

Submission to the Australian Law
Reform Commission's inquiry on
*Protecting the Rights of Older
Australians from Abuse*

August 2016

Background

Our submission is informed by our extensive work in relation to people with disability and community services over the past 14 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 community services, and assisting people with disability to make complaints
- reviewing the pattern and causes of complaints about community services, and making recommendations to improve how services handle and resolve complaints
- monitoring and reviewing the delivery of community services, and making recommendations for improvement
- inquiring into matters affecting people with disability and community 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
- coordinating the Official Community Visitor scheme.

Since 3 December 2014, NSW has had a scheme for the mandatory reporting of allegations relating to abuse and neglect of people with disability who live in¹ supported group accommodation² (under Part 3C of the *NSW Ombudsman Act 1974*) – known as the Disability Reportable Incidents scheme.

All of our functions apply to the National Disability Insurance Scheme (NDIS) sites in NSW.

Reporting and responding to alleged abuse and neglect in NSW disability services settings

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 more vulnerable members of the community, including some older people and some people with disability – and is fundamental to enabling a

¹ 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.

² 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.’

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.

genuinely person-centred approach to supports.

The Disability Reportable Incidents scheme in NSW is the first – and only – legislated scheme in Australia for the reporting and independent oversight of serious incidents involving people with disability in supported accommodation. 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 the Department of Family and Community Services (FACS), or head of a funded provider, must notify our office of any reportable incidents involving people with disability living in supported group accommodation. By virtue of the NSW transitional safeguards working arrangements, NDIS funded providers are also required to notify our office. 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)
 - (iv) **an offence under Part 4AA of the NSW Crimes Act 1900³** committed against the person with disability
 - (v) **ill-treatment or neglect** of the person with disability
- (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**
 - (ii) causes **serious injury**, including, for example, a fracture, burns, deep cuts, extensive bruising or concussion
 - (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

³ 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.

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

More information about the incidents that have to be notified to the Ombudsman's office is available in our [Guide for services: Reportable incidents in disability supported group accommodation](#) on our website.

Data on the Disability Reportable Incidents scheme for the 2015/16 financial year is provided in Appendix 1. Additional information on the disability reportable incidents scheme and data can be found in our:

- [Disability e-News Update](#) newsletters, available on our website
- [Submission to the Senate Community Affairs References Committee's Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings](#)
- [Presentation briefing to the Senate Community Affairs References Committee on the Disability Reportable Incidents scheme](#)
- [Transcript of evidence provided by the Deputy Ombudsman and Public Guardian at the Senate Community Affairs References Committee hearing on 27 August 2015](#)

A significant amount of our work is dedicated to building the capacity of service providers to prevent and effectively respond to disability reportable incidents, and to address abuse and neglect of people with disability more broadly. In this regard, we proactively engage with agencies to influence the direct management of incidents as they unfold, to enable the timely engagement of NSW Police, the provision of medical assistance and other supports for alleged victims, and to ensure appropriate communication with families/carers and guardians.

We also undertake substantial work to identify and address systemic issues that arise through the Disability Reportable Incidents scheme. The following information relating to some of our systemic and service improvement activities over the past year provides the ALRC with a snapshot of the practical and substantial strengths-based work that is enabled by a mandatory reporting scheme with independent oversight.

Best Practice Working Group

Since July 2014, we have convened a Best Practice Working Group to support and inform the work of our office and the broader disability sector in relation to the Disability Reportable Incidents scheme. The group comprises disability leaders and key subject-matter experts within and outside of the disability sector – including representatives from FACS, NSW Police, National Disability Services (NDS), non-government disability accommodation providers, NSW Legal Aid, expert clinicians, advocates, and leading academics. Of recent times, the group has traversed issues that have included reportable incidents arising in the context of staff managing client behaviours of concern and in the delivery of personal care, and critical practice issues that have arisen through our oversight of client to client incidents.

Facilitating disability service provider roundtable meetings

Since March 2016, we have hosted a series of disability service provider roundtable meetings relating to matters arising out of the Disability Reportable Incidents scheme. We use the roundtable meetings to bring together a small number of service providers to

discuss their experience in identifying and responding to reportable incidents, including their successes and challenges. The small forums provide an opportunity for services to discuss ways in which they have sought to overcome the practical challenges they have experienced, to share learning, and to promote good practice in the interests of protecting people with disability from abuse and neglect. Among other things, the roundtable meetings have included a focus on coordinating risk management and investigative responses to incidents.

