Disability Services Commissioner

2018-19 Annual Report

Including *A review of disability service provision to people who have died 2018–19*

It's OK to complain

Disability Services Commissioner

Disability Services Commissioner
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We acknowledge the traditional Aboriginal custodians of country throughout Victoria and pay our respects to them, their culture and their Elders past, present and emerging.

Disability Services Commissioner

16 August 2019

The Hon. Luke Donnellan MP
Minister for Disability, Ageing and Carers
Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Minister,

Pursuant to s.19 of the *Disability Act 2006* (the Act), I am pleased to provide you my annual report for the financial year 2018-19.

As requested by the Ministerial referral in September 2017, I also include a copy of our *Review of disability service provision to people who have died 2018-19*.

Yours sincerely,

Arthur Rogers
Disability Services Commissioner

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About the case studies

This report includes case studies that illustrate our work into the adequacy of disability service provision to people with disability. We use pseudonyms and change identifying details to protect the identity of the people to whom they refer.

Abbreviations, acronyms and definitions

The Act
Disability Act 2006

ACR
Annual Complaints Reporting

Assessment
The stage after a person has made a complaint and we have determined that the issues are within scope. The Act allows 90 days to assess whether a service provider is meeting their obligations and to try and resolve the issues raised in the complaint

Enquiry
Where a person makes contact seeking information or advice about their concerns. This is not a complaint

Complaint
An expression of dissatisfaction made to or about a disability service provider, relating to its products, services, staff or the handling of a complaint, where a response or resolution is explicitly or implicitly expected or legally required

Conciliation
A process that allows all participants to have their voices heard, understand each other's perspective, explore issues and, where possible, reach agreement about a way forward in a safe and facilitated meeting

CCIM
Critical Client Incident Management

CIMS
Client Incident Management System

CVB
Community Visitors Board

DHHS
Department of Health and Human Services

DSB
Disability Services Board

DSC
In this report DSC refers to the office of the Disability Services Commissioner

Disability service
As defined in s. 3 of the Act. It means a service specifically for the support of persons with disability that is provided by a disability service provider

Disability service providers
In this report, disability service providers refers to 'disability service providers' and 'regulated service providers' as defined in the Act.
The Act defines these as follows:

- 'disability service provider' means the Secretary of DHHS, or a person or body registered on the register of disability service providers
- 'regulated service provider' means a contracted service provider, funded service provider or a prescribed service provider
- 'contracted service provider' means a person, organisation or registered body that has entered into a contract with the Secretary of DHHS under s.10 the Act to provide services to a person with disability
- 'funded service provider' means a person, organisation or registered body that provides services to a person with disability, and receives funding from the Secretary of DHHS under s. 9 of the Act, for providing those services
- 'prescribed service provider' is declared specifically for the purposes of the Act, and means a person, organisation or registered body that provides services to a person with disability, specifically for the support of that person

Finalised
A matter that has been completed or closed

Group homes
A type of accommodation that provides housing and support services for people with disability. This is typically a community-based house where rostered staff are available to provide care and support to the people who reside there. Group homes are sometimes referred to as shared supported accommodation (SSA) or Supported Disability Accommodation (SDA)

Incident reports
Matters referred to us from DHHS as per the referral from the Minister

In-scope
In-scope means matters that we have the legislative authority to handle

The Inquiry
Means the *Inquiry into Abuse in Disability Services* conducted by the Family and Community Development Committee in accordance with the terms of reference received from the Legislative Assembly of the Parliament of Victoria on 5 May 2015

Justified
The reported issues were proven

The Minister
Minister for Disability, Ageing and Carers

NDIA
National Disability Insurance Agency

NDIS
National Disability Insurance Scheme

NDIS Commission
National Disability Insurance Scheme Quality and Safeguards Commission

Notice of Advice
Formal advice that we provide on any matter regarding complaints, investigations, and the prevention of and response to abuse and neglect in disability services. These can be provided to disability service providers, the Minister and the Secretary of DHHS

