

Chapter 5

Reporting and investigating

5.1 This chapter addresses the following terms of reference:

(d) the responses to violence, abuse and neglect against people with disability, as well as to whistleblowers, by every organisational level of institutions and residential settings, including governance, risk management and reporting practices;

(e) the different legal, regulatory, policy, governance and data collection frameworks and practices across the Commonwealth, states and territories to address and prevent violence, abuse and neglect against people with disability; and

(h) what should be done to eliminate barriers for responding to violence, abuse and neglect perpetrated against people with disability in institutional and residential settings, including addressing failures in, and barriers to, reporting, investigating and responding to allegations and incidents of violence and abuse.

5.2 This chapter examines the efficacy of reporting and investigating mechanisms for allegations and incidents of violence, abuse and neglect, including:

- internal reporting mechanisms by disability support organisations; and
- external reporting mechanisms to independent bodies.

5.3 Overwhelmingly, the committee heard that Australia's existing legal and policy frameworks are inadequate, overly complex and do not provide adequate protection to people with disability in residential and institutional settings. A number of submissions highlighted that there are no clear or nationally consistent mechanisms for reporting abuse, neglect or violence and recommended the introduction of national, independent reporting mechanisms.¹

5.4 The inadequacy of the current approach means that there is no accurate data on the actual level of violence, neglect and abuse being perpetrated on people with disability.

Reporting allegations of abuse, violence and neglect

International obligations

5.5 Under Article 16 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (Disability Convention), Australia is obliged to ensure that people with disability are not subject to any forms of exploitation, violence or abuse.²

1 See, for example: Australian Cross Disability Alliance, *Submission 147*, pp 12–13; Office of the Anti-Discrimination Commissioner, Tasmania, *Submission 40*, p. 12; Office of the Public Advocate, Queensland, *Submission 73*, p. 16.

2 United Nations Convention on the Rights of Persons with Disabilities, Article 16, <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed 21 August 2015).

5.6 In its concluding observations on Australia's first report on the Disability Convention, the UN Committee on the Rights of Persons with Disabilities (UN Disability Committee) expressed particular concern about reports of high rates of violence against women and girls living in institutional settings, and recommended an urgent investigation.³

5.7 To complement the UN Disability Committee's report, the Australian Human Rights Commission argued that this inquiry should give consideration to the 2012 *Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities* (Civil Society Report), prepared by Australian disability support organisations.⁴ The report highlighted that in Australia:

...there is no specific legal, administrative or policy framework for the protection, investigation and prosecution of exploitation, violence and abuse of people with disability.⁵

5.8 In regard to Article 16 of the Disability Convention, the Civil Society Report recommended that Australia should establish 'an independent, statutory, national protection mechanism that has broad functions and powers to protect, investigate and enforce findings related to situations of exploitation' and a 'national coordinated strategic framework for the prevention of exploitation, violence and abuse experienced by men, women, girls and boys with disability'.⁶

Internal reporting mechanisms

5.9 For the purposes of this report, internal reporting is defined as the reporting of incidents within the service provider, and also the reporting of incidents as required to the government funding body.

5.10 In most jurisdictions, there is a policy requirement for funded disability service providers to report 'serious' or 'critical' incidents to the relevant department providing the funding for investigation and response. Serious or critical incidents are events that threaten the safety of people or property. A serious or critical incident could be:

- the death of, or serious injury to, a resident;
- allegations of, or actual, sexual or physical assault of a resident; or

3 United Nations Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (2–13 September 2013)*, 4 October 2013, p. 6. See: Attorney-General's Department, Convention on the rights of persons with disabilities, <http://www.ag.gov.au/RightsAndProtections/HumanRights/Pages/UnitedNationsConventionontherightsofpersonswithdisabilities.aspx> (accessed 24 September 2015).

4 Australian Human Rights Commission, *Submission 57*, p. 1.

5 Disability Representative, Advocacy, Legal and Human Rights Organisations (DRALHRO), *Disability Rights Now: Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities*, August 2012, p. 102, <http://www.pwd.org.au/issues/crpd-civil-society-shadow-report-group.html> (accessed 24 September 2015).

6 DRALHRO, *Disability Rights Now*, p. 25.

- significant damage to property or serious injury to another person by a resident.⁷

5.11 Serious incidents may be reported to disability service providers by people with disability and their families, or by staff and carers. In many cases, the service provider is responsible for identifying and reporting incidents, and deciding how the response is to be managed.

5.12 Table 5.1 outlines the different requirements across jurisdictions for reporting critical or serious incidents.⁸

7 National Disability Insurance Scheme (NDIS), Proposal for National Disability Insurance Scheme Quality and Safeguarding framework: Consultation paper, pp 23–24.

8 See: Ombudsman NSW, Disability reportable incidents, <https://www.ombo.nsw.gov.au/what-we-do/our-work/community-and-disability-services/part-3c-reportable-incidents>; Department of Human Services, Victoria, Critical client incident reporting, <http://www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services>; Department of Communities, Child Safety and Disability Services, Critical Incident Policy, <https://www.communities.qld.gov.au/resources/disability/publication/critical-incident-policy-dsq-2008.pdf>; Disability Services Commission WA, Serious Incident Reporting, <http://www.disability.wa.gov.au/disability-service-providers-/for-disability-service-providers/contracts2/serious-incident-reporting-/>; Department for Communities and Social Inclusion, South Australia, Disability SA – policies and guidelines, <http://www.dcsi.sa.gov.au/services/disability-sa/disability-sa-policies-and-guidelines>; Department of Health and Human Services, Tasmania, Quality and Safety Standards Framework, https://www.dhhs.tas.gov.au/about_the_department/business/community_sector_relations_unit/quality_and_safety; Disability Services Regulation 2014 (ACT), <http://www.legislation.act.gov.au/sl/2014-12/default.asp>; NT Department of Health, http://www.health.nt.gov.au/Publications/Aged_and_Disability_Publications/index.aspx (all accessed 24 September 2015).

Table 5.1: Reporting requirements of serious or critical incidents for funded disability service providers

Jurisdiction	Legislative/policy requirement	Responsibility to report	Agency to report to
NSW	Legislation – <i>Ombudsman Act 1974</i> , Part 3C	Funded service providers Department of Families and Communities	NSW Ombudsman
Victoria	Policy – Responding to allegations of physical or sexual assault	Funded service providers	Department of Health and Human Services Police
Queensland	Policy – Critical Incident Reporting Procedures	Funded service providers	Department of Communities, Child Safety and Disability Services
WA	Policy – Serious Incident Reporting	Funded service providers	Disability Services Commission
SA	Policy – Managing Critical Client Incidents Policy	Funded service providers	Department for Communities and Social Inclusion Police
Tasmania	Policy – Serious Incident Policy / Preventing and Responding to Abuse in Services Policy	Funded service providers	Department of Health and Human Services
NT	Policy – Disability Service Standards	No formal requirement to report Mandatory reporting for children under 18 only	Department of Children and Families Police
ACT	Regulation – Disability Services Regulation 2014, Section 10	Funded specialist disability service providers	Director-General, Community Services Directorate

Source: Refer to footnote 8.

