Ombudsman
New South Wales

ABN 76 325 886 267
Level 24, 580 George Street, Sydney NSW 2000
T 02 9286 1000 | F 02 9283 2911
Tollfree 1800 451 524 | TTY 02 9264 8050
www.ombo.nsw.gov.au

Submission on the Proposal for a National Disability Insurance Scheme Quality and Safeguarding framework

May 2015

1. Background

Our submission is informed by our extensive work in relation to people with disability and disability services over the past 12 years, and our consultations with the disability sector. Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), the responsibilities of our office include a range of functions targeted at improving the delivery of services to people with disability, including:

- receiving and resolving complaints about disability services, and assisting people with disability to make complaints
- reviewing the pattern and causes of complaints about disability services, and making recommendations to improve how services handle and resolve complaints
- monitoring and reviewing the delivery of disability services, and making recommendations for improvement
- inquiring into matters affecting people with disability and disability services, and reviewing the situation of people with disability in residential care
- reviewing the causes and patterns of the deaths of people with disability in residential care, and making recommendations to reduce preventable deaths, and
- oversighting and coordinating the Official Community Visitor scheme.

On 3 December 2014, the NSW *Disability Inclusion Act 2014* came into effect. The new legislation amended the NSW *Ombudsman Act 1974* to include Part 3C 'Protection of people with disability' ('Part 3C'). Part 3C comprises a scheme for the reporting and oversight of the handling of serious incidents – including abuse and neglect – involving people with disability in supported group accommodation.

All of our functions apply to the NDIS launch sites in NSW.

Of all the jurisdictions in Australia, NSW currently has the greatest range of safeguards for people with disability. It will be important to ensure that the NDIS quality and safeguarding framework strengthens, rather than lessens, the safeguards available for participants in NSW.

In writing this submission, we have considered the submissions and views of other key organisations in relation to the quality and safeguarding framework. As a result, we have not sought to traverse every element in detail, particularly where other stakeholders with relevant expertise have comprehensively covered the issues.

2. Information for participants

We support the views of NSW Council for Intellectual Disability (NSW CID) in its submission regarding the key features of an NDIS information system for people with intellectual disability, including the importance of proactive approaches to reach people with disability who are not accessing necessary support.

Key components in the proposed quality and safeguarding framework have the potential to enable the provision of useful information to participants and their supporters. In particular, there is valuable information that could readily be disseminated regarding practice in relation to complaints, quality indicators and outcomes, serious incidents, and restrictive practices. We agree that information about service quality should be publicly

available, but believe that there would also be considerable merit in regularly and publicly reporting on a broader range of indicators of performance and practice.

In our view, one of the most important features of an NDIS information system for participants is the provision of appropriately targeted information and support to help them to understand and exercise their rights. In particular, there is a need to ensure that early action is taken to engage and work intensively with people with disability on:

- identifying when things are not ok and they need help
- speaking up to make complaints, and report abuse, neglect or ill-treatment
- making decisions, and
- where to get help.

There is substantial work that is required to help participants and other people with disability to develop the necessary skills to meaningfully exercise choice and control over their own supports, and take steps towards becoming savvy consumers. However, it would be a serious injustice to people with disability to provide information about how to exercise their rights without ensuring that appropriate supports are in place to help them to do so. A comprehensive, multifaceted and proactive approach is required. In this regard, we are in discussions with key parties in NSW about undertaking significant rights-based work with people with disability over the next year, involving partnerships between people with disability, advocates, complaints bodies, and other key agencies. It will be important to ensure that a national independent oversight body is established for the NDIS, with ongoing responsibility for driving this kind of work (discussed in section 5 below).

3. Building natural safeguards

We support the submission of NSW CID in relation to building natural safeguards for participants and other people with disability, including the importance of advocacy support.

Our office has seen the benefit of individual advocacy for people with disability, particularly for people without an informal support network, or where the person and their informal supports need assistance to raise and resolve concerns locally and at an early point. Advocates have been effective in bringing matters relating to abuse and neglect to our attention on behalf of individuals with disability, both within and outside of institutional and residential settings.

It will be important to ensure that individual advocacy continues to be available for people with disability (and their families/friends/carers) to access as required. The disability reforms provide a valuable opportunity to consider the necessary role and scope of individual advocacy (and advocacy more broadly) in the new funding and support arrangements. In this regard, it is worth noting the model of advocacy and assistance provided under New Zealand's National Health and Disability Services Advocacy Service, which provides a combined visiting, advocacy and complaints approach (outlined in Part 3 of the NZ *Health and Disability Commissioner Act 1994*).

It is vital that there is a strong and well-considered framework for the provision of timely, accessible and ongoing decision-making support for participants and other people with disability, particularly for those without family or friends. We agree that plan development

and review – with skilled planners – are key mechanisms for facilitating access to decision-making support. However, there also needs to be adequate scope to enable other individuals who may be in contact with the person – such as Local Area Coordinators, Community Visitors, and advocates – to prompt access to decision-making support for those who may not have been previously identified as requiring that type of assistance.

4. NDIA provider registration

We agree that basic registration requirements should include legal requirements and an NDIS code of conduct, which would set out key requirements to uphold the rights of people with disability (including mechanisms for facilitating and effectively handling complaints). We support a proportionate risk-based approach to the additional conditions and requirements that are attached to registration, and agree with the submission of NSW CID that consideration of risk should not be solely focused on the types of support provided: in particular, decisions regarding the registration requirements that apply to a provider should also take into account the vulnerability of the participants they support (including cognitive impairment, communication, and access to informal supports and independent parties).

We would support efforts to minimise the extent of duplication in accreditation requirements across various support sectors (including disability and aged care). In this regard, we note that the Orima online quality reporting system used in NSW enables providers to minimise the reporting they need to do, with automatic population of fields depending on the accreditation acquired.

