Submission S003G
Received 16/07/2015
Family and Community Development Committee

Ombudsman's Recommendations Fail Logic Test

The big flaw in the Ombudsman's disability abuse report

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July 2015

1. People off the hook

The Victorian Ombudsman's recently released report (June 2015) of her investigation into abuse, neglect and violence occurring in Victoria's disability sector, applied an illogical scattergun approach. Her call for a single entity to be responsible for almost everything that moves in disability is illogical. Yet, she provides no acknowledgment that many of the elements she nominates to come under the authority of such an entity, are directly related to service operational responsibilities.

In addition to the above, the Ombudsman also goes soft on those responsible for safeguarding people with disabilities and those responsible for the governance and management of direct services. In doing so, the Ombudsman sought to steer a safe course by casting blame on the 'system'. This then provided the basis for her call for a single entity to control much of the oversighting.

> The Ombudsman provides no explanation as to why requiring service providers to abrogate what must rightly be retained by them, would make for a system better able to address and prevent abuse, neglect and violence against people with disabilities.

While the writers support the call for a more efficient system, they nonetheless argue that it is not systems and processes that fail and perpetrate abuse, neglect and violence – **it is people.**

What then did the Ombudsman say in her report that causes concern? Where does the logic fail, when considered in terms of the only two recommendations made in her report?

2. Ways of addressing abuse, neglect and violence

There are various ways to attack abuse, neglect and violence. Significantly, these already largely exist in the system, albeit those responsible for their application either ignore their mandated responsibilities or lack the skills to apply them. The following matrix highlights the significant safeguarding elements identified by the Ombudsman (P. 87). The writers have listed those already responsible for particular of those elements.

FUNCTIONS	ENTITIES			
	Secretary /DHHS	Public Advocate	DSC	Boards/ CEOs
Investigation of complaints	✓	✓ (i)	✓	✓
Review of Incident Reports to establish learnings	✓	✓	✓	✓
Advocacy & Support	✓	✓	✓	✓
Mandatory Reporting abuse etc (ii)	✓	✓	✓	✓
Applying or recommending penalties	✓	X (iv)	✓	✓
Meeting the mandates of the entity/position (iii)	✓	✓	✓	✓
Agency Registration or Accreditation	✓	X	X	X
Worker Registration	X	X	X	X
Interface with police	✓	✓	✓	✓
Referral to more appropriate authority	✓	✓	✓	✓
Receiving voluntary reports	✓	✓	✓	✓
Education and training to support understanding & responses to incidents	✓	✓	✓	✓
Promote awareness about reporting abuse and quality of care	✓	✓	✓	✓
Reporting on trends associated with incidents and allegations	✓	X (iv)	✓	✓
Publishing best practice guidelines	✓	✓	✓	✓
Sharing information	✓	✓	✓	✓
Own motion powers	✓ S. 8 (f)	X	X	✓
Disability Worker Exclusion Scheme	✓	X	X	✓

Notes:

(i) The Disability Act allows the Public Advocate and Community Visitors, through the Community Visitors Board to submit complaints to the DSC.

(ii) Although mandatory reporting, as prescribed for Child Protection is not enshrined in legalisation, incident reporting is mandated through Funding and Service Agreements as well as under duty of care obligations.

(iii) All of the named entities operate under the Disability Act 2006 while the Public Advocate operates under the Guardianship and Administration Board Act 1986. Both Acts detail clear requirements for the various parties.

(iv) Other than the Public Advocate and Community Visitors, DHHS and funded agencies can impose penalties while the DSC can make recommendations.

The Ombudsman largely failed to acknowledge the significance of the above in that the key entities have most of the functions listed. Therefore, again it comes down to a view of whether the system has failed or whether those responsible for the particular functions have failed to exercise their authority and responsibilities.

This question is of course the critical question when considering whether or not the listed functions should be transferred, or the establishment of new requirements such as mandatory reporting should be overseen by an existing agency or a new one.

3. If a single entity who?

In the body of her report the Ombudsman makes a call for a single entity, either by way of a new entity or an existing entity, to be responsible for the wide-ranging functions detailed in the matrix above.

Although the Ombudsman does not specifically nominate an entity in her Recommendation 1, it is important to note that advocacy is one of the functions listed for inclusion as per page 87 and Appendix 4 of her report. Therefore, given this, by virtue of nominating the Public Advocate to take over responsibility for advocacy as per Recommendation 2, the Ombudsman has in effect nominated the Public Advocate to be the entity to assume authority for the other elements.