Efficacy of internal reporting processes

5.13 As outlined in Table 5.1, in all jurisdictions but New South Wales (NSW), the process for reporting violence, abuse and neglect is defined by government disability-related policy. These policies differ across jurisdictions, including how 'serious' or 'critical' incidents are defined, and how they should be responded to. Submitters and witnesses highlighted that existing policies are not effective in ensuring that 'serious' or 'critical' incidents are adequately reported and investigated.⁹

5.14 Some disability service providers have internal processes to report and respond to incidents of abuse and neglect. For example, the Endeavour Foundation submitted that it has implemented strategies to develop a zero tolerance culture for abuse, neglect and exploitation, including utilising an External Advisory Committee for the Prevention and Response to Abuse Neglect and Exploitation and training all staff in human rights and abuse recognition.¹⁰

5.15 However, evidence to the committee suggested that in many cases, allegations of serious or critical incidents are not consistently reported. The Tasmanian Anti-Discrimination Commissioner submitted that, while service providers are required to notify the relevant department within two working days of being notified of an allegation of abuse:

...complaints made to my office would suggest that not all incidents are reported. Nor is there a clear understanding about the procedures adopted by residential or other accommodation service providers about the mechanisms for investigating such complaints.¹¹

5.16 Evidence was presented to the inquiry that there is a problem with funding bodies investigating the organisations they fund, due to the inherent conflict of interest:

At the moment there is also too much of a conflict in funding bodies investigating who they are funding. The organisations have too much invested, and obviously there is often a direct conflict of interest there in terms of who is independent and who can look at a situation and make a judgement based on probabilities rather than a criminal threshold as to whether or not something has occurred, then perhaps being able to compel a support agency to respond in a more appropriate way.¹²

5.17 This view was echoed by Speaking Up For You. Mr Neal Lakshman, Advocacy Worker, told the committee:

9 This issue was raised by both lived experience submitters as well as organisations such as Women with Disabilities Australia, Australian Cross Disability Alliance, *Committee Hansard*, Sydney 27 August 2015, p.50 and NSW Ombudsman, Submission 29, p. 22.

10 Endeavour Foundation, *Submission 27*, p. 10.

11 Office of the Anti-Discrimination Commissioner, Tasmania, *Submission 40*, p. 13.

12 Ms Leona Berry, Manager, WWILD Sexual Violence Prevention Association, *Committee Hansard*, Brisbane, 16 October 2015, p. 18.

I guess the issue is that Disability Services is investigating itself at the moment. We may have a complaint against a DSQ [Disability Services Queensland] officer, and then six months later he might be in the complaints unit, so it can be quite difficult.¹³

5.18 Where incidents are reported, there may be differences in the way they are handled. The Victorian Disability Services Commissioner noted that, since August 2012, it has reviewed 888 'category one' incident reports relating to allegations of staff-to-client assault and unexplained injury made to the relevant government department and community service organisations. The reviews highlighted that there is a 'lack of focus on people's outcomes and safeguarding people's rights during investigations' and a 'lack of clarity and shared understanding' of the definition of 'assault' and 'poor quality of care'.¹⁴

5.19 One suggested cause for the lack of reporting is the perceived 'conflict of interest' of internal self-reporting. The Australian Cross Disability Alliance (Disability Alliance), representing national disability support organisations, suggested that the current system of having funded disability service providers reporting to funding agencies:

...presents an inherent conflict of interest, and has been found to be a major problem in the reporting (and non-reporting) of violence against people with disability in institutional and residential settings. There is now indisputable evidence to demonstrate that the 'covering up' of complaints, 'serious/critical' and other 'incidents', is rampant at all levels of the system—at the direct service delivery level, at management and governance levels, and at 'funding agency' levels, including large Government Departments.¹⁵

5.20 Some submitters suggested that the governance of institutions and residential facilities did not foster a culture of identifying and reporting incidents and allegations of abuse. Queensland Advocacy Incorporated suggested:

There are significant problems marring the efficacy of the governance, risk management and reporting practices of institutions providing care for people with disability. This flows, to a large degree, from the predominant culture of institutions, which are traditionally hierarchically structured, paternalistic and lack transparency and accountability.¹⁶

5.21 Witnesses suggested some institutions are reluctant to report incidents and allegations of abuse due to possible negative publicity. Ms Heidi Egarter, a disability support worker with the Health and Community Services Union, told the committee of concerns about:

13 Mr Neal Lakshman, Advocacy Worker, Speaking Up For You Inc., *Committee Hansard*, Brisbane, 16 October 2015, p. 37.

14 Disability Services Commissioner, Victoria, *Submission 86*, p. 8.

15 Australian Cross Disability Alliance, *Submission 147*, p. 65.

16 Queensland Advocacy Incorporated, *Submission 43*, p. [8].

...the tardiness and reluctance to act on allegations of abuse by non-government agencies in particular. There appears to be a culture of suppressing information that could lead to negative publicity. I believe this is endemic and perpetuated throughout the management structure.¹⁷

5.22 The committee was particularly concerned by evidence that suggested in some cases allegations of abuse and neglect are not reported at all and are dealt with internally by disability service providers. The Disability Alliance criticised the use of the terms 'serious' and 'critical' incidents to describe 'what is understood and recognised in the broader community as violence, rape, sexual and physical assault, grievous bodily harm, domestic violence, gender-based violence etc', noting that this may lead to incidents not being reported appropriately. Under existing frameworks, these crimes are not reported to police, but treated as internal service incidents:

The reframing of violence, abuse and neglect, including crimes are often reframed by terminology such as 'abuse' or 'service incidents'. This creates a greater potential for such 'incidents' to go undetected, unreported, and not investigated or prosecuted because they are more likely to be dealt with administratively within the service setting.¹⁸

5.23 Evidence presented to the inquiry noted that where allegations were not followed up appropriately, that can create culture which actually fosters abuse and neglect:

When abuse is ignored, or when people report abuse and it is ignored or not properly heeded, that again signals to the person that their issue is not important to somebody, that they are alone and that this kind of practice is acceptable, understandable and even common practice.¹⁹

5.24 The committee notes that the proposed National Disability Insurance Scheme (NDIS) quality and safeguarding framework consultation paper acknowledged the 'need to decide how serious incidents will be handled'. The consultation paper noted that '[i]ncidents involving allegations of assault, theft or any other crime must of course always be reported to the police'. Possible options for reporting serious incidents canvassed in the consultation paper included:

- requiring that all providers have effective internal systems in place to deal with serious incidents; or
- requiring that registered providers report serious incidents to the National Disability Insurance Agency (NDIA) or an independent oversight body.²⁰

17 Ms Heidi Egarter, Member, Health and Community Services Union, *Committee Hansard*, 27 August 2015, p. 10.

18 Australian Cross Disability Alliance, *Submission 147*, p. 56.

19 Ms O'Flynn, Director, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 16 October 2015, p. 2.

20 NDIS, *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework*, February 2015, pp 23–24.

Responses to internal whistleblowers

5.25 The committee is concerned by evidence of negative workplace responses to whistleblowers who seek to report allegations and incidents of abuse, violence and neglect. The Disability Alliance submitted:

...the widespread problem of 'whistleblowers' being bullied, harassed, persecuted, intimidated, deployed to other positions, and sacked, when reporting (or attempting to report) violence against people with disability in institutional and residential settings—is yet another serious dimension in the complaints processes and mechanisms, and remains an un-addressed, systemic issue nationwide.²¹

5.26 One submitter expressed concern that:

Many complaints are often ignored or not investigated because other staff who are witnesses to the abuse are too scared to speak up because they know whistleblowers are hounded out of the system.²²

5.27 During its inquiry, the committee heard from whistleblowers about their experience attempting to report allegations and incidents of violence and abuse to internal and external bodies (see Box 5.1 and 5.2). The committee notes that many witnesses asked to provide evidence in camera or as name withheld, citing concerns about repercussions. The committee believes this is indicative of an environment that inhibits whistleblowers, and highlights the bravery of those who spoke out publicly.

Box 5.1: Whistleblowers – Ms Julie Sullivan

For the past 20 years, Ms Julie Sullivan has spoken out against abuse against people with disability that she witnessed while working at a government run community residential unit for people with disability in Victoria during the 1980s and 1990s. During this time, Ms Sullivan witnessed abuse and violence perpetrated by staff members against residents, including assault and financial abuse. Ms Sullivan submitted that staff who refused to follow instructions to 'hit or restrain clients' were victimised and bullied by supervisors and management. In 1989, Ms Sullivan reported the abuse to community visitors administered by the Office of the Public Advocate.

