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A Critique of the Ombudsman's Report into Victoria's Disability Sector

A Supplementary Submission to the Family and Community Development Committee's Parliamentary Inquiry into Abuse in Victoria's Disability Services

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ABSTRACT

This paper provides a critique of the recently released report (June 2015) of Phase 1 of the Victorian Ombudsman's investigation into abuse, neglect and violence occurring in Victoria's disability sector. The paper only focuses on those aspects of the report associated with people covered by the Disability Act 2006 (the Act).

The paper argues the Ombudsman failed to take a hard-hitting approach. By going soft on those responsible for safeguarding people with disabilities and those responsible for the governance and management of direct services, the Ombudsman sought to steer a safe course.

The paper's writers are not only critical the Ombudsman failed to make findings detailing how those responsible for safeguarding and those responsible for services should more aggressively deal with those who commit abuse, neglect and violence, they are also critical that instead she cast blame on the 'system'.

The paper argues that it is not systems and process that perpetrate abuse, neglect and violence – it is people. The writers argue that it is not legislation, principles and policies that fail to protect - it is people.

PART A: A SOFTLY-SOFTLY APPROACH

1. Victoria's Ombudsman's recently released Phase 1 report – *Effectiveness of Statutory Oversight of the reporting and investigation of alleg*ations *of abuse in disability sector* (June 2015) require a forensic examination because of the hope that many invested in the Ombudsman's investigation.

2. Although a second phase of the Ombudsman's investigation is currently being undertaken and a further report is due for release in late 2015, the first phase report is a major disappointment.

3. While the report provides a blow-by-blow outline of contributions to the investigation, for reasons only known to the Ombudsman, it must be considered as surprising that she did not provide what might be described as hard hitting findings, albeit she did reach a number of conclusions (P 80–90 Para: 487- 566).

4. The nature of information, as in rapes and abuse that occurred at the Yooralla organisation and systemic abuse and neglect across the disability accommodation sector as reported by the Public Advocate, was significant in prompting the Ombudsman to undertake her investigation.

5. Despite the significance of the entry information and the associated responsibilities of particular entities for oversighting Victoria's disability sector, the Ombudsman made only two recommendations (P 91).

6. Although the report is wide-ranging in relation to the issues addressed and the individuals and entities engaged through the investigation, there is a strong focus on blaming the 'system'. This is opposed to calling it as it really is in terms of the failure of oversight authorities.

7. While the system has its faults, nonetheless, it is not as complex as suggested by the Ombudsman. The standout deficit associated with abuse, neglect and violence is much more about individuals and entities failing to do their jobs.

8. The failure is also much more about individuals and entities not adhering to their existing powers and obligations as set down in law.

9. The one critical fact that cannot be ignored is that it is not systems that perpetrate abuse, neglect and violence it is people. Therefore, it is of concern the Ombudsman would place so much focus on systems issues while to a large extent ignoring the people element.

10. By failing to be hard-hitting, the Ombudsman can be considered as having been soft on the power brokers in the disability sector.

11. By drawing conclusions that avoid emphasising the failures of particular oversighting bodies and making only two recommendations, the Ombudsman could be accused of protecting reputations.

12. In order to demonstrate why people with disabilities, their families and those concerned about the fractured system being fixed, Part B of this paper details what the writers contend represent the gaping chasm between what the Ombudsman's identified as conclusions and the failure of the Ombudsman to provide findings consistent with the report's narrative.

PART B: WHERE ARE THE HARD HITTING FINDINGS?

13. Despite the Ombudsman describing a number of significant deficits identified through her investigation and drawing conclusion, surprisingly she failed to provide detailed findings.

14. The writers say there is a significant difference between drawing conclusions to that of making findings. They argue conclusions are simply statements drawn from the presenting information. Findings, on the other hand, are more direct statements that reflect on the entry information and direct ownership of deficits and failures.

15. Critically of course, in simply drawing conclusion there is no requirement to name individuals who have failed to do their jobs. Thus, it is much safer to point the finger at systemic failures and gaps. Whereas, if the much stronger approach of making findings is taken, this then requires holding individuals to account.

16. By avoiding making findings, the Ombudsman has taken the softy-softly approach. As such, the report fails to address the scourge of abuse, neglect and violence occurring in Victoria's system in the hard-edged way that many who have been awaiting the report may have hoped.

17. By comparing and contrasting the commentary in the body of the Ombudsman's report with the failure of individuals to meet their statutory and service obligations and the Ombudsman's conclusions, this submission questions why the Ombudsman did not articulate findings similar to those as suggested further below.

18. **The writers must ask** - Why did the Ombudsman not go hard on those oversight authorities whom her investigation showed had not always acted, either knowingly or unwittingly, in the best interests of people with disabilities and in accordance with their mandated obligations?

