Disability Services Commissioner

2016 Annual Report

Disability
Services
Commissioner

12 August 2016

The Hon. Martin Foley MP
Minister for Housing, Disability and Ageing
Level 22, 50 Lonsdale Street
Melbourne Vic. 3000

Dear Minister,
Pursuant to s.19 of the *Disability Act* 2006, I am pleased to provide you with my report for the year ended 30 June 2016.

Yours sincerely

Laurie Harkin AM
Disability Services Commissioner

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Contents

The Disability Services Commissioner is an independent voice promoting rights and resolving complaints about disability services in Victoria.

Our values

Our principles

From the Disability Services Commissioner

In a landscape that is rapidly changing due to the rollout of the National Disability Insurance Scheme (NDIS) we continue to safeguard the rights of people with a disability. Our increased capacity to conduct investigations into allegations of abuse in Victorian disability services is just one example of the growth and development of my office.

***Laurie Harkin** AM*
Disability Services Commissioner

National Disability Insurance Scheme

While the NDIS offers significant benefits to people with a disability and their families, there is still much work to be done to maximise the scheme's potential and to ensure that people's wellbeing is protected and their rights are respected and upheld. We are working with state and Commonwealth governments to develop a national safeguarding framework to underpin the NDIS.

The existing Victorian safeguards apply while the national framework is being developed. People should still contact my office with complaints about Victorian disability services.

Safeguarding the rights of people with a disability

This year there have been several inquiries into the handling and reporting of allegations of abuse within disability services, highlighting the abhorrent treatment that some people have endured. The Commonwealth Senate inquiry into violence, abuse and neglect against people with disability, the Victorian Ombudsman's investigation into disability abuse reporting and the Victorian Parliamentary Family and Community Development Committee inquiry into abuse in disability services all offer recommendations to tackle abuse and neglect in disability services and increase safeguards for people with a disability.

A number of the recommendations align with advice we have provided over time, not least being the need for an agreed definition of abuse for use in critical incident reporting and the provision of disability supports more broadly. If we are to effectively implement safeguards for people, we need to call out abuse for what it is. We look forward to continuing to work with the Victorian Government to further increase safeguards for people with a disability.

Our investigations this year have involved allegations of abuse of people with a disability, and we have liaised with Victoria Police as appropriate. These investigations have highlighted significant failures by service providers in both delivering support and in responding to allegations of abuse. Actions to Remedy were issued to service providers in the majority of these investigations, requiring implementation of improvements. Our increased investigative capacity would not have been possible without our partnership with the Independent Broad-based Anti-corruption Commission (IBAC) and I thank them for their valuable contribution.

The importance of mandatory reporting

Since 2012, my office has been responsible for the oversight of Category One incident reports for allegations of staff-to-client assault and unexplained injury, and we have provided biannual advice to the Secretary of the Department of Health and Human Services (DHHS). This year the Minister for Housing, Disability and Ageing broadened the scope of our reviews with a greater range of Category One incident reports, including client assault, injury and poor quality of care. This expanded oversight is effective from 1 July 2016 and will continue until 30 June 2019.

Victoria is the only Australian state or territory where service providers are obliged to report all incidents and complaints, so my office is uniquely positioned to influence statewide policy and practice to prevent and respond to abuse in disability services.

Mandatory reporting is supported as a recommendation in various state and national inquiries into abuse in disability services. We also support this recommendation for state-based safeguarding frameworks, and ultimately for the national safeguarding framework.

Conclusion

In 2015–16, we handled more complaints than in any previous year, reduced the time taken to resolve matters and achieved an 87 per cent resolution rate *(see page 10)*. I thank my staff for their continued commitment to upholding and promoting the rights of people with a disability. We are privileged to meaningfully contribute to improving people's experiences with their service providers.

I also thank Liz Corbett and other members of the Disability Services Board for their expertise and insight into the issues relating to improving safeguards for people with a disability.

We look forward to continuing to work with people with a disability, their families and friends, the government, Victoria Police and the disability services sector to promote and protect the wellbeing and rights of our fellow Victorians.

2015–16 Highlights

1,009 enquiries and complaints handled

30 complaints finalised in conciliation

9 investigations finalised

87% resolution rate (fully or partly resolved)

348 incident reports reviewed

2,000+ people attended DSC training or information sessions

30 submissions to inquiries and consultations

24,000 promo, info and educational materials distributed

2,174 complaints reported by service providers

Safeguarding the right of people to be free from abuse

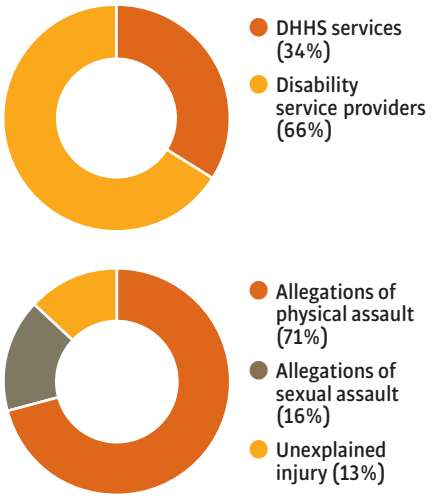
Assault and abuse of people with a disability by the staff who are entrusted to support them has a devastating impact on the victims and undermines people's confidence in the disability service system. **It is completely unacceptable.**

All disability service providers must report Category One and Two incidents to DHHS, in accordance with its *Critical Client Incident Management Instruction*. Since 2012, under s. 16(c) of the *Disability Act* 2006, DSC has provided independent oversight of Category One incident reports relating to allegations of staff-to-client assault and unexplained injuries. Through our oversight of these incident reports we influence policy and practice to improve prevention and responses to abuse. We also provide advice on individual matters where the needs of the person with a disability are not recognised.

In 2015–16 DSC reviewed 348 incident reports, 87 per cent of which related to allegations of staff-to-client assault. Due to the length and complexity of investigations by service providers, and the challenges of data collection, the number of substantiated allegations is difficult to quantify.

On 30 June 2016, the Minister for Housing, Disability and Ageing requested that DSC broaden its scope of Category One incident report reviews to include reports of injury, client assault and poor quality of care, effective 1 July 2016.

2015–16 incident reports reviewed by DSC



CASE STUDY

Marg & Joy's story

Marg raised concerns with her sister Joy's service provider about a sudden change in her behaviour. Joy has only a limited ability to communicate her needs and wishes, but after she returned from a stay in respite care she had trouble sleeping, wouldn't let people touch her and behaved differently at bedtime.

The service provider did not document or follow up Marg's concerns. A few months later when Marg raised the issue again, the service provider submitted an incident report.

The report failed to identify the actions the service provider would take to support Joy or address the incident, so DSC requested more information from the service provider and DHHS. The service provider responded that they had commissioned an independent investigation. They had also reviewed how they communicate with families and how they update their internal policies and resources relating to critical incident reporting.

After DSC reviewed the incident, the service provider notified Victoria Police and suspended the staff members who had been working with Joy, pending completion of the investigation. They arranged additional support for Joy, including counselling from the Centre Against Sexual Assault. They also engaged an external consultant to help them improve their incident reporting management and training, so that disability workers could better identify the signs of abuse, manage disclosures and record incidents.

These actions, including arranging additional support for the client, have improved the service provider's future capacity to prevent abuse and respond more appropriately when people raise concerns.

People with a disability have the right to be heard, to be proactively supported along with their family members, to participate in any investigations relating to allegations and to access the justice system.