Following the reporting of abuse, Ms Sullivan submitted that the department initiated an investigation into the allegations. However, Ms Sullivan asserted that the allegations were not adequately investigated:

What ensued was an absolute travesty...Only those of us who had spoken to the CVs [community visitors] were called to the Regional Office for the 'inquiry.' No other staff including [name removed] were questioned. No documentation or records were taken from Walpole by management. Not one DHS [Department of Human Services] person from management came to the CRU [community residential unit] or to even check on the clients whose awful abuses we had described. No directive came from management to have the clients medically checked.

21 Australian Cross Disability Alliance, *Submission 147*, p. 65.

22 Name withheld, *Submission 60*, p. 5.

Box 5.1 (continued)

After we had given our evidence (which was transcribed, but never given to us later as promised) we waited for an outcome or some contact from management. Approximately 7 weeks later we were informed by [redacted], Regional Manager, that "Allegations have been made but it was found there was not a case to answer".

Ms Sullivan submitted that her experience as a whistleblower and the experience of attempting to speak out against allegations of abuse took a significant personal toll:

I have diagnosed PTSD [Post Traumatic Stress Disorder], clinical depression and other anxiety conditions. I also have adrenal fatigue, which I have been told occurs when a person has endured a prolonged period of circumstances which trigger ongoing "fight or flight" hormonal responses. Adrenal fatigue has numerous and varied symptoms too lengthy to go into. I have become reclusive, distrustful of others. I have lost my organisational and coping skills.

Source: Ms Julie Sullivan, *Submission 157*, p. [16].

5.28 In April 2015, as part of an investigation by journalists Mr Richard Baker and Mr Nick McKenzie, government documents obtained by Ms Sullivan indicated that the serious concerns raised by the Office of the Public Advocate had been 'silenced', by the panel of inquiry established to investigate:

The panel substantiated the most explosive allegations, including the unlawful use of restraints and soap suppositories, and expressed "very serious concerns over programs and potential risk for residents".

Yet it failed to interview everyone connected with the house and quickly began laying a bureaucratic dead-hand over events, telling [the then Community Services Minister Peter] Spyker that no staff had been negligent and only "programmatic issues" had been identified.

Leaked files include one memo written by a public servant who seems more concerned with bad publicity than the bad treatment of residents: "Recommendations of the panel are designed to ensure that initiatives are already being undertaken to minimise any adverse comment and present a positive response to the matter".

Senior bureaucrats also moved to silence the Office of the Public Advocate, with the panel of inquiry advising ministers that: "The role of the Community Visitors in this matter is of grave concern in as much as they have clearly moved into areas in which they appear to have no jurisdiction nor should they seek to have jurisdiction".²³

5.29 Ms Sullivan submitted that her continued attempts to have the abuse investigated have not been supported by government:

23 Richard Baker & Nick McKenzie, 'Disabled were abused in house of horrors and governments covered it up', *The Age*, 11 April 2015, <http://www.theage.com.au/victoria/disabled-were-abused-in-house-of-horrors-and-governments-covered-it-up-20150408-1mgq13> (accessed 20 October 2015).

The official stance...was that all claims had been investigated and there was no evidence to substantiate. In reality, very little investigation of our claims took place. The terms of the inquiry had been so narrow and only limited to four of the lesser abuses.²⁴

Box 5.2: Whistleblowers – Ms Karen Burgess

Ms Karen Burgess was a front-line disability services manager specialising in people with 'behaviours of concern' and 'complex behaviours'. At one time, Ms Burgess was a site manager at a disability day centre in Melbourne. Ms Burgess raised serious concerns about a large wooden box that was erected in 2014 to restrain people with autism, which management considered to be a 'desensitising box' intended to be used as a calming device. Ms Burgess ordered the box to be dismantled once she started working at the facility. Soon after, Ms Burgess was dismissed from her position.

Ms Burgess provided evidence to the inquiry on the toll taken on whistleblowers:

There are many staff that find themselves in this position and end up leaving the industry because they cannot handle the types of situations they are confronted with. There is a lot of pressure that comes to bear on people who are like me, who speak up and out against the type of abuse that is happening in these institutions.

...

There was another staff member at [organisation name withheld] who was fired, two weeks after my termination, because of also raising practice issues and concerns. She is no longer making complaints because of the pressure that came to bear on her, but there was a second staff member who was also fired in this period because she was making direct complaints about concerns at this site.

Ms Burgess noted that there are already many laws in place to protect people with disability, but these are not being followed. However, Ms Burgess recommended that there be an independent body with the powers of investigation leading to prosecution.

Source: Nick Toscano, Beau Donnelly, 'Wooden box built to calm autistic students and day centre', *The Age*, 4 October 2015 and Ms Karen Burgess, *Committee Hansard*, Brisbane, 16 October 2015.

5.30 A number of submitters highlighted the need for greater support and nationally consistent legal protection for whistleblowers who speak out against abuse, violence and neglect.²⁵ For example, United Voice recommended:

Nationally consistent whistle blower legislation must be introduced to support and encourage workers to speak up without fear of being persecuted or targeted by their employers where a report is made in good faith.²⁶

24 Ms Julie Sullivan, *Submission 157*, p. [16].

25 See: Name withheld, *Submission 106*, p. 16.

26 United Voice, *Submission 17*, p. 5.

Committee view

5.31 It is clear from the range of evidence presented to this inquiry from multiple submitters in different jurisdictions across Australia, that no single state or territory has yet devised an acceptable system of disability service complaints reporting.

5.32 Many of these processes allow organisations to self-determine whether an incident requires reporting outside the workplace, leading to a clear conflict of interest.

5.33 The sheer number of whistleblowers who came forward to this inquiry shows that internal reporting requirements are either not being followed, or do not go far enough to protect people with disability from violence, abuse and neglect.

External reporting mechanisms

5.34 In addition to the internal reporting mechanisms that are managed by disability service providers, there are a number of external mechanisms at the Commonwealth, state or territory level for investigating allegations of violence, abuse and neglect against people with disability. Table 5.2 outlines the different mechanisms available in each jurisdiction.²⁷

27 See: NSW Government, *Submission 66*, pp 2–4.

Table 5.2: External complaints, investigation/dispute resolution bodies for people with disability

Jurisdiction	Agency	Role
Commonwealth	National Disability Abuse and Neglect Hotline	Referral service for all allegations of abuse or neglect
	Complaints Resolution and Referral Service	Referral service for complaints about Australian Government funded disability employment and advocacy services
NSW	Ombudsman	Investigates incidents of abuse or neglect of people with disability supported accommodation, monitor service providers and review the deaths of certain persons.
	Official Visitors	Visit disability accommodation and may report allegations of abuse or neglect.
	Child Protection Helpline	Referral service for allegations of abuse or neglect of children
Victoria	Ombudsman	Investigates complaints about public agencies and may investigate individual allegations in state-run facilities (may investigate funded providers on a case-by-case basis).
	Senior Practitioner (Disability)	Responsible for protecting the rights of people subject to restrictive interventions and compulsory treatment, and to ensure that the relevant standards are met.
	Disability Services Commissioner	Resolves complaints raised by or on behalf of people who receive disability services.
	Community Visitors	Visits accommodation facilities and inquire into various matters relating to service delivery, including whether the rights of people with disability are being upheld.
Queensland	Office of the Queensland Ombudsman	Investigates complaints about actions and decisions of public agencies.
	Office of the Public Guardian	Investigates allegations of abuse against adults with impaired capacity and children. Administers community visitor scheme vulnerable adults in disability accommodation and children and young people in out-of-home care.
WA	Ombudsman Western Australia	Investigates complaints about actions and decisions of public agencies.

