# Closed Captions – Miranda Bruyniks

*12 September 2017*

**MIRANDA BRUYNIKS:**  My name is Miranda Bruyniks, the Deputy Commissioner having worked with the Disability Services Commissioner these last three years.  I started my career as an occupational therapist in the area of disability.  Over the years I have worked in other areas of health, disability, alternative dispute resolution in the context of insurance, and while I have been in management roles the last 20 years, it is satisfying to be back where I started.  I am a mum, I am a grandmother.  And I have personal experiences from the perspective of a regulatory provider or agency, as a disability service provider and as someone who has personally experienced health and disability services or the lack therefore, for someone very dear and near.

So today, I am speaking about safeguards in Victoria.  If at any stage you find the content of this conversation distressing, we have a counsellor available at the registration desk.  There are also disability services staff available at the registration desk should you want to make a report about abuse or neglect.  (Pause) There we go, thank you.

As we transition to the National Disability Insurance Scheme, there has been a lot of discussion about safeguards.  But what is a safeguard? To safeguard something or someone means to protect them from being harmed, lost or badly treated.  Or a safeguard is a law, a rule, or a measure intended to prevent someone or something from being harmed.  But we know that safeguards can be informal or formal.  Development safeguards have been proposed under the National Disability Insurance Scheme, quality and safeguards framework aimed to promote inclusion, protection of people with a disability, valuing individuals and recognising family supports and intentional relationships.  These are the informal supports.  Legislation and regulatory powers that are corrective are also safeguards.  Today, we are discussing formal safeguards in Victoria.  We acknowledge we all want to live in an inclusive community where no-one is subject to assault, abuse or neglect.  But, sadly, this is not the case and our reliance on formal safeguards is higher than it should be.  So, what is, or why do we need safeguards in Victoria?

Over the last three years, there have been a number of state-based national inquiries into abuse of people with disability.  In 2014/15, the Victorian Ombudsman found abuse was being perpetrated, the system was fragmented.  The national senate inquiry into violence, abuse and neglect against people with disability in institutional and residential settings identified abuse was Australia wide.  The parliamentary committee looked thoroughly into disability services in Victoria.  All of these inquiries found there was, and is, a need for fundamental change in the sector to address these endemic issues of abuse.

The Victorian parliamentary committee reported abuse takes many forms, including sexual and physical assault, verbal abuse, financial abuse and neglect across the sector.  Abuse occurs in both government and non-government settings.  Some individuals are at a heightened risk of abuse, violence and neglect.  People with an intellectual disability, limited communication skills or needs, capacity, people in socially and physically isolated accommodation settings.  Children with disability are more likely to experience abuse than other children and some stats three to four times more likely.  There is poor data on the experience of Aboriginal people with disability but it is noted Aboriginal people experience higher rates of violence.  Culturally and linguistically diverse groups are less likely to report and there are incidents of under reporting.  Comparing to women, women with a disability are at greater risk of multiple types of abuse and for a longer duration and abuse by more than one perpetrator.  Women with disabilities are also more likely to experience abuse and violence than men with disabilities.

The committee reviewed 200 cases of deaths of people in residential care and identified 7 cases where the deaths could have been avoided.  Examples, there was physical restraints, accidental choking on food and other ingested items, poor supervision and inappropriate access to medication.  Accidental choking was present in four out of the seven cases they looked at.  Recent work published by Professor Julian Trowler at the University of New South Wales confirms this and found people with disability are more likely to die earlier, describing avoidable deaths, largely related to timely access to health services.  We must, as a sector, focus on gaining more knowledge and improving practice in all of these areas.

So, we look at the experience of the abuse across the sector.  Physical assault, hitting, pushing, pulling, spitting, spraying someone in the face with water, spraying someone in the face with vinegar, emotional abuse, including repeated verbal abuse and hurtful statements.  We have investigated cases where a group of workers stands around a young person with a disability and says, "Your mother doesn't love you.  Nobody wants you." I'm sorry - that's abuse.  Financial abuse.  Using an individual's money to pay for something else, stealing house funds.  Neglect such as failure to monitor diet as prescribed, refusing to take someone to the toilet.  Leaving them for periods of isolation on hours on end.  Sexual abuse offences such as rape indecent assault under the Crimes Act including grooming, giving outcomes, forced treatments and interventions and violations of privacy and willful deprivation, restricting access to food, water and bathrooms.