19. **They must ask** – Why is it that whenever significant issues of concern arise in the disability sector there is an avoidance of addressing the failure of individuals with power, responsibility and influence?

20. **They must also ask** – Why is it that the 'system', or an alleged lack of money and resources, or alleged confusion, or not knowing 'right from wrong' are heralded as the causes?

21. **And, it must also be asked** – Why is it that there seems to be a protective web surrounding the power brokers in the disability sector?

22. The writers say the protective web must be unravelled.

23. They say the time has long past whereby the system should continue to be blamed for what is the failure of individuals.

24. The writers urge the Ombudsman to rectify the deficits of her Phase 1 Report in which she did not name those individuals and entities that have failed people with disabilities.

25. The writers call on the Ombudsman to express findings that truly reflect the narrative in the body of her report and issue a Supplementary Report to the Phase 1 Report.

26. The writers contend there is little point in investigations such as the Ombudsman's current investigation, or inquiries such as the current Parliamentary Inquiry in Victoria, or the current Senate Inquiry, if those responsible for their conduct continue the take the softly-softly protectionist approach in the outcome reports.

Translating Conclusions into Findings and Recommendations

27. Expressed below, under each of the headings detailed in the Conclusion section of the Ombudsman's report, are what the writers argue are reasonable findings and conclusions that should stand in place of the Ombudsman's conclusions (P 80 – Para: 90). The commentary is also informed by particular contents as articulated in the information section of the report (P 13 to Para: 79).

28. Where relevant, the writers have also made mention where they consider it appropriate of those matters on which recommendation should have been made as well as the two recommendations detailed in the report.

29. **Ombudsman's Conclusion: Lack of mandatory reporting**: Quite rightly the Ombudsman points to the lack of mandatory reporting in relation to alleged or known cases of abuse, neglect and violence. However, the Department of Health and Human Services (DHHS), under its various guises, has for in excess of two decades operated a mandatory incident reporting system. Although this system allocates incidents into particular categories, there can be no

doubt that those defined as Category 1 incidents do include incidents of abuse, neglect and violence.

30. Incident Reporting is not specifically mandated in the Disability Act 2006 (the Act). Nonetheless, disability providers who are funded by DHHS enter into a contract with the Secretary of the Department under S: 10 (2) of the Act. This contractual arrangement requires funded agencies to apply the department's incident reporting system; as such the contract mandates reporting.

31. DHHS, as a service provider in its own right mandates its own service outlets to report using the incident reporting system through its policy framework.

32. Despite the above however, mandatory reporting is not enshrined in legislation as for example it is in relation to abuse perpetrated against children in this state. The writers made representation to the former Minister urging that mandatory reporting, similar to that as applying in child protection, to be enshrined in legislation. However, the then Minister's Chief of Staff, to whom the matter had been referred to make a response, dismissed this.

33. While the writers unreservedly support the inclusion, in legislation, of mandatory reporting, they find it incomprehensible that the Ombudsman did not make a finding based on Submission references 1 and 2 (P. 82 Para: 497) in her report.

34. Further, the writers also find it incomprehensible that the Ombudsman failed to provide a specific recommendation calling on the government to enshrine in legislation, mandatory reporting for the disability sector similar to that existing for child protection. This being particularly given the comments attributed to the Public Advocate concerning the lower standard of reporting in terms of incident reporting by funded service providers (P. 29 Para: 140).

A reasonable finding: It is found that given the current reporting of abuse, neglect and violence does not have a clearly defined legislative mandate, it fails to provide a system that best protects people with disabilities from abuse, neglect and violence.

A reasonable recommendation: Given the above finding, it is therefore recommended that the Government takes urgent action to amend the Disability Act 2006 by inserting the mandatory requirement to report incidents of abuse, neglect or violence or incidents of suspected abuse, neglect and violence. Further, that this amendment is modelled on that as applying to Child Protection.

35. Ombudsman's Conclusion: Complex oversight arrangements: The Ombudsman makes reference to disability services as being complex and representing a landscape in transition (P 6 Para: 7-10). She expresses the view that "The landscape in Victoria is complex" albeit that "it is dominated by the Department of Health and Human Services (DHHS)."

36. The report details facts and figures associated with various sectors within the 'landscape' and defines the roles and functions as designated by legislation of particular oversight bodies.

37. Additionally, the report also makes reference to the National Disability Insurance Scheme (NDIS) in discussing the landscape (P 17 Para: 71-74).

38. While the writers acknowledge that the Victorian landscape is diverse, they argue it is misleading to equate diversity with complexity.

39. The Ombudsman increased the complexity of her investigation however, by electing to address issues associated with Supported Residential Services (SRS) and the Transport Accident Commission' (TAC) alongside the system specifically prescribed for disability services. Yet, having made the decision to include SRSs and the TAC, she elected to exclude children with disability in the Child Protection program.