	Health and Disability Services Complaints Office	Investigates complaints about health or disability service providers.
	Council of Official Visitors (mental health)	Visits individuals receiving treatment in mental health facilities and inspects hospitals and psychiatric hostels.
SA	Ombudsman	Investigates complaints about actions and decisions of public agencies.
	Community Visitor Scheme	Visits and inspects disability accommodation and supported residential facilities.
	Health and Community Services Complaints Commissioner	Investigate and resolve complaints about health and community services, including disability service providers.
Tasmania	Ombudsman	Investigates complaints about actions and decisions of public agencies.
	Health Complaints Commissioner	Resolve complaints about health services
	Anti-Discrimination Commissioner	Resolves complaints of discrimination, provides policy advice and support to government, promotes awareness of rights and obligation and offers training and education.
NT	Community Visitors (mental health)	Visits people receiving mental health treatment and resolves complaints.
	Health and Community Services Complaints Commissioner	Resolves complaints about health, disability and aged care services.
ACT	Public Advocate	Advocacy services for people with disability and mental health conditions, including monitoring of services for adults with disability.
	Official Visitors	Visits disability accommodation and supported accommodation to detect and prevent systemic dysfunction.
	Disability and Community Services Commissioner	Resolves complaints about the provision of services for people with disability and/or their carers

Source: NDIS, *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework*, February 2015, Table 2.

5.35 As Table 5.2 highlights, the responsibilities and powers of external agencies vary significantly across jurisdictions. A number of submissions highlighted how the complexity of multiple reporting mechanisms affects the ability of people with disability to report allegations of abuse. The Commonwealth Ombudsman submitted:

...responsibility for each of these functions varies significantly across states and territories, and some oversight bodies have greater powers and resources than others to deliver timely and effective support to people with disability. This creates a risk that people affected by violence, abuse or neglect (or others who may wish to report it) may have difficulty identifying which of the many options is the most appropriate in their circumstances, or may receive quite different levels of support or protection depending on where they live.²⁸

5.36 For example, the Victorian Disability Services Commissioner highlighted that misconceptions about its role were common and that it did not have the powers some members of the community assumed:

We are aware some members of the community appear to be under the impression that we have the power to conduct a general investigation into the performance of service providers. In fact, our power to conduct an investigation relates specifically to determining whether or not a complaint is justified, particularly where we believe that the complaint is not suitable for conciliation or an attempt to conciliate the complaint has failed and further action is required.²⁹

5.37 The committee also heard concerns about the efficacy of existing external complaints mechanisms. The Disability Alliance submitted:

...these mechanisms have been found to have limited effect in investigating, responding to, and preventing violence against people with disability across the range of settings and spaces where such violence occurs.³⁰

5.38 In particular, the committee heard concerns about the Commonwealth's National Abuse and Neglect Hotline (Hotline)³¹. The Department of Social Services (DSS) noted that between July 2012 and December 2014, 891 cases of abuse were reported through the Hotline, mainly systemic, psychological and physical abuse, and physical neglect.³² The Civil Society Report asserted that the Hotline 'is a

28 Commonwealth Ombudsman, *Submission 117*, p. 5.

29 Disability Services Commissioner, Victoria, *Submission 86*, pp 4–5.

30 Australian Cross Disability Alliance, *Submission 147*, p. 65.

31 The hotline is for complaints relating to abuse and neglect of people with disability in Commonwealth, State and Territory funded disability services. It is not a complaints resolution service, but instead refers complaints to the relevant State or Territory complaints handling service, or bodies such as various Ombudsman, Anti-Discrimination Boards and the Complaints Resolution and Referral Service.

32 DSS, *Submission 104*, p. 6.

relatively weak safeguard for people with disability as it operates without any legislative base and therefore has no statutory functions, powers and immunities'.³³

5.39 The Hotline is also limited by the agencies to which it can refer complaints. Due to inconsistencies in the responsibilities of independent oversight bodies, some callers are referred back to the agency responsible for the alleged incident or allegation. Ms Samantha Connor told the committee of the importance of a national independent mechanism to address all forms of abuse reported to the Hotline:

...not all types of abuse, when you take it to the national disability abuse hotline, are covered by the hotline. For example, if it is a government organisation you are told to take that back to the government organisation, and they will investigate themselves through their existing processes. I think that asking government to investigate itself is a horrible idea and that there should be independent investigation...Having the argument for an independent statutory body looking down on the whole country and all of those issues and having very, very clear sanctions and very clear guidelines: I think we need to have some national legislation to make sure that happens.³⁴

5.40 The committee heard there was a particular need to support and educate people with disability about what constitutes abuse. Families Australia recommended the development and implementation of 'targeted respectful relationships programmes', highlighting:

Access to targeted respectful relationship programmes for children and young people with disability and their families to support them to understand and promote healthy and respectful relationships and to recognise and report abuse and neglect is also essential.³⁵

5.41 A number of witnesses and submitters highlighted that even where reporting mechanisms might be available, many people with disability and their families may be reluctant to report abuse due to fear of retribution from the service provider. Ms Sharon Richards, from Advocare in WA, told the committee:

...most of the time things are not addressed, because of the fear of retribution in the facility. An older person who is already in a facility is in a more vulnerable position. We have had numerous phone calls from people who are moving their family from one facility to another rather than actually putting in a formal complaint, because it is so hard to deal with and the system does not lend itself in a supportive manner to the families.³⁶

33 DRALHRO, *Disability Rights Now*, p. 102.

34 Ms Samantha Connor, Researcher, People with Disability WA, *Committee Hansard*, Perth, 10 April 2015, p. 34.

35 Families Australia, *Submission 3*, p. [3].

36 Ms Sharon Richards, Acting CEO, Advocare, *Committee Hansard*, Perth, 10 April 2015, p. 2.

Case study – New South Wales Ombudsman

5.42 The committee heard that NSW has recently implemented a unique approach to the reporting of serious incidents. In 2014, the NSW Government introduced the disability reportable incidents scheme, the only legislated scheme in Australia for the mandatory reporting and independent oversight of serious incidents involving people with disability in supported accommodation (see Box 5.3).³⁷

Box 5.3: NSW Ombudsman disability reportable incidents scheme

On 3 December 2014, the *Disability Inclusion Act 2014* (NSW) came into effect, including amendments to the *Ombudsman Act 1974* (NSW) to introduce the disability reportable incidents scheme (scheme) for reporting and oversight of the handling of serious incidents, including abuse and neglect, involving people with disability in supported group accommodation.

The scheme requires that within 30 days of becoming aware of a reportable allegation or reportable conviction, the Secretary of the Department of Family and Community Services (FACS), or head of a funded provider, must give the NSW Ombudsman notice of the allegation and/or conviction.

Under the scheme, the Ombudsman is required to:

- receive and assess notifications concerning reportable allegations or convictions;
- scrutinise agency systems for preventing reportable incidents, and for handling and responding to allegations of reportable incidents;
- monitor and oversight agency investigations of reportable incidents;
- respond to complaints about inappropriate handling of any reportable allegation or conviction;
- conduct direct investigations concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable incident or conviction;
- conduct audits and education and training activities to improve the understanding of, and responses to, reportable incidents; and
- report on trends and issues in connection with reportable incident matters.

Between the introduction of the scheme and 25 August 2015, 437 matters were reported. The reported matters included:

- 55 per cent (240) involving allegations of employee to client matters;
- 34 per cent (148) involving allegations of client to client matters;
- 10 per cent involving allegations relating to unexplained serious injury; and
- one per cent involving allegations of breaches to an apprehended violence order (AVO).

Source: NSW Ombudsman, *Submission 29*, pp 2–10; Mr Steve Kinmond, Community and Disability Services Commissioner and Deputy Ombudsman, *Committee Hansard*, 27 August 2015, pp 16–17.