Sadly, we have seen these examples in our office.  It is outrageous and it is abhorrent.  It is suggested that these behaviours have become normalised in the sector.  Well, we disagree.  These behaviours are not normal.  These behaviours are not tolerated and everyone here in this room makes a difference by calling these behaviours out.  It is important that we explore what a future shared definition of abuse looks like, considering the evidence of lived experience of people with a disability, the risk factors, improving our data collection and undertaking further research.

In 2012, the Disability Services Commissioner commenced oversight of looking at critical incident reports on referral from the minister.  In 2015/16 of the 348 incident reports reviewed, 71% related to allegations of physical assault by a staff member.  Allegations of sexual assault by a staff member were 16% and unexplained injury was 13%.  Then from 1 July 2016, the Minister for Housing Disability and Aging expanded the referral to include all assaults, injury and poor quality of care.  That gave us a bit more information.  Then, of course, from 24 July 2017, the minister expanded the referral again to deaths, unexpected deaths in disability services.  But the expanded oversight of incident reports showed us that people with a disability are at increased risk of physical and sexual assault also by others - family, friends, members of the public, and in the broader community.  Service providers play an important role, all of us in this room.  Support people with a disability to be aware of risks, help minimise the risk of being in the community and impact of assault by others, by undertaking activities for proactive empowerment, educating of people with disabilities so we can contribute to their access to the community in a safe way.

We have got many services here today that are doing that work, as you heard from the panel.  We also encourage the National Disability Insurance and Safeguards Commission to consider the reporting where the abuse is by "other".  Because if we are truly to make a difference across the whole disability community, it is not only in disability services where we need to monitor closely, but we need to take the opportunity that disability services are aware of these other reports and supporting people with disability in the needs that they have at those times.

But looking at our complaints, and we have completed 24 investigations over the last three years, but until 2013/14, there was an average of 6% in scope complaints about physical and sexual assaults made to the Commissioner.  In '15/16 they grew.  The interesting thing that we find, of course, from looking at these complaints is only one of those in-scope complaints relating to allegations of physical and sexual assault in 2015/16 came from a person with a disability.  This is vastly different to inquiries and complaints which are 31% from people with a disability.  The Royal Commission into Institutional Responses into Child Sexual Abuse identified that it took victims, on average, 22 years to disclose sexual abuse.  This is a disturbing finding.  It reinforces the importance of mandatory reporting by staff members.

If we go back to those investigations we have conducted, and you heard from the panel today, a third of them came from staff members who chose to remain anonymous or confidential, all of them.  It is important that you, as a disability service, ensure that staff understand your policy relating to disclosure and you support staff to make those disclosures.  Think about the last time someone raised a serious issue with you and your service.  How did you respond? How did the organisation respond? Do you think that person would be encouraged to raise a report again? If your answer is yes, then that is great and we are on a pathway to improvement.  If your answer is "I'm not sure they would do that again", you need to immediately go back to your service and look at how you encourage those reports.

By the way, if we look at those stats, we can see the other side.  Because who is reporting abuse? Who is calling it out? Well, we acknowledge the good work that community advisors and disability advocacy organisations do in speaking up for people with a disability and calling out abuse.  But here on this particular slide, we can attribute the good work to disability support workers.  These reports would not have occurred unless a disability support worker reported it and called it out.  And these are good people who are out there working to improve the system we have.

If we look at the themes we have from our incidents reports and investigations, we heard this morning the failure to acknowledge is a key theme.  Not recognising professional boundaries, minimisation, particularly by senior leaders.  We conducted one investigation where terrible abuse was referred to by a senior leader as "bad behaviour", "those staff, they were just badly behaved".  After looking into the matters more thoroughly and providing those senior leaders with a bit more detail about their own service, they were horrified, they said "that's abuse".  It is abuse.

Responding to people at the point that there is an allegation made and it is not about waiting for Victoria Police to substantiate.  If there is an allegation made, there is a reason the allegation is made and the immediate reaction of services is to see what they can do.  To ensure the person making the allegation and all others in the service are safe.  We have to ask questions of service providers when we review incident reports: What happened for that person? Were they offered counselling? Often people are not provided counselling or support services because they have limited communication.  That is not an adequate reason.  We need to ensure that everybody is afforded the rights to support following an episode of violence.

Details and outcomes of investigations, including whether one was being conducted, the scope of the investigation and consideration of others who have been impacted, are the other areas that we continually ask information about.