Themes from 2015–16

Year after year DSC has identified the same themes in our reviews of allegations of staff-to-client assault and unexplained injuries, and it is a matter of concern that these continue to exist in 2015–16. These themes include:

- failure to provide additional supports to people immediately after the incident, for example, counselling, debriefing, reviewing support plans and advising family members of the incident
- a lack of information about safeguarding people's rights during investigations and supporting people with a disability to participate in the investigation
- the need for ongoing, proactive engagement with Victoria Police
- the need for further clarification on the scope, timelines and guidelines for Quality of Support Reviews
- a lack of clarity and shared understanding across the disability services sector of the definition of 'assault' and 'poor quality of care' and the required timelines to submit incident reports
- the need to regulate the suitability of staff who work in disability services.

Service providers must give equal weight to investigating an allegation regarding a staff member, protecting the human rights of the person with a disability and addressing the impact of the trauma they have experienced.

Since 2012, DSC has provided biannual Notices of Advice to DHHS that identify recurring issues from our incident report reviews and recommend how these might be addressed. DSC continues to engage with DHHS to track the progress of the recommendations contained in the Notices of Advice.

To drive systemic change, the Commissioner has initiated conversations with the Victorian Police Chief Commissioner to improve access to the justice system for people with a disability. DSC engages with Victoria Police at operational and policy levels, and is a member of the Chief Commissioner's Human Rights Strategic Advisory Committee.

CASE STUDY

Improving practices after DSC feedback

Staff at an accommodation facility reported that a staff member had violently twisted a client's wrist. The incident report, received by DHHS and subsequently DSC, documented that the organisation had taken a number of steps to ensure the safety and wellbeing of their client:

- The client had been offered immediate counselling and support.
- The client's family were advised of the incident.
- The support worker was stood down.
- Victoria Police and the Disability Workers Exclusion Scheme were notified.

The safety and well-being of the client was paramount for the organisation, as they ensured the person was made to feel safe immediately after the incident occurred. Additional supports were offered and the person's family advised of this matter so that they were able to provide family support as well.

This incident led the organisation to reflect on their practice. As a result, they undertook an internal investigation to establish whether they had done everything they could to support the person at the time of the incident and, to learn how to prevent similar incidents.

The organisation determined that the client needed a review of their support plan, examined their internal policies and procedures and, provided additional training to staff on critical incident reporting and prevention of abuse.

While it is unacceptable that this incident occurred in the first place, the organisation's approach to this incident followed recommendations suggested by DSC after a previous incident, resulting in a more person-centred, human rights-based approach.

DSC reviewed **348** incident reports in 2015–16

Our reviews and advice relating to Category One incident reports foster greater understanding in the disability services sector about person-centred approaches to preventing abuse.

Enquiries and complaints to Disability Services Commissioner

DSC supports Victorians in resolving enquiries and complaints about disability service providers.

Figure 1 provides an overview of enquiries and complaints made to DSC in 2015–16. The source, service type, and nature of enquiries and complaints *(Figures 2, 3 and 4)* were consistent with previous years.

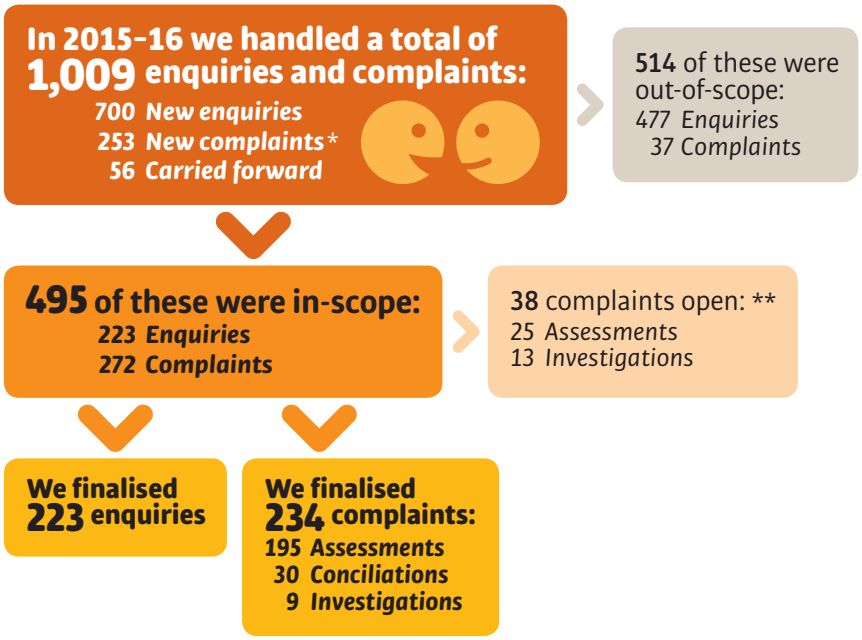
DSC improved our complaints process in 2015–16.

Since 1 July 2015 lodging complaints is faster and easier, with less paperwork. Complaint forms are no longer required. The number of complaints taken over the telephone in 2015–16 rose to 54 per cent of total complaints compared with 42 per cent in 2014–15.

The improved complaints process includes written confirmation from DSC that more clearly clarifies the in-scope issues and preferred outcomes sought by the person making the complaint. Where complaints are out-of-scope as specified in the *Disability Act* 2006, we outline this and if the person gives consent, we refer their complaint to the appropriate agency.

DSC continues to focus on person-centred, rights-based approaches to promote the resolution of complaints, improve outcomes and facilitate positive ongoing relationships. Our complaints resolution process is based on sector research and our own experience, and focuses on the Four A's – **Acknowledgement**, **Answer**, **Action** and **Apology** *(Figure 5)*.

Figure 1: Complaints and enquiries made to DSC in 2015–16



*18 new complaints referred to investigation, 21 new complaints referred to conciliation.

** As at 30 June 2016.

*Figure 2: Top five sources of in-scope enquiries and complaints**

1. **Parent or guardian** (41%)
2. **Person receiving service** (20%)
3. **Family member** (12%)
4. **Staff member** (8%)
5. **Service provider** (5%)

*Figure 3: In-scope enquiries and complaints, by service type**

1. **Shared supported accommodation** (41%)
2. **Individual support package** (16%)
3. **Day service** (14%)
4. **Case management** (9%)
5. **Respite** (9%)

*Figure 4: Issues raised in in-scope enquiries and complaints, by issue type**

1. **Service quality** (48%)
2. **Communication quality** (41%)
3. **Policy and procedure** (37%)
4. **Staff-related issues** (25%)
5. **Group supports** (24%)

* *Multiple responses are possible, so figures may not add up to 100 per cent.*

*Figure 5: Top six ways complaints were resolved using the Four A's**

1. **Acknowledgement:** person's views or issues (66%)
2. **Answer:** provided information or explanation (73%)
3. **Action:** planned or undertaken (37%)
4. **Action:** meetings or reviews arranged by provider (37%)
5. **Action:** communication issues addressed (31%)
6. **Apology provided** (37%)

Note: *More detailed information about complaints to DSC can be found in Appendix 1.*

CASE STUDY

Cathy & Jessie's story

Cathy called DSC with her concerns about in-home support for her daughter Jessie. Jessie's care had been provided by the same disability service provider for many years.

Cathy had complained to the service provider about the quality of Jessie's care, and in particular that a support worker had incorrectly administered medication. Cathy worried that Jessie's health had deteriorated because of this. She told DSC she wanted answers about the incident and why the service provider had not responded to her complaint.

DSC helped Cathy to clarify her concerns and the outcomes she was seeking. As a result of DSC's involvement, the service provider reviewed their records, acknowledged that the staff member who received the complaint did not follow internal complaints processes or alert management.

Following DSC intervention, the service reviewed staff's understanding of medication administration. They also reviewed their policies and procedures for complaints management, incident reporting and internal support planning. Training was provided to their support workers in complaints management, medication procedures and how to escalate concerns.

DSC facilitated a conciliation meeting for Cathy, Jessie and the service provider in Cathy's home. The service gave Cathy and Jessie answers in response to their complaint and explained how they would improve their processes.