In our view, it is worth considering the role that a national disability industry regulatory body may play in relation to quality management and evaluation, including monitoring compliance with the code of conduct and additional quality requirements; providing support and advice to providers of NDIS-funded disability supports to facilitate service improvement; and advising the NDIA where providers do not meet quality requirements. However, it will also be important to ensure that any such national disability industry regulatory body comes under the jurisdiction of an independent oversight agency.

It is essential that any quality requirements and reporting have a strong focus on the direct experience of participants, and the active involvement of people with disability and their supports in the assessment process, and we endorse the views of NSW CID in this regard. We also support the views of the Productivity Commission on the important role that Local Area Coordinators (as well as Community Visitors and advocates) can play in helping to independently assess the quality of service provision, such as through feedback from participants and their supporters. There should be clear mechanisms to enable Local Area Coordinators, Community Visitors and others to feed into the quality monitoring process.

5. Oversight functions

In our view, an independent oversight body is an essential component of an effective quality and safeguarding framework for the NDIS. Core functions of the oversight body should include responsibilities in relation to:

- complaints (discussed in section 6 below)

- oversighting the handling of 'reportable incidents'[1] (see section 7)
- conducting ongoing reviews into the effectiveness of aspects of the NDIS (that is, monitoring, review and inquiry functions)[2]
- community education and training, including in relation to:
    - participants and their supporters – to understand and exercise their rights (including in relation to complaints; abuse and neglect; and decision-making)
    - NDIS-funded supports and mainstream providers – including to promote best practice in complaint handling and resolution; prevention and appropriate responses to abuse and neglect; obligations under the UN Convention on the Rights of Persons with Disabilities and the National Disability Strategy; and whistleblower protections
- promoting access to advocacy and supported decision-making for participants and their supporters, and
- monitoring the implementation of the National Disability Strategy.

In order to effectively carry out its responsibilities, the oversight body will need substantial investigative and oversight powers. For example, powers to require parties to provide statements of information and documents; hold inquiries/hearings; enter and inspect certain premises; make recommendations; and report to Parliament and the public.[3]

In our view, it is important that it is a ***national*** oversight body for the national scheme. We do not have a strong view regarding whether the body should be a stand-alone agency or an additional function for an existing independent national oversight agency. However, in relation to the latter option, there are certain arrangements that would need to be put in place to ensure that the existing agency is able to appropriately respond to the needs of people with disability, and is accepted by people with disability and their supporters.

In this regard, the NSW experience of independent disability oversight is illustrative. In December 2002, the NSW Community Services Commission merged with the NSW Ombudsman's office. When the merger was proposed, the disability sector raised substantial concerns that the amalgamation would result in: a reduced focus on people with disability and broader community services; reduced response to, and public reporting on, matters affecting people with disability; and a loss of the role of the independent Community Services Commissioner. In response to the concerns of the disability sector, the government maintained and enhanced the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, and introduced legislative changes:

- requiring the Ombudsman to establish a Community Services Division as a branch of the office to perform the Ombudsman's functions under the above Act

[1] Part of the functions of the independent oversight body would include notifying the employment screening body of significant adverse employment findings arising through the disability reportable incidents scheme.
[2] See the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), and related provisions in the *Ombudsman Act 1974* (NSW).
[3] The arrangements in NSW provide a useful benchmark, with the NSW Ombudsman having the benefit of both specific and broad functions in relation to people with disability and disability services under the Community Services (Complaints, Reviews and Monitoring) Act, and significant investigative powers under the Ombudsman Act.

- requiring the Community Services Division to comprise the Community and Disability Services Commissioner, who must head the Division, and other staff employed to carry out the functions of the Ombudsman under this Act, and
- specifying that the Community Services Division may not be abolished.

In the 12 years since the merger, the Community Services Division of the Ombudsman's office has undertaken substantial work in relation to people with disability and disability services in NSW, including releasing 32 public reports from its inquiries, investigations, and reviews (see Annexure 1). Over that time, the work of the Community Services Division, and the broader Ombudsman's office, in relation to people with disability has been significantly enhanced, including an expanded jurisdiction to include people with disability in assisted boarding houses; greater funding for the Official Community Visitor scheme, to increase the scope and frequency of visits to people with disability in residential care; and the introduction in December 2014 of the Disability Reportable Incidents scheme.

Against this background, we believe that the option of establishing the NDIS oversight body into an existing national independent oversight agency should be contingent on:

- legislation requiring the establishment and maintenance of a separate NDIS Division (or similar), headed by a Disability Services Commissioner (or equivalent) who is the deputy head of the agency, and comprising staff employed to carry out NDIS-related oversight functions, and
- work commencing at an early point to build capacity within the organisation to understand and appropriately respond to the needs of people with disability; and to undertake proactive engagement with and outreach to participants.

Ability to refer matters to the most appropriate body

In some instances, and in relation to certain functions, the national independent oversight body may identify that a matter would be more appropriately handled by a State or Territory oversight body. We support the inclusion of legislative provisions to enable the national body to refer to other oversight bodies as it considers appropriate.[4]

However, it is vital that the national oversight body can guarantee and drive a nationally consistent and seamless safeguarding system in relation to the NDIS. Accordingly, any power given to the national oversight body to delegate should not be associated with an obligation on it to do so. However, what all stakeholders recognise is the overriding objective of seeking to promote the rights and legitimate interests of people with disability. This 'golden thread' should guide all decisions by the independent national body as to whether certain functions should be delegated – either on a case-by-case basis or more generally – to a State/Territory oversight body.

We note that, in relation to the reporting and oversight of the handling of disability reportable incidents, there are important State and Territory-based systems that need to be considered. In our experience, the effective operation of reportable conduct schemes – and the timely and targeted action the oversight agency needs to take to facilitate positive outcomes for individuals – requires local knowledge and relationships. Importantly, a crucial component of our work in both the employment-related child protection reportable

[4] By way of example, section 10B of the *Ombudsman Act 1974* (NSW) provides for delegation to our office from other jurisdictions. In such situations, the NSW Ombudsman can accept or refuse the delegation or to exercise the function.

conduct and disability reportable incident schemes involves searching and analysing information on the databases of state-based organisations – Police and Family and Community Services – and extensive negotiations with NSW Police, in connection with the identification and investigation of possible crimes under the NSW Crimes Act.