5.43 To complement the scheme, the NSW Ombudsman has also established a Best Practice Working Group made up of disability leaders and subject-matter experts to provide advice and support on sector-wide improvement and cultural change. The working group is currently examining a range of issues including:

37 NSW Ombudsman, *Submission 29*, p. 2.

...staff screening and recruitment practices, the related need for a workable information exchange regime, the availability of and access to relevant commissions and expert advisers, assessing the capacity of individuals to consent to sexual activity, support for victims with disability and, where relevant, their family members and the criminal justice response to people with intellectual disability.³⁸

5.44 The Deputy Ombudsman, Mr Steve Kinmond, estimated that the notification of abuse and neglect matters via the mandatory reportable incidents scheme was over 10 times the number of matters that were received via the existing complaints system.³⁹ Mr Kinmond told the committee that of the 437 matters reported through the scheme since its introduction in December 2014, there had been seven charges made already, a number of which 'would not have been laid were it not for the fact that we were involved'.⁴⁰ Mr Kinmond noted:

...we expect that [number of finalised matters] will climb substantially in the near future. But the fundamental test I have for my staff—at this point in time in terms of the matters that we have before us—is whether there are adequate steps being taken to protect not only the identified victim for the purposes of the matter that we are looking at but also other people who may be at risk. So the timeliness of our response to matters pertaining to protection will be my early focus. And of course over time with those numbers we then start to look at and track very closely whether what is coming in the door is matched by what is being finalised. Otherwise, it becomes unsustainable.⁴¹

Case study – Victorian Ombudsman's investigation

5.45 In December 2014, the Victorian Ombudsman launched an investigation into the capacity and capability of the oversight systems for disability services, prompted by revelations in the media and concerns in the sector.⁴² Phase 1 of the Ombudsman's final report examining the effectiveness of statutory oversight identified serious issues limiting the effectiveness of existing oversight mechanisms:

...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

38 Mr Steve Kinmond, Community and Disability Services Commissioner and Deputy Ombudsman, NSW Ombudsman, *Committee Hansard*, Sydney, 27 August 2015, p. 17.

39 Mr Steve Kinmond, *Committee Hansard*, Sydney, 27 August 2015, p. 16.

40 Mr Steve Kinmond, *Committee Hansard*, Sydney, 27 August 2015, p. 19.

41 Mr Steve Kinmond, *Committee Hansard*, Sydney, 27 August 2015, p. 20.

42 Phase 2 of the report will examine incident reporting and management in more detail. Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight*, June 2015, p. 4, **Error! Hyperlink reference not valid.** (accessed 24 September 2015).

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.⁴³

5.46 The Ombudsman's report found that the response to an allegation of abuse of a person with disability 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.⁴⁴

5.47 Similarly, the Victorian Parliament's Family and Community Development Committee interim report on its inquiry into abuse in disability services noted:

...while there are sophisticated policies and processes in place in Victoria for complaint handling and responding to disclosures or allegations of abuse in disability services, the pathways for making complaints and reporting abuse or neglect are complicated and often confusing. In particular...there is confusion between the policies and processes for handling and escalating complaints, and for the management of reportable incidents.⁴⁵

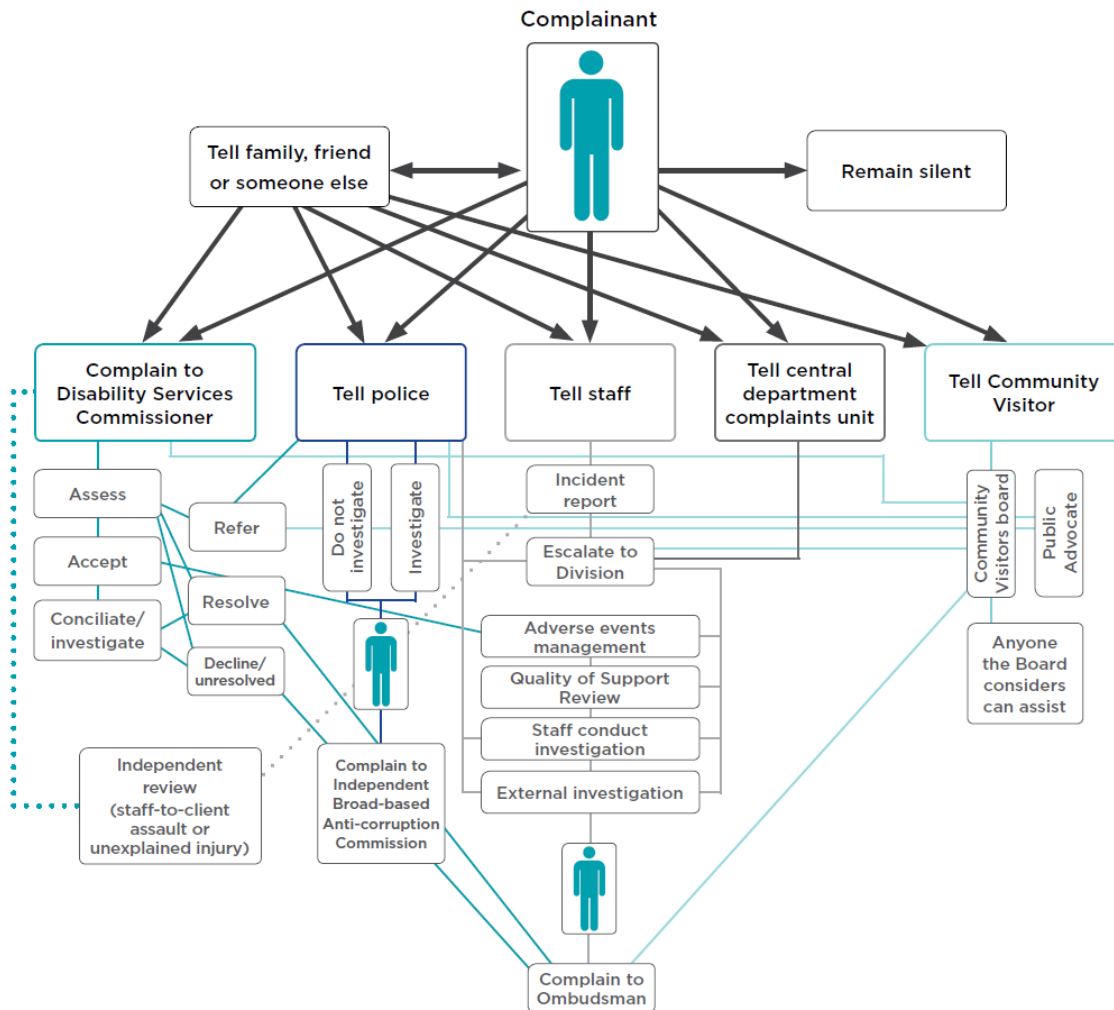
5.48 The complexity of the available reporting pathways for complaints in Victoria is highlighted in Figure 5.1, taken from the Ombudsman's report.

43 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 4.

44 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 8.

45 Parliament of Victoria, Family and Community Development Committee, *Inquiry into Abuse in Disability Services – Interim Report*, 2015, p. xxiv, <http://www.parliament.vic.gov.au/fcdc/article/1854> (accessed 24 September 2015).

Figure 5.1: Disability Act complaint pathways in Victoria



Source: Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, Figure 1, p. 19.

