>
</tbody>
</table>

386. In all six reporting periods, the DSC’s Notices of Advice consistently covered these themes:

- delay in reporting of incidents
- timely and appropriate client support after the incident
- timely completion of Quality of Support Reviews
- engagement with Victoria Police
- absence of an incident type that reports general abuse.

387. In response to the DSC’s first Notice of Advice for the period 1 June 2012 to 30 October 2012, no written response was provided by the department. Instead, a meeting occurred with the DSC Deputy Commissioner to discuss the response.

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\(^{164}\) Sec 17(1)(d), Disability Act 2006 (Vic).
388. In response to the DSC’s subsequent Notices of Advice from November 2012 to December 2013, the Secretary authored brief acknowledgement letters (see Appendix 1 on page 95). These letters do not set out what action the department proposed to take in response to the DSC’s concerns. The following is an extract from a letter dated 16 September 2013, in response to the advice provided for the period 1 November 2012 to 31 March 2013, from the Secretary of the Department of Human Services:

The department is undertaking a program of work to enhance existing safeguard policies, guidelines and practice requirements when responding to incidents of violence, neglect and abuse.

389. This advice was repeated by the Secretary in letters to the DSC dated:

- 3 November 2013 in response to advice for the period April–June 2013

390. In the DSC’s Notice of Advice for the period January–June 2014, the Commissioner made specific recommendations and requested an action plan from the department to demonstrate how it was undertaking the program of work. Recommendations were made in relation to:

- delays in reporting
- timely and appropriate client support
- Quality of Support Review resources
- engagement with Victoria Police
- absence of definition/incident type for abuse.

391. At interview with my office, the Commissioner said:

Thematically we [the DSC] have been saying the same kinds of things for a while … I am a broken record on this … The department has issues around its performance as a provider and it has other issues around its performance as a funder, in the extent to which it adequately monitors the performance of all of the services that it funds and their adherence to departmental instructions and requirements …

The advice before the last I asked for [the department’s] response to be in the form of an action plan as I had become tired of receiving generalisations, … how worthy our advice was, well yeah great but what are you going to do, I wanted more verbs as distinct from adjectives … so we said give us an action plan.

392. A response and action plan was provided by the department on 3 November 2014. The action plan outlines strategies for considering the DSC’s concerns. The primary action taken by the department was to engage KPMG and the Nucleus Group to undertake independent reviews of its internal systems and policies.

393. The department’s action plan relies heavily on the KPMG review of the Critical Client Incident Response and Management approach. This review was not commissioned by the department until August 2014, nearly one year after the former Secretary wrote to the DSC to inform him of the work it was undertaking.

394. The objectives of the KPMG review were broad and systemic, with its findings and key recommendations yet to be implemented.
395. In the interim the department has not identified any practical measures that may be introduced in response to some of the DSC’s recommendations, such as delays in reporting, timely client support and the absence of an incident type that reports general abuse.

396. The department planned to implement practice changes in response to the Nucleus Group review of Quality of Support Reviews in March 2015. My office understands this is yet to occur.

Senior Practitioner’s role in reviewing incident reports

397. The Senior Practitioner is a role within the department which has a number of statutory obligations in relation to restrictive intervention and compulsory treatment[^165]. In addition, the Senior Practitioner provides advice on his areas of expertise when sought by the DSC in its review of incidents.

398. The management of restrictive intervention and compulsory treatment in Victoria is outside the scope of this investigation.

DSC engagement with the Senior Practitioner

399. An informal meeting occurs between the Senior Practitioner and the DSC once a month with the purpose of reviewing the incident reports related to staff-to-client assault and unexplained injury.

400. The DSC advised my office in a letter dated 15 April 2015 that he may also consult with the Senior Practitioner on individual matters as they arise. The letter states:

This includes requests to the OPP [Office of Professional Practice/Senior Practitioner] for confirmation of their involvement with the person subject to the incident, their knowledge of the incident, whether a Behavioural Support Plan has been reviewed and the outcome of that review and whether an incident of unauthorised restraint has been recorded on the RIDS database.

401. The DSC advised my office that the Senior Practitioner ‘has not always had sufficient resources to address as a priority the matters raised by the DSC’.

402. At interview, the Senior Practitioner was asked if he would see benefit in his office reviewing all Category One incident reports. He said:

We used to prior to the restructure … receive most Category One incident reports that were associated with restrictive intervention and compulsory treatment … The issue is in receiving those incidents it is an enormous amount of work to follow up on them, so if we did have that role, and I think it is an important role, it would need to be accompanied with resourcing.

403. The clinical perspective on incident reporting is vital to ensure the individual rights of people with complex or challenging behaviours are protected. The role of the Senior Practitioner is central to the review function and should be further funded to assist an oversight body reviewing incident reports.

[^165]: Part 3, Division 5, Disability Act 2006 (Vic).
Other DSC responsibilities

Education

404. The DSC has produced a number of accessible and practical publications which provide advice and guidance to disability services in managing complaints. These include:

- a good practice guide and self-audit checklist to assist providers in developing a positive complaints culture166
- a resource paper to guide the investigations of incidents of alleged staff-to-client assault or unexplained injuries167
- occasional papers in safeguarding people’s right to be free from abuse168 and families and service providers working together169.

405. The DSC team delivered presentations and training to 1,821 people in 2013-14 on its role and best complaint handling practice.

406. The DSC’s Capacity Development Team works with providers at the end of an individual complaints process to ensure there is an opportunity to learn from mistakes and implement organisation-wide changes.

Annual complaints reporting

407. Annual complaints reporting allows the DSC to identify:

- providers with potentially inadequate complaint handling systems
- service types with the most common complaints
- opportunities for improvement
- training and education opportunities for providers.

408. In 2013-14, 1,855 complaints were recorded from 100 per cent of service providers required to report170. Capturing this data helps to identify systemic concerns and trends, highlight areas of improvement, and build best practice complaint models in the disability sector.

409. The DSC provides an online system for service providers called the Annual Complaints Reporting (ACR) Tool.

410. My officers were given access to the ACR Tool by the DSC and reported that it allows service providers to:

- easily record complaints in one location
- view complaints data in time periods
- filter complaints data to identify themes or trends
- monitor the status of a complaint
- record compliments.

411. The ACR Tool has been implemented by New South Wales and Western Australia will commence utilising the tool on 1 July 2015.

The Office of the Public Advocate

The role of OPA

412. The Public Advocate is appointed by the Governor in Council under Schedule 3, section 1(1), Guardianship and Administration Act 1986 (Vic) to promote and protect the rights of people with disability in Victoria. OPA reports to the Victorian Parliament but sits within the Department of Justice and Regulation. The main functions of the Public Advocate are to:

- promote the provision and co-ordination of services and facilities provided by government, community and voluntary organisations for people with disability
- support the establishment of organisations involved with people with disability, relatives, guardians and friends
- arrange, co-ordinate and promote informed public awareness and understanding of the provisions of the Guardianship and Administration Act and any other legislation dealing with or affecting persons with disability.

413. The Public Advocate acts as a guardian of last resort with responsibilities including advocacy and the Community Visitors Program.

414. In fulfilling her powers and duties, the Public Advocate can:

- seek assistance in the best interests of any person with disability from any government department, institution, welfare organisation or service provider
- make representations on behalf of or act for a person with disability
- give advice to any person in respect of guardianship/administration applications
- investigate any complaint or allegation that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship.

Guardianship

415. Guardianship of people with disability is the main component of OPA’s work. Guardianship is the appointment of a person to make decisions for an adult with a disability when they are unable to do so. 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 VCAT.

416. The Advocate Guardian Program provides services across three areas:

- guardianship
- investigation
- advocacy.

417. The term Advocate/Guardian reflects the wording in the Guardianship and Administration Act which requires guardians to act as an advocate, and also OPA’s intention to maintain a focus on its advocacy for individuals with a disability.

418. In 2013-14 there were 781 new guardianship matters with carryover of 738 matters from the previous year.

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171 Schedule 3, section 1(1), Guardianship and Administration Act 1986 (Vic).
172 Sec 15 (a),(b),(c), Guardianship and Administration Act 1986 (Vic).
173 Sec 16 (e)(f)(g)(h), Guardianship and Administration Act 1986 (Vic).
174 The Public Advocate is appointed by the Victorian Civil and Administrative Tribunal under the Guardianship and Administration Act 1986 as the guardian of last resort when there is no other party either able or willing to act. In some cases the Public Advocate delegates the role to a Community Guardian.
Investigation

419. 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’\textsuperscript{175}. The Public Advocate investigates matters at the request of VCAT or in response to a complaint.