6. Systems for handling complaints

We support the aim of developing an effective and nationally consistent complaints mechanism, as suggested in the consultation paper. In relation to the NDIS, it should be as easy as possible for participants and their supporters to make a complaint and obtain resolution of the issues, irrespective of where they live or which NDIS-funded supports the complaint involves.

It is vital that all providers of NDIS-funded supports have effective mechanisms for encouraging, receiving and resolving complaints from participants and their supporters. We support the need for providers to have codes of conduct (or similar) that include minimum complaint handling requirements, such as the need to have processes for receiving and effectively resolving complaints; providing support to participants to make a complaint; and protecting complainants from retribution.

There is also a need to ensure that mainstream complaint handling bodies, such as consumer protection agencies, health care complaints agencies, and professional associations, are able to appropriately facilitate and respond to complaints by people with disability.

However, our extensive experience in relation to complaint handling and people with disability has shown that the development of an effective complaints mechanism for people with disability in relation to the NDIS necessitates an independent external statutory complaints function. In our view, there is a clear need for an independent oversight body with legislated responsibilities in relation to complaints, including:

- receiving, resolving and investigating complaints about NDIS-funded supports and the NDIA
- handling complaints at any point (not necessarily requiring the complainant to have raised the matter with the support provider in the first instance)
- making 'warm referrals' of matters that are more appropriately handled by another complaints body
- assisting people with disability to make complaints
- reviewing the pattern and causes of complaints, identifying systemic issues for service improvement, and making recommendations to improve the handling and resolution of complaints
- conducting 'own motion' inquiries and investigations as required[5]
- providing information, education, training and advice about matters relating to complaints and complaint handling, and
- promoting access to advocacy and decision-making support to facilitate complaints and the resolution of issues.

[5] 'Own motion' inquiries should be able to be conducted in relation to matters about which a complaint could be made.

It is essential that there is a strong focus on the resolution of complaints at the local level, and through alternative dispute resolution where required. The legislation should strongly emphasise the resolution of complaints consistent with a person-centred and rights-based approach to service delivery.[6] The legislation also needs to include clear protection for complainants against retribution,[7] and protections for whistleblowers.

In addition to facilitating warm referrals to mainstream complaint agencies, the independent oversight body should play an important capacity-building role to assist these agencies to meet the needs of people with disability. For example, this should include working in partnership to conduct complaints outreach to people with disability; and deliver joint education and training to people with disability on making complaints, making decisions and exercising their rights.

Nationally consistent complaints reporting system

In our view, an effective and nationally consistent complaints mechanism should include a nationally consistent complaints reporting system. We support the views of the Victorian Disability Services Commissioner in his submission regarding the positive outcomes that have resulted from the mandatory disability complaints reporting process in Victoria, including helping to provide a person-centred approach to complaint handling. Among other things, a nationally consistent complaints reporting system for the NDIS would enable the provision of comprehensive feedback to participants, support providers and the NDIA on significant issues of complaint, outcomes, and areas for attention; enable the oversight agency to identify serious issues of complaint that may require intervention or additional action; and enhance participant and sector confidence in the new support scheme.

The Orima online complaints reporting tool that was developed by the Victorian Disability Services Commissioner has also been adopted by NSW, and will commence in WA on 1 July 2015. There would be benefit in exploring opportunities to adopt and build on this online reporting system on a national basis for complaints, as well as other reporting requirements (such as serious incidents, quality assurance, and restrictive practices). In our view, complaints reporting should be required in relation to the NDIA and (at least) direct care NDIS-funded supports.

Community Visitors

We strongly support the development of a national community visitor scheme in the NDIS.

The Official Community Visitor (OCV) scheme in NSW plays an important role in relation to people with disability in residential care. The OCVs are independent, paid, Ministerial appointees who conduct visits – including unannounced visits – to people with disability in the full-time care of disability accommodation providers.

Among other things, the OCVs can confer alone with any resident or staff member; inspect documents relating to the operation of the accommodation service; and provide the relevant Minister and the Ombudsman with advice or reports on any matters relating to the conduct of the service. OCVs perform a critical role in independent monitoring,

[6] The objects and principles of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) provide a useful example.

[7] See, for example, section 47 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW)

resolution of complaints and emerging issues, and advocacy support. Our office coordinates the OCV scheme and provides support to the Visitors.

OCVs have played a significant part in many of the disability abuse-related matters that have been handled by our office, including:

- identifying and raising concerns about the actions by services to prevent serious incidents (including placement decisions)
- identifying and reporting serious incidents and systemic issues relating to abuse and neglect with services and our office (including assaults, inappropriate use of restrictive practices, and neglect)
- receiving information from residents, family members and staff about issues of concern, and
- monitoring the progress of actions by services to address critical issues.

We have achieved substantial change and improved outcomes for people with disability as a result of the close link between the OCV scheme and our office's complaints functions – particularly in relation to matters concerning violence, abuse and neglect in residential care. These matters have benefitted from the separate but complementary functions we perform: notably, the ability of Visitors to identify incidents of abuse and neglect and the associated impact on individual residents, and to act to raise and resolve the issues as independent persons; and the powers and ability of our office to progress these matters on an individual and/or systemic basis when escalated by the Visitors.[8] Links to the OCV Annual Reports on their work and outcomes are provided in Annexure 1.