5.49 The Ombudsman's report identified further inconsistencies in the way different allegations of abuse are managed, such as:

- serious incidents in SRS [supported residential services] are not subject to DHHS [Department of Health and Human Services] 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 [Disability Services Commissioner] 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; and

- Community Visitors can inspect SRS or accommodation provided by DHHS or CSOs [community service organisations], but not day services or TAC [Transport Accident Commission] accommodation.⁴⁶

5.50 Other issues identified by the Ombudsman included:

- no single source of information or common framework in the disability sector to guide the reporting of abuse;
- no independent review of all serious incidents;
- lack of consistent approach to investigating serious misconduct by funded providers;
- constraints on some parts of the system from sharing information;
- limited appreciation of the importance of the role of advocates, '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'; and
- tension between the roles of the department [DHHS], 'particularly its dual functions as both funder/provider of services and regulator'.⁴⁷

5.51 The Ombudsman made two key recommendations to address the lack of consistent mandatory reporting, complex oversight arrangements, gaps in oversight and lack of advocacy services:

- establish, or transfer responsibility to an existing agency, for a single independent statutory oversight body to incorporate mandatory reporting, assessment and advocacy, community visitors, senior practitioner and disability worker exclusion scheme; and
- undertake a comprehensive assessment of the advocacy needs of people with disability and transfer sufficient funding and responsibility to the Office of the Public Advocate.⁴⁸

5.52 The recommendations of the Ombudsman's report were supported by a number of submitters and witnesses in Victoria. Mr David Craig, Project Coordinator from the Victorian Advocacy League for Individuals with a Disability (VALID) told the committee:

VALID supports the Ombudsman's recommendations for an independent investigative agency that can bring a measure of coherence, consistency and vigour to keeping people with intellectual disabilities safe.⁴⁹

46 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 8, <https://www.ombudsman.vic.gov.au/Investigations/Investigation-into-disability-abuse-reporting> [accessed 25 September 2015].

47 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 8.

48 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 91.

49 Mr David Craig, *Committee Hansard*, Melbourne, 30 June 2015, p. 44.

5.53 The committee also heard support for the Ombudsman's recommendations across jurisdictions. For example, in Queensland, the Office of the Public Guardian noted:

An independent complaints mechanism separate from funding and service provision is a critical element of any protective framework to guard against and prosecute cases of violence, abuse and neglect.⁵⁰

5.54 However, some witnesses criticised the Ombudsman's report for not taking a 'hard-hitting approach' towards perpetrators of abuse and violence. JacksonRyan Partners, a Victorian disability consultancy, was critical that the Ombudsman:

...failed to make findings detailing how those responsible for safeguarding and those responsible for services should more aggressively deal with those who commit abuse, neglect and violence...it is not systems and process that perpetrate abuse, neglect and violence—it is people.⁵¹

5.55 Going beyond critiques of existing state and territory based complaints bodies, the committee heard strong support for national, independent oversight mechanisms to identify and respond to allegations and incidents of abuse, violence and neglect. The Queensland Office of the Public Advocate (OPA) submitted:

Integral to an effective system is the existence of independent entities with strong investigative powers to handle complaints; these entities should be removed from the service provider, or department or agency funding the service.

Without such independent oversight and investigative powers there is a danger that cultures of violence, abuse and neglect go unchallenged. Apart from the service provider itself, even the department or agency responsible for funding the service also has a vested interest. For this reason there must be an independent statutory authority that can conduct investigations into serious, systemic and/or unresolved allegations of violence, abuse and neglect.

The independent entity or body should have powers to receive, resolve and investigate complaints; request information and conduct investigations both in response to complaints and of its own volition; report on the outcomes of investigations and make recommendations and/or directions to regulatory bodies concerning funding and registration of the service provider subject to the complaint.⁵²

5.56 The committee notes that the proposed quality and safeguarding framework consultation paper discusses the role of external oversight under the NDIS:

A key issue for the scheme is whether there is also a case for establishing a body with an independent oversight function to provide an additional level of assurance for the NDIS. Such a body would provide a leadership role

50 Office of the Public Guardian Queensland, *Submission 18*, p. 10.

51 JacksonRyan, *Submission 42j*, p. 2.

52 Office of the Public Advocate, Queensland, *Submission 73*, p. 16.

across the NDIS to ensure that registered organisations hear and respond to complaints and other feedback in positive ways.⁵³

5.57 The role of the NDIS in establishing a national monitoring and reporting framework is discussed in greater detail in chapter nine.

Community visitor programs

5.58 One effective external mechanism identified by the Victorian Ombudsman was the volunteer Community Visitors program in Victoria. The Ombudsman noted that program provides:

...an important protection at a minimal cost, and actively foster[s] the social inclusion of people with disability in the community.⁵⁴

5.59 Across all jurisdictions, the roles and responsibilities of community visitor schemes differ widely. Some jurisdictions have community visitor programs responsible for inspecting residential facilities for people with disability. Other jurisdictions have community visitors for mental health services only. The different roles of community visitor programs across jurisdictions are outlined in Table 5.3 below.⁵⁵

53 NDIS, *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework*, February 2015, p. 25.

54 Victorian Ombudsman, *Reporting and investigation of allegations of abuse*, p. 7.

55 See: NSW Ombudsman, Official Community Visitors, <https://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/official-community-visitors>; Office of the Public Advocate Victoria, *Community Visitors*, <http://www.publicadvocate.vic.gov.au/our-services/community-visitors>; Queensland Office of the Public Guardian, *Community Visitors*, <http://publicguardian.qld.gov.au/adult-guardian/adult-community-visitors>; WA Council of Official Visitors, <http://coov.org/>; South Australian Government, *Community Visitor Scheme*, <https://www.sa.gov.au/topics/citizens-and-your-rights/feedback-and-complaints/community-visitor-scheme>; Tasmanian Government, Official Visitor Programs, <http://officialvisitors.tas.gov.au/home>; Public Trustee for the ACT, ACT Official Visitor Scheme, <http://www.publictrustee.act.gov.au/visitor-scheme>; NT Community Visitor Program, <http://www.cvp.nt.gov.au/index.html> (all accessed 24 August 2015).

Table 5.3: Community visitor programs by jurisdiction

Jurisdiction	Agency	Visited sites	Capacity	Appointment
NSW	NSW Ombudsman	<ul style="list-style-type: none"> • Disability accommodation • Assisted boarding houses 	Part-time	Minister for Disability Services
Victoria	Office of the Public Advocate	<ul style="list-style-type: none"> • Disability accommodation • Supported residential facilities • Mental health facilities 	Volunteer	Governor in Council
Queensland	Office of the Public Guardian	<ul style="list-style-type: none"> • Disability accommodation • Mental health services • Private hostels 	Casual	Office of the Public Guardian
WA	Council of Official Visitors (established by WA Parliament)	<ul style="list-style-type: none"> • Mental health services and hospitals • Psychiatric hostels 	Sessional (paid sitting fees and expenses)	Council of Official Visitors
SA	Community Visitor Scheme	<ul style="list-style-type: none"> • Hospital emergency departments/acute mental health units • Disability accommodation • Supported residential facilities 	Trained volunteer	Governor
Tasmania	Office of the Ombudsman and Health Complaints Commissioner	<ul style="list-style-type: none"> • Mental health facilities • Prisons and corrections facilities 	Volunteer	Principal Official Visitor
NT	Community Visitor Program	<ul style="list-style-type: none"> • Mental health services and hospitals 	Sessional	
ACT	Public Trustee for the ACT	<ul style="list-style-type: none"> • Disability accommodation • Mental health facilities • Detention and correction facilities • Therapeutic protection places 	Part-time	Attorney-General

Source: Refer to footnote 54.

