Submission by Matthew Potocnik 30/10/2016 - addressing concerns and Stage 2 Questions.
(I would like to be contacted to present myself before the Committee at the Public hearings)

In my first submission I attempted to qualify the body conducting this inquiry.

When you have a child with disability the most difficult thing to deal with is – what is.
The next thing to deal with, which is no less overwhelming is – what do I do now?

Some people may say, everyone feels that way about their children when they arrive. But really there is no comparison.

Our son is a beautiful young man; and I say in the same sentence, it is essential that this committee understands the huge gap between what exists currently and what needs to be done and put into place.

I also wrote to the Chair of this Inquiry last week (Ms Maree Edwards MP) via her website but currently I have received no response.

I started working in disability services when our son was three, and I made that change in occupation to ensure I would be most experienced and knowledgeable to bring him up.

It is no understatement to say, as a parent I have been totally ostracized from the service sector. When I read Sandra Guy's submission I can identify with it directly and then some. While the issues that have emerged from this inquiry are very good it is still very subjective in its comprehension of service delivery and the necessary measures to be implemented are uncommitted on a number of levels.
Recommendations
(1) Compliance with State and Commonwealth law.
(2) As a consumer - (fee for service/delivery) and its accountability to be delivered.
(3) Basic (incident) registration dynamics and accountability to line management **and back to the client** which is not present in the current incident reporting system. (Initial numbered incident reports)
(4) Cultural development and identity inclusive of parents in cultural develop capacity.

As a parent I do expect to be respected in my efforts and professional capacity to help reform the disability sector.

I demand that laws are complied with. Our family suffered terribly with the government's failure to deliver upon its legislated and support.

Accountability and the appropriate consequence for poor conduct is essential in the development of good service delivery, there is no room for apathy.

The Parliamentary Committee has ignored important issues I have highlighted in my previous submission that cannot and should not be omitted. The Parliamentary Committee is a parliamentary committee; and by definition must acknowledge the citizens of our democratic process and the rights of eligible citizens to participate in our electoral process. This is abuse and discrimination.

It is necessary that the electoral process is reviewed, and the Smart Roll process extended to register recipients of disability funding. It is paramount that eligible Victorian citizens in receipt of funded supports and those in Disability Accommodation Services (DAS) are accountable to participate in the Federal election in 2016.

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Service provision must be accountable to its' delivery in compliance with the law, to support clients and their rights, and from a service/consumer perspective, but also in relation to "Duty of Care"; particularly with the National Disability Insurance Scheme (NDIS) rolling out nationally.
This is what we are paying for.
If this accountability is not provided, this will be the first major failure of the NDIS; and is a very poor reflection on the powers and processes of this Committee.

There is huge disparity between what is delivered and what organizations must comply with in their delivery and service to people with disability. This is easily apparent when you read the acronyms of organizations and their compliance – I refer to DHHS. This is also an Occupational Health and Safety violation for workers who are bound by "Duty of Care" and yet not supported to deliver it. This is also stereotypical of the incident process, where there is a fundamental need for numbers to be attributed to each incident, which act as a receipt to the worker this provides an independent foundation to 'Duty of Care," this has not been mentioned. This number would make workers and management accountable to the client a relationship previously lacking.

When the Committee asks how do you change the culture – you can start by making sure incident reports are foundational and independent and fiduciary to the worker and their 'Duty of Care. Line management and management is not accountable to this "current" apathetic incident registration process.

Not wishing to going on and on - I ask the Parliamentary Committee to base their evaluations and recommendations on and in perspective with current State and Commonwealth Laws and the United Nations Convention on the Rights of Persons with Disabilities, to which Australia is a party and which sets out: (1) rights for people with disability to recognition before the law, to legal capacity and to access to justice on an equal basis with others, and (2) a general principle of respect for inherent dignity, individual autonomy, including freedom to make one's own choices, and independence of persons, and their compliance.