Scope of a Community Visitor scheme

In NSW, the OCV scheme is currently limited to accommodation services in which a person with disability is in the full-time care of the service provider, and assisted boarding houses. We note that submissions to the NSW Law Reform Commission's 1999 review of the then *Community Services (Complaints, Appeals and Monitoring) Act 1993* (NSW) indicated support for expansion of the jurisdiction of the OCV scheme to include people with disability living in 'some of the more flexible arrangements for supported accommodation, such as those people living in private or rented accommodation who receive significant support, or those living in accommodation which is provided by a

[8] In progressing new disability support arrangements nationally, it is worth considering the role of 'independent persons' more generally, and how this support and oversight may best be legislated and managed to ensure that people with disability have maximum choice and control; that their rights are being upheld; and support is provided where required. In particular, we believe that there is likely to be an important and increasing role for independent persons where the person with disability does not have an informal support network, or where there are higher levels of vulnerability and/or risk involved. In the shift to individualised funding and support arrangements, there would be merit in considering the use of independent persons who could:
1) visit people with disability in the community (where the planning process identified this need) to talk about their living and support arrangements; assist the person to understand and exercise their rights and options; support them to resolve matters of concern; and alert authorised agencies where the person requires formal assistance, such as in relation to abuse or neglect;
2) discuss proposed restrictive interventions (and the person's rights) with the person with disability who is directly affected, and report where the person does not understand or legislative requirements are not being met; and
3) assist/support decision-making with people with disability – particularly where the person does not have an informal support network.

service provider but leased in the name of the resident.'[9]

There was also some support for the jurisdiction to extend to, inter alia, people with disability not living in visitable services who directly request access to a Visitor. The Law Reform Commission's view at that time was that the jurisdiction should not be extended, because the focus of Visitor schemes in other contexts is on monitoring publicly-funded services, and on those in the full-time care of the services visited.

Against the background of the vital role Visitors play in helping to identify and appropriately resolve significant matters involving people with disability in residential care, we believe that there would be merit in considering the scope for expanding the OCV scheme to potentially include other kinds of care arrangements that will emerge under the reform agenda.[10] For example, people living in private accommodation and receiving full-time disability support; and people in private living arrangements that may expose them to high levels of risk. However, any expansion of the scheme to these areas would need to be informed by the wishes of people with disability who live in these settings.

7. Serious incident reporting

In our view, a reporting and independent oversight system is an important and necessary component of a comprehensive framework for preventing, and effectively responding to, abuse, neglect and exploitation of people with disability – and is fundamental to enabling a genuinely person-centred approach to supports.

Since 3 December 2014, our office has had responsibility for the first, and only, legislated scheme in Australia for the reporting and independent oversight of serious incidents – including abuse and neglect – involving people with disability in supported accommodation (under Part 3C of the *Ombudsman Act 1974*).

The disability reportable incidents scheme requires our office to keep under scrutiny the systems of the Department of Family and Community Services (FACS) and funded providers for preventing, handling, and responding to reportable incidents involving people living in[11] disability 'supported group accommodation'.[12] Disability supported group

---

[9] Law Reform Commission (1999) *Report 90 – Review of the Community Services (Complaints, Appeals and Monitoring) Act 1993 (NSW)*, section 4.53.

[10] We note that the Victorian Community Visitors Disability Board expressed concern in its 2010/11 Annual Report that Visitors were unable to visit people on Individual Support Packages. The Board noted that, while visiting people with individualised funding in private homes had never been within the ambit of the Community Visitor's role, work was needed to clarify the status of situations where people live together independently with 'pooled' packages.

[11] While the scope of the scheme is focused on people with disability living in supported group accommodation, the incident does not necessarily need to have occurred in the accommodation itself. For example, the scheme includes reportable incidents that occur in day programs providing support to people who live in supported group accommodation.

[12] Section 22(1) of the Disability Inclusion Act defines supported group accommodation as: 'premises in which:

(a) a person with disability is living in a shared living arrangement (whether short-term or permanently) with at least one other person with disability, other than an arrangement in which one or more of the persons with disability is living with a guardian of the person or a member of the person's family who is responsible for the care of the person, and

(b) support is provided on-site:

(i) for a fee, or

(ii) whether or not for a fee if the support is provided as respite care.'

accommodation includes any accommodation where at least two people with disability are living together (with some exceptions[13]) and support is provided on-site (including respite services).

Part 3C of the Ombudsman Act requires and enables the Ombudsman 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.

Within 30 days of becoming aware of a reportable allegation or reportable conviction, the Secretary of FACS, or head of a funded provider, must give the Ombudsman notice of the allegation and/or conviction. Under Part 3C, a reportable incident involves any of the following:

(a) an incident involving any of the following in connection with **an employee of FACS or a funded provider and a person with disability** living in supported group accommodation:

  (i) **any sexual offence** committed against, with or in the presence of the person with disability,

  (ii) **sexual misconduct** committed against, with or in the presence of the person with disability, including grooming of the person for sexual activity,

  (iii) **an assault** of the person with disability, not including the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated under workplace employment procedures,

---

Under section 9(1) of the *Disability Inclusion Regulation 2014*, premises are prescribed as 'supported group accommodation' to the extent that the premises are premises in which on-site support (whether or not as respite care) is provided by:

(a) the Secretary under s25 of the Act, or

(b) an eligible entity provided with financial assistance by the Secretary under s29(1) of the Act.

[13] Under section 22(3) of the Disability Inclusion Act, supported group accommodation does not include an assisted boarding house, or other premises, or a type of premises, prescribed by the regulations not to be supported group accommodation. Under section 9(2) of the Disability Inclusion Regulation, premises are prescribed not to be supported group accommodation 'if:

(a) the premises are not under the control, direction or management of a disability service provider, or

(b) support provided on-site for a fee in the premises is substantially under the control, direction or management of either or both of the following:

  (i) one or more of the people with disability living at the premises,

  (ii) a guardian or member of the family who is responsible for the care of a person with disability who is living at the premises.'

(iv) **an offence under Part 4AA of the NSW *Crimes Act 1900***[14] committed against the person with disability,

(v) **ill-treatment or neglect** of the person with disability, or

(b) an incident involving an **assault of a person with disability living in supported group accommodation by another person with disability** living in the same supported group accommodation that:

(i) **is a sexual offence**, or

(ii) **causes serious injury**, including, for example, a fracture, burns, deep cuts, extensive bruising or concussion, or

(iii) **involves the use of a weapon**, or

(iv) **is part of a pattern of abuse** of the person with disability by the other person, or

(c) an incident occurring in supported group accommodation and involving a **contravention of an apprehended violence order** (AVO) made for the protection of a person with disability, regardless of whether the order is contravened by an employee of FACS or a funded provider, a person with disability living in the supported group accommodation or another person, or

(d) an incident involving an **unexplained serious injury** to a person with disability living in supported group accommodation.