5.60 The committee heard from the administrators of a number of community visitor schemes across jurisdictions.⁵⁶ In Victoria, the OPA noted that between 2009-10 and 2013-14, 880 incidents have been reported by community visitors, including 'troubling cases of assault by staff, serious and unexplained injuries and people living in fear of violence'.⁵⁷

5.61 Submitters highlighted the benefits of community visitor schemes in identifying incidents of abuse, violence and neglect.⁵⁸ The South Australian Community Visitor Scheme suggested the implementation of community visitor programs in all jurisdictions across all institutions:

...we think it is vital that there be Community or Official Visitor programs to all institutions and residential facilities as an important means to detect violence, abuse and neglect of people with a disability, including those with a mental illness. Evidence from almost four years of operating also suggests that our Community Visitors build trusting relationships with not only service users but also staff who disclose many issues of concern relating to the care and treatment of vulnerable individuals.⁵⁹

5.62 Similarly the Queensland OPA submitted that community visitors should have greater powers to investigate and refer complaints:

The Community Visitor Programs, or a similar inspectorate should operate as an inquisitorial process in terms of identifying, investigating and resolving complaints. These informal processes can be of great benefit particularly to people with impaired capacity who may have difficulty making complaints. However, they can and should have a role in referring complaints to external, independent complaints bodies.⁶⁰

5.63 However, Ms Susan Salthouse, an Official Visitor for Disability in the Australian Capital Territory, told the committee that the scheme is limited in providing ongoing support to vulnerable and isolated people:

Official visitors provide that additional safeguard but what we can ascertain on a visit of about one hour, every six to nine months, is not foolproof. There are levels of vulnerability with increased isolation from the community.⁶¹

5.64 A number of witnesses expressed concern that reports made by community visitors, particularly to government departments, don't necessarily result in positive

56 See: Office of the Public Guardian, Queensland, *Submission 18*, p. 6; South Australian Community Visitor Scheme, *Submission 16*, p. 2; Ms Susan Salthouse, Official Visitor for Disability in the ACT, ACT Government Official Visitor Scheme, *Committee Hansard*, Canberra, 21 August 2015, pp 27–28.

57 OPA Victoria, *Submission 64*, p. 4.

58 ACT Human Rights Commission, *Submission 114*, p. 2; SACVS, *Submission 16*, p. 1.

59 South Australian Community Visitor Scheme, *Submission 16*, p. 1.

60 OPA, Queensland, *Submission 73*, p. 18.

61 Ms Susan Salthouse, *Committee Hansard*, Canberra, 21 August 2015, p. 28.

change. The Victorian OPA noted that its community visitors report long delays in responses from departments to reports of abuse. In one case cited by the Victorian OPA:

Community Visitors have been reporting serious and significant issues at this house including staff abuse and misconduct since 2012 and, despite a service review by an external consultant, they report there were no significant improvements to the environment by the end of 2014.⁶²

5.65 Ms Pauline Williams from Action for More Independence and Dignity in Accommodation highlighted that although facilities are regularly visited, and issues regularly reported, issues are not resolved:

...in investigating all of the monitoring of the supported residential services that has gone on, it has been clear that, time after time, they have been non-compliant. In some cases, visiting has happened monthly for 34 months and they have still been non-compliant on issues like medication dispensing, food quality, emergency services and safety procedures. If time and time again, over many years, noncompliance is shown by a sector, why is it still allowed to function? Why is it still licensed, registered and supported by governments?⁶³

5.66 Similarly, the Intellectual Disability Rights Service told the committee feedback from its consultations found that people who had contacted community visitors were frustrated with the outcomes:

While one caller was happy with action taken when a matter was raised with the community visitor program of the Ombudsman, 3 other callers raised their frustration with the long delays and process involved in investigation. Two callers did not feel the Ombudsman had sufficient power to achieve solutions to problems of neglect.⁶⁴

5.67 Ms Sandra Guy, the parent of a Yooralla client in Victoria, expressed frustration that reports made by community visitors may not result in action, and that community visitors do not engage with the families of people with disability to advise on the progress of reports:

The problem is that I cannot tell you how many times I have called the community visitors in relation to the concerns at my son's house, which have been going on now for six long years, and what happens is that they might go to my son's house but you have no idea what went on. They might lodge a report with the department and that is as far as it goes—end of story. What you do not see is any change...They refuse to talk to families, and we do not know what happened when they went or what was in the

62 OPA Victoria, *Submission 64*, p. 21.

63 Ms Pauline Williams, Housing Rights Co-ordinator, Action for More Independence and Dignity in Accommodation, *Committee Hansard*, Melbourne, 30 June 2015, p. 52.

64 Intellectual Disability Rights Service, *Submission 128a*, p. 7.

report. It appears to go nowhere, because there is no change, despite these claims.⁶⁵

5.68 Another concern was that the voluntary basis of the scheme in most jurisdictions reduced the capacity of visitors to provide support to families. Ms Colleen Pearce, the Victorian Public Advocate, told the committee:

The programs simply do not have the capacity to be in contact with parents. Where parents are at a facility on the day when the community visitors visit, they will talk to parents. But there is a lack of the capacity of volunteers to follow up and provide information, giving out personal telephone numbers—we are talking about 450 volunteers...We are lucky if our volunteers get reimbursed for out-of-pocket expenses.⁶⁶

5.69 Some submitters suggested that existing community visitor schemes continue under the NDIS. The Victorian OPA recommended:

...the Community Visitors Program continue to be funded during the NDIS transition period and, secondly, that existing state and territory community visitor programs continue to have a mandate to operate in the context of the full rollout.⁶⁷

5.70 Other submitters suggested that the NDIS quality and safeguarding framework should include a community visitor scheme.⁶⁸ The Queensland OPA recommended that the NDIS framework should include:

...independent safeguarding mechanisms such as the Community Visitor Program that can cast an independent eye over service arrangements and that have the potential to seek out issues of concern for people with disability, rather than requiring people with disability to independently navigate formal complaints management systems.⁶⁹

Mandatory reporting

5.71 A number of submitters and witnesses supported the introduction of an independent, mandatory reporting process, such as the NSW scheme, in ensuring incidents are adequately reported and investigated.⁷⁰ The Law Council of Australia recommended in relation to elder abuse:

...that now is the time for Government to conduct a review of mandatory reporting requirements and to strike an appropriate balance between

65 Ms Sandra Guy, *Committee Hansard*, Melbourne, 30 June 2015, p. 15.

66 Ms Colleen Pearce, *Committee Hansard*, Melbourne, 30 June 2015, p. 36.

67 Ms Colleen Pearce, *Committee Hansard*, Melbourne, 30 June 2015, p. 33.

68 See: United Voice, *Submission 17*, p. 6; Disability and Community Services Commissioner, ACT, *Submission 114*, p. 9.

69 OPA Queensland, *Submission 73*, p. 23.

70 See: Disability Justice Advocacy, *Submission 14*, p. 5; Name withheld, *Submission 60*, p. 4; Advocacy Tasmania Inc, *Submission 97*, p. 8; NSW Council for Intellectual Disability, *Submission 103a*, p. 5; Commonwealth Ombudsman, *Submission 117*, p. 7.

safeguarding against elder abuse and ensuring the regulatory burden on aged care facilities are minimised.⁷¹

5.72 The Hon Kelly Vincent MLC, a member of the South Australian Legislative Council representing the Dignity for Disability Party, told the committee she strongly supports a mandatory reporting scheme. Ms Vincent noted that legislation she has introduced into the South Australian Parliament to introduce a mandatory scheme has not been supported by that Government:

The government is not amenable to it because it believes that (a) it is better to have safeguarding mechanisms against abuse and (b) the existing child mandatory reporting scheme is overburdened and basically broken so it would be almost inefficient to implement another. My rebuttal to that would be we certainly never said that it was either mandatory reporting or safeguarding...The other point I would make in rebuttal to the government's argument is, in terms of the child mandatory reporting mechanism already being broken and therefore it not be worth doing anything else, if I break a window in my house, I do not go through the house and break all the other windows so that they match; I fix the window. I think perhaps rather than saying the system is broken so we cannot do anything else, we could perhaps look at fixing the system.⁷²

5.73 The South Australian OPA emphasised that mandatory reporting is not sufficient, and supported instead a system of 'mandatory response':

...that provides clear duties for all providers when they become aware of a risk of abuse, or actual abuse. These duties may include immediate action to keep a person safe, working with other sectors (e.g. the police, or social work services), and a clear strategy of escalation and reporting.⁷³

A national approach to reporting abuse

5.74 A number of submitters and witnesses recommended the establishment of a national, independent, statutory body with powers to investigate and respond to allegations of violence, abuse and violence against people with disability in all settings. The committee heard support for such a body from a range of stakeholders including public advocates and guardians, peak bodies, advocacy groups and families.⁷⁴

5.75 For example, Mr Damian Griffis, representing the First Peoples Disability Network Australia as part of the Disability Alliance, told the committee:

71 Law Council of Australia, *Submission 139*, p. 22.

72 The Hon Kelly Vincent MLC, *Committee Hansard*, Adelaide, 28 August 2015, p. 62.

73 Office of the Public Advocate, South Australia, *Submission 13*, p. 2.

74 See, for example: Health Services Union, *Submission 69*, p. 5; Disability Clothesline, *Submission 68*, p. [840]; Advocacy for Disability, *Submission 83*, p. 33; Intellectual Disability Rights Service, *Submission 128*, p. [5]; Ms Julie Phillips, *Submission 131*, p. 65; Dr Sherene Devanesen, CEO, Yooralla, *Committee Hansard*, Melbourne, 30 June 2015, p. 3.