420. The Public Advocate has the power\textsuperscript{176} to enter and inspect some premises. At present, this power is limited to inspection of premises where services are provided under the Disability Act, the Health Services Act 1988 and the Mental Health Act 2014.

Advocacy

421. OPA provides advocacy that focuses on the best interests of a person with disability. The advocacy services provided by OPA have developed from its understanding of the Guardianship and Administration Act. These services can be distinguished from other forms of advocacy in that the principles which underlie it are contained within the Act\textsuperscript{177}.

422. In providing advocacy services, OPA gives priority to matters involving allegations of abuse, exploitation, neglect, at risk behaviour or significant conflict. In addition, where resources permit, OPA provides advocacy to people who have no other advocacy options, such as family, friends or local advocacy networks. In this regard, OPA sees its role is to advocate when all other advocacy options have failed. While advocacy may occur in guardianship matters, OPA also undertakes individual advocacy for other people with disability. This may follow a referral from VCAT, a request from an individual or support service, or an approach from another source, such as OPA’s Community Visitors Program.

Effectiveness of OPA

Guardianship and investigation

423. In 2013–14, OPA conducted 362 investigations at the request of VCAT of which 56 per cent related to people aged 65 and over.

424. 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.

425. At interview, the Public Advocate said:

> We had a case where Community Visitors were really concerned about an elderly resident in a country SRS. … she was a person with limited communication and I was so concerned about her that I got an Advocate/Guardian to do an investigation of her circumstances and determine whether guardianship was warranted … it would only be where a person in the community may be vulnerable and a lack of capacity was clear [that OPA can investigate]. But if a member of the community was vulnerable and there was no evidence of a lack of capacity… I couldn’t [investigate].

426. The Victorian Law Reform Commission’s review and report in 2012 on the desirability of changes to the Guardianship and Administration Act, made a series of recommendations to support the Public Advocate in exercising her existing functions and also proposed broader investigative powers to advance the interests of people with disability. However, the subsequent Guardianship and Administration Bill 2014 has since lapsed.

\textsuperscript{175} Sec 16(1)(h), Guardianship and Administration Act 1986 (Vic).
\textsuperscript{176} Sec 18A, Guardianship and Administration Act 1986 (Vic).
\textsuperscript{177} Sec 16 (e) (f) (h), Guardianship and Administration Act 1986 (Vic).
427. The Public Advocate is still seeking a review of the Guardianship and Administration Act and an increase in her powers aligned to the expertise of the office and the recommendations of the Law Reform Commission. At interview, the Public Advocate said:

It’s really the capacity to go in and make some assessment of vulnerable people and then get the right body to either do the investigation or perhaps a more limited investigation myself in order to make people safe.

428. That an investigation cannot be undertaken unless it is related to a guardianship concern represents a missed opportunity to maximise the contribution of a statutory officer who is well positioned and equipped to identify and respond to suspected mistreatment.

Individual advocacy

429. In 2013-14, OPA undertook 156 new advocacy cases as part of the Advocate Guardian program. 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. Advocacy matters arising from the Disability Act remain unchanged but VCAT liaison advocacy has decreased. Formal individual advocacy for clients is broken down into categories in table 7.

Table 7: Advocacy cases 2013-14

<table>
<thead>
<tr>
<th>Category</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carried over from previous year 12-13</td>
<td>105</td>
</tr>
<tr>
<td>Advocate Guardian Program (new matters)</td>
<td>156</td>
</tr>
<tr>
<td>Disability Act Officer (new matters)</td>
<td>70</td>
</tr>
<tr>
<td>VCAT Liaison Advocacy (new matters)</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>365</strong></td>
</tr>
</tbody>
</table>

430. As Table 8 shows, people with an intellectual disability are by far the largest disability group type receiving advocacy services. This figure is higher this year due to the inclusion of NDIS participants where intellectual disability is the predominant group. There are also a substantial number of matters where the nature and extent of disability is not clear.

Table 8: Advocacy client types 2013-14

<table>
<thead>
<tr>
<th>Disability Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual disability</td>
<td>46.9%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>20%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>12%</td>
</tr>
<tr>
<td>Physical</td>
<td>7.4%</td>
</tr>
<tr>
<td>Acquired Brain Injury</td>
<td>7.4%</td>
</tr>
<tr>
<td>Dementia</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

431. Advocacy services can be provided in cases where the stricter provisions of guardianship and investigation might otherwise rule out assistance.

432. As a senior OPA Officer recently advised my officers:

I don’t believe the NDIS process can work unless you have substantial advocacy input ... [there is] no suggestion of bucket loads of funding to keep going – its problematic – we have to work out what we can refer to local advocates – we have to turn down stuff.

... the Public Advocate has a slight advantage to get information. We can’t walk in, but we can knock on the door and ask to be let in. Most of the NGO [Non-government organisations] advocacy groups work on invitation. If there’s no-one to invite them there are problems as to how they get involved. In an ideal world we’d have greater capacity to do good advocacy and we would pick up the cases of higher level abuse and neglect. Last year OPA had 1400 new cases and about 150 were advocacy – we would like to be doing twice that number.


OPA and the NDIS trial – Barwon region

433. The early indications from OPA's involvement in the NDIS trial in the Barwon region are that demand for its advocacy services is increasing. In this trial OPA has supported residents who had no family available to assume responsibility for the process.

434. The Public Advocate has been appointed as guardian to five people participating in the NDIS, and therefore has formal involvement in their NDIS matters.

435. The Advocate Guardian Program provided advocacy for 28 people in shared supported accommodation who became participants in the NDIS between April and May 2014. This arrangement only applied to people living in the department’s accommodation, although an equivalent or greater number of people live in non-government accommodation funded by the department.

436. OPA received an additional 28 referrals for advocacy for people living at Colanda, the only residential institution in the Barwon area, as they transitioned to the NDIS between July and September 2014. All residents required high level care and most were unable to communicate.

437. An Advocate Guardian explained this process to my officers:

While residents might be able to agree or disagree or express thoughts about things ... the people in Colanda are non-verbal and cannot speak, so at that point you need someone to advocate ...

438. My officers reviewed a selection of the assessments and plans OPA was involved with in the Barwon trial to consider the effectiveness of advocacy and guardianship services within the NDIS process.

439. The assessments Advocate Guardians completed with Colanda participants and NDIA planners show that the overall experience was positive and resulted in consistent plans. However, they also show that Advocate Guardians believed it necessary to incorporate the position of 'coordinator' as a funded support into the plan, to ensure client supports were implemented, providers engaged, clients were assisted with decision-making and a mechanism was in place to explore long-term accommodation options.

440. The NDIS is currently trialling a variety of models to determine best practice in advocacy including the role of Support Coordinators. In cases where planners identify participants who require intensive assistance to implement their plan, the NDIS funds support coordination for the person and incorporates that function into the plan.

441. The following case study illustrates the importance of this.

**Case study**

Mr S is an older man with a recently diagnosed intellectual disability. Up until the death of his parents, he had no involvement with the disability community and received no supports. There were concerns about whether Mr S could manage to live at home by himself. He used his personal funds to purchase the supports he could afford, but was unable to maintain his personal care or the upkeep of his home. In 2013 Mr S refused help and supports from the NDIA. As a result, remaining family made an application for the appointment of a guardian, as they did not believe that he could continue to live independently.
VCAT made an order granting OPA guardianship with powers to make decisions concerning: accommodation; health care, and access to services; including Mr S’s application to the NDIS and assistance to develop his plan.

Mr S’s plan included daily, recreational and psychological supports, and a support co-ordinator to ensure services were in place and reviewed. The intervention of the guardian was necessary to authorise the supports in light of resistance from Mr S. Once the supports were in place, Mr S could see the benefit of the support coordinator who worked hard to assist him implement his plan according to his wishes.

442. An OPA Advocate Guardian informed my officers that:

... without the support of the NDIS and service coordinator Mr S would not have been able to reside successfully in the community ... and would have required residential placement180.

180 Investigation information from OPA Advocate Guardian Program, 6 May 2015.
Community Visitors

The role of Community Visitors

443. Community Visitors are volunteers appointed by the Governor in Council to visit accommodation facilities operating under the Disability Act\(^{181}\), the SRS Act and Mental Health Act. They can inquire into various matters relating to service delivery, including whether the rights of people with disability are being upheld.

444. Community Visitors can visit:

- disability services – department-provided and community-based facilities DAS and CSOs
- SRS
- mental health facilities providing 24-hour care\(^{182}\).