Notice to Take Action
A Notice to Take Action (NTTA) can be individual or systemic. It is a direction to take action that we have issued to a disability service provider, the Secretary and/or the Minister after an investigation. This notice specifies actions that are required to be undertaken to resolve issues identified during the investigation and improve services and/or prevent abuse and neglect

Open
A matter still active or in progress

Out-of-scope
Out-of-scope means any matter that we do not have legislative authority to handle

Resolved
Where the person who made the complaint decides that the issue/s have been addressed

Review
An inquiry into or consideration of a matter or incident. The process includes seeking further information or documentation, and determining what actions we, or another person or entity should take, if any, to address or respond to a matter or whether to investigate the matter

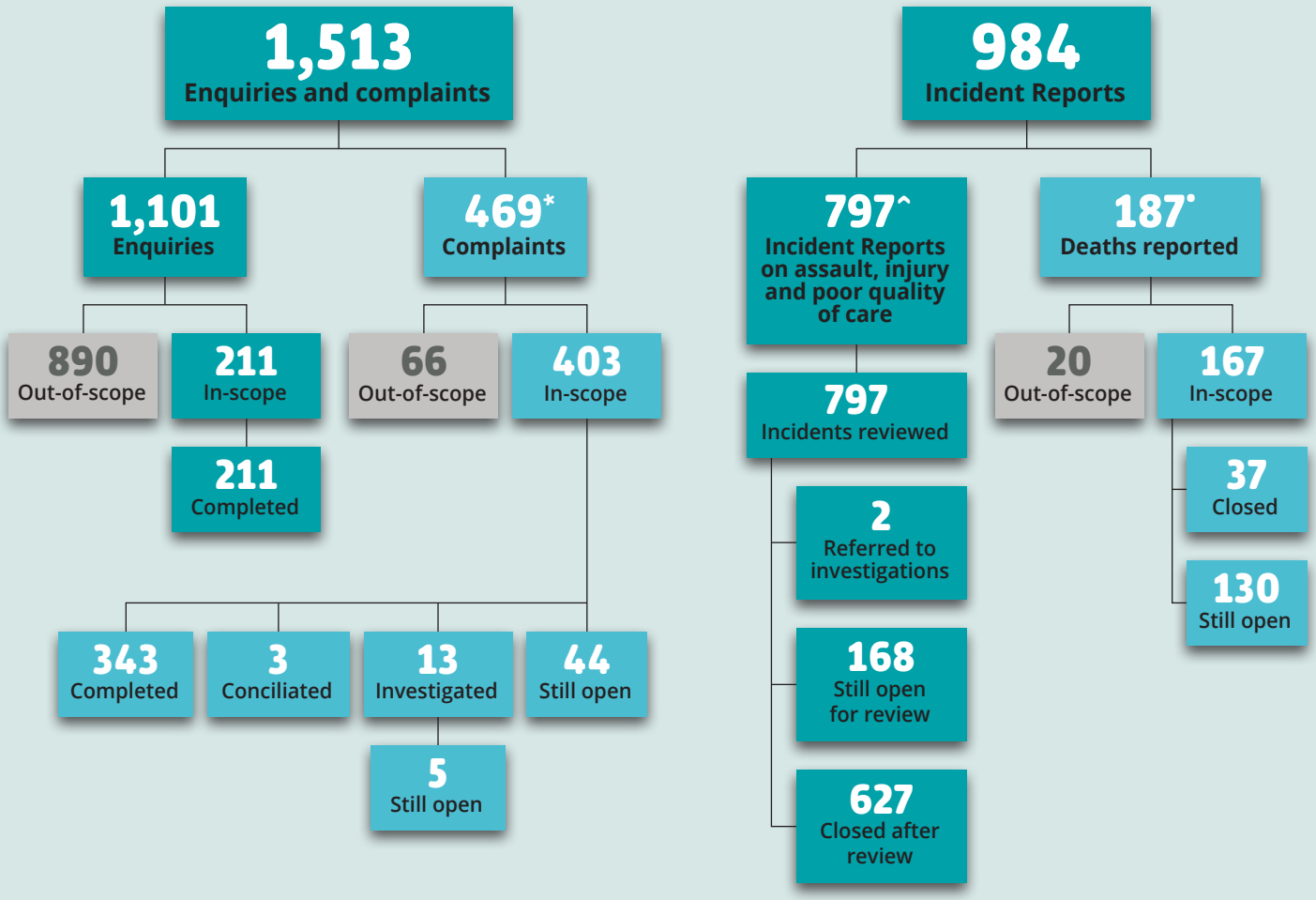
Referrals
Matters referred to us from a variety of sources including the Minister, the Secretary of DHHS, State Coroner or the Community Visitors Board. This term also covers matters we refer on to other bodies such as the Mental Health Complaints Commissioner or the NDIA