Education and training on preventing and responding to serious incidents in disability services

Since 2012, we have run workshops with disability services staff on responding to serious incidents in disability services settings. The training provides practical advice to enable staff to understand:

- how to identify and respond to abuse, neglect, and other serious incidents
- the systems and processes that contribute to a 'client-safe' environment
- the fundamental principles and strategies for conducting an investigation, and
- the responsibilities of key agencies – including the NSW Police, FACS and the NSW Ombudsman.

In 2015/16, we delivered 68 workshops to approximately 1,322 staff of disability services. Since the start of the Disability Reportable Incidents scheme, we have also provided a modified version of the workshop to direct care staff. This workshop has focused on identifying, responding to, and reporting incidents and the broader requirements relating to people with disability in supported accommodation.

Developing guidance on responding to serious incidents

We are finalising guidance for staff in disability services on the initial and early response they need to provide to serious incidents, including a comprehensive resource guide, a quick guide, and a one-page flowchart. The resources were developed in consultation with a range of NSW agencies, including NSW Police. However, we are conscious that anything we develop in this area must have an eye to the national landscape. In this context, in November 2015 we convened a roundtable meeting in Melbourne to discuss the draft resource guide with key NSW, Victorian and Commonwealth parties, including representatives of NSW and Victorian Police.

We have also developed a Joint Protocol to reduce the contact of people with disability in supported accommodation with the criminal justice system. The core principles of the Joint Protocol are based on a protocol we have developed and implemented in relation to young people in residential out-of-home care. Among other things, the Joint Protocol aims to:

- reduce the frequency of police involvement in responding to behaviour by people with disability living in supported accommodation, particularly in circumstances which can be better managed by the disability service provider
- promote the safety, welfare and wellbeing of people with disability living in supported accommodation by improving relationships, communication and information sharing between local police and disability services, and
- ensure that appropriate responses are provided to people with disability living in supported accommodation who are victims.

We have conducted extensive consultations with a range of parties in relation to the Joint Protocol in NSW, including NSW Police, FACS, NDS, the Intellectual Disability Rights Service, the NSW Council for Intellectual Disability, the NSW Mental Health Commission,

People with Disability Australia, and Legal Aid.

A copy of the draft Resource Guide and Joint Protocol are attached for the ALRC's reference.

Data collection, analysis and reporting

In 2015/16, we reviewed our information holdings relating to notifications of disability reportable incidents by provider, to identify potential areas of under-reporting. Our analysis identified:

- providers who had yet to notify our office of any disability reportable incidents
- providers who appeared to be under-reporting particular types of reportable incidents (such as client to client incidents), given our other information holdings, and
- under-reporting of unexplained serious injuries by non-government providers.

To ensure that all providers across the sector have a strong awareness and working knowledge of the scheme, we are providing refresher training to those who have not yet notified our office of any reportable incidents. We have also met with a range of providers in relation to identified areas of potential under-reporting, and have noted improved practice by these agencies in response to our discussions, including internal changes to enable a coordinated and consistent approach to assessing incident reports.

Client to client (or peer to peer) abuse

One of the important and unique elements of the disability reportable incidents scheme in NSW is the inclusion of incidents and allegations of client to client abuse. In seeking the inclusion of client to client matters, we were conscious of the violence that tends to occur in supported group accommodation environments, and the need for independent oversight of agencies' responses to such incidents and their actions to prevent recurrence.

Reporting, and independent oversight of the handling of, client to client (or peer to peer) matters is important for a range of reasons, including enabling:

- accurate analysis of the prevalence and cause of such incidents
- action to be taken to provide appropriate support to both clients, and
- steps to be taken to prevent such incidents from occurring and recurring.

In our [submission to the NSW Legislative Council's General Purpose Standing Committee's recent inquiry into elder abuse](#), we indicated our agreement with the evidence to the Committee by the NSW Nurses and Midwives Association that: a) it is inappropriate to criminalise people who are not culpable for their actions due to cognitive impairment, and b) there must be reporting of such matters in order to ensure that effective action is taken to address the underlying issues. It is important to recognise that, in the Disability Reportable Incidents scheme, different approaches are generally taken with client to client matters as distinct from employee to client matters.