445. The role of Community Visitors is to observe, listen, question and monitor. They are empowered by law\(^{183}\) to visit accommodation facilities at any time, unannounced, for the purpose of ‘minimis[ing] abuse and neglect in services and mak[ing] communities more inclusive, by visiting residential care and treatment institutions’\(^{184}\). They can speak with residents, identify concerns about the care being provided and liaise with staff and management to resolve these matters\(^{185}\).

446. OPA funds and provides board, program and administrative support to Community Visitors. The Community Visitors program is made up of both volunteers and paid staff:

- the Community Visitors Board (Disability) comprising the Public Advocate and two elected Community Visitors, with the ability to report matters to OPA or the responsible Minister. The Board also has powers to refer matters to any other person including the Secretary, the DSC, the Senior Practitioner or the Ombudsman
- the Community Visitor Program Coordinator – an OPA employee responsible for coordinating and supporting the work of Community Visitors and Regional Convenors in regions of Victoria
- 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.

447. This investigation is primarily concerned with the role of Community Visitors in visiting disability and residential services under the Disability Act and the SRS Act. My October 2014 report, *Investigation following concerns raised by Community Visitors about a mental health facility*\(^{186}\), examined the role of Community Visitors in relation to mental health facilities.

448. The number of Community Visitors has grown significantly since its inception in 1987. There are currently 443 Community Visitors conducting 5,079 visits throughout Victoria\(^{187}\).

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181 Sec 28(1), Disability Act 2006 (Vic).
182 Services operating under the Disability Act 2006, the Supported Residential Services (Private Proprietors) Act 2010 and the Mental Health Act 2014.
183 Sec 129 (1), Disability Act 2006 (Vic); Section 186(1), Supported Residential Services (Private Proprietors) Act 2010 (Vic); Section 218, Mental Health Act 2014 (Vic).
185 Sec 130, Disability Act 2006 (Vic).
186 Victorian Ombudsman, Investigation following concerns raised by Community Visitors about a mental health facility, October 2014.
Visits
449. The Disability Act specifies that each residential institution (Sandhurst and Colanda) must be visited at least monthly by a Community Visitor. The Act does not include any minimum requirements for other residential services, however the Public Advocate and the department have agreed on a minimum of two visits each year. Community Visitors aim to exceed this and endeavour to make four visits per year.
450. Community Visitors are not always able to achieve four visits a year, due primarily to shortages of volunteers in some areas, but also for budgetary reasons: a request has been made by OPA that Community Visitors consider reducing visits to facilities they consider do not require four visits a year.
451. Any resident of a service managed by a disability service provider, or any person on their behalf, can ask the service provider to arrange for a Community Visitor to see them. The Disability Act requires the service provider to forward the request to the Community Visitors Board within 72 hours of receiving it. The Board must respond within seven days of receiving the request.
452. Community Visitors have no authority to visit day programs, or group homes funded by the TAC.

Records of Visit
453. Visits by Community Visitors are captured in the Records of Visit which incorporates the Community Visitors functions and inspection powers. These entitle them to:
- inspect any part of the premises
- see any resident
- make enquiries about the provision of services to the residents
- inspect any document related to any resident which is not a medical record
- inspect any medical record relating to a resident with the consent of the resident or resident’s guardian.
454. The Regional Convenor is responsible for receiving all Records of Visit from Community Visitors in their region. Their role is to ensure that all issues raised and responses from providers are documented, and that progress in resolving each issue is monitored and reported to the Community Visitors Board at least twice a year.
455. A Regional Convenor can also notify the Public Advocate of serious and significant issues at any time.

My investigation
456. My officers reviewed a random sample of Records of Visit for 2013-14 to assess whether the comments recorded by Community Visitors reflect their statutory functions.

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188 Sec 129(2), Disability Act 2006 (Vic).
189 Community Visitors protocol between the Office of the Public Advocate, Community Visitors (Disability Services) Program, the Department of Human Services and National Disability Services Victoria.
190 The legislation establishes three respective boards chaired by the Public Advocate: Disability Services, Residential Services and Mental Health. These boards are responsible for representing Community Visitors, training, preparing publications about the role and writing an annual report to Parliament with recommendations for sector improvement.
191 Sec 191, Disability Act 2006 (Vic).
192 Sec 30, Disability Act 2006 (Vic).
193 ibid, Sec 130.
194 ibid, Sec 34.
Below are examples of notes from Records of Visit to illustrate the range of settings and circumstances Community Visitors attend and observe:

1. Problems continue and are escalating at this house; police recently called when the resident attempted to strangle a female staff member; the resident has attempted to kick and strangle another resident and when a staff member intervened, the staff member was assaulted; there is a BSP [Behaviour Support Plan] to follow and PRN\textsuperscript{195} medication for the resident; the atmosphere in the house is radically changed – it is no longer happy; pictures removed from walls; the CVs [Community Visitors] spoke to residents; the sectioned off part of the house is bare and unhomely there is an unfortunate mix of permanent residents; stability is needed\textsuperscript{196}.

2. CVs [Community Visitors] made to feel welcome by staff and residents; house is old and non-purpose built but is tidy, clean and homely; residents’ rooms are personalised and decorated; residents’ placements and activities are noted. Not enough staff, faulty equipment – out of order or broken, house supervisor missing, lack of continuity of staff for clients who are very high needs\textsuperscript{197}.

The Records of Visit reviewed by my officers were generally consistent with the Community Visitors statutory functions, indicative of careful observations, and compliant with Community Visitor Scheme requirements. 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.

Records of Visit made in response to calls to OPA’s Telephone Advice Line\textsuperscript{198} reflected the Community Visitor function to inquire into any case of suspected abuse or neglect of a resident or any complaint made to a Community Visitor by a resident\textsuperscript{199}.

The Records of Visit show a dual purpose: individually they provide a snapshot of conditions at a specific moment in time; and taken as a series, they track and monitor the quarterly changes to residents and residential settings.

**Protocol for addressing issues**

Issues identified during a visit are addressed in accordance with the protocol in place between Community Visitors, the department and NDSV\textsuperscript{200}. The protocol requires that an attempt must be made to address issues at the most local level in the first instance. If Community Visitors are not satisfied with the response they receive from staff on duty at the time of their visit, they can request a written response to their enquiries.

\textsuperscript{195} PRN: As required medication.
\textsuperscript{196} Community Visitor Record of Visit, 28 August 2013.
\textsuperscript{197} Community Visitor Record of Visit, 15 December 2014.
\textsuperscript{198} OPA runs the Telephone Advice Line; it is a key source of complaints and enquiries from the public to OPA and Community Visitors.
\textsuperscript{199} Sec 30, Disability Act 2006 (Vic).
462. According to the protocol, the report completed by Community Visitors is left at the facility and must be stored on the premises. It is the responsibility of the organisation’s nominated service manager to provide a written response within 21 days. Notifications to the Public Advocate

Notifications to the Public Advocate

463. Following an increase in abuse and violence reported by Community Visitors in the 2009-10 financial year, the Public Advocate required program areas within OPA to notify her of all matters concerning sexual assault or serious abuse and unexplained injury.

464. Under a protocol agreed with the department, the Public Advocate assesses the matter notified to her, and in most instances refers it directly to the department’s relevant operational divisional Deputy Secretary for immediate attention. The first response from the department must be an assurance of the immediate safety of the resident concerned.

465. My officers reviewed 22 notifications made to the Public Advocate of serious or significant issues between 1 July 2013 and 31 December 2014, covering a range of matters including: assault, unexplained injuries, inadequate behaviour support, and poor standards of care.

466. The three main categories of notifications were:

- violence – resident to resident (36 per cent)
- violence – staff to resident (21 per cent)
- unexplained/unintentional injury (10 per cent).

Escalating serious concerns

467. The following documents guide the escalation process of serious and significant matters arising from Community Visitor reports:

- the Protocol: this describes the agreed process Community Visitors follow to escalate matters when they have not had a satisfactory response to their enquiries. They do this through direct contact with senior managers in an organisation, and with the support of Community Visitors Program staff
- Disability Services Board, Guidelines for escalating serious and significant issues: this describes the interrelated roles and responsibilities of Community Visitors, Regional Convenors and Community Visitor Program Coordinators to develop an escalation strategy
- OPA Community Visitor Program: Notification of Serious and Significant Matters Policy: this ensures that Community Visitor Program Coordinators inform the Public Advocate about serious and significant issues. These are issues that place the physical or mental health or well-being of a resident at risk, and include:
  - an allegation of physical or sexual assault
  - an allegation of abuse and neglect
  - harm by omission of duty of care
  - unlawful behaviour by a service provider, its staff or subcontractors.

201 For department-run supported accommodation facilities, the nominated service manager is the Operations Manager, although the department’s Disability Accommodation Service Manager is ultimately accountable.