Cathy and Jessie appreciated that the service provider acknowledged their concerns and apologised. They felt reassured that other people at the service would be treated better. They felt more confident about making a complaint in the future.

Enquiries and complaints to Disability Services Commissioner

A person-centred approach to complaints resolution

DSC continues to promote a person-centred complaints process, which includes actions such as meeting with people making a complaint in environments where they feel comfortable and improving the timeliness of the process.

In 2015–16, there were 21 new complaints referred to conciliation in addition to the nine carried over from the previous year. We completed conciliations for 30 complaints achieving the highest number of agreements for person-centred actions than any previous year.

Through our practice improvements in 2015–16, we reduced the average time taken to assess a complaint from 63 to 55 days, and the total time taken to finalise complaints referred to conciliation from 366 days to 125 days *(Figure 6)*.

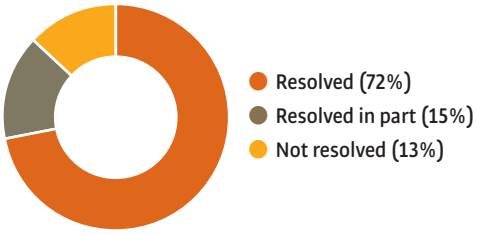
At the same time, we have achieved a resolution rate of 87 per cent, an increase from 85 per cent in 2014–15. When we determine whether a complaint has been resolved, we are guided by the person making a complaint, not DSC or the service provider.

Figure 6: Number of days for complaints resolution in 2014–15 and 2015–16

	2015–16	2014–15
Assessment: time to finalise as informally resolved	**55**	63
Conciliation: time to consider and refer to conciliation	**65**	50*
Conciliation: time from referral to finalisation	**60**	316
Investigation: time to consider and refer to investigation	**19**	30
Investigation: time from referral to finalisation	**117**	N/A

* *The time taken to refer a complaint to conciliation was shorter in 2014–15, as we were able to address multiple complaints about the same issue and service provider via one conciliation process.*

Figure 7: Resolution rates for in-scope complaints



In 2015–16, DSC achieved a resolution rate of 87 per cent (fully resolved and resolved in part), as measured from the perspective of the person making the complaint.

CASE STUDY

Conciliation promotes clear communication

DSC received complaints from the families of Hun, Sofia, Jade and Rebecca, who all live in the same house. They were happy for the complaints to be handled together.

Hun, Sofia, Jade and Rebecca were scared of Sam, another resident. Sam yelled and had hurt support staff. They felt that the service provider wasn't taking their concerns seriously.

A DSC Resolutions Officer visited the house and met with the residents and their families. They all raised concerns that people were choosing to stay in their bedrooms or at the shops from fear of Sam. The house didn't feel like home. They wanted Sam to move out of the house.

The Resolutions Officer explained that the resolution process would focus on how the service provider was ensuring all people in the house were safe, supported according to their individual needs and treated with respect. DSC talked to the service provider about this.

During the process Sam moved out of the house. DSC found that the service provider did not keep residents and their families up to date with what was happening.

The Resolutions Officer facilitated a conciliation meeting with residents, family members, advocates and the service provider. Hun attended the meeting for twenty minutes. Sofia's father read out a letter that Sofia had written so that Sofia's voice was heard. It resulted in agreements about providing counselling for residents, improved processes for how people should transition into the house, and proactive communication, including regular residents and families meetings.

The residents and their families felt that the issues were resolved. They felt that they had been heard and that the conciliation agreements would ensure things were managed better in the future.

DSC completed conciliations for 30 complaints in 2015–16, compared with 11 in 2014–15.

Conciliations are a formal opportunity for people to be heard and a chance to reach agreement on changes to disability support services.

Enquiries and complaints to Disability Services Commissioner

Driving change as a result of complaints

An important step in the complaints process is to ensure that the actions identified for continued service improvements are acted upon. To support this process, DSC can request a report on actions undertaken from a service provider, or issue a Notice of Advice.

Reports on action

During the resolution process, the parties involved will plan certain actions to be undertaken. In some situations, DSC will ask the service provider to report back on the progress of these actions. Where we don't request a report back, we encourage the person who made the complaint to contact us if they feel the actions have not been completed.

In 2015–16, DSC requested 34 reports on action from service providers. Where the person with a disability continued to receive services from the provider, the actions due in 2015–16 were completed. Where the person with a disability had changed services, actions were not always completed.

Notice of Advice

A Notice of Advice in accordance with s.17 (1) of the *Disability Act* 2006 is issued by DSC when we have identified areas requiring further action to ensure quality outcomes for people receiving disability services.

DSC provided 20 Notices of Advice to service providers as a result of complaints to our office.

CASE STUDY

Reviewing fees and charges

John is the financial administrator for Jenny who lives by herself in a home managed by her service provider. John complained to DSC that the service provider was incorrectly charging Jenny. Their invoices were confusing and they said Jenny owed them a lot of money. John had spoken to the service provider but nothing had changed.

DSC contacted the service provider and reviewed their policies and financial documents. At our request the service provider reviewed and amended Jenny's account and invoices with information provided by John. They found that Jenny owed much less than originally invoiced.

DSC discussed with John and the service provider the need for improved communication and accounting. The parties met and agreed on how they would communicate and address issues in the future.

DSC gave the service provider a Notice of Advice. This meant that the service provider had to review their complaints handling policy, provide an updated residential statement to John and Jenny, audit invoices issued to other clients and implement a new process for managing fees and communicating about money owed.

John considered the complaint resolved and thought the resolution process worked well for Jenny and would help other people too. He felt like he would be able to talk to the service provider in the future if he had questions.

Continuous improvement through feedback

DSC seeks feedback from people who make complaints and from disability service providers after a complaint has been closed. We implemented a new feedback system in 2015–16, including an Easy English form that can be completed online or in hard copy. The 2015–16 feedback survey completion rate of 38 per cent is an improvement on the 30 per cent completion rate in 2014–15.

Feedback allows DSC to make continual improvements to the way we manage our complaints process. In 2015–16, there were some common themes to the feedback received. DSC has taken action to improve our practice as a result of this feedback.

More face-to-face interactions

'Face-to-face contact with our clients made it easier for them to express their opinion. Our clients have a disability and some may not speak clearly, therefore, the face-to-face contact allows you to observe their body language and understand them better.'
Service Provider

Reflecting our person-centred approach, DSC Resolutions Officers meet people making a complaint at whatever location they feel most comfortable. It could be in public settings like their favourite café, or places they visit every day, for example, their day service. This face-to-face approach is reflected in the increased number of conciliations we have conducted in 2015–16 (30 complaints, compared to 11 last year) that allow the person making the complaint to have their concerns heard in person by the service provider in a safe setting.

Timelines for complaints resolution

'The time between the first conversation and the formal complaint being lodged is very long. I realise it may be hard to change but a shorter timeframe would have been better.'
Person Making a Complaint

In 2015–16, DSC reduced the average length of time taken to assess complaints to 55 days for an informal resolution, and 19 days before referral to investigation *(Figure 6)*. We also reduced the time taken to finalise a conciliation, from 366 days in 2014–15 to only 125 days in 2015–16. We will continue to streamline our processes so that we handle complaints swiftly without compromising the integrity of our assessments, conciliations and investigations.

Clarity about what is achievable

'Be honest from the outset if assistance cannot be given rather than going through a meaningless process. A clear outline at the beginning of the process about what powers DSC has.'
Person Making a Complaint

After a person makes a complaint to DSC, we clarify in writing what aspects of the complaint are in and out-of-scope, what can be assessed by DSC, and the desired outcomes sought by the person. We also clarify what aspects of the complaint we will need to refer to another agency.

