

29 June 2015

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email to: community.affairs.sen@aph.gov.au

Dear Secretary

**Senate Inquiry into violence, abuse and neglect of people with disability in
institutional and residential settings**

Please find attached my office's submission to the Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, which is currently being conducted by the Senate Standing Committees on Community Affairs.

I trust this submission will be of assistance to the Committees' Inquiry into this important topic.

If you would like to speak to my office regarding this submission, please contact Mr George Masri on (02) 6276 0129. If the Committee would like to speak with me directly, I can be contacted on (02) 6276 3707.

Yours sincerely



Richard Glenn
Acting Commonwealth Ombudsman



**Submission by the
Commonwealth Ombudsman**

**VIOLENCE, ABUSE AND NEGLECT
AGAINST PEOPLE WITH DISABILITY IN
INSTITUTIONAL AND RESIDENTIAL
SETTINGS**

**CONDUCTED BY
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE**

Richard Glenn
Acting Commonwealth Ombudsman

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BACKGROUND

The office of the Commonwealth Ombudsman was established in Australia by the *Ombudsman Act 1976*. The Commonwealth Ombudsman safeguards the community in its dealings with Australian Government agencies by:

- correcting administrative deficiencies through independent review of complaints about Australian Government administrative action
- fostering good public administration that is accountable, lawful, fair, transparent and responsive
- assisting people to resolve complaints about government administrative action
- developing policies and principles for accountability
- reviewing statutory compliance by agencies.

The Commonwealth Ombudsman's unique position in the Australian administrative law landscape provides us with an understanding of many individual experiences of members of the public, who are dissatisfied with the way that government has dealt with their issue. The Commonwealth Parliament has given the Ombudsman's office the power to investigate those complaints by obtaining records and information from the agency that would not ordinarily be available to a person acting on their own behalf. The office also engages with peak bodies and community representatives to gain an understanding of the experience of their constituencies in dealing with government.

Over time, through investigating complaints about the actions of Commonwealth agencies and speaking to the community about their experiences; the Ombudsman's office is able to build up a detailed picture of those agencies' operations.

RESPONSE TO TERMS OF REFERENCE

The Ombudsman's office welcomes the opportunity to contribute to the Committee's Inquiry into violence, abuse and neglect of people with disability in residential and institutional settings. We provide the following comments based on our experience in dealing with complaints and our work in anticipation of the development of a national quality and safeguarding framework for participants of the National Disability Insurance Scheme (NDIS) (terms of reference (l) and (m)).

The Ombudsman's role

The Commonwealth Ombudsman has jurisdiction to consider complaints about the administrative actions of Australian Government departments and agencies, as well as the delivery of services by contracted service providers for and on behalf of the Australian Government.

At present, state and territory bodies are responsible for oversight of the delivery of the majority of goods, services and daily interactions with which people with disability in residential and institutional care are engaged.

Notwithstanding the significant role that states and territories play in handling complaints from people with disability in residential and institutional care, there are two areas of the Commonwealth Ombudsman's jurisdiction that are of particular relevance to this Inquiry. They include jurisdiction in relation to the National Disability Insurance Agency and its

administration of the NDIS and to jurisdiction the office has over aged care complaints. We have, on occasion, received anecdotal reports of violence, abuse or neglect against people with disability in the provision of aged care services and in the delivery of disability supports funded by the NDIS to people in residential and institutional settings. This feedback stems from consultations we have had with community groups in the disability and aged care sectors and from complaints we did not investigate.

Although we are not in a position to verify the claims, analysis of this anecdotal feedback reveals a number of themes such as:

- under-staffing and/or under-resourcing of residential aged care and disability facilities, particularly in those sections of a facility where the type or severity of the residents' disability is such that they are unaware their care is being compromised and/or are unable to complain
- overmedicating residents as a method of restraint, particularly those residents with intellectual disability or cognitive impairment that makes their behaviour difficult or unpredictable
- the inability of residents (or the family or carer on their behalf) to obtain a suitable, alternative residential aged care or disability placement, in order to escape violence, abuse or neglect; particularly where the resident has high care needs.

We also note and support the general findings and recommendations set out in the Victorian Ombudsman's recent report into *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight. June 2015*.

Visibility of violence, abuse and neglect in complaints

There are a number of reasons why this office (and others) may not receive specific or direct complaints from, or on behalf of people with disability in residential and institutional settings who experience violence, abuse and neglect. These reasons are likely to include but not be limited to:

- the person subject to the behaviour:
 - does not understand the conduct they have been subjected to is inappropriate
 - (or their family or carer) lacks the confidence or ability to represent themselves or properly articulate their concerns
 - (or their family or carer) is not aware of a suitable body to consider their concerns
 - (or their family or carer) is unwilling to disclose the conduct for fear of retribution such as withdrawal of services, social or physical isolation, or continued/increased mistreatment
- the complaint is made to another oversight body, at the state/territory or national level (as above).

Protections for people with disability

Current arrangements and challenges

There are a number of different safeguards and oversight mechanisms that apply to engagement with people with disability. Some of these are more general and apply to all people with disability, such as disability and health services complaints systems. Others exist specifically to provide protections to people in residential and institutional settings, such as

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the NSW Ombudsman's oversight of mandatory reporting arrangements in residential care. Almost all are administered at the state or territory level.