202 OPA submission to the Victorian Ombudsman, 18 February 2015.

203 Appendix 3: Community Visitors protocol: Escalation flowchart.

204 Disability Services Board, Guidelines for escalating serious and significant issues.
Effectiveness of Community Visitors

Volunteer role and independence
468. The benefits of having an independent volunteer Community Visitor Program are promoted on the OPA website205:

You can feel free to talk to Community Visitors. They are volunteers. They don’t work for the government or the mental health unit or residential facility.

469. At interview, the Public Advocate reinforced this view:

I believe there is a higher level of credibility in the Victorian Community Visitors program on the basis that they are volunteers. They are not paid to do this work; they are doing it because of their generous spirit.

... You can put all the policies and procedures in place ... but if you don’t have an independent person going in and looking at it, how will you know. It’s about bringing the world into that environment.

Use of powers
470. The protocol and guideline for Community Visitors includes principles that underpin the escalation process and state ‘that every effort should be made to resolve the issue at the local level and in a timely way’.

471. My officers’ review of OPA notification files found that Community Visitors frequently exceed their obligation to resolve issues at a local level and continue to attempt resolution when matters ought to be escalated.

472. The following case study highlights the difficulties Community Visitors face when raising serious concerns with service providers and the department. It also provides an example of a situation that would have been more effectively addressed had Community Visitors exercised their powers of referral under section 33 of the Disability Act.

Case study
Mr D is a young man who lives in a group home; he has intellectual disability and mental ill health. Mr D’s co-residents are all much older than he is and have more profound disabilities.

Over a 12-month period Community Visitors reported serious concerns about the safety and well-being of the people living in the group home due to Mr D’s escalating violent behaviour.

In December 2014, in an email to the department, the Community Visitor Program Coordinator, detailed allegations that Mr D had repeatedly assaulted residents and staff, made threats to kill other residents, had been found to have concealed a weapon in his bedroom and had lit fires in the house. The Community Visitor Coordinator told the department that the other residents were remaining in their rooms, and eating and urinating there, rather than risk coming into contact with Mr D.

Community Visitors repeatedly attempted to address their concerns with both the management of the CSO that runs the group home and with the department.

Between January 2014 and January 2015, Community Visitors made seven visits to the house and submitted two notifications to the Public Advocate. They had numerous meetings with the department, and both the Public Advocate and the Community Visitor Program Coordinator corresponded with the department on their behalf.

(See Appendix 2 on page 99 for a timeline of the Community Visitors’ escalation process.)

Community Visitors stated that despite repeatedly raising their concerns and receiving commitments from the service provider and the department to address the issues, the level of aggression and violence escalated and Mr D remains in the house.

473. The Public Advocate commented on the systemic implications of this case:

The department has many houses where it has the wrong configuration of residents. They don't often have the ability to move people so people are stuck. So in that situation, circumstances are tolerated that you and I would not tolerate. And Community Visitors see, and say this is not acceptable.

The system is incredibly tight. Issue is that there are no options... The department clearly took a long time to act, and in the interim the residents deteriorated and the house deteriorated... into an incident with violence...

474. Community Visitors have consistently expressed their frustration with delayed or poor responses received from service providers and the department in their annual reports. However, Community Visitors continue to participate in protracted exchanges prescribed by the protocol that often fail to deliver the outcomes they seek.

475. A board member told my officers:

There is a clear escalation process, however there is a reluctance to use it - it's not understood - it's about Community Visitors being confident enough to work through the process.

476. While it is understandable that Community Visitors take ownership of these issues and aim to hold the service provider or department accountable, it is imperative that urgent issues are escalated quickly and decisions made about which options will provide the optimum result.

477. As well as the need for Community Visitors to escalate matters earlier, there is also a need to review the processes in place to escalate matters. The issues escalation flowchart (see Appendix 3 on page 101) that depicts the protocol between Community Visitors and the department is intended to simplify the escalation process, but its many tiers appear to delay and hinder resolution.

478. Finally, the Community Visitor Board should make more use of its statutory powers. The Disability Act permits the Community Visitors Board to refer matters to ‘any other person’, for example the Secretary of the department, the DSC, the Senior Practitioner or the Ombudsman. This provides an option to refer a matter which Community Visitors cannot resolve in a timely manner to a relevant authority that has the powers to deal with it.

479. My investigation identified that the Community Visitor Board has only referred three matters in five years, all of which were referred to my office:

- April 2010 – a complaint about the treatment of a disability services client which resulted in the Ombudsman’s report, Assault of a Disability Services Client by Department of Human Services Staff, March 2011
- December 2010 – enquiries into the deficient standard of overnight care at a disability services residential unit
- February 2011 – enquiries into concerns regarding the treatment of clients and staff residing in a community residential unit.

480. Each of these complaints was resolved and resulted in action being taken by the department to address the concerns.

481. The Community Visitors Board is not fully exercising existing powers to escalate appropriate matters.

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207 Sec 33, Disability Act 2006 (Vic).
Funding

482. In 2013-14, the Community Visitors scheme cost $1,614,115 to run, more than double the funds provided by the department.

483. At interview the Public Advocate indicated that this demand on resources is causing strain:

I am on record as saying ‘why have I got waiting-lists for statutory guardians? Because I fund the shortfall as it is for CVP [Community Visitors Program] out of OPA funding’.

484. The Public Advocate highlighted a disadvantage of Community Visitors being volunteers:

... is that people think it’s free ... we have to recruit and train and retain staff. That’s a huge cost. We’ve got approximately 400 volunteers and people don’t factor that in - they say; they’re only doing four visits – why the cost? But you have to invest in volunteers.

485. Rising costs associated with running Community Visitors and fewer people volunteering makes it increasingly difficult to meet the demand to visit all the residential settings at a minimum frequency. This is consistent with the findings of the Productivity Commission’s Report\(^{208}\) which pointed to the rising costs of using volunteers.

486. However, OPA does not believe the Community Visitor program could function without the contribution of volunteer Community Visitors. In correspondence to the Treasurer dated 23 December 2013, the Community Visitors Combined Board stated:

Our conservative calculation of the value of the Community Visitors’ contribution to the Victorian community is $3.6M 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.

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\(^{208}\)Productivity Commission, Contribution of the Not for Profit Sector, February 2010.
Conclusions: The key issues

487. The preceding chapters describe the current statutory oversight arrangements with a role in disability abuse reporting and investigation, both in principle and practice, and the key issues to be addressed – in particular where there is a gap between the principle and the practice.

488. There are a number of cross-cutting themes that highlight both links and gaps between the different bodies, as set out below.

Lack of mandatory reporting

489. In conducting this investigation, I sought to obtain a clear picture of the scale of abuse in the disability sector in Victoria. However, there is no single source of information or common framework for the reporting of abuse in the disability sector. Instead, my officers obtained a range of data, in a number of different formats, from a number of different bodies, such as the department, the DSC, and Community Visitors. This data includes “reportable incidents” within departmental facilities and funded providers, “prescribed incidents” in SRS, “serious incidents” to the TAC, complaints to the DSC, and notifications by Community Visitors to the Public Advocate.

490. It is not surprising that there is no single source of data about reported abuse in the disability sector in Victoria. However, there is no single source of information or common framework for the reporting of abuse in the disability sector. Instead, my officers obtained a range of data, in a number of different formats, from a number of different bodies, such as the department, the DSC, and Community Visitors. This data includes “reportable incidents” within departmental facilities and funded providers, “prescribed incidents” in SRS, “serious incidents” to the TAC, complaints to the DSC, and notifications by Community Visitors to the Public Advocate.

491. If it is not possible to say with any certainty what the scope of the problem is, it is difficult to address systemic issues to prevent abuse. To quote a departmental staff member:

We don’t know what we don’t know.

Comparative models

492. By way of comparison, my investigation considered the processes of other bodies involved in the independent review of incident reports. New South Wales is the only state with a legislated system of independent review of incidents. Set out below is information regarding the NSW Disability Reportable Incidents scheme.

**NSW experience**

On 3 December 2014, the Ombudsman Act 1974 (NSW) was amended by the Disability Inclusion Act 2014 (NSW) to include a system for reporting and oversight of the handling of serious incidents – including abuse and neglect – involving people with disability in supported group accommodation.

In its submission to the current Senate Inquiry into violence, abuse and neglect against people with disability, the NSW Ombudsman referred to the situation which existed prior to mandatory reporting being introduced:

- there were inconsistent reporting requirements across the sector ...
- there was no independent oversight of these matters (outside of complaints to our office)
- there was no comprehensive picture of the extent of abuse, neglect and/or exploitation of people with a disability in disability services, and
• there was a paucity of guidance for disability services in relation to responding to serious incidents, particularly client-to-client assaults and decisions relating to reporting to Police\textsuperscript{209}.