40. The writers submit that whatever the complexity and no matter how significant the current landscape, this can in no way be accepted as a reason for the abuse, neglect and violence that has occurred, and continues to occur in Victoria.

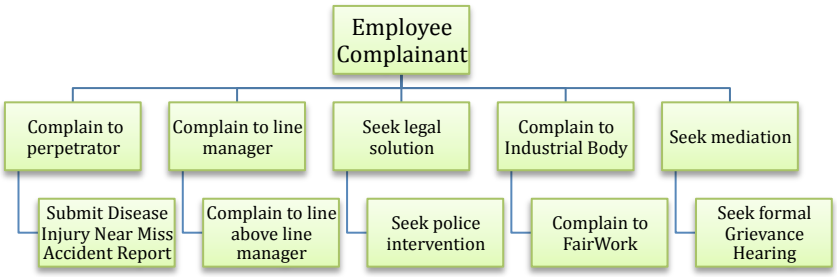
41. The writers note the schematic diagram (Figure 1 P 19) of the report, which on first glace can suggest a complex and confusing system for addressing complaints.

42. The writers argue however, that when the flow of possible options to make complaints and have them followed up is traced through the diagram, what it actually reflects is a diversity of opportunity.

43. Indeed, by comparing and contrasting the diversity of opportunity available to employees in the public sector in particular, to lodge and have complaints addressed, a similar diagram can be drawn.

44. The following first lines of a similar diagram reflect this. It should be noted that if the same degree of cross lineage were to be applied to this diagram as to that on page 19 of the report, with the same references to reporting, assessment, investigation, referral, acceptance or non-acceptance and resolutions or escalation, a similar view would emerge. Yet, the opportunity for employees to have several complaint pathways is accepted and indeed considered desirable.

45. It is of interest to note that the range of options and diversity available to employees is generally applauded as being a positive.



46. The writers therefore argue that it can reasonably be concluded that the Ombudsman has been seduced by the notion of complexity. Further, this has been at the expense of seeking to truly understand the importance of people with disabilities having the same rights and opportunities as others in society, and in this particular case afforded to employees, to have a number of those complaint paths.

47. The writers do not oppose the establishment of a single entity to be responsible for the oversight activities of mandatory reporting, complaints management, investigations, worker registration and provider accreditation, compliance and to also have a directive authority.

48. However, they do question why the Ombudsman seems to have ignored the fact that whatever the system or model, unless those responsible for its operations adhere to their legislative responsibilities and enact their mandated obligations, the system will fail.

49. As such, the writers again question why the Ombudsman appears to have let off the hook those currently with responsibility for the functions as in 46 above along with those responsible for the governance, management and delivery of direct services.

50. The writers also note the relationship between the two recommendations made by the Ombudsman and what they argue to be an incongruence in part of the wording.

51. By way of explanation, the writers note that the Ombudsman in Recommendation 1 recommends either the establishment of a single entity or alternatively the transfer of the stated responsibilities as detailed in Appendix 4 of the report (P 102) to an existing agency.

52. The Ombudsman appears to have been somewhat coy in making any comment in Recommendation 1 that if a transfer arrangement is undertaken to an existing agency, which agency that should be. Given Recommendation 2, it can be argued she has been less than transparent.

53. The possibility of the above claim has its roots in the fact that the Ombudsman is unambiguous in Recommendation 2. There she states that responsibility for administering advocacy services should be transferred to the Office of the Public Advocate.

54. Given that Appendix 4 includes advocacy along with assessment as well as Community Visitors, noting they currently come under the jurisdiction of OPA, it stands to reason, that although not stated in Recommendation 1, considering the two recommendations in concert with each other, it is reasonable to assume that the Ombudsman is clearly pointing to OPA as the agency that should be considered as the entity to which the transfer of responsibilities should be made.

55. Notwithstanding the above, and notwithstanding Recommendation 1, the writers submit the following as a reasonable finding and recommendation.

A reasonable finding: That while the current system as applying to reporting complaints and managing and investigating complaints is failing, and while there are gaps in terms of worker registration and provider accreditation, and

also while the current system lacks compliance muscle and directive authority, it is of significance that some of those charged with oversight responsibilities and some responsible for the governance and management of direct services have failed to meet their legislative mandates and responsibilities.

A reasonable recommendation: That the Government establishes, as an interim arrangement pending the full rollout of the NDIS, a new and independent entity to be known as the Victorian Disability Compliance Authority (VDCA).

Further, that the VDCA is established for the purpose of upholding the rights of persons with disabilities to receive high quality supports and to live free from abuse, neglect, exploitation and violence, by having sole authority and responsibility for:

- Accreditation of individuals and entities funded through the DHHS
- Registration of individuals seeking to provide specialist disability services
- Monitoring standards and quality assurance
- Operating a state-wide complaints mechanism,
- Undertaking investigation of complaints, and
- Establishing and implementing a statewide inspectorial system.