Royal Commission
The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability established on 4 April 2019

The Secretary
The Secretary of DHHS

Our year in summary

Figure 1: Our year in summary



**412 received in 2018–19 + 57 carried over from 2017–18*

ˆ691 received in 2018–19 + 106 carried over from 2017–18
•119 received in 2018–19 + 68 carried over from 2017–18

Highlights from 2018-19 Highlights from 2018-19 Highlig

8
Investigations closed

58.4
Average number of days to close complaints

99
Notifications of deaths from DHHS and the State Coroner in-scope for our review

59
Presentations and information sessions reaching over 2,000 people

3,638
Complaints reported by service providers in Annual Complaints Reporting data

ghts from 2018-19 Highlights from 2018-19 Highlights from 2

412
New complaints to DSC

26
Notices to Take Action issued

22
Inspections of disability service premises conducted by Authorised Officers

343
Complaints completed

37
Investigations completed into disability service provision to people who have died

691
Incident reports received

Message from the Commissioner

The past 12 months have seen a continuation of the significant changes occurring within the Victorian disability sector. These include the rollout of the National Disability Insurance Scheme (NDIS), and the start of the transfer of group homes previously operated by the Department of Health and Human Services (DHHS) to non-government service providers.

With these changes, it is now even more important that the processes and supports available to help people 'speak up', are accessible and promoted to all, including people with disability, family, carers, advocates and others. It is also essential that all feedback, including complaints, is openly received and responded to.

I welcome the announcement of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*. I urge all involved to ensure that the voices of people with disability are heard, and through this that they have the opportunity to direct their future disability supports.

Just as critical is that disability service providers ensure that whilst they prepare for or adapt to the new business and operating requirements of the NDIS, they continue to focus on the quality of the services they provide, to reduce the risk of people experiencing poor quality supports, as happens more often than it should.

Throughout this year we have been working on the Building Safe and Respectful Cultures research project. This project was initiated by former Disability Services Commissioner Laurie Harkin AM as an opportunity for us to look into the best way to have primary prevention against exploitation, abuse and neglect incorporated into daily practice for those working in the disability sector. I encourage everyone to review the findings of this research and continue working on all forms of prevention, including primary (before something happens), to improve the lives of people with disability.

This is the first year we have had the opportunity to collect a full year of data for our annual review of disability service provision to people who have died, to add to the 11 months of data from matters investigated in 2017-18. Many of the service issues we highlighted in our inaugural 2017–18 report on disability supports provided to people who had died continue to pose risks for people in receipt of disability services. Every death is tragic, expected or unexpected, and is an opportunity for service providers – and the sector as a whole – to learn and to further improve the quality of the disability services to which people have access. If we are to collectively achieve the expected benefits of the NDIS, it is critical that first and foremost we ensure that people are safe. I urge everyone involved in supporting people with disability to maintain this focus. Again, I encourage everyone to consider the findings of this report, and to consider how we can improve services provided to people with disability.

A final note

I thank the people who have been brave enough to come forward and make complaints, some of whom have done so on behalf of others. I want to acknowledge that coming forward to complain is a big step that deserves recognition, as it is often the first step in improving the situation of many people.