**Ombudsman’s role**

The Ombudsman’s role in relation to reportable incidents is articulated in Part 3C of the NSW Ombudsman Act:

• the Ombudsman must be notified of all reportable incidents
• any investigations conducted by the Department\textsuperscript{210} or a funded agency of a reportable incident may be monitored by the Ombudsman
• the Department or funded agency must provide the Ombudsman with a copy of any investigation report relating to a reportable incident once complete
• the Ombudsman may conduct his own investigation into a reportable incident
• the Ombudsman may conduct his own investigation into any inappropriate handling of or response to the reportable incident, on his own motion or in response to a complaint
• the Ombudsman is to keep under scrutiny the systems of the Department and funded providers for preventing, and for handling and responding to, reportable incidents
• any law that restricts the provision or disclosure of any information does not operate in respect to an Ombudsman investigation under this Part.

**Definition of reportable incident**

A reportable incident is defined by section 25P of the NSW Ombudsman Act to mean:

• an incident involving any of the following in connection with an employee of the Department or a funded provider and a person with disability living in supported group accommodation:
  • any sexual offence
  • sexual misconduct
  • assault
  • offence under Part 4AA of the *Crimes Act 1900* (NSW), i.e. fraud
  • ill-treatment or neglect
• assault of a person with disability in supported group accommodation by another person with disability living in the same accommodation that:
  • is a sexual offence
  • causes serious injury
  • involves the use of a weapon, or
  • is part of a pattern of abuse
• an incident occurring in supported group accommodation and involving a contravention of an apprehended violence order made for the protection of a person with disability, or
• unexplained serious injury to a person with disability living in supported group accommodation.

\textsuperscript{209} New South Wales Ombudsman, Submission No 29 to Senate Standing Committee on Community Affairs, Senate 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, 27 April 2015, pages 2–3.

\textsuperscript{210} Department of Family and Community Services, New South Wales.
Emerging issues

Although the reportable incidents scheme has been in place less than a year, the NSW Ombudsman has already identified key areas that warrant consideration by the sector:

- pre-placement planning and decisions
- post-placement management
- response to serious incidents including:
  - recognition and rapid response
  - reporting and communication
  - process and practice
  - critical legal issues
  - review of existing guidance and practice.

493. Where children are suspected of being victims of abuse, there is a statutory obligation on service providers to report that abuse to particular authorities. When introducing Victoria’s mandatory report provisions in August 1992, then Minister for Community Services, the Hon. Kaye Setches said in her second reading speech:

The purpose of the proposed amendment is to uncover hidden but serious abuse and to underline the criminal nature of sexual abuse and severe physical abuse.

494. In NSW this statutory obligation is multifaceted, as the NSW Ombudsman also operates a scheme for overseeing the handling of allegations of a child protection nature against employees of government and certain non-government agencies. Placing the reporting of abuse in disability and child protection schemes in a single agency assists in ensuring a comprehensive response to allegations of abuse of vulnerable people. In particular it provides the critical mass of investigative work required to develop the capabilities to investigate allegations of serious misconduct.

495. The 2013 Report on an Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations by the Family and Community Development Committee recommended that Victoria adopt the model operated by the NSW Ombudsman.

496. There is no similar obligation where people with disability are suspected of being victims of abuse but do not have the capacity to make an informed decision about whether or not to report it.

497. A number of submissions to my office highlighted the need for the mandatory reporting of incidents in Victoria:

Submission 1

… That the protection of people with disabilities be engaged by

- inserting relevant clauses into the Disability Act 2006 requiring mandatory reporting of any abuse or neglect or violence perpetrated on a person with a disability, or any abuse, neglect or violence that may be suspected as having been perpetrated on a person with a disability
- that these clauses reflect the same requirements as the mandatory reporting associated with children ...

Submission 2

There should be a requirement on all residential support staff in both DHS [DHHS] and non-government residential settings for mandatory reporting of abuse and assault to police, in much the same way as the process for Child Protection.
498. A requirement for mandatory reporting of all complaints, allegations or incidents which could indicate abuse of a person with disability would address:

- inconsistent reporting systems and treatment of abuse allegations between the department’s disability program and supported residential services, the DSC and the TAC
- the inability of the system to capture statistics around the extent of abuse experienced by people with disability in Victoria.

499. Any requirement for mandatory reporting in relation to people with disability needs to take into account the capacity of each person to make decisions about whether any further action should be taken.

500. It is also clear that many people with disability do not report abuse at all. During the investigation, my officers spoke with many individuals, including clients, families, carers and workers, as well as groups involved in the disability sector. We were told that many people with disability will simply not report abuse as they fear that they will either not be believed, nothing will happen if they do report it, or that they will suffer repercussions if they report it.

501. Some people with disability either do not have the capacity to tell someone, for example if they are non-verbal, or they have no trusted family, friends, or advocate to tell. The available statistics on reported abuse are therefore almost certainly an underestimation of the extent of abuse being committed against people with disability. This issue will be explored in more detail in Phase 2 of the investigation.

Complex oversight arrangements

502. My investigation identified that the existing oversight arrangements for dealing with incidents of abuse in the disability sector are complex, fragmented and confusing. It is extremely difficult for anyone to understand which body, if any, is ultimately responsible for the oversight of incidents in the disability sector, including that lessons are learned and reforms are implemented to prevent further abuse. (See Figure 1 on page 19.)

503. The effect of this patchwork nature of oversight is that, no one body has specific responsibility for receiving abuse allegations/incident reports or for reviewing incidents, reporting on deficiencies and addressing systemic issues to prevent abuse in the disability sector.

504. There is also an inherent tension in the many roles of the department, in particular as both provider and regulator of services. For example, if enforcement action in the SRS sector reduces the number of available places, this puts pressure on the department as a provider of last resort.

Gaps in oversight of incidents

505. Independent review of all serious incident reports is critical to ensuring that the department and funded agencies are meeting their obligations under the Charter of Human Rights and Responsibilities Act 2006, which requires that people with disability are protected from torture and cruel, inhuman or degrading treatment.
506. The DSC and OPA are the only bodies that have a specific role in the oversight landscape of abuse against people with disability. However, each has a limited role: the DSC in taking complaints about abuse and in reviewing some incident reports dealt with by the department, and OPA in referring abuse to the department and elsewhere.

507. Complaints of abuse or neglect should be considered for investigation by the DSC where conciliation is not appropriate, or has failed and further action is required. This does not mean that the investigation must be a formal process, but it ensures that the DSC can rely on its formal powers, including determining what action should be taken to remedy the complaint\(^\text{211}\), and the power to name a disability service provider which has unreasonably failed to take action\(^\text{212}\).

508. The DSC’s education function helps to improve the capacity of the sector in responding to complaints through education, occasional papers and the annual reporting tool. In my view, this model should be considered for integration into the national system.

509. Currently the DSC does not have jurisdiction to review the department’s handling of all abuse allegations, including allegations of sexual abuse, and physical abuse relating to a “client on client” incident. Despite a protocol between the DSC and the department, the department has no legislative obligation to respond to DSC concerns and has been slow to respond to the concerns raised by DSC as part of this process.

510. The DSC is also reliant on receiving a complaint about abuse allegations before being able to utilise legislative powers. The DSC does not have jurisdiction to conduct own motion investigations without a specific complaint, although as described in this report, it is loath to use the investigation powers it does have.

511. Where allegations of abuse are reported to the department by funded providers, as is required by their service agreements with the department, these allegations may not be subject to any external oversight unless a person with disability or a service provider also made a complaint to the DSC or OPA. The department has no guidance about when an external investigator should be engaged, and how investigations are conducted within funded providers appears to be largely ad hoc. The limited numbers reviewed by the DSC or OPA suggest that the vast majority of allegations of abuse receive no independent oversight.

512. SRS residents cannot complain to the DSC, and people with disability who are clients in TAC accommodation are outside the remit of Community Visitors.

513. There are no current reviews or oversight of allegations of abuse relating to people with disability living in SRS facilities. While SRS proprietors are required to report allegations of serious abuse to the department, there is currently no internal review process for these allegations. This is in contrast to the situation where a person with disability is living in department-funded or provided services. In the latter circumstances, there is an internal review process which is conducted by the department in some cases, however, there is no similar mechanism for allegations arising in SRS facilities.