That in terms of jurisdictional coverage, this new entity should apply to all individuals across Victoria who are registered and entities that are accredited to provide specialist disability services and supports to people with disabilities, but who have not come under the jurisdiction of the NDIS.

56. Ombudsman's Conclusion: Gaps in oversight of incidents: The report details the regulatory role of DHHS including the registration of disability services providers, monitoring standards and independently monitoring compliance (P. 21 Para: 94-98).

57. The report notes that the department states "That it also ensures funded agencies comply with mandatory policies through contract management." (P 21. Para: 101.)

58. Table 2 (P 27 Para: 131) makes mention of 84 deaths reported as Category 1 deaths in 2013-2014. No mention was made however, of changes to the reporting of deaths made in December 2011 and how some deaths are now reported as Category 2 incidents and DHHS does not publish these.

59. Further, on the matter of deaths of people with disabilities that occur in supported accommodation, as the table below shows, on average in excess of five deaths occurred per week prior to a change in reporting in December 2011. The change to reporting was one whereby not all deaths were then required to be reported as Category 1 incidents. Instead, particular classes of death were reported as Category 2 incidents and indeed still are.

60. This change led to the department refusing to publically disclose all death figures. Yet, despite this, the Ombudsman appeared not to pursue this as part of her investigation and certainly did not make any reference to it in her report. The only reference to death is the 84 as noted in 57 above.

61. What is not now publicly reported in terms of deaths occurring in supported accommodation is – How many, in total, have occurred since December 2011?

62. Table 1 below, emphasises the change in reporting:

Category 1 Critical Incident Reporting Deaths in Disability Services

Category 1 Reporting	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Client deaths	208	272	156	65	84

63. The significance of the above table in terms of the Ombudsman's investigation and her report is twofold.

64. Firstly, not all deaths have been publicly reported since December 2011. Hence, the illusion that deaths have decreased is just that when the 2009-2010 and 2010-2011, suggest otherwise.

65. Secondly, is that the public, including the Family and Community Development Committee inquiry, do not know how many, if any, of the deaths that have occurred may have been as a result of abuse, neglect or violence.

66. The writers argue that this represents a significant deficit in terms of the Ombudsman's investigation and associated report.

67. By contrast, the New South Wales Ombudsman has taken a more direct approach to the reporting and analysis of the death of people with disabilities occurring in care.

68. In the Foreword to his eighth report (2012 and 2013) on the deaths of people with disability in residential care, the NSW Ombudsman makes the following comment:

"This report identifies significant issues arising from our reviews of the deaths in 2012 and 2013 of 239 people with disability who lived in residential care – including opportunities for reducing preventable deaths associated with, for example, choking on food; falls and fractures; and delayed diagnosis of life threatening conditions.

Our recommendations are targeted at ensuring, as much as possible, that there is appropriate support for people in residential care (and the staff who support them) to improve and maximise their health outcomes. …

While we welcome and support the introduction and broader roll out of the NDIS, my office's unique role in reviewing the deaths of people with disability in residential care has enabled us to clearly identify the significant health challenges and risks faced by this population, …

Finally, the information in this report highlights the vital role that the reviews of the deaths of people with disability play in shining a light on the current experience of this population, the support they require to maximise their health outcomes and life expectancy, and the considerable existing gaps in the service system.

It has been my privilege to be involved in this work, and to have responsibility for bringing this information to public attention."

69. Why is it that the New South Wales Ombudsman recognises the significance of deaths of people with disabilities occurring in residential care and reports on this, noting particularly that neglect can be reasonable concluded to be a cause of some deaths, and yet Victoria's Ombudsman ignores this in her investigation of neglect, abuse and violence? The writers submit that this significant deficit must be addressed.

70. On the matter of responding to incidents, the department's Assistant Director, Service Outcomes is quoted as saying, "There have been attempts to strengthen instructions and strengthen guidance to consider the services user or the client. I think the greater focus is on reporting rather than reflecting on the client." (P 28 Para: 136).

71. In terms of analysing reports, the State Manager of National Disability Services Victoria (NDSV) is quoted in the report as saying, "There is a sense from service providers that a lot of the department's reporting is transactional …" and "… there's not a lot of feedback…"(P 28. Para: 139)

72. A KPMG report is highlighted as noting that since 2006 "There have been five separate reports or inquiries concerning various aspects of the department's management of incident reporting." (P 29 Para: 142)

73. In terms of what are referred to as Quality of Support Reviews or Quality of Service Reviews (QSR) a review of a sample of 171 of the 478 undertaken in 2012, 2013 and 2014 undertaken by Ombudsman staff noted significant delays between when a incident occurred and the completion of the QRS, areas for action not being followed up and inconsistency in templates across divisions (P 30 Para: 147–155).