Further details about the disability reportable incidents scheme, initial data from the scheme, and information about current areas of focus for sector improvement, can be found in our recent submission to the Federal Senate inquiry into violence, abuse and neglect of people with disability: http://www.ombo.nsw.gov.au/news-and-publications/publications/reports/community-and-disability-services/nsw-ombudsman-submission-to-federal-senate-inquiry-into-abuse-and-neglect-of-people-with-disability-april-2015.

Separate to our oversight of the handling of serious incidents reported under Part 3C, our office also has responsibility for reviewing the deaths of people with disability in residential care in NSW.[15] All FACS-operated and funded disability residential care providers, and assisted boarding houses, are required to notify our office of the death of any resident within 30 days.[16] In addition to its core purpose of reducing the preventable deaths of people with disability in residential care (including deaths that may be neglect-related), the function has enabled the identification of important factors associated with violence, abuse and neglect in residential settings, including:

- inappropriate use of restrictive practices, including chemical restraint
- patterns of abuse between residents
- poor reporting and response to critical incidents

[14] Section 4AA of the Crimes Act includes fraud and other similar offences. It includes where a person, by any deception, dishonestly obtains property belonging to another or obtains a financial advantage or causes any financial disadvantage.

[15] As outlined in Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

[16] The reviewable deaths functions of the Ombudsman's office complement, but do not replace, the functions of the State Coroner.

- poor development and implementation of behaviour support strategies, and
- failure to implement the recommendations of expert health and behaviour practitioners.[17]

We note that current *National Disability Insurance Scheme (Registered Providers of Support) Rules* require registered providers to report serious incidents to the NDIS State Manager and to the relevant statutory authority in the local jurisdiction. Among other things, under the Rules a serious incident includes the death of, or serious injury to, a participant; allegations of, or actual sexual or physical assault of a participant; and significant damage to property or serious injury to another person by a participant. While it will be important for the NDIA to continue to be notified of serious incidents involving NDIS participants, there is also a need to establish national arrangements, as part of the NDIS quality and safeguarding framework, for mandatory reporting and independent oversight of particular serious incidents.

The nature of our oversight of serious incidents

It is important to fully appreciate what is required to meaningfully and effectively respond to serious incidents and to facilitate appropriate action. Reporting is not sufficient on its own, and there is no place for passive oversight. Our extensive work in relation to employment-related child protection reportable conduct,[18] and more recent activity in relation to disability reportable incidents, demonstrates the importance of a hands-on, comprehensive, and proactive approach to oversighting, and responding to, reportable allegations and incidents. In this regard, we encourage agencies to notify us at the earliest possible opportunity so that we can play an early role in guiding them through their initial response.

In addition, agencies are expected to respond to allegations by conducting an investigation, and undertaking any risk management or other action that may be required. Upon receipt of a notification, the role we play varies depending on the circumstances. We may actively monitor the progress of the investigation, in which case we may require the agency to provide us with relevant documents and information about the investigation. We also have the power to observe interviews conducted by or on behalf of an agency, and confer with those involved in conducting the investigation. At the end of their investigation, the involved agency must provide us with a range of information; such as the report and advice on any action taken as a result of the investigation. We also have the power to directly investigate any reportable allegation, or to directly investigate an agency's handling of the reportable allegation/incident.

In relation to our child protection reportable conduct oversight work, many of the agencies we oversight have, over time, increased their competency in handling reportable allegations. As a result, we have entered into over 20 'class or kind' determinations with various agencies, which exempt these agencies from having to notify us of less serious forms of alleged reportable conduct. This has reduced the number of notifications by over 50%. As the competency of disability agencies to deal with disability reportable incidents improves, we anticipate that we will also be in a position to exempt from notification to our office significant numbers of disability incidents.

[17] Links to our reviewable deaths reports to the NSW Parliament are included in Annexure 1.

[18] The reportable conduct scheme is outlined in Part 3A of the Ombudsman Act (as distinct from the more recent Part 3C scheme which is modelled on aspects of Part 3A, and focuses on reportable incidents involving people with disability living in supported group accommodation).

It is largely due to these class or kind determinations that notifications involving serious criminal allegations now make up a significant proportion of our child protection work; for example, we currently have 120 open matters concerning individuals who have been charged with criminal offences relating to children. The support we provide to both disability and child and family agencies includes our most experienced investigators regularly liaising with senior Police from local area commands, specialist squads and senior Police executives. In addition, we routinely refer detailed briefings to Police, which often results in the commencement and/or enhancement of police investigations and the preferment of criminal charges. To mitigate risks, we also work closely with Family and Community Services, employers and other stakeholders to ensure that critical risk related information is identified, appropriately shared and managed.

Our office is in a unique position to contribute to identifying risks through our direct access to the policing and child protection databases combined with our own reportable conduct /incident holdings – this access often provides us with a 'helicopter' view of critical information that is not readily accessible to other agencies. Our office is often the only agency with access to all relevant information about a particular matter, and in these circumstances, we take an active role in ensuring information is shared with appropriate parties and appropriate action is taken. When new notifications are received, we check these databases and assess the adequacy of the response to any risk we can identify from analysing the totality of the information we review. Where additional actions are required, we make telephone contact with the involved agency to explain our concerns and canvass potential options for strengthening the response.

We also work closely with employers who have not recognised their responsibility to refer allegations – or certain evidence – to the Police, guiding them through the process, and ensuring that their workplace response to these matters does not compromise any police investigation.