I thank all DSC staff for their dedication to protecting and advancing the rights of people with disability. In spite of the impending closure of the office, their person-centred focus continues to ensure that the thoughts, feelings and voices of people with disability are listened to and incorporated in our daily practice. I also want to acknowledge the important leadership role of Anthony Kolmus as Deputy Disability Services Commissioner.

I thank Laurie Harkin, the inaugural Disability Services Commissioner, for his instrumental role in establishing and developing this office. The work he led in growing the capacity of people with disability to speak up, and the capacity of disability service providers to approach complaints handling positively and transparently, has contributed significantly to improving complaint cultures in Victorian disability services.

I thank Dr Lynne Coulson Barr who was Acting Disability Services Commissioner until August 2018, for the support she afforded me when I commenced in this role.

I thank the Minister for Disability, Ageing and Carers, the Hon. Luke Donnellan MP, as well as Georgina Frost, President of the Disability Services Board and other board members, for their continued support of the work of this office, and I acknowledge their commitment to improving safeguards and increasing opportunities for people with disability.

Whilst DSC has been operating for 12 years, this has been my first year as the Commissioner. It has been a privilege to work with DSC staff to uphold our mission of protecting the rights of, and improving services for, people with disability.

Arthur Rogers
Disability Services Commissioner

August 2019

Retirement of Disability Services Commissioner Laurie Harkin AM

Laurie Harkin AM, Victoria's inaugural Disability Services Commissioner, retired in July 2018, after 11 years of valued service in this role and many more in the Victorian public service more broadly.

Having successfully established our office in 2007, subsequent to the passing of the Act, Laurie led the development of DSC processes and approaches that significantly improved the complaints culture that exists within Victorian disability services and, in turn, the quality of disability supports people have access to.

Laurie's focus on the rights of people with disability, combined with his willingness to engage directly with people in receipt of disability services, their families and service providers, was central to the important role that DSC has played in enhancing the confidence of people to speak up about their disability supports and service providers responding effectively to those complaints. In addition, the contributions he made to the development of the NDIS quality and safeguarding arrangements and the establishment of a network of disability complaints Commissioners from around Australia and New Zealand have ensured that his legacy extends far beyond Victoria.

We wish Laurie all the best for the future in what will be a well-deserved retirement.

Message from the President of the Disability Services Board

Throughout the year the Disability Services Board (DSB) worked closely with the Disability Services Commissioner and the National Disability Insurance Agency (NDIA) to ensure there were appropriate safeguards in place for people with disability whilst Victoria transitioned into the NDIS framework.

This year, we have highlighted and provided advice on the following issues:

- the important role the Victorian Government played as a 'provider of last resort' and the need to identify alternative options under the NDIS
- the importance of continuing reviews of disability services provided to people who have died whilst in receipt of disability services
- approaches to meet the needs of Victorians with disability accessing mainstream health and education services
- questions on the application of the Victorian Charter of Human Rights and Responsibilities to NDIS providers.

The DSB will continue working to ensure that quality and safety remain at the forefront of system design during the transition to and following the implementation of the NDIS. We will use the experiences of DSC as a benchmark to provide advice about the effectiveness of the Victorian complaints system, including any changes and any potential gaps once the NDIS is fully implemented. We will also continue to seek to influence a national model of complaints that improves safeguards, supports and outcomes for people with disability.

The term of the DSB has been extended beyond its original three-year term, to coincide with Victoria's transition to the NDIS and the DSC's continued role. I thank my fellow board members for their continued dedication to improving the safety and quality of Victorian disability services. I extend a special thanks to Llewellyn Prain, who will retire as a DSB member in 2019.

Finally, I thank the Disability Services Commissioner and his staff for their support of our activities. On behalf of the DSB, I reiterate our commitment to ensuring that Victorians with disability will always be able to access safe and high-quality disability services.

Members of the Disability Services Board at 30 June 2019

Georgina Frost *(President)*

Christian Astourian
Chris Asquini
Karen Cusack
Glenn Foard
Helen Kostiuk
Jill Linklater
Rocca Salcedo Mesa
Llewellyn Prain
Dr Ruth Webber
Bryan Woodford OAM

Georgina Frost
President,
Disability Services Board

Legislative changes

The principle of people having control and choice over their disability supports is core to the NDIS. It is equally essential that the future disability service sector has strong, integrated safeguards, quality assurance mechanisms, and disability service registration processes in place to ensure that people's rights are upheld.