\(^{211}\) Sec 118(4), Disability Act 2006 (Vic).
\(^{212}\) ibid, Sec 19(2).
514. Allegations arising in SRS facilities are also subject to a different enforcement regime than allegations arising in department-funded or provided services. While the SRS Act provides a range of enforcement powers for Authorised Officers, these powers are rarely used by the department, which has still not established an infringements process to enable this power to be used.

515. While incidents may come to the attention of Community Visitors and the Public Advocate, neither has the power to investigate them. Community Visitors are only able to visit registered disability accommodation which does not include all services.

Lack of ownership

516. The gaps and fragmentation described above also highlight the lack of ownership of the problems around the reporting of abuse. This is encapsulated in the many different roles of the department, which has not only the legislative responsibility to promote the rights of people accessing disability services, but also roles as a provider, funder, and regulator of services.

517. For example, while the department has invested a significant amount of money in reviewing its incident reporting system in response to concerns expressed in numerous reports, it is yet to take action to remedy those concerns, and remains unable to effectively collect and analyse incident data.

518. It is also not clear which entity should be responsible for education and prevention in the area of abuse. While the DSC’s education function, and in particular its “It’s OK to Complain” campaign is to be commended, from the complaint statistics it does not appear to be effective in this area. The DSC’s own track record in dealing with complaints of abuse may well be a contributing factor.

519. While OPA has developed the IGUANA practice guide for agencies for dealing with violence, neglect and abuse, this has no formal standing and has not been endorsed by the department. The department has however issued no guidance of its own in this area.

Lack of information sharing

520. While the law is intended to balance the public interest in the free flow of information with the public interest in protecting the privacy of personal information in the public sector, the evidence suggests either reluctance or legislative inability of different parts of the system to share information. For example, both Community Visitors and the DSC have secrecy provisions within the Disability Act 2006 restricting the way information is communicated to other bodies or people.

521. At present the department provides limited information publicly about incident reports. It does not publish the types of incident reports received, or the number of incident reports at a particular location or within a particular service. The absence of this information lacks transparency and rules out the analysis of data to develop informed prevention strategies. Thus Community Visitors are unable to prioritise high risk houses, the DSC is unable to target particular areas to promote its complaints service and one agency could be considering an issue at a service provider simultaneous to another.

213 Sec 5, Privacy and Data Protection Act 2014 (Vic).
214 Sec 36, Disability Act 2006 (Vic) and Sec 196, Supported Residential Services (Private Proprietors) Act 2010 (Vic).
215 Sec 128, Disability Act 2006 (Vic).
Advocacy

522. In the disability sector, service users ‘belong to one of the most disenfranchised groups in modern society and are unlikely to be aware of their rights let alone be in a position to be able to exercise them’\textsuperscript{216}.

523. My investigation has found that there is a critical role for advocates to assist people with disability. This has already been evidenced in the NDIS pilot sites in Victoria, assisting people to develop plans for their care and service provision.

524. The role of advocacy is particularly important in the highly sensitive area of complaints about abuse, where people may be afraid to complain, and for those people who do not have the ability to communicate or make a complaint on their own behalf. Organisations that encourage self-advocacy also play a key role in this area.

525. While Community Visitors have a role in advocating on behalf of people with disability and following up with the department on action taken by the department to address the issues raised, they are volunteers and their role does not extend to individual advocacy.

526. The department funds 24 advocacy services to assist people with disability in Victoria. However, the funding provided is extremely limited with only around 30 per cent going to individual advocacy. As a result many of these services do not have the resources to provide individual services to people with disability but instead focus on systemic advocacy.

527. 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.

528. There must also be 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.

529. OPA also provides some advocacy services to people with disability, limited by its funding arrangements.

530. The need for additional support to be provided to victims of sexual assault and physical assault is recognised in the criminal justice system with victim/witness support programs attached to the Offices of Director of Public Prosecutions. The need for additional support to be provided to assist victims of sexual and physical assault with disability to navigate the complex oversight system for allegations of abuse and to be supported through that process should also be recognised.

531. Inadequate funding and inconsistent provision of advocacy services in the Victorian disability sector require a single body to establish and operate the services and functions of advocates. This role will become all the more essential with the introduction of the NDIS, as set out further below.

Good practice

532. There are however, many aspects of good practice in the Victorian model. While this investigation has highlighted weaknesses in the office’s discharge of its functions, the existence of an independent Disability Services Commissioner to whom people with disability can make complaints is an important protection.

533. The Community Visitors program provides a network of volunteers throughout Victoria, who are an important protection for people with disability in the community. They provide considerable skills at a negligible cost, and should receive greater support.

534. The Senior Practitioner, who among other things monitors restrictive interventions and provides a clinical perspective in his advice to the DSC in reviewing incidents, is an important source of professional expertise which should be encouraged and supported.

535. The Public Advocate also provides a vital role in protecting the interests of vulnerable people as an advocate of last resort. This advocacy role should be further enhanced.

536. The TAC’s system of welfare checks by Support Coordinators, both in home and in supported accommodation, is also an example of good practice.

Potential solutions and considerations

Independent oversight body

537. In principle, a single independent oversight body should be accountable for dealing with serious incident reports involving people with disability. The oversight body should have the clear jurisdiction, powers and independence to effectively deal with these matters.

538. Independent monitoring is also enshrined in the UN Convention on the Rights of Persons with Disabilities\(^\text{217}\):

- ensure that all facilities and programmes designed to service persons with disabilities are effectively monitored by independent authorities.

539. A single oversight body should be easy to understand and explain to people. This is even more important in a system overseeing protection of people with disability, many of whom may have minimal or no capacity to navigate a complex system.

540. Its functions should include:

- receiving mandatory reports of all serious incidents, including complaints/allegations of physical and sexual abuse, unexplained injuries and deaths, from all registered disability service providers, including SRS, DHHS, Community Visitors, OPA, the TAC and independent advocates
  - receiving voluntary reports of incidents/allegations of abuse or quality care concerns by other individuals or groups
  - interface with police regarding investigations
  - consultation with the Senior Practitioner
  - powers to investigate individual complaints and systemic issues, including own motion powers
  - the ability to refer matters to more suitable bodies for investigation and monitor the outcomes of the investigations
  - review of all incident reports to identify learnings and ensure that appropriate action is taken following the reporting of incidents
  - promote awareness about reporting abuse and/or quality of care concerns with disability clients and service providers
  - education and training activities to improve the understanding of, and responses to reported incidents/allegations
  - reporting on trends and issues in connection with incidents/allegations
  - preparing and publicising best practice guides for complaint handling
  - the ability to share information about incidents/allegations with other bodies as appropriate
  - a Disability Worker Exclusion Scheme.

\(^{217}\) Article 16(3), The UN Convention on the Rights of Persons with Disabilities.
541. While the Disability Worker Exclusion Scheme is a step in the right direction, it would be strengthened by mandatory reporting to a single body, application to all disability facilities and services regardless of provider, and legislative backing which resolves any conflicts.

Enhancing advocacy

542. As noted above, advocacy – including self-advocacy – is a core protection that remains under-utilised and underfunded.

543. There is a need to fully assess the role of individual advocacy within the system. With the increasing reliance on individuals to look after their own interests, the need will be greater than ever to assist those who are unable to do so. No entity has the responsibility at present to assess the need for advocacy in an individual case, allocate an advocate and monitor as necessary the advocate’s performance of their functions.

544. To avoid any potential conflicts, this role should not sit within a department which provides services.

The impact of the NDIS

545. The quality and safeguarding system to be implemented as part of the NDIS is subject to consultation and as yet unformed. With the transfer of disability funding to the Commonwealth, the likelihood is that any new system of oversight will be administered by a Commonwealth agency. This raises a number of key issues.

546. First, new oversight arrangements may leave Victorians with disability with less oversight and a weaker system than is currently in place. While a single agency to deal with allegations would resolve many of the problems in Victoria relating to inconsistencies, fragmentation and gaps in this area, the principles set out above for a single oversight body would need to apply in each State and Territory.

547. Second, the NDIS is not expected to be fully implemented across the country until 2019. This leaves up to four years during which a State government may, not wholly unreasonably, consider that major reform of the current system is not justifiable. However, to do nothing would be equally unjustifiable.

NDIA consultation paper on safeguarding

548. While the NDIS approach should provide choice and control to participants, the evidence of this investigation confirms that safeguarding arrangements that protect the rights of participants to live free from exploitation, violence and abuse should be a vital element of any structure.

549. The development of a national safeguarding scheme offers an important opportunity for the good practice operating in Victoria and other states to be adopted nationally. This includes the role of Community Visitors and other models of good practice set out in this report.