2015–16 feedback survey results

85% **of those surveyed thought DSC focused on the rights and needs of the person with a disability**

82% **thought the complaints process was timely and efficient**

83% **thought communication from DSC was good**

78% **of people who made a complaint felt confident to speak up again in the future**

Looking to the future

DSC survey feedback revealed issues that we will need to monitor and evaluate over the coming months. For example, 12 per cent of respondents disagreed with the statement 'The agreed actions were made clear to me when the complaint was finalised' and 13 per cent of respondents disagreed with the statement 'The DSC process focused on the rights and needs of the person with a disability'.

This feedback gives DSC guidance on how to improve the service we deliver to individuals with a disability, people making a complaint and service providers.

'The officers who helped me were very professional and empathetic, and treated me fairly. We achieved a fantastic outcome together.'
Person Making a Complaint

Protecting rights through the investigation of complaints

DSC has powers under s. 118 of the *Disability Act* 2006 to investigate complaints, where the Commissioner has determined that the complaint is not suitable for conciliation or when conciliation has failed and further action is required.

When conducting an investigation DSC can compel all service providers (including DHHS) to provide information and documents.

Complaints about physical and sexual assault

From 2007–08 to 2013–14 about six per cent of all in-scope complaints made made directly to DSC related to allegations of physical and sexual assault. This rose to 15 per cent in 2014–15 and to 21 per cent in 2015–16. DSC attributes this growth to greater public awareness created by the recent inquiries into abuse of people with disability by the Victorian Ombudsman, the Commonwealth Senate and the Victorian Parliamentary Committee.

Victims of abuse, particularly people with limited communication and a cognitive disability, are unlikely to make a complaint about their abuse.

Complaints and investigations data show that people with a disability who were victims of abuse are unlikely to make a complaint about their abuse. In 2015–16, only one in-scope complaint relating to allegations of physical and sexual assault was made directly by a person with a disability, whereas 31 per cent of the total number of enquiries and complaints were made by people with a disability. Disability support staff made up 33 per cent of those making a complaint about allegations of physical and sexual assault, but they represented only five per cent of the total number of enquiries and complaints.

This is a disturbing trend that highlights the need for a strong safeguarding framework for people with a disability and reinforces the importance of mandatory reporting of abuse by disability staff.

Working with Victoria Police

DSC is empowered by the *Disability Act* 2006 to provide advice and resolve complaints arising from the provision of a disability service through informal agreements, conciliation and, under certain circumstances, investigation. Where it becomes evident that the complaint involves potential criminal conduct, DSC will refer the relevant aspects of that complaint to Victoria Police. In 2015–16 we referred three investigations to Victoria Police.

To assist in ensuring access to justice for people with a disability, DSC is working collaboratively with Victoria Police on a protocol to guide how our organisations work together when investigating allegations of abuse in disability services.

Partnership with the Independent Broad-based Anti-corruption Commission

In early 2015–16, while allegations of abuse were increasing significantly, DSC had only one Senior Quality Analyst to conduct investigations. To address this demand for investigations expertise, we arranged for a six month secondment for a Principal Investigator from IBAC from September 2015. The Principal Investigator was provided by IBAC as part of a partnership in increasing opportunity for sharing of knowledge and skills relating to disability and investigations.

A number of investigations into allegations of abuse were commenced were commenced during this time, which would not have been possible without the investment of IBAC in outcomes for people with disability. Fixed-term funding was secured from DHHS by the end of the financial year for one Principal Investigator and one Investigations Officer. We acknowledge that the length of time taken to complete some investigations in 2015–16 was impacted by the limited resources available. This has also impacted the carry-over of investigations into the 2016–17 year.

Themes from investigations

There were 18 complaints referred for investigation in 2015–16, with four investigations carried over from the previous year. The majority of investigations related to shared supported accommodation, followed by respite and day services. Matters referred for investigation included:

- allegations of physical and sexual assault
- inappropriate use of restrictive practices, ranging from chemical restraint to kitchens and toilets being locked at night
- verbal abuse including racist language
- people being locked in confined spaces including bedrooms and bathrooms
- health procedures conducted without the consent of the person or their guardian
- a variety of medication issues including intentional withholding and incorrect administration of medications.

Inadequate follow-up of incidents, poor complaints management and poor communication – including staff refusing to communicate with clients – were also identified.

After an investigation

At the conclusion of an investigation, the Commissioner determines whether the complaint is Justified (s. 118(4), *Disability Act* 2006). Where a complaint is Justified, DSC can issue Actions to Remedy the complaint to the service provider (s. 119, *Disability Act* 2006). The service provider has 45 days to report back to DSC on the actions taken, with the opportunity for one extension of 15 days at the discretion of DSC. To date the Actions to Remedy have included review and development of staff training, review of policies and procedures, notifications to the Disability Workers Exclusion Scheme, and service providers acknowledging the impact on the clients and their families. One investigation led to service reviews and the decision by funding bodies to revoke the registration of the disability service provider in question.

As a result of these Actions to Remedy, service providers have improved their policy and procedures, implemented staff training and development, made changes to their services and, where allegations were substantiated, terminated individual staff members.

At 30 June 2016, nine investigations had been finalised. Open investigations included four completed investigations in Actions to Remedy phase, two suspended and seven active investigations.

Figure 8: Investigations open as at 30 June 2016

Status	Number of complaints
Active investigations	7
Suspended investigations (referred to other agencies)	2
Complaint(s) justified – awaiting responses to Actions to Remedy	4
Total	13

The power to compel evidence for investigations allows DSC access to valuable information and first-person accounts of any incidents of concern. This enhances our ability to make the right decisions and issue Actions to Remedy that will be of benefit to the person making the complaint and other people who use disability services.

CASE STUDY

Robert's story

DSC received a complaint from Robert's family. Robert's behaviour had changed – he no longer enjoyed his day service, and would often get upset and become physically ill before attending. His family could prove that staff had verbally abused Robert and neglected his needs.

DSC decided this matter was appropriate for investigation and used our investigative powers to compel the disability service provider to attend meetings and interviews and to provide documents. We interviewed Robert's family as well as employees and managers at the service. We reviewed documents including a communication book, support plans, incident reports and policies and procedures.

As required by DHHS instruction 'Responding to allegations of physical or sexual assault', DSC instructed the service provider to report the incident to Victoria Police. Following contact with Victoria Police, DSC continued to investigate this complaint from a practice improvement perspective.

DSC decided this complaint was Justified in accordance with the *Disability Act* 2006, and issued Actions to Remedy to the service provider. This included:

- an acknowledgement of the impact of the abuse and neglect on Robert
- an apology to Robert and his family
- an immediate review of Robert's support plan and support arrangements
- changes to the way the service provider responds to concerns
- training for staff.

The service provider completed all the Actions to Remedy within the 60 days required under the *Disability Act* 2006. Some staff had their employment terminated, and the service provider took steps to ensure that all staff understood the organisation's commitment to a person-centred approach to service delivery and zero tolerance of abuse.

Robert and his family chose to stay with the service provider because they were encouraged by the implementation of all the actions and the inclusive way the provider was now working with them.

National Disability Insurance Scheme trial in Barwon

In 2015–16, DSC delivered 13 presentations to a total of 487 people with a disability, family members, friends, caregivers and service providers in the Barwon trial site.

In the second full year of complete operations in the NDIS Barwon trial, DSC received 12 complaints from the Barwon region. Themes of complaints remain similar to state-wide trends *(see page 9)*.