Not to do so introduces hypocrisy that excludes people with disability from their rights and safeguards, safeguards, which mainstream society, often take for granted. An example of this is the Royal Commission into family violence; this does not include people living in supported accommodation.

Hence by not acknowledging the abuse of people living in supported accommodation and their democratic rights and civic obligation to our electoral process and mandatory compliance to State and Commonwealth law this Parliamentary Committee defaces its own authority and is legally culpable.

Please refer to my submission to the Commonwealth Parliamentary Electoral Matters Committee, Inquiry into education. Submission number 32.
http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Electoral_Matters/Electoral_Education/Submissions
Also see the submission made to the Victorian Parliamentary Matters Committee on the effectiveness of the Victorian 2014 State election.

It is essential when developing these new bodies and departments of responsibility that it isn't just a reshuffle of people working in the same defunct/replaced departments.

It is essential that people with disability, service providers and family/carers can make suggestions on an ongoing basis to the new independent oversight body and that there is provision to do so that incorporates an accountable response.

Questions for Stage 2

1.1 What experiences have people with disability, families and carers had when disclosing or reporting abuse?

Watching my son in respite, I pointed out he was having drop seizures and needed attention. (I had just come out of the cardiac ward of the Royal Melbourne Hospital, and was unable to care for him.) The supervisor turned to me and said, "we don't see those as seizures". Short of any capacity to address the situation, I had to leave my son (who is non verbal and non ambulant and incontinent, 9 years of age at the time) seizuring in the "lack of care of Yooralla." It is impossible to fully understand the devastation, of this circumstance unless you were there – as a father or mother. The supervisor was moved to another part of the service. This is an example where appropriate consequence should present; and the person should have been dismissed.

I reported abuse when I witnessed a worker throwing a young male client to the ground by his throat. The worker then spat at point blank range in the client's face, while pinning him to the concrete.

I was told that I needed to write an incident report, even though the perpetrator had written one. I was very overwhelmed and stated I wasn't capable and asked that the Domain worker at the time help me to write it. I was told no, "you have to write it". Eventually I wrote the report, and informed management that I did not feel safe continuing to work there. I was told, "you need to go back to work". I went home and was very unwell. I stayed home for about four weeks and asked to work somewhere else but this was denied. The DHS did an investigation but I was not invited. I was medically assessed and I was asked what do you want, and I said, "to be paid for the weeks I have not been able to attend work and given another place of work". I was told that that would be ok. I was told that I would have to go for an interview which I did and I started work again shortly afterwards. I have found since that my continued employment was registered as being ceased for that period and I have lost long service leave and other benefits. I subsequently had a breakdown and left DHS for one year before returning.

In 2008 I mentioned the abuse of a client at DHS in a Parliamentary inquiry and the need for initial numbers on incident reports and nothing was done.

I met with the [redacted] and asked for the support from [redacted] to meet with [redacted] the Liberal Secretary to try to get the incident process amended to have initial numbers on it. I told him of my sons' neglect and abuse at Yooralla, He said, "I get parents coming here all the time thinking that they can change the world". When we left the meeting he said, "we'll pretend this meeting never happened".

In 2012 I reported my son's abuse to [redacted] the Liberal Secretary and she wrote it down, I asked that the incident process be amended to include initial numbers to help reform direct care – of course nothing was done.

1.2 What systems and processes do disability service providers have in place to prevent abuse occurring in their organisation or to respond to any allegations of abuse or neglect of people accessing their disability services?

The Residential Practice Manual, an incident report process (that doesn't register from the place of the incident), a Danger Injury Near Miss (DINMA) form, compliance to the Human Rights Charter and progress notes. Observations by others, including staff and clients. There is no line management accountability. Medical administration and treatment sheets.

Human rights and safeguards

3.1 How can the rights provided under the Charter of Human Rights in Victoria be maintained for people accessing disability services in the transition to the NDIS once it has been fully rolled out?