While the precise arrangements vary across states and territories, most jurisdictions have a mix of some or all of a:

- state or territory Ombudsman¹
- disability services commissioner
- health complaints commissioner
- fair trading or consumer protection authorities
- police force.

Many states and territories also have a mix of some or all of a:

- mandatory incident reporting scheme
- community visitor scheme
- system for employee background / police checks to confirm suitability to work with children, aged people, people with disability
- system for approving and/or monitoring the use of restrictive practices.

Each of these offices and schemes provides opportunities to identify, address and prevent violence, abuse and neglect against people in residential and institutional care.

However, 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.

Looking to the future

With respect to the National Disability Insurance Scheme (NDIS), the Australian Government has identified that the current system of fragmented, state- and territory- based protections and oversight is problematic and may result in inconsistent outcomes for participants.

As the NDIS moves towards national rollout between July 2016 and June 2019, the Government anticipates implementing a nationally consistent system of protections for people with disability accessing NDIS-funded supports. People with disability in residential and institutional settings are only a small cohort of the eventual participant pool, but are likely to require particular protection and support as they engage in the NDIS.

The Department of Social Services' (DSS) consultation paper *Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework* (the Framework consultation paper) outlines the need for consideration of a national system of safeguards that ensures NDIS participants are:

- enabled to build capacity to make informed decisions when planning, selecting and purchasing supports;

¹ The powers and jurisdiction of Parliamentary Ombudsmen across Australia vary significantly.

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- offered a level of assurance and protection about the quality, qualification and suitability of organisations and people engaged in delivering those supports; and
- provided with assistance to resolve any problems they experience with the delivery of those supports.

Quality and safeguarding measures for people with disability

This office made a submission to the NDIS Framework consultation in May 2015, following extensive consultation with state and territory Ombudsmen. That submission makes comments on the importance of multi-layered protections to address the various risks and challenges posed to NDIS participants as greater choice and competition become available in the provision of disability supports.

While our comments were framed in direct response to the NDIS Framework consultation, our submission also raised that there may be scope for a number of the safeguards to be applied more broadly and consistently to the oversight of all disability services.

We believe our submission to the NDIS Framework consultation is directly relevant to the Committee's considerations in this Inquiry. It assesses the protections and safeguards that are, and should be provided to people with disability to ensure that violence, abuse and neglect is identified, addressed and prevented: within the NDIS; in their residential or institutional setting; or in their daily lives more generally.

The Ombudsman's full submission to the NDIS Framework consultation can be found online on the DSS website.² The key aspects of our office's comments are also summarised below for the Committee's reference.

1. Government should consider simplifying and streamlining the complaints and oversight arrangements for disability matters by appointing an independent, well-resourced and well-advertised central complaints and oversight body³ tasked with:
 - receiving all complaints about disability
 - assessing complaints to identify whether the matter should be investigated directly or delegated or transferred to another oversight body that is better placed to consider the issues
 - investigating, making inquiries into, and resolving individual and system complaints
 - conducting investigations and inquiries on its own motion, including of systemic issues
 - protecting, and ensuring the confidentiality of information collected in the course of its investigations
 - providing protections for whistle-blowers and other people wishing to make public interest disclosures, and protection from retribution as a result of making a complaint or allegation
 - reaching conclusions about an investigated matter and, where warranted, furnishing a report to a service provider, the NDIA, a Minister, Parliament, the Council of Australian Governments Disability Reform Council, Parliamentary Committees and other designated regulatory bodies, directly or by publication.

² The full submission can be found on the Department of Social Services' consultation page at <https://engage.dss.gov.au/ndis-qsf-submissions/1432615332/>.

³ The Commonwealth Ombudsman has suggested that Government consider his office to take on the role of a national, independent complaints and oversight body for disability complaints.

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2. Government should consider the Commonwealth Ombudsman's office to take on the role of the national, independent complaints and oversight body for disability complaints.
3. Government should consider improving participants' and providers' understanding of rights and responsibilities in reporting and responding to wrong-doing, by tasking the central oversight body with:
 - engaging in community education about its role and powers, and the way its work intersects with that of related oversight, regulatory and law enforcement organisations
 - assisting individuals and organisations to make complaints and disclosures relating to disability issues.
4. Government should ensure that people with a disability – particularly those who may be isolated and/or without robust support networks – have a safety net to identify, and where appropriate refer for action, issues affecting their rights, safety or access to services, by implementing:
 - a well-resourced nationally-represented community visitor service
 - a nationally consistent system for mandatory incident reporting.
5. Government should ensure people with disability are empowered to complain about, and seek resolution of disability issues by implementing a well-funded, well-advertised and accessible national disability advocacy service.
6. Government should ensure that, wherever possible and reasonable, both the organisations and individuals delivering supports under the NDIS are deemed suitable to engage with people with disability (while still ensuring that wherever possible participants are afforded choice and competition in selecting their support providers) by implementing:
 - a 'mixed' model of provider registration that allows registration requirements to vary according to the type, frequency and location of the support to be provided
 - a nationally-consistent system of staff vetting, including a register of 'barred' persons.
7. Government should ensure each facet of the eventual Quality and Safeguarding Framework represents recognises and incorporates best practice systems of protection, by examining the existing state- and territory-based models for:
 - complaints and oversight
 - mandatory reporting
 - an official visitor program
 - provider registration and regulation, and staff vetting
 - approving and monitoring the use of restrictive practices.