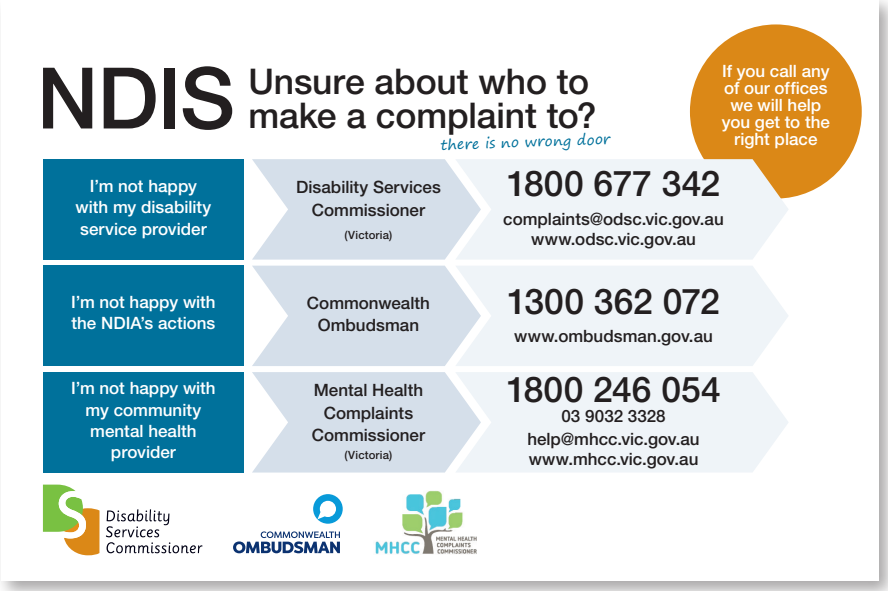
DSC reviewed 13 incident reports in the Barwon trial site in 2015–16. The themes underpinning the information we requested were consistent across all incident reports requiring additional information.

Existing safeguards under the rollout of NDIS may not cover all situations under the new service delivery model. There are concerns that non-registered providers are not reporting incidents. An incident was reported by a registered provider about a non-registered provider. It is not clear who was responsible for addressing matters and ensuring that the person with a disability was safe and well. Issues such as these require close attention both now and into the future.

The complaint rate in Barwon was low relative to the number of people receiving support, which has increased as a result of the NDIS trial. The low number of complaints may reflect people's tendency to switch services when they are dissatisfied, their satisfaction with the services provided, a lack of awareness that they can still complain to DSC about disability services, or their confusion resulting from the fragmentation of complaints pathways arising from the NDIS.[1]

DSC received feedback that the fragmentation of complaints pathways under the NDIS creates confusion for people, their families and service providers. We have worked with the relevant agencies to ensure there is 'no wrong door' for making complaints. Figure 9 illustrates a resource distributed to 2,300 people with a disability, families and service providers to clarify complaints pathways.

Figure 9: Guide to making complaints during the NDIS transition



1. Complaints about the National Disability Insurance Agency (NDIA) are addressed first by NDIA. If the person wishes to pursue their complaint, they can speak to the Commonwealth Ombudsman. DSC's role in handling complaints about Victorian disability services encompasses NDIS funded disability supports. Complaints about NDIS funded mental health services are handled by the Mental Health Complaints Commissioner.

CASE STUDY

Zed's story

Zed lives in the Barwon area and receives NDIS funding. He contacted DSC because he was worried that his service provider wasn't filling all his shifts and that staff were not properly trained in how to support him. The service provider hadn't responded to his concerns. Zed didn't want to continually meet and train new staff. He suggested using photos to show new staff how to support him appropriately.

DSC reviewed Zed's support plans and found they were suitable. However, review of the staff roster revealed a high turnover of staff and the frequent use of agency staff to fill shifts.

Following discussions with DSC, the service provider met with Zed and his advocate Rose and agreed on a plan to address the issues. Zed and Rose participated in recruiting new support staff and in producing a training video. The service provider also agreed to meet with Zed and Rose every month.

Zed was happy with the outcome of the complaint, but ultimately chose to change his service provider.

Victorian service providers of NDIS funded disability supports need to comply with DHHS critical incident reporting requirements.

People using NDIS funded services can choose their service providers. To attract and keep clients, service providers will need to provide best practice supports and great customer service.

Creating change through education and training

Drawing on our work in resolving and investigating complaints, and our oversight of critical incidents, DSC has begun delivering workshops on safeguarding people with a disability to be free from abuse. The workshops support and challenge frontline disability staff to consider their role in responding to abuse. DSC has also supported a series of workshops called *Understanding Abuse*, delivered by National Disability Services and VALID.

The NDIS allows people with a disability, like any other consumer in the community, to purchase their disability supports from the provider of their choice. Our training and information sessions have increasingly focused on the importance of good customer service to the viability of service providers, supporting them to make that shift within their organisations.

In 2015–16 we delivered:

- **training and information sessions to over 2,000 people and had information stalls at 13 forums**
- **information sessions to Transport Accident Commission (TAC) staff and funded service providers on the role of our office and trends in Victorian complaints data**
- **two fee-for-service workshops for Department of Education and Training (DET) staff on responding effectively to complaints and provided feedback on changes being made to the DET complaints process.**

CASE STUDY

Training staff to handle complaints

An organisational culture that embraces customer feedback is one of the most effective ways of improving services, policies and procedures and enhancing outcomes for people.

After completing the DSC Complaints culture survey and Complaints systems and practice self audit checklist, a disability service provider concluded that their staff needed training in handling complaints.

At their request DSC worked with the service provider to develop a customised training program for their direct support staff. The staff attended workshops about the role of DSC and the 4A's of complaints resolution – Acknowledgement, Answer, Action and Apology.

DSC also reviewed the service provider's complaints policies and procedures to ensure they would support a positive complaints culture.

The service provider has continued to create a positive complaints culture, one where people feel safe to speak up about what's working and not working with their disability service.

'One thing I will change about the way I support people following this training is that I will utilise the 4A's when responding to complaints. I will monitor my own "Be curious, not furious" response.'

Disability worker who attended DSC training

'I know who you are. You're keeping everyone honest.'

Family member of a person with a disability

CASE STUDY

David & Richard's story

David called DSC about the quality of support his son Richard was receiving in respite care. Richard wasn't being properly supported at mealtimes or with his personal care. Richard's day service reported that Richard often appeared untidy and wearing dirty clothes after respite care.

David told the respite service provider about his concerns and that Richard would not return to respite. The service provider never responded to David.

When DSC contacted the respite service provider they said that they had started investigating David's concerns. Richard had received poor-quality support from agency staff who did not know people's support needs as well as permanent staff.

DSC reviewed the service provider's investigation report and Richard's support plan, which had not been updated and had no information on how to support Richard with his personal care.

The service acknowledged that their standards of service had dropped – they had not fully supported Richard, failed to recognise his changing support needs and paid insufficient attention to staff training.

As a result of David's complaint, the service provide decided that a permanent employee would work alongside agency staff on every shift. All employees were given additional training, including training by a specialist nurse. Richard's support plan was updated in consultation with David.

David felt his complaint was resolved and he intended to meet with the service provider to discuss future respite bookings.

Complaining about a disability service provider can help them identify where they need to improve.

Your complaint can result in better outcomes for yourself and others using the service.

From the President of the Disability Services Board

The Victorian Disability Services Board was established under the *Disability Act* 2006 to represent and express the interests of adults and children with a disability and disability services. Drawing on extensive experience and expertise in the disability services sector, the board provides advice to the Commissioner and the Minister for Housing, Disability and Ageing.

Elizabeth Corbett
President, Disability Services Board

This year the Victorian Disability Services Board (the Board) has worked strategically and in partnership with key stakeholders to contribute to the design of the National Disability Insurance Scheme (NDIS).

Drawing on our knowledge and experience of complaints and critical incident processes in Victoria, the Board advocates for a national quality and safeguards framework. This framework should include national complaints handling and oversight of adverse incidents.