4. A composite of flawed information and logic – The argument against an existing entity

While the writers support the Ombudsman's call for a single entity to be responsible for several of the functions listed in the above matrix, and as explored further under Section 7 below, they challenge her logic that the single entity should be the Public Advocate, or indeed any other existing entity.

(i) Why not the Public Advocate (OPA)?

- As expressed further below, the writers argue that to suggest OPA should be the single entity, ignores the fact that this would create a conflict of interest between the Public Advocate's main powers and duties, as in guardianship and matters associated with guardianship, and that of the other functions.
- Essentially, to place the functions as listed by the Ombudsman under OPA would create the same range of conflicts that currently exist for DHHS.
- Additionally, the writers also argue that just as the Ombudsman has what might be called an elevated role, whereby the position is able to keep a discrete distance from dealing on a day-by-day basis with issues arising from operations, the same argument applies to the Public Advocate.
- Indeed, the writers note that OPA has at times compromised its roles and functions by entering into debate that challenges the principle of choice and the individuals with a disability having the right, and being able to choose for example, the type of accommodation they want.
- Further, it is important to note that while Community Visitors come under the Disability Act 2006, the role and authority of the Public Advocate is enshrined in the Guardianship and Administration Act 1986.
- Therefore, to add additional functions, when the Public Advocate and her staff have demonstrated a conflict of role and function, fails the logic test.

(ii) Why not the Disability Services Commissioner (DSC)?

- Despite his relatively limited set of functions, the current Disability Services Commissioner has demonstrated an inability to fulfil his main function of investigating complaints.
- Apart from this however, even if a new Commissioner were to be appointed, the writers argue the role has proven itself to be limited and contradictory to the necessity of linking a range of functions to meet, what has shown to be necessary, since the creation of the role in 2006, and to be complementary, in the sense that the main task of resolving complaint is too limiting.
- Thus, while it might be argued that the DSC's role and functions should be expanded to encompass those promoted by the Ombudsman, the writers argue that the creation of an entirely new entity, which encompasses the DSC, and to be known as the Disability Compliance Authority and to replace the DSC would be more appropriate.
- Maintaining the existing DSC, albeit with expanded functions and authorities would no doubt meet with the challenge of changing old habits - which the writers argue would be a bridge too far.

(iii) Why not the Department of Health and Human Services (DHHS)?

- As noted by the Ombudsman, DHHS is a multifaceted organisation. As a funder, a policy setter, a policeman, a service monitor and most significantly a service provider, many of the functions currently assigned to DHHS, create a conflict of interest.
- Given the above, and based on the view expressed by the Ombudsman, the writers suggest it is clear why DHHS should not continue to be the 'one stop shop'.

(iv) Why not the Ombudsman?

- Other than VCAT being the complaint agent of last resort for some decisions such as residential, the Ombudsman in effect acts in that capacity for many of the actions that cause conflict in the disability sector, as the entity of last resort to raise complaints.
- The writers argue that to locate what might be called reviewable decisions under the Ombudsman without at first providing for an option below the Ombudsman, would inappropriately amalgamate all types of incidents, regardless of level of seriousness.
- They argue this would not only unnecessarily escalate lower level issues, but would burden the Ombudsman with an additional responsibility on top of what is already an onerous role.
- Additionally, the location of the wide-ranging functions listed by the Ombudsman would be outside the primary functions of that role.

(v) Why not Victorian Equal Opportunity and Human Rights Commission? (VEOHRC)

- While some might argue that this entity might be the most appropriate of the existing entities, to assume responsibility for the range of functions nominated by the Ombudsman, the writers argue that many of the nominated functions would create conflict or weaken the primary function of VEOHRC, which is to promote and protect human rights.
- However, given the Ombudsman highlighted the Victorian Charter of Human Rights as being unique in Australia and the significance of human rights and Victoria's uniqueness in terms of its charter, the writers argue that advocacy should be managed by VEOHRC.
- They contend that advocacy, as a support intervention, very much fits with the role of VEOHRC in advocating for rights and taking actions to seek to ensure that an individual's rights under the Equal Opportunity Act 2010 and the Racial Discrimination Act 2001, are protected.

5. Why a new entity?

Based on the above, the writers therefore support the call as made by the Ombudsman in her Recommendation 1, for a single entity to be established and to be responsible for a range of functions. They do however, for the reasons listed in 4 (i) above, reject the Ombudsman's Recommendation 2, that the Office of the Public Advocate should be assigned the additional functions. They also reject the Ombudsman's call that the full range of functions listed by her on page 87 and in Appendix 4 of report, should be included in a new entity, based on the logic flaws as detailed in 6 below.