A number of sectors and agencies within our jurisdiction have spoken of our beneficial role in facilitating the provision of information to Police, FACS and other agencies, and have regularly sought advice and support from our office in liaising with these agencies on their behalf. As a practical illustration of our strong relationship with Police, our submission to the Senate Inquiry (link provided on page 12) includes a copy of Standard Operating Procedures that we have developed with Police, which essentially provide a guarantee of service in relation to the ongoing support and advice Police should provide to agencies in relation to child-related employment investigations. It is our intention to develop a similar set of procedures with Police in connection with matters arising under our reportable disability incidents function.

Mechanisms for reporting

We are currently exploring options for building on the existing online complaint reporting system developed by Orima for the Disability Services Commissioner in Victoria, and adapted by FACS for use in NSW.[19] If this initiative is successful, there is the potential to make available nationally a reasonably sophisticated and integrated IT system for reporting complaints, serious incidents, restrictive practices and quality management, at a very low cost.

[19] We note that Western Australia has developed its own complaints reporting technology based on the same parameters as Victoria and NSW, and New Zealand is also looking at adopting the tool. FACS in NSW has also adapted the tool to enable disability services to undertake reporting on their quality management systems and compliance, and the use of restrictive practices.

Information sharing

We believe that relevant information sharing provisions are a necessary component of an effective safeguarding system, including a reportable incidents scheme. In our view, the provisions should address the following issues:

Providing information to victims

The system should allow for the provision of information by agencies to victims, their guardians, and families (as appropriate). After having raised our concerns about the need to guarantee that agencies have a legal right to provide appropriate information to victims – under both our child protection reportable conduct and disability reportable incidents functions – we understand that legislation in NSW will be introduced this year to deliver this outcome.

Exchange of information between agencies

We believe that a disability reportable incidents scheme should allow for provision of information for the purposes of enabling the head of a registered provider to provide to, and receive from, other registered providers and public authorities, information that relates to the promotion of the safety of people with disability in connection with responding to a reportable allegation or conviction under the reportable incidents scheme.

We do not believe it is consistent with the rights of people with disability who are adults to be affected by a broad information exchange provision (such as that under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* NSW). However, from our extensive experience, we are nevertheless convinced that it will be essential that providers dealing with abuse allegations under a disability reportable incidents scheme have the ability to exchange information consistent with their legislative obligations and existing common law duty of care responsibilities. In our view, there is a need for a legislative provision to enable agencies that have responsibilities relating to the safety of people with disability to be able to provide and receive information that promotes the safety of people with disability.[20]

In the context of the NDIS, it will also be important to ensure that there are adequate information exchange arrangements to enable the independent oversight body to provide and receive relevant information in a timely way with the NDIA relating to serious incidents involving participants, to, among other things, inform NDIA actions in relation to planning, reviews and assessments of risks to participants; registration of providers; and broader operation of the scheme.[21]

Interstate exchange of information

In past reports highlighting the value of the information exchange provisions in the child protection area, we have noted that it is important to acknowledge the challenges that still exist in relation to the interstate exchange of information. For example, in our submissions to the Royal Commission, we have advocated for a nationally consistent approach to information sharing provisions. Against this background, it is vital to consider these cross-

[20] Including matters relating to abuse, neglect and exploitation, and serious health issues

[21] Including the identification of any links between a participant's death and the support provided (or not provided) – including support to prevent or address violence, abuse and neglect.

border information exchange challenges in the context of the need to develop national disability complaints and reportable incidents schemes.

Scope of a disability reportable incidents scheme

In identifying a potential initial target group for the disability reportable incidents scheme, we observed that there is considerable consistency across jurisdictions in relation to those adults with disability who are considered to be vulnerable. In relation to serious incident reporting systems, vulnerable adults with disability are generally deemed to be those who meet two requirements:

- they have been abused or neglected, or are at risk of abuse or neglect, *and*
- as a result of their disability, they need support to safeguard their own rights, seek assistance, complain and/or care for themselves.

In this context, we proposed that NSW should introduce a reporting system that focuses on serious incidents involving any person living in residential care. However, we are acutely aware that it is not only people with disability in supported group accommodation who are at risk of, and vulnerable to, abuse, neglect and exploitation. Indeed, in our extensive discussions with the providers of disability supported group accommodation that are included in the current scope of our disability reportable incidents scheme, we have received consistent feedback that:

- they welcome the introduction of the scheme, and are keen to receive feedback and guidance on best practice in preventing and responding to serious incidents, and
- they consider the scope of the scheme should be broader, to include day programs, and drop-in support arrangements.

Our proposal also recommended that assisted boarding houses be included in the scope of the disability reportable incidents scheme. However, this accommodation setting is not currently included, due to the separate reporting requirements associated with assisted boarding house residents under the *Boarding Houses Act 2012* (NSW) and the *Boarding Houses Regulation 2013* (NSW). Given the support needs and vulnerability of many people with disability in assisted boarding houses, and the absence of independent oversight of reporting in this area, we believe that any future reporting scheme ought to include people with disability living in these facilities.

8. Ensuring staff are safe to work with participants

It is of vital importance to ensure that, wherever practical, those individuals in the community who engage in inappropriate behaviour or take advantage of vulnerable people are prevented from working in care-focused disability support roles. It will be essential to ensure that there is a suitable workforce to enable and support participants to exercise and enjoy their full complement of rights. The importance of a highly skilled workforce that has the capacity to appropriately support people with disability cannot be overstated.

We support the introduction, via legislation, of a comprehensive system for screening people engaged to support people with disability. The development of such a system should be informed by existing screening systems: for example, the Working With Children Check system in the *Child Protection (Working With Children) Act 2012* (NSW);

the *Working With Vulnerable People (Background Checking) Act 2011* (ACT); and the *Disability Services Act 2006* (Qld). In this regard, there would be merit in exploring the introduction of a nationally consistent screening system for vulnerable people more broadly (including child-related, aged care, and disability support work).

Related to the establishment of an appropriate screening system, we believe that there is a need for certain barring offences. However, consistent with the right of people with disability to exercise control over their own lives, we would have significant concerns about any system that did not allow for people with disability to seek limited work or 'engagement' exemptions for those individuals who are barred, in circumstances where the person with disability demonstrates that the granting of the exemption would serve to promote (and not prejudice) their rights.