Communication barriers.  So, not supporting or facilitating non-verbal communication where it is needed, limiting the service user's involvement in decision-making.  So in some cases, communication plans had not been developed for people with limited communication for years.  I'm sorry - but this is a fundamental aspect of care and support.  If we cannot communicate our needs on a fairly basic level on a day-to-day basis, how are we ever to speak up when something that is not right has happened? If you're going back to your service tomorrow, just find out when was that last communication plan done and was it ever implemented?

Workforce culture and staffing capacity issues, and I think that has been well covered by the panel today so I won't go into, but I will point out the Australian Institute of Company Directors released the survey or outcomes and it identified 70% of company directors working in not-for-profit organisations indicated that they would recommend their organisations as a great place to work.  But 50% of the boards indicated that they had not had culture on the agenda in the last 12 months.  There was little actively done in the organisation to manage culture and there was an acknowledgement of a need for a robust whistle-blower programme.  These are the company directors of not-for-profit organisations.  So we see this theme once again confirmed.

So, someone said to me earlier today, "I want to know what I can do in my organisation".  I think we are getting so much really good advice today.  But going back and ensuring organisations have good robust whistle-blower programmes is one way staff can feel supported to speak up.  Because we know we rely on staff to speak up, because people who are victims of violence will not feel empowered to do so.  So, our findings were fairly consistent with those inquiries.

The parliamentary committee made 49 recommendations which included strengthening the powers of the Commissioner and embedding the zero-tolerance approach in the Disability Act.  What is in the Act? There are own-initiated investigations or what might be referred to as own-motion powers.  They are of an individual or a systemic nature.  Investigation of matters referred by the minister.  So I am going to talk a bit more about investigations soon.  Inspection of premises of disability services without a warrant.  A notice to take action that can be issued to service providers, including some follow-up investigations if needed.  And last, but not least, education and information to support the prevention and the response to abuse.

So if we talk about these investigations first, the Commissioner has always had the power to refer any incident to investigation, especially if the complaint is not suitable for conciliation.  But these were the only matters that we could investigate.  The amended Disability Act provides the Disability Services Commissioner with the power to investigate disability services where there are individual or systemic issues relating to abuse or neglect.  An individual-Commissioner-initiated investigation may be conducted if the Commissioner receives information that abuse or neglect has occurred in the provision of services to an individual with disability.  A systemic-Commissioner-initiated investigation - get your tongue around these long names - may be conducted if the Disability Services Commissioner identifies a persistent or recurring systemic issue about abuse or neglect matters.  These investigations will only be undertaken if the Commissioner considers the investigation will support the improvement of services for people with a disability.

The Act also gives us the power to conduct investigations into matters referred by the Minister for Housing, Disability and Aging.  And these are those things that the minister has previously referred to us for inquiry into, so we are talking about incident reports.  So, the Act now allows the minister to refer to the Commissioner for investigation of such matters.  These different types of investigations, the existing investigations that we have from complaints, the own-initiated investigations and the investigations that are linked to a minister's referral, and a fourth, follow-up investigations, where service providers don't follow through on actions.  They are all known in the Act as "accountability investigations".  And the Commissioner has the power now to conduct all these investigations.  I encourage you to visit our website, to download the information sheets about these new powers and types of investigations and to ensure that all your staff are aware.

You can see on this slide a short summary and the powers that are attributed to every one of those investigations, which is the power to request information, compel documents and attendance, inspection powers and a warrant if needed.  Let's talk about those inspection powers, because they are new.  What does it mean? A number of senior disability services staff have been appointed as authorised officers.  They are immediately available to inspect disability service providers where concerns about abuse and neglect have been raised.  The authorised officer will be equipped with an official DSC officer identification card.  You should be able to ask for the card, see it.  It will have a photograph of the authorised officer it, their name underneath it.  On the back of the card will be the signature of the Disability Services Commissioner.  You can call the office on 1800 677 342 if you need to confirm the identity of an officer.

Any report of assault must be referred to Victoria Police, but yesterday they signed a protocol to investigate matters where there may be an overlap, ensuring the two agencies can share information and criminal affairs are investigated by Victoria Police and quality services are handled by the Commissioner.