As such, the writers strongly recommend the establishment of an entirely new entity to be known as the Victorian Disability Compliance Authority under the control of a Commissioner for Disability Compliance. Further, that the particular functions as detailed in 7 below be established as the principal functions and authorities of this new body.

They note that the creation of such a body would necessitate the transfer of some functions from other entities as well as the discontinuation of the Disability Services Commissioner.

6. The logic flaws

As already noted, the Ombudsman proposed a significant number of functions to be placed exclusively under the authority of this 'new' entity. While the writers agree with some of these, they argue that restricting some functions to a single agency denies particular legal and operational responsibilities and authorities that should rightly be maintained by existing entities. Essentially, the Ombudsman has based her call on a flawed logic as to how the system should be operating in terms of the link between oversighting, governance and direct service provision.

The concept of ownership, in the sense of being directly responsible, is one that appears to have completely eluded the Ombudsman. The reality, that once responsibility is transferred obligation ceases, appears to have also eluded the Ombudsman.

The Ombudsman has totally omitted any consideration of the legal oversight and management responsibilities that Boards and Chief Executive Officers have, and must continue to have, in terms of the governance, management and provision of services.

In other words, of itself, a single all embracing agency may inappropriately assume particular authorities and responsibilities that must rightly be retained by others.

Examples of this flawed logic demonstrate why the transfer of particular functions would be inappropriate:

(i) Interface with police

If a service provider, be it DHHS or a funded agency, becomes aware or has a suspicion that a criminal act such as abuse or violence has been committed, management has an obligation to report direct to and therefore interface with the police in relation to any such matter.

To suggest that authority and responsibility for this function should be transferred to a single agency is not only inefficient but of greater concern, ignores line authority, management responsibility and individual rights.

(ii) Consultation with Senior Practitioner

The Senior Practitioner has a clearly defined role and set of responsibilities under the Disability Act 2006 (the Act). Significantly, included among these is the provision of advice and direction to disability services providers, as well as

undertaking research aimed at providing information on practice to disability service providers as per S. 24 (1) (b) (d) (e) and (g) of the Act.
The nature of the Senior Practitioner currently having a direct relationship with service providers must be maintained. The Ombudsman's suggestion of locating the Senior Practitioner within a single entity that would become the consultation platform is illogical given that the Senior Practitioner is already located within DHHS – a single entity. The ombudsman provides no argument to support such a move.

(iii) Power to investigate individual complaints

It is not uncommon that service providers may receive many individual complaints concerning matters to do with their service. Some of these may be somewhat minor while others may have significance for service delivery, client rights and the like and as such may require investigation. Given that combined, DHHS and funded agencies provide services through several hundred outlets, the suggestion of a single entity becoming the focal point for the investigation of "individual complaints" creates great inefficiency and hence potentially time lost in initiating investigations.

However, the concern goes beyond inefficiency. Investigation of complaints, at least as an initial action, if outsourced to a single entity, not only ignores line responsibility, but equally it potentially allows entity management to abrogate what is their responsibility.

(iv) The ability to refer matters to more suitable bodies

The option and ability to refer as appropriate, to other bodies should not be confined to a single entity. To do that, would not only be clearly inefficient but would deny individual entities an authority to do so. Additionally, service entities responsible for clients must be considered as being best placed, and indeed legally responsible to determine if referral is appropriate. To remove this ability would cause them to become subservient to the single authority.

(v) Review of all incident reports

Based on the Ombudsman's report as per table 1 on page 26, the total number of incident reports generated by disability service providers in 2014 numbered 13,262. This figure only included one single Category 3 incident compared, for example to 2011 when 8,206 Category 3 incidents were submitted to the department. The change in numbers was due to a change in policy of agencies not being required to submit Category 3 Incidents. Without this policy change the figure for 2014 could reasonably have touched on 20,000 reports or more.

Therefore, given the significance of the number of incident reports, the writers argue that purely from a practical perspective to suggest that a single entity, other than a monolith such as DHHS, should assume the incident review function, when placed alongside all the other functions recommended by the Ombudsman, defies logic. Noting of course that based on five separate reviews, the Ombudsman noted that all the reviews "consistently questioned" DHHS's "rigour and effectiveness" in reviewing incident reports. Or, in effect, the department had failed to meet it obligation to adequately review all incident reports.

Certainly, DHHS recognised how fruitless their task was by not now requiring Category 3 Incident Reports to be submitted to the department. Even so, the current DHHS disability budget of approximately $1.78 billion (2015/16) suggests that the amount allocated for reviewing disability services incident reports would constitute a drop in the bucket. By contrast however, whatever funding might be given to an independent agency would put pressure on that entity's budget given the Ombudsman's call for "***all incident reports***" to be reviewed.