By implementing a specific care manual for each individual where service provision tasks and requirements are specified. Ensure there is access to report incidents, where the incident report can't be tampered with. Where the Human Rights Charter is suitably resourced to conduct audits and have periodic investigations to ensure compliance.

Independent oversight body

3.2 During the interim period of transition to the NDIS from 2016 to 2020, should the Victorian Government:

- create a new body under new legislation
- allocate the responsibilities to a single existing body
- improve the integration of existing bodies to fill the gaps and address overlaps on the boundaries?

Create a new body under new legislation

3.3 If the current safeguarding responsibilities were allocated to a single existing body, should this body be:

- Disability Services Commissioner
- Victorian Equal Opportunity and Human Rights Commissioner.
- Victorian Ombudsman
- another existing body?

The Victorian Equal Opportunity and Human Rights Commissioner – suitably resourced.

3.4 Should the state maintain responsibility for some elements of the safeguarding system during and after the transition to the NDIS?

Yes, but only if there are no negative jurisdictional issues.

3.5 If a single oversight body were established in Victoria what governance, accountability and oversight arrangements would need to be established to ensure it is accountable in safeguarding people who access disability services?

The oversight body needs to be able to visit service providers upon their terms and need to be suitably qualified in knowing what to look for, not like OPA. Families and individuals need to be involved as much as possible. The independent oversight body needs to be available and responsible to implement recommendations without going through unnecessary red tape. The oversight body needs to be accountable and active in its responses and action, when contacted, not like the DSC. The independent oversight body needs to have powers to dismiss people and recommend people be dismissed.

Disability advocacy services

3.6 What would be the most appropriate approach to the administration of funding disability and advocacy services, bearing in mind there are both state and federal funding streams?

- Should an existing or new body have responsibility for this role?

Yes, a new body should have the responsibilities of this role and advocacy must be independent to be effective in representing and promoting human rights in disability. A new body incorporating individuals who have run advocacy and understand the issues and needs, so that these people are accountable to the organizations they fund in a capacity where feed back is given and open dialogue accepted and welcomed. This body needs to talk with advocacy organizations. This body needs to be responsible for the development and maintenance of a Systemic Register. Too often advocacy goes around and around and a huge amount of money and resources are wasted. The development of a Systemic Register would allow for systemic issues to be logged according to the number of people they affect and minority they affect and the cost relative to amend the systemic problem. This should be done by the Government body who fund and support independent advocacy; responsible government

needs this information to develop change and to ensure safeguards and the successful reform of the disability sector.

3.7 In undertaking a comprehensive assessment of advocacy needs, what components of the advocacy system need to be evaluated or reviewed?
Advocacy needs to stand-alone and there can be no service provision in an advocacy organization. The advocacy organization must have direct access to report to the Independent oversight body. Service Providers should be legally accountable to comply with surveys developed by advocacy organizations and the independent oversight body. Advocacy organizations must be able to have access to clients in service provider environments and assess service providers upon the delivery and quality of service that the upon the clients request – the service provider must be compliant. There must be reporting and evaluation to develop the Systemic Register.

Prevention, screening and accreditation
4.1 Should the Victorian Government develop a prevention and risk management strategy for the Victorian disability workforce from 2016 to 2019?
- If so, what specific components would comprise such a strategy?

Too often management are the ones that shouldn't be in the job. But there does need to be mandatory qualifications of at least Certificate IV. The Police Check and Child Safety Check are essential.

Line management processes and activities should be audited. This is where workers and service provision issues are documented via emails; this area (if audited) would expose good and bad practice and provide a real understanding of the capacity and risks that happen in each service provider and where the weaknesses are. It is ignorant to assume, that prevention and risk are isolated to direct care; it is just unfortunate that this is where it precipitates too.

Again it has come to my knowledge that DHS was responsible for not ensuring Police Checks and this was found in an audit where 350 people for the best part of a decade have been working without the Policy Check having been processed. Words fail me. ?? There needs to be consequences and fines.