In the first instance, the threshold for notification of client to client incidents to the NSW Ombudsman is much higher than it is for employee to client – for physical assaults, they must result in *serious* injury, involve the use of a weapon, or be part of a pattern of abuse against the alleged victim. Secondly, while the response to allegations of employee to client abuse focuses on reporting to the Police and possible disciplinary action, we stress the need for the main focus in responding to client to client abuse to be on managing and reducing risks – including identifying the cause of the abuse, and the action that needs to be taken (and the support that needs to be provided) to prevent recurrence.

Strengthening safeguards for vulnerable adults

Our office is increasingly contacted by people raising concerns about abuse, neglect and/or exploitation of individuals with disability living in community settings (such as their family home). In response to existing gaps in the coordination and response to these matters, we are undertaking the following action.

Work with the National Disability Abuse and Neglect Hotline

Since early this year, we have had an agreement with the National Disability Abuse and Neglect Hotline that it will make 'warm referrals' to our office of matters involving allegations or concerns about abuse, neglect or exploitation of people with disability in community settings (following provision of consent by the caller). In response to these matters, we typically undertake inquiries, check available intelligence, and identify further actions that may be required to resolve the concerns or to establish whether the person requires protection and/or supports.

Work with the NSW Public Guardian

In some cases, we identify that further investigations are required to establish whether the person with disability is in need of guardianship or other protection/support. In such cases, we have an agreement with the Public Guardian to refer relevant information for his consideration. When appropriate, the Public Guardian may decide to submit a guardianship application.

In relation to these matters, common scenarios involve information that raises concerns about potential abuse and/or neglect of an adult with cognitive impairment in their family home. For example, that the person does not seem to have access to their own money; shows signs of neglect (such as untreated medical conditions; limited access to food; dirty and unkempt appearance); or has restricted access to the community and to services. There is generally limited information about what is happening to the person within the home, or the person's views about the current situation.

The NSW *Guardianship Act 1987* does not presently enable the Public Guardian to automatically investigate complaints or allegations that he receives, irrespective of their urgency. In order to respond to the information we provide, the Public Guardian has to submit an application to the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT), recommending a short-term order for the Public Guardian (or other suitable party) to investigate the person's current care and circumstances. That investigation could include meeting with the person who is reported to be at risk and ascertaining their wishes; and making relevant inquiries to determine whether the person requires guardianship or other protections or supports.

It is problematic that a guardianship order is the only mechanism currently available for the Public Guardian to conduct investigations in relation to vulnerable adults who are reported to be at risk in the community. It does not enable a swift response, and is not the least restrictive option. It also unnecessarily adds to the workload and hearing delays of the Tribunal.

In our recent [preliminary submission](#) to the NSW Law Reform Commission's review of the Guardianship Act, we indicated that there is a vital need to amend the legislation to expand the functions and powers of the Public Guardian to strengthen the Public Guardian's ability to investigate allegations that an adult is being abused, neglected or exploited, in order to ascertain whether the person requires guardianship or other protections and supports.

We note that guardianship legislation in some other jurisdictions in Australia include provisions for investigation by the Public Guardian/ Adult Guardian/ Public Advocate. For example, Part 3 of the *Public Guardian Act 2014* (QLD) and section 16(1)(h) of the *Guardianship and Administration Act 1986* (Vic) include provisions for the Public Guardian and Public Advocate respectively to investigate a complaint or allegation regarding exploitation or abuse of an adult.

We have indicated that consideration of potential investigation-related provisions in the Guardianship Act in NSW should take into account, and seek to avoid, the limitations of other jurisdictions' legislation. For example, we note the findings and recommendations of the Victorian Law Reform Commission's *Guardianship: Final Report 24* of January 2012 regarding the need to:

- broaden the circumstances in which the Public Advocate can investigate a complaint – including conducting an own motion investigation where the Public Advocate believes it is warranted in relation to (among other things) the abuse, neglect or exploitation of people with impaired decision-making ability due to disability, and
- clearly describe the range of powers open to the Public Advocate when conducting investigations – including powers to require people to provide documents, answer questions, attend compulsory conferences, and allow entry to premises with judicial permission in limited circumstances (when there are reasonable grounds for suspecting that a person with impaired decision-making ability due to disability, who has been neglected, exploited or abused, is on the premises).⁴