Apart from the practical consideration however, of equal import is the part incident reports can play as a management information tool. To strip the review function, and any required follow-up action from service entity management and locate it in the hands of a single entity ignores both the practicalities and the responsibilities.

This does not of course deny the option of mandated reports as relating to all serious incidents, being submitted to a single entity for review and investigation as required.

(vi) Promotion of awareness about reporting

All agencies involved in the disability sector have a duty for care to clients. This may either be by way of an oversighting responsibility or as a direct service provider. Therefore, logic dictates that all agencies have an obligation to be aware about the reporting requirements as well as the need to promote this awareness within their own agency.

To suggest that this responsibility should be located within a single entity is neither sensible nor logical.

(vii) Education and training

Again, all agencies involved in the disability sector have a responsibility for their own in-service education and training as well as supporting their staff to access external education and training options. Education and training are not matters for a single control.

Again, to suggest that this responsibility should be located within a single entity is neither sensible nor logical.

(viii) Ability to share information,

And yet again, all agencies involved in the disability sector have a responsibility to share formation as appropriate.

Therefore yet again, to suggest that this responsibility should be located within a single agency is neither sensible nor logical.

7. What is appropriate to be controlled by a single independent entity?

By taking account of the Ombudsman's list on page 87 of her report and excluding those functions as listed under 6 above for the reasons given, the writers contend that the following should be established under a single independent entity.

- Accreditation of service provider entities
- Registration of individuals seeking to provide specialist disability services
- Disability Worker Exclusion Scheme
- Monitoring standards and quality assurance
- Operating a state-wide complaints mechanism
- Mandatory Reporting and the review and investigation of serious incidents
- Establishing and implementing a state-wide inspectorial system
- Having own motion powers legislated
- Applying penalties

Significance for existing entities

The above transfer/creation under a single entity of course has significance for existing entities.

- **The Disability Services Commissioner:** By the inclusion of a statewide complaints mechanism and investigative powers this would then necessitate the discontinuation of the Disability Services Commissioner role.

- **Community Visitors:** By the establishment of a paid statewide inspectorial system this would then necessitate the discontinuation of the current volunteer Community Visitors program in the disability sector.

- **Department of Health and Human Services:** By including in a new entity, the accreditation of entities as currently registered by DHHS, the Disability Worker Exclusion Scheme and the monitoring standards and quality assurance; this would necessitate the discontinuation of these functions in the department.

- **Advocacy:** The Ombudsman is highly critical of advocacy being a responsibility of DHHS. She argues that represents a conflict, as the department is also a service provider. In her Recommendation 2, the Ombudsman recommends that advocacy be located in OPA. The writers argue that to do this ignores the fact that this would also create a conflict of interest between the Public Advocate's main powers and duties, as in guardianship and matters associated with guardianship, and that of advocacy.

  Therefore, as noted under 4 (v) above, the writers urge that advocacy is located under VEOHRC for the reasons given.

8. Concluding Comment

What then can be made of the two recommendations detailed in the Ombudsman's report? As demonstrated through this paper, three standout deficits demonstrate how the Ombudsman has failed the logic test:

(i) The failure in Recommendation 1 to nominate an entity to be the single entity responsible for the functions listed by her, and yet then nominating the Public Advocate, in Recommendation 2, to be given responsibility for advocacy when advocacy is listed as one of the functions in Recommendation 1.

(ii) The failure to acknowledge that several of the functions listed in Recommendation 1, by way of the list on page 87 and Appendix 4 of the report, deny the significance of line management responsibilities and those functions being critical in watchdogs and provider organisations 'owning' their responsibilities.

(iii) The failure to recognise why the flaws noted in her report and as associated with particular existing entities, including the Public Advocate, would deem them inappropriate to assume responsibility for the identified functions.

The Ombudsman's report will no doubt be heralded as a significant document, if for no other reason than it is from the Ombudsman. As such, it could be seen as setting the pathway for the future of Victoria's disability sector in better dealing with abuse, neglect and violence. But should it?

No, it must not be accepted without question. It must not be assumed to provide the definitive word simply because it has come out of the Ombudsman's office. As this paper has shown, the Ombudsman's recommendations are based on flawed logic and with apparent disregard for matters raised in her report.

This now demands that the Victorian Parliamentary Inquiry into disability abuse does not uncritically accept the Ombudsman's report and her two recommendations.

The Ombudsman's report must be challenged. Particularly given the clearly demonstrated flaws in the logic and the rationale underlying the two recommendations. The report must not stand as the basis for future decisions.

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