4.2 In Victoria, what would be the most preferable screening system to establish:
- a legislated disability worker exclusion scheme
- a legislated working with vulnerable persons check
- a combined version of an exclusion scheme and a working with vulnerable persons check?

A combined version of an exclusion scheme and a working with vulnerable persons check would be a good start. It also ensures the understanding that vulnerable persons, are just that, and need the appropriate person with the right state of mind and aptitude.

4.3 Should a disability worker registration scheme be established, similar to the Australian Health Practitioner Regulation Agency (AHPRA)?
- If so, should this be a national or state agency?

Yes, and this should be a national not just state.

4.4 Should an independent body be established to oversee service standards, accreditation and registration?
- If so, should this be a national or state agency?

Yes, and this should be a national not just state.

4.5 Should minimum qualifications be introduced for all disability workers?
- If so, what should be the minimum qualification?
- Should this be a state or national requirement?

Yes mandatory qualifications of at least Certificate IV and this should be national.

4.6 Should there be compulsory requirements for professional development for disability workers?

· If so, what core components of ongoing professional development would be required?

Yes.

(1)* The reliance on an incident registration process that is numbered from the source of the incident and sanctioned as a fundamental foundation available to workers to independently ensure their duty to "Duty of Care" of clients is protected. (2) Active support. (3) Specific and individual medical issue training (4) Client and family engagement training. (5) Service delivery requirements relative to positive culture. (5) Administrative and computer/application training. (6) Human rights and its application (7) Compliance to deliver services – including service support relative to State and Commonwealth Law. (8) Mandatory reporting of abuse. (9) Behavior Management training (10) Training for workers to bring issues to management that are not compliant with "Duty of Care" and State and Commonwealth Law. (11) Training on the fiduciary responsibility of management to implement better practice (12) Training on and the, specific, defining of definition, in various environments, of the term – "Best Practice". (13) National Decision-Making Principles and Guidelines should be a big component of study and active support that workers should be trained in – especially in relation to supporting people to enroll and vote.

(1)*In this report, incident reporting has failed to focus on the basic registration and the protection of that registration.

Too often I have been witness to the disappearance of incident reports and threats by management to re-write incident reports once they have gone missing. I am privileged to the knowledge of middle management and upper management physically destroying incident reports – these managers I can name. I have requested reform of this process for more than a decade.

If incidents are not numbered and continue to be numbered or registered from a removed location I will be taking this issue further. As a disability professional under the "Duty of Care" and OHS and as a parent this process must be implemented and is totally inadequate.

Workforce culture

4.7 What does the Victorian Government need to do to support a disability workforce culture that does not tolerate abuse, neglect or exploitation?

Implement professional development recommendations - (1)* (13) from question 4.6

(1) Work closely with families and people with disabilities to develop greater empathy and understanding to the roll of looking after some one else's child/adult who are reliant on them. (2) Remove the intolerable attitude and work ethic that is dismissive and mitigating. (3) Remind workers that they are in a service capacity for which they are paid for and any self-interest outside caring for client welfare is not tolerated. Management must remove the areas of grey and ensure workers are supported and avoid areas where self-justification becomes rational – I am referring to, for example workers using their own cars because the department has not got a car available; hence workers feel entitled and take liberties which manifest into poor culture. Understand much of the poor culture is, in fact, perpetrated and excised by management. This impacts directly on direct care staff and culture.

Employ parents in management rolls – while I fill out these inquiry questions, I am on long service leave, but cannot get a job in the sector despite my extensive experience.

4.8 What do Victorian disability service providers need to do to promote and achieve a workforce culture that does not tolerate abuse, neglect or exploitation?
They need to support their workers and ensure line management does not mitigate and that management is responsive to workers requirements and by implementing training (1)* - (13) from question 4.6
Workers should also be provided with a care manual specific to each clients needs and services delivered during each shift so that their responsibilities are made accountable. This care manual should include the organizations values and current law around service delivery requirements.