In our view, the inclusion of comprehensive investigation provisions and powers for the Public Guardian in the Guardianship Act would serve to complement, not duplicate, the investigative and community services-related functions of our office. It would enable us – and any national oversight body under the NDIS – to build on our existing cooperative relationship with the Public Guardian to safeguard vulnerable adults in the community. We note that recommendations from the NSW Legislative Council's recent inquiry into elder abuse in NSW include the need for legislative reform to establish a Public Advocate 'with powers to investigate complaints and allegations about abuse, neglect and exploitation of vulnerable adults, to initiate its own investigations where it considers this warranted, and to promote and protect the rights of vulnerable adults at risk of abuse.'⁵

Convening interagency meetings

A key role our office plays in relation to concerns that have been raised about potential abuse, neglect or exploitation of a person with disability is to bring relevant agencies together to discuss the information that is known about the person's current care, circumstances and risks – and to reach agreement on what action is required. These agencies may include any disability service currently or formerly involved with the person, the NSW Police, the Public Guardian, and mainstream services such as housing and health services. We facilitate the exchange of relevant information, the coordination of the safeguarding approach for the person with disability, and the oversight of the agreed actions.

Forum on addressing the abuse, neglect and exploitation of people with disability

More broadly, we believe there is a need for more comprehensive adult safeguarding mechanisms in NSW and nationally, including clear interagency mechanisms to identify

⁴ Victorian Law Reform Commission, 2012, *Guardianship: Final Report 24*, Chapter 20.

⁵ NSW Legislative Council General Purpose Standing Committee No 2, June 2016, *Elder abuse in New South Wales* (recommendations 1 and 11).

and effectively respond to alleged abuse and neglect of adults with cognitive impairment across a range of settings. In this regard, our office will hold a [forum on Addressing the abuse, neglect and exploitation of people with disability](#) in Sydney on 24 November 2016, with a focus on abuse, neglect and exploitation in disability service settings, and in community settings.

Strengthening safeguards for adults – key elements

We are highly conscious that safeguarding in relation to adults necessitates a different approach to safeguards and protections for children and young people. We agree with the key principles of the ALRC inquiry and their important focus on both autonomy and protection. In our view, these dual principles – and their application – should underpin the approach to identifying and appropriately responding to suspected abuse, neglect and exploitation of adults across all settings.

In our experience, the development of a comprehensive adult safeguarding mechanism(s) needs to include consideration of, among other things:

- effective and targeted strategies to empower and support vulnerable adults to identify and report abuse
- having a single point of contact for people to raise concerns (in addition to the Police in relation to criminal matters), with concerns able to be raised by anyone
- the need to have a lead agency to coordinate (when required) an effective response – with appropriate information sharing provisions relating to the safety of individuals, and appropriate powers on the part of the lead agency to require information and to monitor the implementation of agreed actions
- appropriate measures to provide vulnerable adults access to the support they may require in exercising their legal capacity, including application of the ALRC's recommended National Decision-Making Principles
- ways to increase the visibility of vulnerable adults and to raise the awareness of specialist and mainstream services and the broader community (including neighbours) of signs/indicators of possible abuse and what to do in response, including who to contact, and
- the legislative frameworks that are needed to address the issue – including Public Advocates with investigation and coordination roles; and recognition of the responsibilities of all parties, particularly key mainstream government agencies, to provide an effective interagency response.

It is important to recognise that investigating and making inquiries into reported concerns does not equate to removing or denying the autonomy of the individual at the centre of the concerns. While for some individuals the response may include measures such as applications for guardianship, for others the response may be increased support for the individual and/or their carer (and external monitoring of what is happening); increased connections to external parties/ the community; and assistance to understand their rights, and the available options for help and how to obtain it when needed.

Community Visitors and identifying and reporting abuse

The Official Community Visitor (OCV) scheme in NSW plays an important role in relation to vulnerable people who live in residential care. The OCVs are independent, paid, Ministerial appointees who conduct visits – primarily unannounced visits – to people in the full-time care of providers of disability supported accommodation, assisted boarding houses, or residential out-of-home care.