74. The report details a litany of what can only be described as significant deficits in the way the former DHS Secretary addressed her statutory obligations, the failure of DHS to properly address incident management, undertake and apply the recommendations of QSR and the number of reviews undertaken but where the department's failed to adequately follow-up.

75. The report does not note that the current Deputy Secretary Social Housing & NDIS Reform (Director of Housing) had direct overall senior management responsibilities for disability for well in excess of a decade.

76. The writers note the significance of the matters being investigated by the Ombudsman. They also note the acknowledged multifaceted role of DHHS along with the noted statutory responsibility "to promote the rights of people accessing disability services and to support the provision of quality services" (P 20 Para: 82).

77. Yet, despite the above and the obvious failure of DHHS through it various managers to adequately meet their statutory obligations and the failure, over several years, to address major deficits particularly in relation to incident reporting and management, the writers find it incomprehensible that the Ombudsman, in her comments regarding alleged gaps in the oversight of incidents, (P 83 -85 Para: 505–515), virtually ignores this.

78. Given the clear and unambiguous statutory role, function and responsibilities the Secretary of DHHS has (and the former DHS Secretary had) the writers contend that any failures that have occurred in relation to oversighting incidents

rest squarely with the Secretary of DHHS and the senior managers in that department.

79. The writers therefore challenge the Ombudsman's conclusion that there are gaps or confusion in relation to incident reporting. They argue that the problem rests more in the application of the Disability Act and DHHS policy and procedures. Also, the failure of the Secretary of DHHS to ensure compliance with the terms and conditions of Funding and Service Agreements with funded agencies.

80. The Ombudsman states in her conclusion, that the "DSC and OPA are the only bodies that have a specific role in the oversight landscape of abuse against people with disability albeit that each has a "limited role" (P 84 Para: 506). The writers argue that this totally ignores the role and function of the Secretary of DHHS as mandated under S. 8, S. 9 and S. 10 of the Disability Act.

81. Indeed, the writers argue that not only does the DHHS Secretary have a specific role, but given the composite of these sections of the Act, even more telling is that the Secretary who has the authority, administer the Act, "to develop policies for disability services" as per S. 8 (2), "to monitor, evaluate and review disability services" as per S. 8. (f), "to allocate funds" S. 9 (3) and to enter into contracts as per S. 10 of the Act.

82. Despite the Ombudsman's reference to the formal powers of the DSC to investigate complaints, she failed to make any criticism of the DSC in failing to initiate one single investigation since 2010, even though the DSC has received complaints associated with abuse, neglect or violence.

83. Despite the report noting that the neither the Community Visitors nor the Public Advocate have the power to investigate complaints in their own right, the Ombudsman does note that the Disability Act provides the Community Visitors Board with the power to refer matters to "any person", including the Ombudsman, the Disability Services Commissioner, the Secretary of DHHS and the Senior Practitioner (P 78 Para: 478).

84. Yet, despite the above, the Ombudsman failed to make any comment as to whether or not the Community Visitors Board had referred any matters to any of the above entities, other than herself.

85. This must be considered as a significant failure given in particular, the role of the Disability Services Commissioner and given the report provides no information as to whether or not the Community Visitors Board made any referrals to the Commissioner.

86. The only reference to actual referral was that the Community Visitors Board had "only referred three matters in five years, all of which were referred to" the Ombudsman's office (P 78 Para: 479). Therefore, it must be considered reasonable to assume the Community Visitors Board did not make any other referrals other than those noted by the Ombudsman.

87. The Ombudsman has throughout her report, in effect, positively promoted the Public Advocate and the Community Visitors as being key players in the disability system. Yet, other than commenting that, "The Community Visitors Board is not fully exercising existing powers to escalate appropriate matters (P 78 Para: 481), she makes no critical comment of this failure.

88. The writers consider this as a concern of major significance. This being particularly given that it was the Public Advocate and Community Visitors who, exposed what they described as "systemic abuse and neglect and as being "the tip of the iceberg".

89. Yet, despite their call for action and waving the flag of concern, the Community Visitors Board has ignored using the Disability Services Commissioner to pursue their concerns, by failing to refer and requesting him to investigate.

90. Therefore, once again, the writers express concern that the Ombudsman failed to cast blame on individuals and entities with particular responsibilities and powers. In this case, she failed to pursue the failure or make comment that the failure was not due to the system.

91. Given the above, the writers contend that a reasonable finding and recommendation would have been:

A reasonable finding: Despite the fact that there are some limitations in terms of the legislation applying to the DSC and the Public Advocate, nonetheless, it is concerning the Disability Services Commissioner has failed to exercise his legislative mandate to investigate any complaint since 2010, this being despite his own reporting identified that he has received complaints associated with neglect, abuse and violence.