A further area the Board has been increasingly interested in as the NDIS rollout progresses across the state is the adequacy of pricing for service providers and the correlating impact on service quality.

Inadequate pricing can lead to questionable service quality and potentially to the diminution of safeguards. While there may be a view that cost reductions could drive greater efficiency, it may also lead to scarcity of innovation and hinder market entrance into new service offerings.

The lack of service options is one reason why people are reticent to complain at times. The Board sees this as potentially impacting on people's confidence in challenging service delivery through complaints.

Quality services require well trained and supervised staff. Competent staff will seek secure appropriately remunerated employment. What we don't want to see is large-scale employment of casual staff and a reduced emphasis on systems that support and oversee staff behaviour. It is generally the case that consumers' best interests are served by continuity of permanent support staff.

I would like to thank my fellow Board members for their contribution and support over the last three years. Thank you also to Laurie Harkin AM for his passion and expertise. I wish the incoming board well for the future and trust that they will build on the work we have started.

Complaints to disability service providers

Victoria's *Disability Act* 2006 is unique within Australia in that it requires all registered, funded and contracted disability service providers to report annually to DSC on the number and types of complaints they receive and how these complaints are resolved. DSC now has nine years of valuable complaints data. We can identify trends and areas for improvement to inform government and influence policy.

Victorian organisations delivering NDIS funded disability supports must comply with all complaints-related requirements of the *Disability Act* 2006, including annual complaints reporting to DSC.

Complaints in 2015–16

In 2015–16, service providers reported a total of 2,174 complaints, comprising complaints carried forward from 2014–15 and new complaints. Although the total number of complaints has fallen slightly compared to last year, the number of new complaints has increased. This follows significant growth in complaints in 2014–15 *(see Figure 10)*. As in previous years, complaints are made primarily by family members (49 per cent, Figure 11), followed by the person receiving the service (23 per cent). Increased complaints are an indication of the confidence of people to speak up about their concerns.

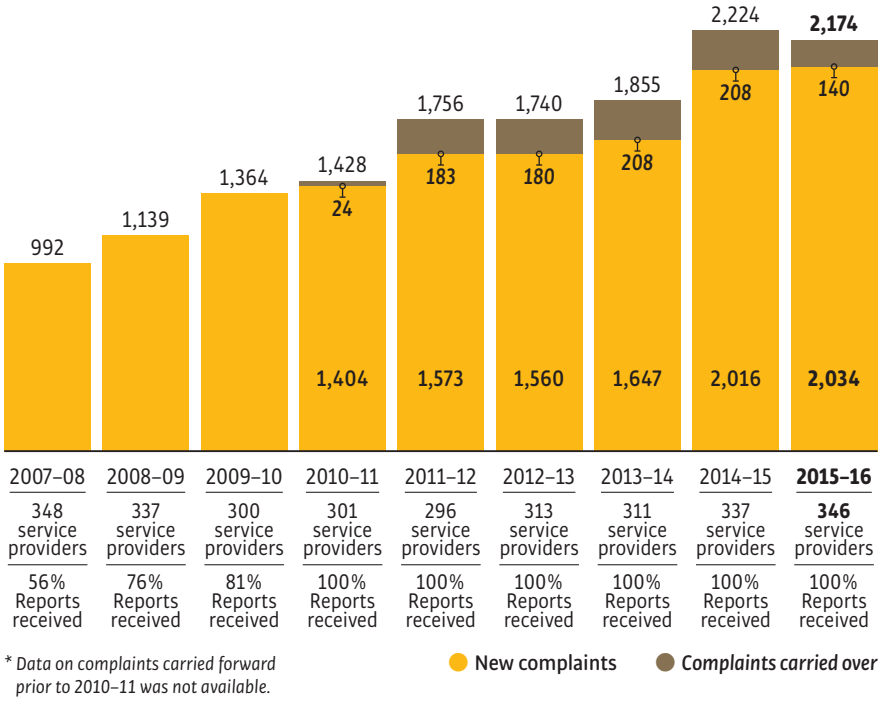
Of all complaints, 64 per cent related to services funded or directly provided by DHHS, and 39 per cent related to supports delivered through DHHS individual support packages (ISPs), NDIS packages and TAC (Figures 12 and 13, multiple responses are possible so may not add up to 100 per cent).

The issues raised by people making a complaint were varied. The primary issue was dissatisfaction with the quality of service being provided, followed by concerns about staff behaviour and attitude and, the physical and psychological health and safety of the person receiving services. The types of issues raised in complaints are shown in Figure 14.

Outcomes from the resolution of complaints in 2015–16 are similar to previous years, with most complaints resulting in an acknowledgement of the person's views and issues. Where actions were taken to address the complaint, they were commonly in relation to addressing communication issues, disciplinary action or extra training for staff members and changes to service practices. See Figures 15 and 16 for more information.

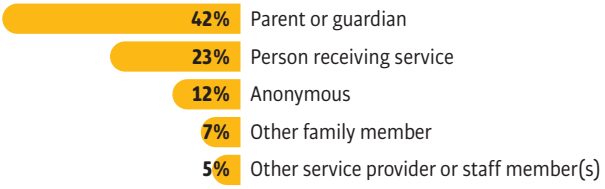
Service providers have indicated that the majority of complaints have, in their opinion, been resolved at least to some degree *(Figure 17)*. Service providers also indicated that 24 per cent of all complaints (whether open or closed) had been raised with an agency or authority apart from their service, most notably with DSC (11 per cent) or DHHS (6 per cent).

Figure 10: Number of complaints reported by service providers, 2007–08 to 2015–16*



** Data on complaints carried forward prior to 2010–11 was not available.*

***Figure 11: Top five sources of complaints** (n=2,109) **



** Accounting for at least five per cent. Multiple responses are possible, so figures may not add up to 100 per cent.*

Complaints to disability service providers

*Figure 12: Complaints by service type – supports funded through individualised funding (n=808)**