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

As part of our input to the development of the NDIS Quality and Safeguarding Framework, we have indicated that, against the background of the vital role Visitors play in helping to identify and appropriately resolve significant matters involving vulnerable people in residential care, we believe 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. 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 (or other additional needs) who live in these settings.

More information about the work and outcomes of Official Community Visitors in NSW can be found in the [OCV Annual Reports](#), located on the Ombudsman's website.

Empowering people with cognitive impairment to identify and report abuse

It is critical that concerted and ongoing efforts are made to maximise the ability of more vulnerable members of the community, including people with cognitive impairment, to be able to speak up about abuse and other unacceptable situations.

The NSW Department of Family and Community Services (FACS) has funded our office to deliver the Rights Project for People with Disability, a capacity-building project aimed at developing a practical and lasting framework that enables people with disability and their

supporters to better understand and exercise their rights in the transition to the NDIS. Our focus is on three main areas:

- empowering people with disability to understand and exercise their rights
- promoting accessible complaint systems and practices among NSW government agencies and disability service providers, and
- strengthening systems to prevent, identify and respond to abuse, neglect and exploitation of people with disability.

We are developing a range of practical and targeted resources for people with disability in a variety of formats, and are prioritising the delivery of training to people with cognitive impairment who live in large residential centres and group homes.

As part of the project, we have convened meetings with expert advisory groups – including forums with people with intellectual disability on their practical experience in exercising their rights, and with expert disability advocates, practitioners, researchers and policy makers from across Australia on leading practice in rights-based initiatives and resources.

Improving investigative interviewing of people with cognitive impairment

There are substantial barriers to people with cognitive impairment engaging with the criminal justice system on an equal basis with others, including reporting to police and participating in investigations and court proceedings. To ensure allegations of abuse are effectively investigated and prosecuted, it is essential that investigators have the resources to assist them to interview people with cognitive impairment using an appropriate and sensitive approach.

As part of our Rights Project for People with Disability, we have started to develop a guidance and training package for complaint handling staff and investigators in disability services to improve their communication skills with people with cognitive impairment, and to provide advice on obtaining ‘best evidence’ from people with cognitive impairment who are the subject of, or witnesses to, alleged abuse. The resources will provide practical advice about the impact of trauma and cognitive disability on communication, fundamental principles of investigative interviewing, specific interview techniques, and practices to avoid. The resources will also include a broad disability awareness component which focuses on cognitive disability, and will be tailored for use by police in their training of investigators and other officers.

To assist us to develop these resources, we are engaging an expert with extensive knowledge and experience in relation to communication with people with a cognitive disability in an investigative environment. We will also seek input and advice from a range of stakeholders in the disability and criminal justice sectors.

Specialised skills within the NSW Police

Evidence given at the Royal Commission’s public hearing on 12 and 13 July 2016 in relation to disability services included views on the need for a specialised team within the NSW Joint Investigation Response Teams (JIRT) to work with children with disability. The evidence to the Commission included statements about the need for:

- more consultation by interviewers on the child’s capabilities, including with families, and
- more funding and training for police dealing with, and interviewing, children with disability.

In our experience, there is a need to improve investigative interviewing of people with cognitive impairment more broadly – including children and adults – to maximise their ability to give evidence and gain effective access to justice. Our current project, outlined above, is focused specifically on this issue.

We agree that there would be merit in having a specialised team within the NSW Police to enable appropriate, sensitive and informed communication and interviewing of people with cognitive impairment. In our view, there would be considerable benefit in enhancing an existing specialist team, such as the Child Abuse Squad, to have a broader jurisdiction in relation to vulnerable persons, including people with cognitive impairment (including matters relating to elder abuse). The UK Metropolitan Police, which includes Sexual Exploitation Teams that focus on children and vulnerable adults, may provide a useful example.

We appreciate that there is an alternative view regarding the need to build capacity in NSW frontline officers, Local Area Commands, and Regional Commands through expansion of Vulnerable Community Support Officers, including recommendation 10 in the recent report from the NSW Legislative Council inquiry into elder abuse in NSW.⁶ While we support the development of identified positions in the Regional Commands to provide advice and assistance with matters involving vulnerable persons, the nature of the matters that have been reported to the Disability Reportable Incidents scheme – involving serious criminal allegations – warrant a more comprehensive approach. However, in making this point, we believe that staff working in a specialist squad could complement, as distinct from replace, the role of Vulnerable Community Support Officers.