It is also concerning to note that despite the Disability Act providing the Commissioner with the power to "consult with any person or body which the Disability Services Commissioner consider appropriate" [S. 17 (1) (a) of the Act], and despite the Act providing opportunity for the Public Advocate and Community Visitors, through the Community Visitors Board, to submit complaints to the Commissioner, there has been a lack of liaison between the two bodies. This failure has been in relation to OPA apparently not lodging complaints and the Commissioner apparently not consulting with OPA.

In relation to the above findings the Ombudsman should have expressed her criticism of the above failures and condemned the Disability Services Commissioner and Public Advocate.

A reasonable recommendation: That the Government investigate the failure of the Disability Services Commissioner to undertake investigations into complaints concerning abuse, neglect and violence.

Further, that advice be sought from the Public Advocate as to how many formal complaints she has submitted, either in her own right or on behalf of the Community Visitors Board, to the Disability Services Commissioner concerning abuse, neglect or violence since 2010.

92. Ombudsman's Conclusion: Lack of ownership: Associated with the above the Ombudsman suggested that this "highlights the lack of ownership of the problem around reporting of abuse." (P 85 Para. 516).

93. Clearly, based on the matters discussed further above this conclusion is misleading in that it is not supported by the facts.

94. The writers argue that each of the key entities in terms of oversighting and reporting as in DHHS, the Public Advocate, Community Visitors and the

Disability Services Commissioner have clearly defined roles, responsibilities and mandated authorities. Yet, each can stand accused of failing to meet the full range of their obligations.

95. The Public Advocate does not refer to the DSC, and despite the comment made in the report (P74 Para. 456) Community Visitors fail to report against their functions.

96. The Disability Services Commissioner refuses to investigate and DHHS does not adequately monitor and ensure the requirements of Funding and Service Agreements are observed.

97. Therefore, in terms of reasonable findings and recommendation the following are suggested:

Reasonable Findings: That while there are gaps and fragmentation in the reporting of abuse, this is not due to a systems deficit. It is directly related to a failure of key entities including the former Secretary of the former DHS, the Disability Services Commissioner, the Public Advocate and Community Visitors to fully meet their statutory obligations.

Further, that establishment of protocols between the various entities, rather than facilitate coordination, has lead to a dispersal of responsibility and ownership.

Reasonable Recommendations: That the Government investigate why the Disability Services Commissioner has failed to meet his statutory obligation in not investigating complaints of abuse, neglect and violence in those cases where conciliation has not been tried or was tried and failed.

That the Government modify the reporting format for Community Visitors reports so as to ensure all functions of the Community Visitors are reported on as per S. 30 (a) to (h) inclusive of the Disability Act 2006.

That the Government seek advice from the former DHS Secretary as to compliance or non-compliance of registered funded agencies to meet the full requirements of their Funding and Service Agreements.

98. **Ombudsman's Conclusion: Lack of information sharing:** The Ombudsman is critical in particular of DHHS for only providing "limited information publicly about incident reports." (P 85 Para. 512).

99. The report failes however, to emphasise the potential significance of death figures and how these are generally hidden from public scrutiny.

100. The report also fails to emphasise how despite S. 36 of the Disability Act imposing secrecy provision on Community Visitors, this section of the Act does provide some flexibility where this flexibility could particularly relate to a family member or guardian of a person with a disability who resides in a supported accommodation facility. Yet, the Ombudsman makes no reference to the road blocking imposed by the Public Advocate by refusing requests by family members or guardians to see reports made by Community Visitors where particular sections of relevant reports may relate to the family member with a disability of the person making the request.

101. Nor does the report highlight the many gaps in successive Annual Reports produced by the Disability Services Commissioner and the failure of those reports to report on matters such as why no investigations were undertaken in those case where conciliation had failed or had not been tried.

102. Given the gaps in the Ombudsman's report in relation to information sharing, the writers submit that the following therefore provide appropriate findings and recommendations.

Reasonable Finding: That the failure of DHHS, the Public Advocate, via the Community Visitors, and the Disability Services Commissioner to adequately make key information publicly available hinders information sharing and public scrutiny.

Reasonable Recommendations: That the Secretary of DHHS be instructed by the relevant Minister to publicly report all information about all levels and types of incidents.

That the Disability Services Commissioner be requested, by the relevant Minister to declare all information relevant to the non-investigation of complaints related to abuse, neglect and violence in his annual reports

That the Government changes the reporting format for Community Visitors, by way of the relevant regulation, in order to ensure that such reports address all eight functions as listed under S. 30 of the Disability Act 2006. Further, that the reporting format also be modified to include information pertaining to those individuals who the Community Visitors engage with on their visits and the time of the start and finish of visits.

That the relevant Minister requests the Public Advocate to facilitate access by family members and guardians to meet with Community Visitors and to be given access to relevant report of visits as relating to the family or guardian's family member with a disability.