Purchased through ISPs, NDIS or TAC

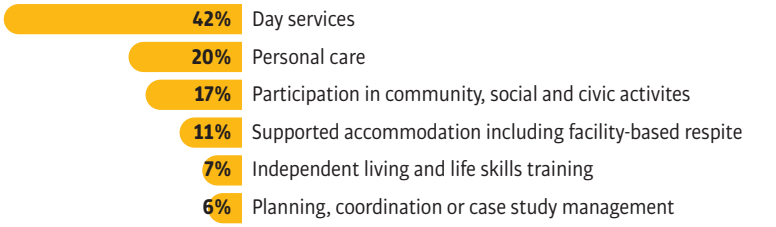


*Figure 13: Complaints by service type – DHHS-funded programs (n=1,361)**

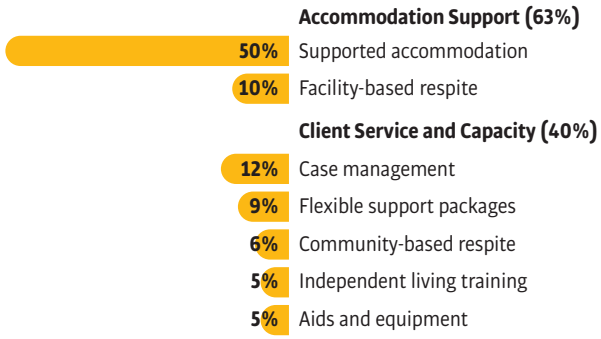


*Figure 14: Issues raised in complaints (n=2,151)**

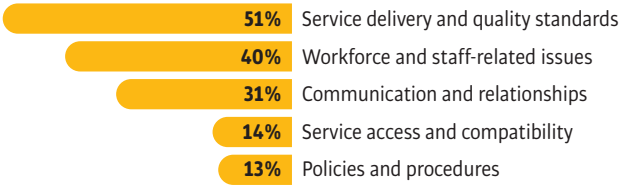


*Figure 15: Top six ways complaints were resolved using the Four A's (n=2,124)**

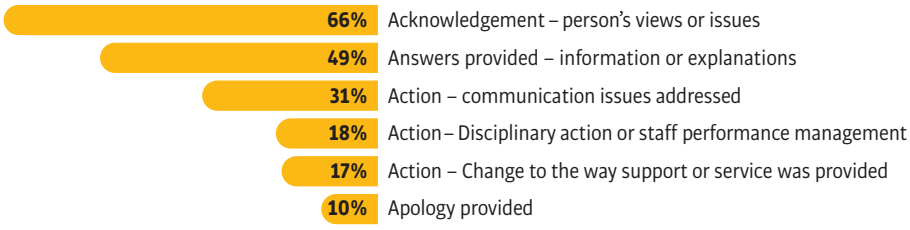
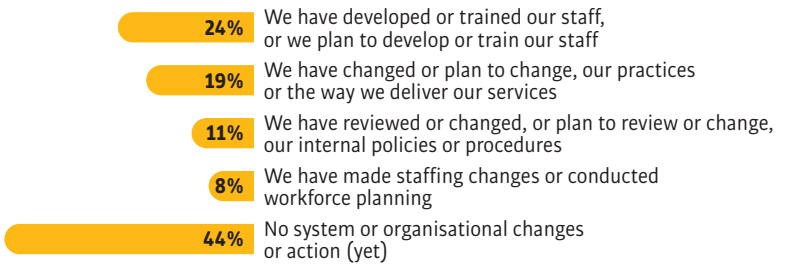
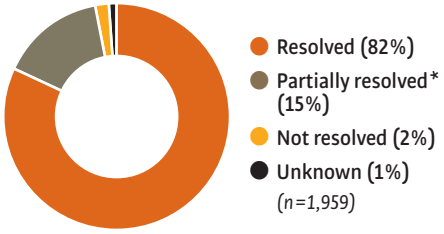


*Figure 16: Actions taken as a result of the complaint (n=2,009)**



* *Accounting for at least five per cent. Multiple responses are possible, so figures may not add up to 100 per cent.*

Figure 17: Resolution rates for complaints



* *Complaints classified as 'mostly' and 'partially' resolved have been combined to form 'partially' resolved.*

Refer to Appendix 2 for more detailed information about complaints reported by disability service providers.

'We should not be reactionary to complaints – we should view them as an opportunity to learn how to improve communication outcomes with families and provide better services.'

Service provider

Why is mandatory reporting of complaints important?

According to the bilateral agreement between the Commonwealth and state governments, Victorian providers of NDIS funded disability supports must continue to comply with mandatory complaints reporting requirements during the NDIS transition period.

Multi-year data and information on sector-wide trends derived from mandatory reporting allows us to identify both time-limited and recurring issues that need to be addressed in order to improve the experience of people with a disability receiving supports.

DSC has analysed and presented this data in two occasional papers in our 'learning from complaints' series:

- *Occasional paper no. 1: safeguarding people's right to be free from abuse* (June 2012)
- *Occasional paper no. 2: families and service providers working together* (February 2014)

These papers identify opportunities for systemic change and key considerations for practice and service improvement to address the underlying causes of complaints.

Mandatory reporting provides valuable data and feedback to service providers to identify service improvements and increase people's satisfaction with their service. There has been a 39 per cent increase in data reported by service providers in the category of 'what we have learnt from complaints' over the past four years.

Mandatory reporting is more important than ever in the context of the NDIS – responding to customer feedback is essential to the viability of disability service providers.

'Complaints are an opportunity to fix the problem and better design the service for the person with a disability.'

Mike McKinstry, CEO Karingal

CASE STUDY

George and his housemates

A few people in a shared home were worried about a person with high support needs moving into the house. George, one of the residents, spoke up on everyone's behalf.

The service provider met with George and the case manager. George told them that the residents were concerned about:

- how they would keep their personal belongings safe
- whether they could still entertain friends and family at the house
- whether the high support needs of the new resident would affect the support they received.

Recognising their concerns, the service provider set up a transition plan over eight to ten weeks to manage the new resident's move into the house. The plan included buying a shed to store people's bicycles, securing personal property and creating a new outdoor setting for entertaining friends and family.

They spoke with the residents' families to make sure that their concerns had been addressed, and engaged an occupational therapist to do an environmental assessment and plan. They kept DSC informed and engaged at various steps of this consultation.

The organisation's long-term aim is to provide counselling and assertive training for the residents in the house who didn't want to speak up for themselves. They want people to feel comfortable advocating for their own rights.

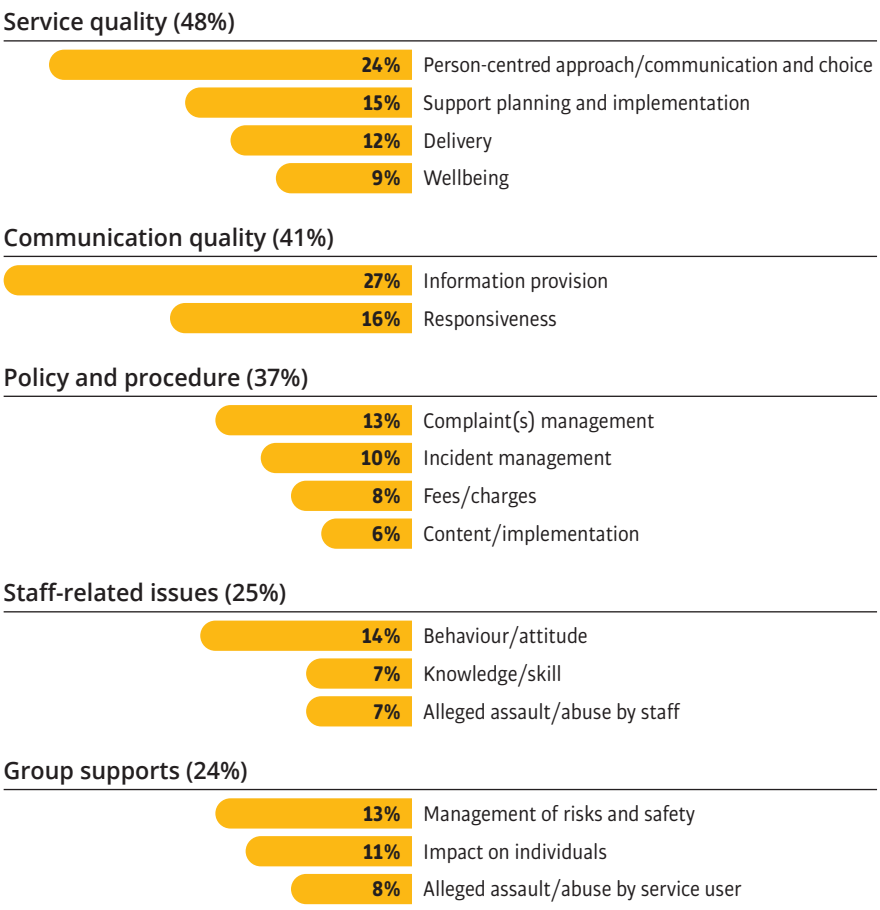
'One often focuses on supporting individuals with behaviours of concern – to the possible disadvantage of other residents. It is vital to always ensure that all parties who are impacted are supported.'

Service provider

Appendix 1: Complaints to Disability Services Commissioner

*Figure 18: Types of issues raised in enquiries and complaints**

Accounting for at least five per cent.