In our discussions with the NSW Police on this issue in recent years, they have pointed to the need for there to be data that demonstrates the need for a specialist squad. However, we note that the data captured by NSW Police in this area does not allow an informed judgement to be made about the extent of the need. We believe that the establishment of our Disability Reportable Incidents scheme has provided a compelling case to demonstrate that there is a substantial number of matters involving people with disability that require a sophisticated response.

For example, since the commencement of the scheme in December 2014, we have been notified of:

- 275 matters involving criminal allegations against employees of disability services, including sexual offences, physical assaults, and fraud, against people with disability in supported accommodation
- 208 matters involving criminal allegations against clients of disability services, including sexual offences and physical assaults of other people with disability in supported accommodation, and
- 4 matters involving breaches of apprehended violence orders (AVO) that had been taken out to protect people with disability in supported accommodation.

To date, 17 people have been charged with one or more criminal offences.

⁶ Recommendation 10 is ‘That the NSW Police Force establish a Vulnerable Community Support Officer in each Regional Command in New South Wales, with the position entailing training and support to front line officers, police response, liaison with local service providers and other government agencies, community education, awareness and engagement.’

Intersection with the NDIS

We are actively involved in providing input to the development of the NDIS Quality and Safeguarding Framework, with a view to ensuring that it provides a comprehensive and nationally consistent approach to safeguards for people with disability that are at least as strong as what currently exists in NSW. Against the background of our work in relation to the NSW disability reportable incidents and reportable conduct schemes, our views have particularly been sought on the reporting and handling of serious incidents involving NDIS participants, and the screening of employees seeking to work with participants. In this regard, we have emphasised the need for:

- an independent national oversight body to have a proactive and hands-on approach to oversighting reportable incidents
- expansion of the current reportable incidents scheme to encompass a broader range of participants and providers, with provision to prescribe the suppliers/types of supports that are included in the scheme, so that it can be adjusted over time
- information exchange provisions relating to the safety of participants, and
- a nationally consistent approach to screening employees and prospective employees of registered and (certain) unregistered providers.

National consistency and exchange of information

In the context of the NDIS and other national reforms, and in line with the ALRC's recommendations from its inquiry into *Equality, Capacity and Disability in Commonwealth Laws*, it is vital that the objective of national consistency is a key consideration in any reviews and legislative amendments relating to people with disability and vulnerable people in the community. Any proposed changes to Commonwealth, state and territory legislation need to be viewed through a national lens and consider mechanisms for facilitating consistency across borders.

In this regard, in our recent preliminary submission to the NSW Law Reform Commission's review of the NSW *Guardianship Act 1987*, we indicated that, to enable consistent safeguards for vulnerable adults, the review should include consideration of the provisions that will be necessary to maximise cross-jurisdictional recognition of arrangements, and to support appropriate sharing of information. In our view, in relation to the Guardianship Act, information exchange provisions should be focused on ensuring the safety of people with cognitive impairment – including consideration of:

- mechanisms for the Public Guardian (or equivalent) in each jurisdiction to refer complaints or allegations of abuse and neglect to each other for investigation or other appropriate action in response to alleged victims and/or subjects of allegation moving across borders, and
- provisions for the Public Guardian, NSWTAG and/or NCAT to exchange information with relevant state and national bodies (including our office, the National Disability Insurance Agency (NDIA) and/or national oversight body) on matters affecting the safety of a participant or other person with disability – such as information relating to the inappropriate use of restrictive practices, and allegations of abuse and neglect.

Similarly, in our submission on the proposed [NDIS Quality and Safeguarding framework](#), we emphasised the importance of addressing cross-border information exchange challenges in the context of the development of national disability complaints and reportable incidents schemes. In relation to serious incidents, we have indicated that:

- While we do not believe it is consistent with the rights of adults with disability 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*), 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.⁷
- It will be important to ensure that there are adequate information exchange arrangements to enable the independent national oversight body to exchange relevant information in a timely way with the National Disability Insurance Agency (NDIA) and other safeguarding bodies 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.⁸
- 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-border information exchange challenges in the context of the need to develop national mechanisms for reporting and effectively responding to abuse, neglect and exploitation of vulnerable adults.