The Commission will follow up on time-critical matters on service delivery that impacts on the immediate health and safety of individuals receiving services.  Collection of some evidence and information can be time-critical.  So, the officers are able to inspect disability services or the premises of disability services, make inquiries in relation to relevant persons with a disability, obtain access to documents, to examine, copy and remove them; see and interview a person with a disability, their relatives, support persons, staff and volunteers.  Disability service providers are required to continue to support and care for people in the service, ensuring that the Commissioner or the authorised officer when they arrive are aware of specialised supports or communication supports.  The service provider is required under the Act to give reasonable assistance to the authorised officer for access to people or documents.  It is an offence to refuse an inspection and there are penalties under the Act.

So, what do we do with that information that comes from an inspection? If during an accountability investigation we have identified concerns, including that from an inspection, the Commissioner can issue a notice to take action.  In 2015/16, the Commissioner gave actions to service providers to improve policies and procedures, implement staff training, review individual support plans, give notifications to the disability worker exclusion scheme.  These are some of the notices to take action that you might expect.  The legislation will give you service providers 45 days to respond and take those actions.  Though there is an additional 15-day extension, but only one.  If the Commissioner is not satisfied that a service provider has acted appropriately within the time specified, the Commissioner can now conduct a follow-up investigation.  Providers who fail to take action in a timely manner and satisfy the Commissioner that they have done so can be subject to penalties under the Act and will be named in the annual report.  A full list of penalties are in the amended Disability Act.

The last area that we have changed in the Disability Amendment Act is the area of information and education, where previously the Commissioner provided lots of resources and tools about handling complaints and making sure people are empowered to speak up and be heard, which is still the key theme of making sure that people are supported.  But information and education has now been extended to prevention.  We have already published two occasional papers, safeguarding people's rights to be free from violence and abuse.  Some of you might be familiar with that and you can find it on the website.  The importance of service providers working alongside with families, and that is important in safeguarding people's use of services.  We have engaged La Trobe University to undertake a literature review.  We have appointed an expert and we will partner with the resources already in the sector developed by many here in the room.  This forum is the first of the prevention initiatives.

So, we have been asked are all these changes to the legislation, are all these increased powers of the Disability Services Commissioner, are they enough? Are they enough to make a change? The plain answer is, no.  We have been talking about formal safeguards and if we are serious about embracing and promoting choice and control and empowering people to speak up, we need to work towards a world where everybody with a disability is respected, valued and connected, where they have a voice and service providers listen to them and act, where they are part of a strong and committed network and they have unpaid contacts and unpaid people in their lives who can act as an informal safeguard.  The staff are trained to deliver the type of supports that they have been asked to provide, providing active support, rather than doing things for individuals, recognising when health and dental services are needed, and supporting individuals to access the health services they need.  And, finally, resources and attention and energy put into all the three areas of primary, secondary and tertiary prevention.  In an ideal world, we wouldn't need these formal safeguards.  Community and service culture would be underpinned with a human rights framework, where abuse and violence is not tolerated and all people would feel okay to speak up and disclose.  But we would have all those active prevention measures in place.

Now, I believe we have some time for some questions.  We are going to be using sli.do.  Thank you.  The first question is: How does the Disability Services Commissioner work with the DHHS when they are conducting a quality of support review?  For those people who are aware of the requirements for following up incidents or critical incidents of staff-to-client assault or unexplained injury, the DHHS has a process in place that requires a quality-of-support review to be conducted.  The department, as the funding body, has set up those requirements and they do require that of providers.  When the Disability Services Commissioner follows up an incident, the quality of support review is generally not completed.  We will follow up concerns that are raised in matters of incidents, immediately, and we will await quality support reviews where the issues are non-critical or non-urgent.  So how we work together with the Department of Health and Human Services, and we have the same requirements, but we do find quality support reviews take a very, very long time to be completed, and the recommendations made from them can often come very late.  Whereas we will form a view and work with you, the service provider, to follow up those particular incidents straight away.  I recognise that there is duplication in that process but we will continue to take a timely approach to following up those matters.  One thing we do, when we do investigations or complaints, we do request quality of support reviews.  On a number of occasions, we found that really, really good recommendations and thoughtful consideration has gone into a quality of support review but the recommendations haven't been implemented.  So it is good to go back and look at the work and make sure it is implemented.