I think the answer is pretty simple. An independent statutory body is the answer. That is something that has been articulated by advocates for a long time, and I think its time is well overdue. That is a critical part of the picture. One of the problems with the National Disability Abuse and Neglect Hotline is its lack of enforceability. It is just a reporting mechanism, really. So I think that is a critical part of the puzzle, and I think its time is well and truly here—in fact, it is long overdue.⁷⁵

5.76 There were numerous proposals for the specific form such a body could take. For example, the Disability Alliance recommended that a national body should have the following functions:

- a 'no wrong door' complaint handling function—the ability to receive, investigate, determine, and make recommendations in relation to complaints raised;
- the ability to initiate 'own motion' complaints and to undertake own motion enquiries into systemic issues;
- the power to make recommendations to relevant respondents, including Commonwealth and State and territory governments, for remedial action;
- the ability to conduct policy and programme reviews and 'audits';
- the ability to publicly report on the outcomes of systemic enquiries and group, policy and programme reviews, or audits, including through the tabling of an Annual Report to Parliament; the ability to develop and publish policy recommendations, guidelines, and standards to promote service quality improvement;
- the ability to collect, develop and publish information, and conduct professional and public educational programs; and
- the power to enable enforcement of its recommendations, including for redress and reparation for harms perpetrated.⁷⁶

5.77 Some submissions also suggested that a national body should also have oversight of restrictive practices. Children with Disability Australia recommended:

...the creation of a national body charged with monitoring and reporting the use of restrictive practices, with the explicit aim of ensuring restraint and seclusion is recognised as abuse and its use is reduced.⁷⁷

5.78 The committee notes that oversight mechanisms are being considered by the NDIA as part of its consultation paper on the proposed NDIS quality and safeguarding framework. This proposed approach will be examined in chapter nine.⁷⁸

75 Mr Damian Griffis, *Committee Hansard*, 27 August 2015, p. 46.

76 Australian Cross Disability Alliance, *Submission 147*, pp 12–13.

77 Children with Disability Australia, *Submission 144*, p. 43.

78 NDIS, Proposal for National Disability Insurance Scheme Quality and Safeguarding framework: Consultation paper, pp 23–24.

National safeguarding systems

5.79 Some submitters suggested adopting a system-wide approach to safeguarding against abuse and violence against all vulnerable people, based on models in the United Kingdom and Scotland. These models implement safeguards across the health, social welfare and justice sectors to protect all 'at-risk' adults, including those with disability.⁷⁹ This includes early intervention approaches to identifying and reporting incidents and allegations of abuse, violence and neglect (see Boxes 5.4 and 5.5).

Box 5.4: Scotland—Adult Support and Protection

Under the *Adult Support and Protection (Scotland) Act 2007*, Scottish local councils and a range of public bodies are required to work together to support and protect adults who are unable to safeguard themselves, their property and their rights.

The Act defines adults at risk as people aged 16 years or over who meet all three of the following criteria:

- are unable to safeguard themselves, their property (their home, the things they own), their rights or other interests;
- are at risk of harm; and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.

The Act introduced measures to identify and protect individuals who fall into the category of adults at risk. These measures include:

- requiring councils to make the necessary enquiries and investigations to see if action is needed to stop or prevent harm happening;
- requiring specific organisations to cooperate with councils and each other about adult protection investigations;
- the introduction of a range of protection orders including assessment orders, removal orders and banning orders; and
- a legislative framework for the establishment of local multi-agency Adult Protection Committees across Scotland.

The Act places a duty on councils to make enquiries about an individual's well-being, property or financial affairs where the council knows or believes that the person is an adult at risk and that it may need to intervene to protect him or her from being harmed. It authorises council officers to:

- carry out visits;
- conduct interviews;
- be accompanied by a doctor or nurse to carry out a medical examination in private; and
- require health, financial or other records to be produced in respect of the adult at risk.

The council can also apply for a protection order if they think the adult is at risk of, or is being seriously harmed.

Source: Scottish Government, *Adult Support and Protection*, <http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection>; Scottish Government, *Act Against Harm*, <http://www.actagainstharm.org/> (accessed 23 September 2015).

79 See: Office of the Public Advocate, SA, *Submission 13*, p. 2; OPA Queensland, *Submission 73*, p. 20.

Box 5.5: Care Act 2014 (UK)

In April 2015, the *Care Act 2014* came into effect in the United Kingdom. The Act introduced guidance on safeguarding vulnerable adults from abuse to replace the 'No Secrets' guidance introduced in 2000.

According to the guidance, 'safeguarding' means:

...protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

The Act introduces mandatory reporting requirements that require local authorities to:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom;
- set up a Safeguarding Adults Board;
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them; and
- co-operate with each of its relevant partners in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

The safeguarding approach is underpinned by the following principles:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent.
- Prevention – It is better to take action before harm occurs.
- Proportionality – The least intrusive response appropriate to the risk presented.
- Protection – Support and representation for those in greatest need.
- Partnership – Local solutions through services working with their communities.
- Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding.

Source: UK Government, *Care Act 2014: Statutory guidance for implementation*, Chapter 14: Safeguarding, <https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation> (accessed 23 September 2015).

5.80 The South Australian OPA noted the principles of its report on rights-based protection for older people, *Closing the Gaps*, could be applied to people with disability.⁸⁰ The report found the current legal framework in South Australia:

...provides protective frameworks for serious cases of abuse and for those who are particularly vulnerable due to mental illness or incapacity, but it does not provide a framework for less intrusive methods of intervention, or early intervention, and at a time when serious abuse or neglect could be avoided. In these respects, the current legal system is not preventative in nature and fails to provide an incremental approach to intervention that recognises degrees of vulnerability falling short of complete incapacity.⁸¹

Concluding committee view

5.81 The evidence presented to this inquiry shows that existing internal and external mechanisms for reporting abuse are complex and there is no national consistency in how allegations and incidents are reported. This has had the effect of both discouraging reporting meaning cases of abuse go unreported, as well as reducing the efficacy of investigations.

5.82 The committee acknowledges the findings of the 2015 Victorian Ombudsman's report and evidence from inquiry witnesses that existing mechanisms are not effective in reporting and responding to allegations and incidents of violence, abuse and neglect.

5.83 After reviewing oversight mechanisms across Australia, the committee recognises the important role played by community visitor schemes. However, for these schemes to be effective, most require better funding to improve training, increased numbers of visits, increased capacity to communicate with families, and to be granted the authority to report and investigate allegations and incidents.

5.84 The committee recognises that a clear and consistent recommendation was made by many submitters and witnesses, including government agencies, that there is a need for a single, independent oversight body for all entities and individuals providing services to people with disability, with appropriate whistleblower protections.

5.85 In establishing such a national body, the committee recognises the value of the NSW Ombudsman disability reportable incidents scheme. The committee particularly notes the strength of this system is based on the mandatory reporting requirements.

80 Office of the Public Advocate, SA, *Submission 13*, p. 2.

81 Office of the Public Advocate and the University of South Australia, 'Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People,' October 2011, *Submission 13, Attachment 1*, p. 23.