Independent statutory oversight body

550. The principle of an independent oversight body outlined above applies equally to the NDIS. It should have the full range of functions presently carried out by a number of different bodies in Victoria, including overall responsibility for information to help people with disability understand their rights, the power to conduct enquiries and investigations into complaints, as well as own motion powers, for example, where a number of complaints raise similar concerns, to determine the root cause of the problem and determine if there are any systemic issues.

551. It should be both visible and accessible, with a complaints process which is easy to use and flexible enough to cater for people with different disabilities and levels of understanding.
552. A key to achieving improvement from a complaints handling system lies in having a systematic approach to recording complaints and outcomes. Information on complaint trends, aggregated complaints data and individual and systemic issues should be publicly reported at least annually.

553. The oversight body should be transparent in relation to the work it performs and its decision-making. There should be appropriate reporting on the operation of the complaints process against set performance standards.

**Application to providers**

554. NDIS participants can purchase support from service providers who are registered with NDIS or, if they are self-managing their funding, from anyone they wish. Although the NDIS has proposed a number of approaches for managing the risk to participants who self-manage their funding, it is clear that participants may not have the same protections as those whose plans are managed by NDIS.

555. The NDIS promotes a risk-based framework for provider registration, meaning ‘that providers of support types where there is potentially a greater risk to participants will have to comply with a stronger regulatory framework than providers in low-risk areas like home handyman services’. Focusing on the provider alone will not determine the risk a service may pose to a user. A service user at home may be equally at risk of abuse and exploitation as one living in a supported accommodation environment.

556. A system focused on individual needs should recognise that some users are more vulnerable than others, regardless of how or where they purchase their supports. It is important that the NDIS safeguarding system includes mandatory reporting, and a greater role for assessment of capacity and need for advocacy.

**Mandatory reporting**

557. In order to minimise confusion, ensure consistency and build confidence in the disability sector, I consider there to be significant benefit in requiring the mandatory reporting of all serious incidents to the independent oversight body. This requirement should apply to all service providers.

558. To ensure that the risks that may emerge from self-managed funding are appropriately managed, a mandatory reporting scheme should also consider the child protection model operating in Victoria and elsewhere in which third parties including health care professionals would be obliged to report potential serious incidents that come to their attention.

**Advocacy**

559. The evidence of this investigation strongly suggests that the role of advocacy will need to be strengthened further with the introduction of the NDIS. While I support the guiding principles of the National Disability Insurance Scheme Act 2013 (C’th) promoting equality, social inclusion and choice, the practical application of these principles in relation to people with cognitive impairment, limited communication or no informal supports must be highly questionable. Throughout my investigation, my officers and I have attended disability forums and taken extensive evidence from which it is clear that many people with disability have no family or friends in their lives, and often rely on the goodwill of paid staff or scheduled visits by Community Visitors for support.

219 ibid, part 2.
220 Disability Reform Council, above n 1, page 10.
221 Sec 4, ‘General principles guiding actions under this Act’, National Disability Insurance Scheme Act 2013 (C’th).
560. The NDIS is a market driven model, rooted in the belief that people with disability are best placed to decide how their money should be spent on services to support them. For many people with disability, this is a long awaited improvement, however for people with severe cognitive impairment and/or limited communication, it can present new barriers. For the most vulnerable, capacity will never improve; it is not a developmental challenge that will be rectified as people ‘become more confident and skilled consumers in the market’\(^!\text{222}\). This fact must be acknowledged and provided for within the NDIS.

561. Without a strategy to embed the role of advocacy, a market-based model appears inaccessible for a large sector of people with diminished capacity to make informed decisions.

562. It is not viable for advocacy to take a secondary position in the safeguards framework. I consider advocacy to be key in a framework for Victorian people with disability who have no prospect of becoming empowered consumers and have no family or friends to voice their best interests.

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563. The Victorian Charter of Human Rights and Responsibilities extends a vital protection to people with disability in this state. It is essential that this protection is not reduced in any substantive way through the transfer of safeguarding responsibilities to the Commonwealth.

564. The obligation to act compatibly with the Charter does not extend to Commonwealth authorities. There is a risk that 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.

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**Extent of the NDIS in Victoria**

566. An important area that remains unclear is the extent to which disability services will continue to be provided at local level after the implementation of the NDIS, and therefore the extent to which local protections will still be necessary. It is already clear that the TAC and WorkSafe systems will not be affected by the NDIS. Given that they are not government funded, SRS may not be covered by a national safeguarding regime. It is possible that other services will continue to be provided at a state or local level. As the NDIS is rolled out, careful consideration will need to be given to each element of the system to ensure that adequate safeguards remain in place for those who need them.

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Recommendations

The conclusions in the previous chapter give rise to a clear reform agenda, addressing the gaps while retaining good practice. As noted, however, the implementation of the NDIS by 2019 raises real questions about the level of reform that is both realistic and achievable in Victoria within that timeframe. While they are subject to broad consultation, the future safeguarding arrangements under the NDIS will eventually be a matter for the Commonwealth.

At this time, it is unclear how long the state system will prevail, or what aspects, if any, of the current state-based system will continue after the implementation of the NDIS. While my recommendations are by necessity limited to Victoria, I am providing them as points of principle on two key issues:

- the need for a single independent statutory oversight body
- advocacy to support decision making by people with disability.

**Recommendation 1**

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, containing the elements in Appendix 4 (see page 102).

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.

**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.
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<th><strong>Glossary</strong></th>
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<td><strong>Abuse</strong></td>
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<td><strong>Adverse event</strong></td>
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<td><strong>Behaviour support plan</strong></td>
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<td><strong>Complaint</strong></td>
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<td><strong>Critical client incident management instruction</strong></td>
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<td>Disability Services Commissioner (DSC)</td>
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<td>Disability Support Register (DSR)</td>
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<td>Disability Worker Exclusion Scheme</td>
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<td>Disability Worker Exclusion Scheme List</td>
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<td>Ethical Standards Unit</td>
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<td>Group home</td>
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<td>Guardianship</td>
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<td>Incident report</td>
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<td>Interagency Guideline for Addressing Violence, Neglect and Abuse (IGUANA)</td>
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<td>Minister</td>
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<td>National Disability Insurance Agency (NDIA)</td>
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<td>Quality of Support Review (QoSR)</td>
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<td>Register of disability service providers</td>
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<td>Residential Independence Pty Ltd (RIPL)</td>
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<td>Senior Practitioner</td>
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<td>Transport Accident Commission (TAC)</td>
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<td>Victorian Civil and Administrative Tribunal (VCAT)</td>
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<td>WorkSafe Victoria</td>
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<td>Zero Tolerance</td>
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Mr Laurie Harkin AM  
Disability Services Commissioner  
Level 30  
570 Bourke Street  
MELBOURNE VIC 3000  

Dear Mr Harkin,

Thank you for your Statement on Advice on the department’s Incident Report and Quality Support Reviews for the period 1 November 2012 to 31 March 2013, received by my office on 14 August 2013.

The thematic analysis in your statement provides a valuable independent reflection of potential areas for improvement that could assist in achieving improved safeguarding and outcomes for clients of the department and funded disability services.

I am aware that you have recently attended the Divisional Strategic Oversight and Coordination Committee and had some valuable discussion with the Divisional Executive Directors and the Deputy Secretary, [redacted]. It is pleasing to hear of the ongoing discussions between your office and the Divisional Executive Directors with the objective of ensuring continual improvements in our shared work in ensuring client safety and wellbeing.

As you are aware, the department is undertaking a program of work to enhance existing safeguarding policies, guidelines and practices requirements when responding to incidents of violence, neglect and abuse. [redacted] Assistant Director Service Outcomes, will be contacting your office to invite your contribution to this work.

I look forward to receiving future statements and to the continuing beneficial work between your office and my department.

Yours sincerely,

Gill Callister  
Secretary
03 NOV 2013

e3259854

Mr Laurie Harkin AM
Disability Services Commissioner
Level 30
570 Bourke Street
MELBOURNE VIC 3000

Dear Mr Harkin

Thank you for your Statement of Advice on the department’s Incident Reporting and Quality of Support Reviews for the period 1 April to 30 June 2013 and for the annual review you also provided. The key themes and areas for consideration you provide in your reports are of great assistance in informing the work of my department.

While improvements continue to be made in the department’s safeguarding of vulnerable individuals, the matter of effective prevention of, and response to, client incidents should be seen within a quality improvement framework. As such, and as noted in your Statements of Advice, there is continued room for improvement both at a systemic level and in practice in individual situations.

As you are aware the department is undertaking a program of work to enhance existing safeguarding policies, guidelines and practice requirements when responding to allegations of violence, neglect and abuse. Many of the improvement opportunities you have identified in your annual review will be captured in this comprehensive program of work. I am pleased to know that your office will be working with the department in the development of this work.