Inclusion of significant adverse employment findings

In our view, significant findings from any legislated 'reportable incident' scheme should feed into any legislative system for screening individuals who are applying to work with people with disability. The inclusion of relevant misconduct findings – and other critical sources of information – in the screening system, is important because it allows conduct falling short of criminal charges to be taken into account.

Significant adverse employment related matters should be able to be considered by the screening body and, along with criminal matters, form the basis of a decision to bar an individual from working with vulnerable persons (subject to appeal rights). These same significant adverse employment matters should also be able to be made available to prospective employers when they are verifying the ongoing validity of a prospective employee's vulnerable persons clearance certificate.

In relation to child protection in NSW, the allegation-based model of notification required by our employment-related child protection reportable conduct scheme complements the notification/reporting based model integral to the Working With Children Act. In determining whether an investigation into a reportable allegation or conviction against an employee of a designated agency that has been notified to us has been properly conducted, and whether appropriate action has been taken as a result of the investigation, we identify whether relevant misconduct findings have been notified to the Children's Guardian as required under the Working With Children Act.

In this regard, NSW legislation requires prescribed reporting bodies to notify the Children's Guardian of certain findings of misconduct in relation to children.[22] In addition, the legislation enables the Ombudsman to make a 'notification of concern' to the Children's Guardian if we form the view, as a result of concerns arising from the receipt of information by our office in the course of exercising any of our functions, that '*on a risk assessment by the Children's Guardian, the Children's Guardian may be satisfied that the person poses a risk to the safety of childre*n'.[23] Both types of referrals by our office trigger a 'risk assessment' by the Children's Guardian in relation to whether a person poses a risk to children.

[22] *Child Protection (Working with Children) Act 2012* (NSW), section 35 – prescribed reporting bodies are required to notify the Children's Guardian of findings of misconduct in relation to: 1) sexual misconduct committed against, with or in the presence of a child, including grooming of a child; and 2) any serious physical assault of a child.

[23] *Child Protection (Working with Children) Act 2012* (NSW), Schedule 1, Clause 2A

It is important to recognise that the effective operation of such a system in relation to disability support (as is the case in relation to child protection), is dependent on an independent statutory body ensuring the quality of reportable incident investigations, including adherence to procedural fairness principles.

In considering this issue, we believe that a relatively low cost and effective IT solution – and related practice framework – could be developed that would provide for probity screening that involves both consideration of criminal matters and significant adverse employment findings.

Given our extensive experience in relation to the reportable conduct scheme in NSW, we would be happy to participate in early discussions regarding the potential scope and operation of a screening system under the NDIS.

9. Safeguards for participants who manage their own plans

We support the views in NSW CID's submission regarding safeguards for self-managing participants, including the importance of the NDIS:

- providing a range of incentives and assistance to participants to self-manage their plans, and
- not restricting self-managing participants to registered providers (apart from the provision of certain services requiring technical expertise)[24].

Employee screening should be compulsory in relation to disability support (not generic services[25]). While self-managing participants may wish to opt for an unregistered provider, the individual worker would still need to undergo screening to provide disability support. As mentioned earlier, a self-managing participant should be able to seek limited work or 'engagement' exemptions for those individuals who are barred, in circumstances where the person with disability demonstrates that the granting of the exemption would serve to promote (and not prejudice) their rights.

The NDIA's review process will be a critical safeguard for identifying potential risks to self-managing participants, and ascertaining whether additional supports are required to assist the person to self-manage, or whether continued self-management would present an unreasonable risk for the individual.

It will also be important to ensure that agencies or individuals working with the self-managing participant for capacity-building, decision-making, and/or inclusion support – such as Local Area Coordinators – identify and report to the NDIA any concerns regarding risks to the participant that may need to be explored and addressed.

10. Reducing and eliminating restrictive practices in NDIS funded supports

Our work points to the need for consistent legislative requirements to be introduced relating to the use of restrictive and restricted practices. In particular, our reviews of the

[24] Although we recognise that certain disability supports will need to be provided by appropriately qualified individuals/agencies.

[25] Such as a mainstream fitness centre

deaths of people with disability in residential care have highlighted systemic problems with the use, and regulation, of restrictive practices across residential services, including:

- failure to follow policy in relation to the use of psychotropic medication for some people in disability services, and
- the frequent use of psychotropic medication as a primary behaviour management strategy.[26]

While noting that there is an agreed national framework for reducing and eliminating the use of restrictive practices in the disability service sector, our work in relation to reviewable deaths has underscored the need for requirements in this area to have legislative force. We consider that there is a need for a nationally consistent legislated approach relating to the use of restrictive practices to increase accountability and transparency, and to ensure that the rights of people with disability are upheld.

Authorisation

We support the views of NSW CID in its submission regarding the additional points that should be added to the aims of the NDIS quality and safeguarding system in relation to restrictive practices, including that such practices should not be permissible in the absence of person-centred active support and a comprehensive positive behaviour support plan.

Our preference is that authorisation of the use of certain restrictive practices (restricted practices[27]) would be provided by an independent decision-maker. However, we recognise the significant resources that would be required to meet this requirement (and in a timely way). We can see merit in enabling authorisation by provider-initiated panels, provided that:

- each panel compulsorily includes at least one independent party (with knowledge about positive and appropriate behaviour support)
- where the independent party has any concerns about the use of the restrictive practice/s, they should raise the issue with a designated agency (such as the independent oversight body, and/or industry regulatory body)
- there are legislated requirements regarding the panels, including the required expertise of individuals involved; minimum requirements that need to be met for authorisation; time limits on authorisation; and mandatory reporting requirements, and
- the formation and operation of the panels, and the use of restrictive practices, is monitored by an independent party.