A second question: Do you believe managers have the skills to appropriately investigate allegations of abuse or should organisations have dedicated investigators? I think it is a bit of matter of both.  In some cases, we need to ensure that everyone in the organisation is trained to understand what we need to look at in terms of investigating, when an incident occurs or when there has been - I say "incident", because it covers so many things, including restrictive practices and injury.  But those follow ups are so important and we have a guide on the website and we expect service providers to take those particular principles that we have outlined in that guide into account.  There are occasions, however, and we expect managers in services to recognise when it is not useful to conduct your own investigation, when the matter is so serious that it is useful to have an external investigator who has got some independence and separate expertise to delve more deeply into a matter.  There will be occasions where there is conflict of interest, where there is numerous activities in the past or recurrent things that service providers choose to take that approach.  I think the difference going forward is the Disability Services Commissioner may also investigate now.

Are services available to help people with restricted communication access counselling after a critical incident? Yes, there are a number of services available and they are available through our partners at CASA and I am sure Women with Disabilities Victoria also has resources available.  One of the things we are doing as an organisation is trying to bring together the resources available in the sector and you will find them in one place.  The Department of Health and Human Services, and I shouldn't forget the Office of the Senior Practitioner, also provides a lot of tools and resources.  This is a question that I have been asked before.

Now, do we have to comply with a DSC investigation? What are the penalties? (Chuckling) Yes.  You must comply with the Disability Services Commissioner investigation.  The penalties under the Act for someone who does not comply are 60 penalty points for an individual, there are 300 penalty points for a corporate agency.  There are further points for individuals or organisations that refuse an inspection, further penalties and points for organisations and individuals who fail to meet the actions to remedy.  So, the plain answer is, yes.  The Act includes more information about that.

In terms of the next question, really good questions here.  What if somebody is already investigating, for example, the Ombudsman, what does the Disability Services Commissioner do in that situation? That is an excellent question.  I would like to thank you for that question.  One of the things the Disability Services Commissioner is required to do under the Act, particularly in the case of a systemic investigation where there are recurring issues and we would publicly announce a systemic investigation, we wouldn't actually go out and do a systemic investigation if the ombudsman is doing one or perhaps a parliamentary committee is doing one.  We will conduct an environmental scan before we announce a systemic review to ensure we are not duplicating work that is already being done.

In terms of individual investigations, Victoria Police have primacy for criminal matters.  Through our protocol we work closely with Victoria Police.  Sometimes they prefer to continue with the investigation of quality matters because it helps them in terms of us making sure that people in the service are safe.  Whilst they investigate the criminal matters.  On other occasions, Victoria Police has asked us to suspend our investigation until they are completed and that means the investigation can take well over a year.

But we do work with other bodies.  The Department of Health and Human Services conducts investigations and service providers conduct investigations on individual matters.  What we do is on a case-by-case basis when we make a decision to investigate, we will consider these other investigations that are under way.  If we believe that we can wait for the outcome of those investigations, we will.  And then determine whether we need to investigate further.  In other cases, we have simply gone ahead because we have considered the issues far too critical to wait.  So we do decide that on a case-by-case basis.

I think I have lost the rest of the questions.  That is okay.  No, I have lost the questions, I'm sorry.  How am I going for time? Would you like some more questions?

Do services still need to report incidents to Victoria Police? All assault, sexual assault, physical assault, must be reported to Victoria Police and that remains in place.  The Disability Services Commissioner, if we receive a complaint or if we look into that incidents, that is the first question we will ask you as a service provider: Did you report this to Victoria Police? People with a disability have a right to access the justice system.  And the protocol that we have with Victoria Police is about ensuring that access to justice is improved and that people do have that access.  So, the Disability Services Commissioner investigation does not replace access to the disability access - access to the justice system.  People with disability have that right and we want to make sure that we are all supporting that particular right.

There is a question here about unregistered service providers.  The Disability Services Commissioner's jurisdiction is on regulated service providers.  So, no, we can't take action or take complaints about unregistered service providers.  What we do is work very closely with the National Disability Insurance Scheme and the Commonwealth Ombudsman to raise matters relating to unregistered providers that are funded by the NDIS, directly with the NDIS.  And a number of matters have progressed and been managed that way.  We do know the Quality and Safeguards Commission, when it is established, will have a code of conduct and it will include unregistered providers as part of that code of conduct.

How you going? I am the only thing between you and lunch.  Does anybody want more? There are quite a few questions here.  Put your hand up if you would like some more questions?  Put your hands up if you would like to go to lunch? Okay.  They have to go through you.  Okay.  So I am going to close this presentation now.  Thank you very much for your attention.