Staff screening

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 support roles. It is essential to ensure that there is a suitable workforce to enable and support people with disability and vulnerable adults to exercise and enjoy their full complement of rights. The importance of a highly skilled workforce that has the capacity to appropriately support vulnerable adults cannot be overstated.

In relation to the proposed NDIS Quality and Safeguarding Framework, we have indicated that we support the introduction, via legislation, of a comprehensive system for screening people engaged to support people with disability. We have advised that the development of such a system should be informed by existing screening systems, and indicated that 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).

Restrictive practices

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

⁷ Including matters relating to abuse, neglect and exploitation, and serious health issues.

⁸ 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.

strategy.⁹

Our work across a range of functions (including the Disability Reportable Incidents scheme; complaints; reviewable deaths; and the Official Community Visitor scheme) has highlighted the inappropriate use of restrictive practices as a behaviour management strategy in the absence of, among other things, positive behaviour support strategies and clear plans for reducing and eliminating their use. The reasons for the person's presenting 'behaviours of concern' are not always explored; and alternative, less restrictive, strategies are infrequently considered. In addition, restrictive practices that are implemented in a residential care environment to reduce risks for one person often restrict the freedom and choices of other residents.

While noting that there is an agreed national framework for reducing and eliminating the use of restrictive practices in the disability services sector, our work 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.

We agree with the ALRC that current national work – including development of the NDIS Quality and Safeguarding framework and the National Seclusion and Restraint Project – present a timely opportunity to consider a national approach to reform of restrictive practices. We also support the view of the ALRC that, in order to be effective, 'the regulation of restrictive practices needs to cover the use of restrictive practices in a range of settings',¹⁰ noting that people with disability can be – and are – subjected to restrictive practices in a variety of contexts, including disability, mental health, education, and aged care settings. Given that the NDIS Quality and Safeguarding framework only applies to participants and providers under the NDIS, there is additional work to be done to enable consistent requirements across the NDIS and non-NDIS disability settings, and other support settings.

Importantly, national reforms, and current inquiries and reviews, provide a valuable opportunity to ensure that the person who is proposed to be subject to the restrictive practice(s) is involved in any decisions regarding its use. In our experience, the person with disability is too often missing from the discussion and decisions in relation to restrictive practices, despite the significant and direct impact of such practices on the individual's rights and autonomy. It is critical that there are legislative requirements regarding the direct involvement of the person and the provision of support to maximise the person's ability to exercise their rights, will and preferences.

As part of our submission on the proposal for an NDIS Quality and Safeguarding Framework, we indicated support for the inclusion of the 'independent person' role as part of the restrictive practices authorisation and consent process, and emphasised that, in addition to family and 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). Our submission also stressed the need for:

- mandatory reporting on the use of restrictive practices, and building on existing

⁹ 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*.

¹⁰ Australian Law Reform Commission, 2014, *Equality, Capacity and Disability in Commonwealth Laws*, p202.

online reporting systems in Victoria and NSW to establish a mandatory national reporting system

- effective monitoring and oversight of the use of restrictive practices, including review of the data and information 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, and
- a range of mechanisms to monitor the use of restrictive practices and report inappropriate use – including Community Visitors, Local Area Coordinators, and advocates.

We would be pleased to discuss any aspect of our submission with the Commission, and to provide further information as needed. Please do not hesitate to contact Kathryn McKenzie, Director Disability, on (02) 9286 0984 or kmckenzie@ombo.nsw.gov.au.

Appendix 1

Table 1: Notifications of disability reportable incidents in 2015-16

	Notifications
Employee to client incidents	310
Client to client incidents	260
Unexplained serious injury	113
Breach of an AVO	3
Total	686

Table 2: Employee to client disability reportable incidents in 2015-16

Issue	Total
Physical assault	108
Ill-treatment	67
Neglect	56
Not in jurisdiction	42
Sexual offence	16
Sexual misconduct	13
Fraud	7
Reportable conviction	1
Total	310

Table 3: Client to client disability reportable incidents in 2015-16

Issue	Total
Pattern of abuse	139
Sexual offence	51
Assault causing serious injury	48
Assault involving the use of a weapon	15
Not in jurisdiction	7
Total	260