* *Multiple responses are possible, so figures may not add up to 100 per cent.*

*Figure 19: Type of disability of person(s) receiving services**

	2015–16
Intellectual disability	63%
Physical impairment	50%
Autism	32%
Neurological impairment	18%
Mental illness	17%
Acquired brain injury	11%
Sensory impairment	9%
Developmental delay	4%

Figure 20: Gender of person(s) receiving service – enquiries and complaints

	2015–16
Males	57%
Females	42%
Groups	1%

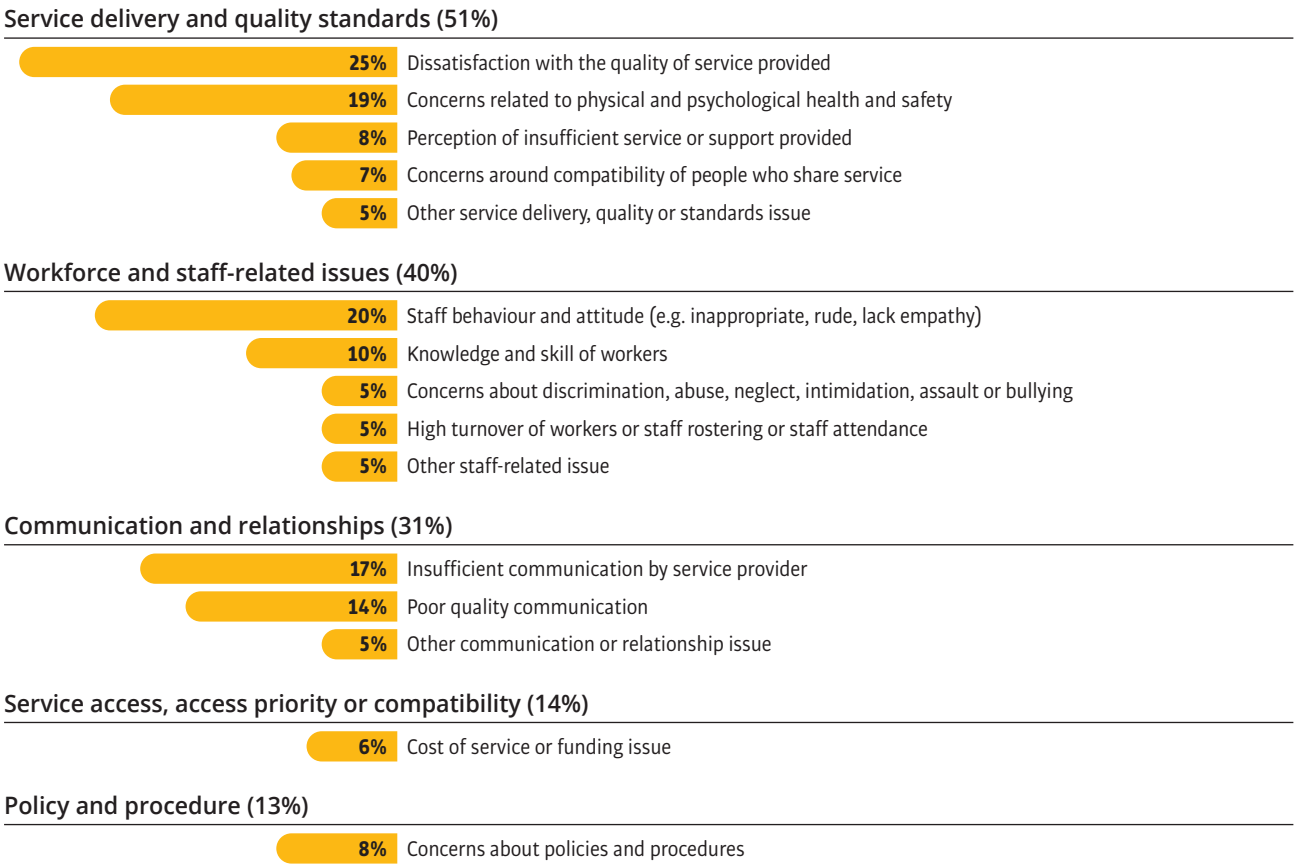
Figure 21: Age of person(s) receiving service – enquiries and complaints

	2015–16
People aged 30 years or under	55%
People aged 31 years or over	44%

Appendix 2:
Complaints to disability service providers

Figure 22: Types of issues raised in complaints to disability service providers (n=2,151)

Accounting for at least five per cent. Multiple responses are possible, so figures may not add up to 100 per cent.



Appendix 2: Complaints to disability service providers

Figure 23: Type of disability of the person receiving service *(n=1,802)*

Percentage of complaints. Multiple responses are possible, so figures may not add up to 100 per cent (n=1,802)

	2015–16
Intellectual disability	52%
Physical impairment	24%
Autism	16%
Neurological impairment	12%
Acquired brain injury	6%
Mental illness	5%
Sensory impairment	4%
Developmental delay	3%
Other disability	12%

Figure 24: Age of person(s) receiving service *(n=1,570)*

	2015–16
35 years of age or under	55%
Over 35 years of age	46%

Figure 25: Gender of person(s) receiving service *(n=1,731)*

	2015–16
Female	45%
Male	57%
Transgender	0%

Appendix 3: Operations

Financial statement for the year ended 30 June 2016

DHHS provides financial services to DSC.

The financial operations of DSC are consolidated into those of DHHS and are audited by the Victorian Auditor-General's Office. A complete financial report is therefore not provided in this annual report. A financial summary of expenditure for 2015–16 is provided below.

Operating statement for the year ended 30 June 2016

Expenses from continuing activities	
Salaries	$1,961,491
Salary on-costs	$311,626
Supplies and consumables	$298,792
External services delivered	$23,773
Indirect expenses *(includes depreciation and long-service leave)*	$85,066
Total expenses	**$2,680,748**

Staffing

17.6 FTE as at 30 June 2016.

20 staff positions.

52 per cent of DSC staff have a lived experience of disability.

5 DSC Resolutions Officers are nationally accredited mediators.

5 DSC staff members are qualified with a minimum Diploma of Government (Investigations).

Appendix 4: Compliance and accountability

Privacy and Data Protection Act 2014

DSC is an organisation bound by the provisions of the *Privacy and Data Protection Act* 2014. DSC complies with this Act in its collection and handling of personal information.

Freedom of Information Act 1982

Victoria's *Freedom of Information Act* 1982 provides members of the public the right to apply for access to information held by ministers, state government departments, local councils, public hospitals and statutory authorities.

The Freedom of Information Act allows people to request access to documents held by an agency whether they are hardcopy or electronic. The majority of requests relate to individuals asking for access to, or correction of, documents held by the agency relating to their personal affairs.

In 2015–16 there was one request made for access to information pursuant to the Freedom of Information Act. No documents were held by the office in relation to this request. On two occasions DSC received requests for information outside of the Freedom of Information Act and at the time of reporting DSC was processing these requests by way of administrative release pursuant to s. 16(2) of the Freedom of Information Act. In addition, there was a request to amend records held by DSC pursuant to s. 39 of the Freedom of Information Act.

Charter of Human Rights and Responsibilities Act 2006

The *Charter of Human Rights and Responsibilities Act* 2006 sets out individuals' civil and political rights and freedoms, and the responsibilities that go with them.

DSC complies with the legislative requirements outlined in the Charter, and gives consideration to human rights when dealing with enquiries and complaints.

Protected Disclosure Act 2012

Disclosures of improper conduct by DSC or its officers can be made verbally or in writing to:

Independent Broad-based Anti-corruption Commission

GPO Box 24234
Melbourne VIC 3000

Phone: 1300 735 135
Fax: (03) 8635 6444
Email: submit@ibac.vic.gov.au

More information about Victoria's *Protected Disclosure Act* 2012 is available from the Independent Broad-based Anti-corruption Commission website at: www.ibac.vic.gov.au