103. **Ombudsman's Conclusion: Advocacy –** Reference to advocacy is addressed under a separate heading in the body of the report (P 42 - 47 Para: 251 – 161) as well as under the section on the Office of the Public Advocate (P 69. Para: 421 & 422) and in the Conclusions' section (P 86 Para: 522 to 531).

104. Recommendation 2 (P 91) states that the "investigation support an increase in the funding for advocacy which should be informed by a comprehensive assessment of the need."

105. Recommendation 2 further states that the government should "transfer sufficient funding provision from DHHS, and responsibly for administering advocacy services to the Officer of the Public Advocate." And further, the Office of the Public Advocate should provide "oversight for advocacy services to ensure consistency and best practice."

106. The recommendation is clearly driven by comments made on page 86 including Para: 527 where it is stated that "there is no systemic understanding of the actual demand for advocacy", Para: 529 that "OPA also provides some advocacy services to people with disabilities, limited by its funding arrangements" and Para: 531 that there should be "a single body to establish and operate the services and functions of advocates."

107. Despite the claim there is no systemic understanding of the actual demand, the Ombudsman nonetheless, in Recommendation 2 still makes a call for more money

108. Despite suggesting there should be a single entity to administer advocacy services, the Ombudsman fails to explore options but is categorical in her recommendation that it should be OPA.

109. Of even great concern however, the Ombudsman totally ignores what are real and practical realities. For example she ignores that her proposal will require legislative change, she ignores that it will require willingness of existing advocacy entities to give up their independence, she totally ignores the fact the these entities are legal entities in their own right with their own structures, governance regimes, legal requirements to do certain things.

110. On the matter of funding, the Ombudsman is silent in recognising the likelihood that as independent entities, advocacy organisations are unlikely to be willing to give up funds currently allocated. And, although the writers acknowledge that the government can withdraw current allocations to entities and redirect them to a single advocacy bucket, the uproar that occurred when the Federal Government attempted something along these lines cannot be ignored.

111. In terms of allocating more money, it seems reasonable to conclude that there may be a lack of willingness by the State Government to fund additional advocacy without knowing precisely how the current allocation is used, how much in additional funds is required and for what purpose.

112. The Ombudsman also seems to ignore that some entitles are jointly funded by both the state and the federal governments while there are those with only Federal funding?

113. The Ombudsman noted that there are 24 organisations funded for advocacy in Victoria. Of these, 17 are state funded only, 7 are jointly funded, plus another 10 are solely federally funded. In addition to this, there are those bodies funded for "information" and a number of these are also funded as "advocacy"

114. In terms of the NDIS, and what happens in Victoria as the interim arrangements pending the full rollout, the Ombudsman failed to note the Federal consultation on the advocacy framework, including that which open to the public, and 'targeted' consultations on the National Disability Advocacy Program.

115. Given the above, the writers suggest that the Ombudsman has missed the mark in terms of translating her comments into Recommendation 2.

A reasonable finding: It is found that advocacy, in all its forms, is diverse and significant doubt exists as to the efficiency and effectiveness of the current arrangements. Concern is expressed as to whether funds allocated by the State Government to disability related organisations for advocacy and/or related activities, are being used to the best advantage of individuals with disabilities who require advocacy support.

A reasonable recommendation: That the Government, through DHHS engage an independent organisation to undertake an urgent review of state funds allocated specifically for advocacy and/or other related activities with a view to redistributing funds in order to better target advocacy activities.

Note: The writers have issued a companion document with this paper entitled – Disability Advocacy in Victoria.

116. **Ombudsman's Conclusion: Good practice:** In the Foreword to her report, the Ombudsman highlights the UN Convention on the Rights of Persons with Disabilities - Article 16. She also highlights how Victoria has "a unique protection for people with disabilities under its Charter of Human Rights".

117. Also in her Foreword, the Ombudsman states, "there is a widely accepted view that Victoria has one of the strongest oversight regimes in Australia.

118. The Ombudsman then identifies what she suggests constitute areas of "good practice (P 7 Para: 11) and this includes the Disability Services Commissioner, the Community Visitors Program, the Senior Practitioner and the Public Advocate.

119. The writers contend that for particular entities the facts do not support the claim as in 118 above.

120. Of the two recommendations made by the Ombudsman, the first in its entry statement makes reference to "*the lack of consistent mandatory reporting, complex oversight arrangements and gaps in oversights"*. The recommendation then presents an each-way bet by suggesting, "*The Victorian Government either establish, or transfers responsibility to an existing agency for a single independent oversight body."* Appendix 4 of the report supports this recommendation.

121. In relation to the reference to Appendix 4 (P 102), the writers note that it refers back to page 87. Significantly however, the key features listed on page 87 added to 13 while those listed in Appendix 4 only added up to five.