Complaints handling
5.1 If the Victorian Government introduces an independent oversight body, should it have responsibility for handling general complaints about disability service providers, as the Disability Services Commissioner currently does?
The Disability Services Commissioner currently does not by any stretch of the term, "handle complaints". I have specifically asked to lodge complaints with the Disability Services Commissioner and been verbally told, "we will call this an inquiry". I can name the person I spoke with, who I met again personally at the forum conducted by National Disability Service; "Zero Tolerance".

The independent oversight body must have powers to act on complaints and issues in a real sense where there are accountable and specific outcomes given to those who raise issues, including investigations. If this Inquiry does not ensure the independent oversight body has powers then this Inquiry is a waste of our time and effort and taxpayers money.

5.2 If there is a new independent oversight body with responsibility for complaints handling and responding to serious incidents, should it have the power to conduct own-motion investigations?
· Should these powers relate to both complaints and the investigation of allegations of abuse and neglect?
Yes, most definitely.

Guidelines for responding to abuse
5.3 If an independent oversight body is established in Victoria, should that body have responsibility for developing a standard set of guidelines for responding to allegations of abuse and neglect in disability services?
Yes.
Visiting Schemes
5.4 In view of the skills necessary in identifying and responding to abuse and neglect, should consideration be given to paid inspectors or paid official visitors in Victoria?
Yes.
5.5 If a paid inspector or paid official visitor role is introduced in Victoria, should they be located with an independent oversight body or other entity?
Located with the independent oversight body.
5.6 In relation to visiting schemes and the existing Community Visitor scheme:
· Should volunteer Community Visitors continue to be part of the safeguarding framework in Victoria?
No. The Community Visitors scheme in my experience is uneducated to the necessary requirements and understanding required to do the job properly.
· If Community Visitors continue to be part of a safeguarding framework in Victoria, should they be located within the Office of the Public Advocate, a new independent oversight entity or another body?
Located with the new independent oversight body.

Mandatory reporting

5.7 Should the Victorian Government introduce mandatory reporting of serious or critical incidents to a new independent oversight body? If so:

- What individuals and organisations should be mandated to make such reports?
- What current functions of the Department of Health and Human Services regarding the management of critical incidents should be transferred to the new body? And should the Department retain any functions relating to critical incident management?

Yes. All disability direct care workers, management and service organizations must be mandated to report to the new independent oversight body in regard to any abuse.

The duties held and managed by the Department of Health and Human Services regarding the management of critical incidents should all be transferred to the new independent oversight body.

The Department of Health and Human Services should not have any roll in relation to complaints and incidents except as a service provider who is responsibilities are to comply with mandatory reporting of incidents and abuse.

Oversight of restrictive practices

6.1 Should the Senior Practitioner be independent from the Department of Health and Human Services in its role in oversight of restrictive practices?

Yes. I don't think they should be in the same building, either. I was appalled at the appointment of a recent Senior Practitioner who was previously employed by the DHS. Once employed in his new capacity none of the recommendations of the Senior Practitioners review were implemented.

6.2 If the view is that the Senior Practitioner should be independent, what option would be most appropriate for the nature of that independence:

- a specific entity with independent statutory powers and its own office
- a new single independent oversight body?

It should be a new single independent oversight body.

How is it that to write a behavior management plan and process for restrictive intervention that you only need a Certificate IV in disability?

How does DHS continue to operate when it has fraudulently filled in restrictive intervention paper work for the Independent person – never appointed or introduced the individual put on RI?

6.3 Should Authorised Program Officers in disability services have minimum qualifications for making decisions in relation to emergency restrictive practices, such as restraint?

Having worked for many years with people who have behaviours of concern, where restrictive intervention was part of my daily experience - I would like to see something better than minimum qualifications and also include communication strategies from professional agencies such as Communication Rights Australia to provide workers with skills inline with National Decision-Making Principles and Guidelines.