I understand that you will be meeting with the Divisional Executive Directors at the upcoming Divisional Strategic Oversight and Coordination Committee on 14 November. I am sure these discussions will continue to be fruitful in the sharing your insights and those of the department Executives in the efforts at continual improvements in ensuring client safety and wellbeing.

Thank you for your continued efforts in this most important work.

Yours sincerely

Gill Callister
Secretary

Department of Human Services
Secretary

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Melbourne
Victoria 3001
Telephone: 1300 450 172
Facsimile: (03) 9956 9220
www.dhs.vic.gov.au
D2100081
Dear Mr. Harkin,

Thank you for your Notice of Advice on the department’s Incident Reporting and Quality of Support Reviews for the period 1 July 2013 to 31 December 2013. The key themes and areas for improvement identified in your advice provide valuable insight to inform the department’s work to improve safeguards for vulnerable people with disabilities.

I share your views regarding the need for ongoing improvement with respect to ensuring a client-centred approach is used to prevent, and respond to, critical client incidents. I appreciate your continued vigilance and support of our endeavours to continually improve our responses.

As you know, department-wide service improvement is an organisational priority, requiring time and significant effort from all sides. The department is undertaking a program of work this year to improve policies and practice guidelines for disability services which will go some way to addressing the issues you have identified. We will also be undertaking a review of the department’s incident management approach and we continue to work on raising awareness about the value of a strong quality and safeguarding framework for vulnerable clients.

To assist in the promotion of a strengthened focus on client experience, I would like to invite you to speak directly to all divisions to share your insights on supporting vulnerable people. Your experience and observations will be most valuable and will assist us in meeting our objectives around service improvement.

I have asked [Name] Chief Adviser, Disability to contact your office to arrange a convenient time for you to speak with staff on this matter.

I thank you and your staff for your continued work with my department around strengthening our client-centred approach. I am sure that our ongoing discussions will continue to provide a valuable opportunity for information sharing and harnessing expertise on both sides.

Thank you again for your continued efforts in this important work.

Yours sincerely,

[Signature]

Gill Callister
Secretary
Dear Mr Harkin

Thank you for your Notice of Advice on the department’s Incident Reporting and Quality of Support Reviews for the period 1 January to 30 June 2014. The key themes and areas for improvement identified in your advice provide valuable insights to inform the department’s work to improve safeguards for vulnerable people with disabilities.

As you would be aware, the department is undertaking a number of important reform initiatives to strengthen safeguards and identify opportunities where improvements can be made to ensure we are meeting our commitment and responsibilities around client safety, client rights and wellbeing.

While some of this work is still in its early stages, I am pleased to inform you that since your last Notice of Advice to me in relation to incident reporting, a number of key initiatives have commenced which will go some way to addressing the key themes and observations contained in your latest (and previous) reports to me. In particular, KPMG has been retained to conduct an end to end review of the department’s Critical Client Incident Response and Management Approach (CCIRMA). This review will identify improvement opportunities for the way the department and funded services respond to and report incidents, support client outcomes after an incident and achieve systemic learning.

It is expected that the findings of the review will have a strong focus on education, streamlining incident reporting and response processes and on ensuring timely and appropriate client support following a critical incident.

As per your request, and to inform you of work being undertaken by my department to address the issues you have identified in your advice, I have enclosed the department’s Action Plan to strengthen incident reporting and client safeguarding processes for people with a disability. Should you have any questions, please don’t hesitate to contact

Manager Quality and Oversight on [Contact Information]

Thank you and your staff again for your continued efforts in this important work.

Yours sincerely

[Signature]

Gill Callister
Secretary
Appendix 2: Mr D Case study timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
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<tbody>
<tr>
<td>January 2014</td>
<td>Community Visitors visit house and express concern in their report about the impact of Mr D’s behaviour on residents and staff.</td>
</tr>
<tr>
<td>April 2014</td>
<td>Community Visitors visit house. Record of Visit states: ‘... we are now concerned about the safety, wellbeing and human rights of several other residents whom Mr D has assaulted recently. Has serious consideration been given to Mr D moving ...?’</td>
</tr>
<tr>
<td>May 2014</td>
<td>Community Visitors meet department. Raise concerns about the impact of the violence on the dignity, rights and lifestyle of the [other] residents who cannot defend themselves from his attacks. The Regional Convenor requests that the department move Mr D; department’s Senior Local Engagement Officer agrees to check that Mr D is on the is on the DSR and report back.</td>
</tr>
<tr>
<td>July 2014</td>
<td>Community Visitors visit house. Record of Visit expresses their concerns about the continued behaviour of Mr D on residents and staff.</td>
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<tr>
<td>August 2014</td>
<td>• Call to OPA Telephone Advice Service. Caller concerned about the safety and welfare of their family member.</td>
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<td></td>
<td>• Community Visitors visit house and speak with residents, one of whom says they fears ‘someone will be killed’.</td>
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<tr>
<td></td>
<td>Record of Visit states: ‘...incident reports ... convince us of the need to remove Mr D from the house immediately, for the safety of the ... residents. What is being done to expedite this, given Mr D’s listing on the DSR [Disability Services Register] more than a year ago?’</td>
</tr>
<tr>
<td></td>
<td>• Community Visitors meet with department. Regional Convenor requests Mr D be moved due to the negative effect his behaviour is having on other residents. The department’s Manager Agency Connections agreed to follow-up.</td>
</tr>
<tr>
<td></td>
<td>• Community Visitor Program Coordinator submits a notification to the Acting Public Advocate.</td>
</tr>
<tr>
<td></td>
<td>• Acting Public Advocate formally notifies the service provider of serious and significant issues at the house.</td>
</tr>
<tr>
<td>October 2014</td>
<td>Community Visitors visit house and express concerns about the impact on other residents of Mr D’s behaviour.</td>
</tr>
<tr>
<td>November 2014</td>
<td>• Community Visitors meet with the department’s Manager Local Connections and Service Manager Local Connections. Regional Convenor expresses fears of ‘a potential death at the group home’ resulting from Mr D’s escalating behaviours.</td>
</tr>
</tbody>
</table>
### December 2014
- Community Visitors visit. Report that residents are adopting avoidance strategies by remaining in their rooms on return from their day programs; this includes eating and urinating in their rooms. CSO manager advised that Mr D lit two fires within the building, physically assaulted residents and threatened to ‘gut’ one of them.
- Community Visitor Program Coordinator has conversation with CSO operations manager who tells him about increasing levels of violence and avoidance strategies adopted by other residents, including eating and urinating in their rooms.
- Community Visitor Program Coordinator emails department expressing grave concerns for residents if immediate action not taken.
- Mr D allegedly assaults a staff member.

### January 2015
- 05/01/15 – Community Visitor Program Coordinator informed by OPA Independent Third Person volunteer that Mr D was charged with assault of a resident.
- Coordinator emails divisional departmental managers and Regional Director.
- 07/01/15 – Assistant Director responds that the Behaviour Intervention Support Team, the Senior Practitioner and the Disability Forensic Assessment and Treatment Service involved.
- 08/01/15 – Community Visitor Regional Convener informed that police attended the group home and that an elderly resident had been capsicum sprayed due to agitated behaviour as a result of aggression directed towards him by Mr D.
- 09/01/15 – Coordinator submits notification to Public Advocate who formally notifies Divisional Deputy Secretary.

### March 2015
- 30/03/15 – Divisional Deputy Secretary responds to Public Advocate.
Appendix 3: Community Visitors protocol: Escalation flowchart

Appendix 4: Key features of an independent oversight framework

**Independent statutory oversight body**
This body should have the powers and functions described on page 87. It should also be accessible, engaging in regular outreach to regional and remote areas.

**Mandatory reporting**
The regulatory framework should require mandatory reporting of all serious incidents by all service providers, along the model of the NSW Disability Reportable Incidents scheme. The benefit of extending mandatory reporting by third parties along the child protection models in Victoria and NSW should also be considered.

**Assessment and advocacy**
The capacity of a person with disability accepted into the NDIS should be assessed by the NDIA on reception and, if required, at nominated intervals, to determine their need for access to funded advocacy services.

**Community Visitors**
A Community Visitors scheme to check on people with disability in supported accommodation should be established and appropriately funded, along the Victorian or NSW models.

**Senior Practitioner**
A Senior Practitioner should be available to the oversight body, to provide a clinical perspective to the review of incidents and other professional advice as needed.

**Disability Worker Exclusion Scheme**
A Disability Worker Exclusion Scheme should cover all facilities and services utilised by people with disability.