However, it is important to recognise that authorisation does not replace consent. The former is authorising the use of the practice (such as considering whether it is appropriate; whether all other less restrictive measures have been attempted; whether the potential causes and triggers for the behaviour have been identified and actions taken to resolve

[26] NSW Ombudsman, 2011, *Report of Reviewable Deaths in 2008 & 2009, Volume 2: Deaths of people with disabilities in care*, pp21-22; and NSW Ombudsman, 2013, *Report of Reviewable Deaths in 2010 and 2011, Volume 2: Deaths of people with disabilities in care*.

[27] Restricted practices would include seclusion; exclusionary time-out; administration of psychotropic medication (routine or PRN) for behaviour management purposes; response cost; restricted access; and physical restraint.

them). Consent is the person (or a substitute decision-maker) agreeing to the use of the practice(s).

We agree that families and others who know the person well should be used to ensure the person understands and agrees (to the greatest extent possible) with the behaviour support plan, including any restrictive practices. However, we are acutely aware that many people with disability do not currently have family or others who know them well (outside of paid staff). In this context, while we support the inclusion of the 'independent person' role as part of the restrictive practices authorisation and consent process, we would emphasise that, in addition to family or friends, there is a need to have independent individuals who could be appointed to fulfil this role. In this regard, there would be benefit in exploring the potential to have a pool of individuals who could be drawn on for this purpose (in addition to providing other assistance, such as broader decision-making support).

Consent should be required prior to the use of any restrictive practice. However, consent to the use of restricted practices (where the person themselves is not able to provide informed consent) should only be provided by a guardian appointed with a relevant decision-making function.

Monitoring and reporting

Noting the frequent lack of knowledge and understanding across the disability sector about the appropriate use of restrictive practices – and the impact of the use of such practices on the rights of people with disability – we support mandatory reporting on their use.

We agree with the views of NDS in its submission regarding the need for a responsive online system with a streamlined process for reporting the use of restrictive practices. In this regard, we note that there has already been work undertaken in some jurisdictions to facilitate online reporting by disability services on the use of restrictive practices, including the Restrictive Interventions Data System in Victoria, and the use of the Orima data system in NSW.[28] Opportunities for aligning and building on these data systems to establish a mandatory national reporting system should be explored, with a view to making reporting for support providers as easy as possible while ensuring that there is effective monitoring and oversight of the use of restrictive practices.

It will be important for the data and information to be reviewed by an independent body with appropriate expertise (such as a Senior Practitioner role), with legislative requirements and powers regarding visits and inspections; auditing and monitoring the use of restrictive practices; ability to direct a service to discontinue or alter a restrictive practice; public reporting; development of guidelines and standards, and provision of education, training, information and advice.[29]

There would be merit in considering the potential role of an industry regulator in relation to restrictive practices, including whether this body could incorporate a Senior Practitioner

[28] The same Orima data system is used in Victoria, NSW and WA for complaints reporting by disability services; and is also used in NSW for disability services' quality reporting requirements.

[29] We note that the framework and requirements outlined in the *Disability Act 2006* (Vic) includes relevant provisions regarding the functions and responsibilities of the Office of the Senior Practitioner, including those listed here.

position and functions. The independent oversight body would need to have jurisdiction over the industry regulator (and Senior Practitioner).

Our work has highlighted the important role that Community Visitors play in monitoring the use of restrictive practices in relation to people with disability in residential care. They are in an ideal position to identify issues relating to the use, authorisation and reporting of, and consent to, the use of restrictive practices – including identifying critical issues via unannounced visits. We note that Local Area Coordinators under the NDIS may also be in a valuable position to identify and report on any issues regarding the use of restrictive practices for the people with disability they support. In our view, it will be important to ensure that the role(s) of key individuals such as Community Visitors, Local Area Coordinators, and advocates are considered as part of the development of an effective framework for reducing and eliminating the use of restrictive practices.

Contact: Kathryn McKenzie, Director Disability
(02) 9286 0984
kmckenzie@ombo.nsw.gov.au

Annexure 1

NSW Ombudsman public reports relating to people with disability

Denial of rights: the need to improve accommodation and support for people with psychiatric disability report November 2012

More than board and lodging - the need for boarding house reform - Special report to Parliament October 2011

Consultations with families of children with disabilities on access to services and support June 2011

Improving probity standards for funded organisations Special report to Parliament December 2010

Improving service delivery to Aboriginal people with a disability Special report to Parliament September 2010

Inquiry into services provided or funded by ADHC for children with disabilities Submission September 2010

Inquiry into services provided or funded by ADHC Submission August 2010

People with disabilities and the closure of residential centres Special report to Parliament August 2010

The implementation of the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing Special report to Parliament November 2009

Community participation complaint handling - C&DS review June 2009

Individual planning in DADHC large residential centres - C&DS review June 2009

Individual planning in DADHC large residential centres summary - C&DS report June 2009

Supporting people with an intellectual disability in the criminal justice system progress report June 2008

Young people with disabilities leaving statutory care report December 2004

Senior Officers Group for Intellectual Disability and the Criminal Justice System investigation report December 2004

Monitoring of disability services report September 2004

Audit of individual planning in funded disability accommodation services report September 2004

DADHC - The need to improve services for children, young people and their families Special report to Parliament April 2004

Report of Reviewable Deaths in 2010 and 2011 Volume 2: Deaths of people with disabilities in care

Report of Reviewable Deaths in 2008 and 2009 Volume 2: Deaths of people with disabilities

Report of Reviewable Deaths in 2007 Volume 1: Deaths of people with disabilities

Report of Reviewable Deaths in 2006 Volume 1: Deaths of people with disabilities

Report of Reviewable Deaths in 2005 Volume 1: Deaths of people with disabilities in care

Report of Reviewable Deaths in 2004 annual report

Report of Reviewable Deaths Annual Report 2003-2004

Official Community Visitors Annual Report 2012 - 2013

Official Community Visitors Annual Report 2011 - 2012

Official Community Visitors Annual Report 2010 - 2011

Official Community Visitors Annual Report 2008 - 2009

Official Community Visitors Annual Report 2007 - 2008

Official Community Visitors Annual Report 2006 - 2007

Official Community Visitors Annual Report 2004 - 2005