122. The writers argue that the gaps, contradictions and the softy–softly approach inherent in Recommendation 1 and its associated appendix also contradict the claim as in 118 above.

123. The writers suggest that "transferring responsibilities to an existing agency", when clearly each of the existing oversight agencies, at least to some degree, have contributed to the fractured system, is not only highly questionable but would be inappropriate.

124. Further, why even contemplate this as an alternative given entities such as the Department of Health and Human Services and its former iteration the Department of Human Services have overseen the disability sector since 1986. That Community Visitors and the Office of the Public Advocate have also existed since 1986, and the Disability Services Commissioner position has existed since 2007.

125. The suggested framework as provided in Appendix 4 to Recommendation 1, other than including mandatory reporting lacks any form of innovation. It takes what exists, such as Community Visitors, advocacy, the Senior Practitioner and the relatively recently Disability Worker Exclusion Scheme, and simply dumps them in an independent oversight agency.

126. There is no acknowledgement that each of these entities and individuals has also been part of the fractured system.

127. There is no mention of the fact the Disability Worker Exclusion Scheme is an after-the-event action, where a worker is only excluded after having committed abuse or neglect or violence.

128. There is no sense of innovation or of thinking outside the square such as creating paid Disability Compliance Officers with legislated powers similar to those of Workplace Inspectors who protect the interest of employees, or establishing mandated consequences.

129. The Ombudsman makes no reference to standing down Boards who fail their governance responsibilities and Chief Executive Officers and other staff who fail to do their jobs.

130. There is no mention of the legal requirement of duty of care and how this must be promoted.

131. The writers therefore argue that the Ombudsman confuses what might be good practice and what might represent an efficient and effective system.

132. They further argue that while a single entity as described in 55 above will enhance oversighting, that this will only occur if those responsible for its operation do their jobs and meet their legislated mandates.

133. What has occurred in Victoria, and has led to the Ombudsman's investigation and the Parliamentary Inquiry, is not a system's failure. It is a failure of those responsible for oversighting and the governance and management of services.

134. The so-called good practices described by the Ombudsman in her report, in reality do not represent good practice. They simply identify what in essence might be claimed to be necessary elements of an oversight system.

135. On the above point it must be said that when used as a verb, 'practice' is action based and as such is not an entity. The real issue is how the entities practice their mandated responsibilities and in effect do their jobs.

136. Therefore, in terms of good practice the writers submit the following should have been the findings and recommendations:

Reasonable Findings: It is found that good practice is just that – good practice.

The legislative base and the myriad of policies and guidelines, and Rights and Charters such as the UN Convention and Victoria's Charter of Human Rights, along with criminal law as it applies to abuse and violence set the framework. Duty of care legislation applies to neglect, and combined with the framework elements combine to provide an unambiguous necessity and requirement for good practice to be actually practised.

Despite this however, it is found that good practice is frequently not applied. In its stead blame is cast on the "system". A significant finding therefore is that while some refinements to the system are necessary, the real and first order change rests with the existing oversight bodies and the Boards, Chief Executive Officers and managers of service providers to ensure good practice

Reasonable Recommendations: All entities responsible for oversight functions and all entities responsible for service provision must be called on to

meet their legislative mandates and ensure they practice their duty of care obligations to address abuse, neglect and violence occurring in the disability sector in Victoria.

For those who refuse or are unable to do so, the individual or entity responsible for the individual agency or the individual with the authority to replace them must act immediately to do so.

PART C: A CONCLUDING COMMENT

137. This paper has argued that the Ombudsman has failed to take a hard-hitting approach in her report.

138. The writers have argued that the Ombudsman has been soft on those responsible for safeguarding people with disabilities and those responsible for the governance and management of direct services. They argued the Ombudsman sought to steer a safe course.

139. The writers submit that evidence of the above claims resides in the report itself. Not only did the Ombudsman fail to make findings detailing how those responsible for safeguarding and those responsible for services have failed to aggressively deal with those who have committed abuse, neglect and violence, they are also critical that instead she also cast blame on the 'system'.

140. The writers further argue that in going soft on the people responsible for the various oversighting functions, despite the evidence of failures and deficits detailed in the body of the report (P 20-79 Para: 82-486), instead the Ombudsman has largely blamed the system.

141. This system's focus ignores the mandates enshrined in legislation, the principles and policies, and the UN Convention and Victoria's Charter of Human Rights.

142. Unfortunately, the Ombudsman has failed to call it as it truly is by avoiding making hard-hitting findings and recommendations.

143. As such, the writers consider the challenge for the Parliamentary Inquiry, given the Committee's brief to consider the Ombudsman's report, is not to be seduced by the title - Ombudsman, and instead consider the undeniable facts of the people failures largely ignored by the Ombudsman.

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End of Submission

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