To support the transition to the full rollout of the NDIS in Victoria, the *Disability (National Disability Insurance Scheme Transition) Amendment Act 2019* was passed in June 2019. This and the *Bilateral Agreement between the Commonwealth of Australia and Victoria on the National Disability Insurance Scheme* (which was signed on 17 June), represent important steps in safeguarding the rights of those people not yet transitioned to the NDIS and those living in group homes funded through in-kind arrangements.

Drawing on the knowledge and experience we have gained over the past 12 years, DSC has actively engaged with, and wherever appropriate, assisted representatives of the NDIS Quality and Safeguards Commission (NDIS Commission) as they prepared to begin operating in Victoria on 1 July 2019. The establishment of the NDIS Commission will result in further changes for the Victorian disability sector as it marks the formal beginning of the significant reduction of the role of DHHS as the body responsible for the regulatory oversight of disability services in Victoria, and the phasing out of the role of DSC as the independent complaints body for Victorian disability services.

Following the passing of the *Disability Services Safeguards Act 2018* in August, we were also pleased to offer support and advice to DHHS staff involved in establishing the Disability Worker Commission (DWC) and Disability Worker Registration Board, both of which will begin operating in July 2020. DSC commends the Victorian Government for their initiative in establishing Australia's first registration scheme for disability workers, which can only help to further improve the quality of disability services in Victoria.

DSC will continue to work with the NDIS Commission, the NDIA, DHHS and the DWC to ensure that the transition of safeguarding arrangements for Victorians in receipt of disability services occurs as seamlessly as possible.

DSC will continue to work with the sector throughout the transition period to ensure all people have access to accurate and timely information about the changes occurring.

Enquiries and complaints

This year we received a total of 1,513 enquiries and complaints (1,101 enquiries and 412 new complaints). We also continued working on 57 complaints carried over from 2017–18.

Of the 1,101 enquiries, 890 were out-of-scope and 211 were in-scope for DSC. All of these enquiries were finalised in accordance with the Act, including researching the issues raised and responding to the person making the enquiry.

Of the 412 new and 57 carried over complaints, 66 were out-of-scope and 403 were in-scope. The in-scope complaints were assessed in accordance with the Act. This included 13 complaints being investigated following assessment, three complaints finalised through conciliation, 20 Notices of Advice being issued and follow up actions requested from service providers in 54 complaints.

Of these complaints, one preliminary assessment took longer than the legislated 90 day period. The Commissioner considered that this was reasonable because of the complexity of the complaint and to allow for appropriate inclusion of the person who made the complaint. The complaint was ultimately finalised, with the identified systemic issues addressed within a Notice of Advice, which was issued to the service provider. This Notice of Advice required the service provider to address the specific individual concerns raised along with all other identified issues.

The concerns raised through in-scope complaints were similar to previous years with the key areas of concerns being:

- service quality
- quality of communications
- staff related issues
- group supports, and
- policy or procedures.

58.4 **average number of days to close complaints**

85.7 **average number of days before deciding to conciliate**

31.3 **average number of days before deciding to investigate**

Enquiries and complaints about group homes

Consistent with all our past reports, the service type that triggered the largest number of complaints to our office was group homes (of the top five service types reported in in-scope enquiries and complaints, 41% were about group homes. See Figure 8 for more information). To a degree, this is to be expected given the whole-of-life nature of this service type and the often strained circumstances where people with different personalities and preferences are living together simply because they all have a disability. However, even taking this into account, there continue to be many complaints that directly relate to the quality of the services provided.

There has been an increase in the average number of days we have taken to assess complaints and to decide to conciliate or investigate them. This is due to a number of factors including a significant increase in complaint numbers in the first half of the year, increased complexity of complaints and staff turnover due to the impending closure of the office with the transition to the NDIS.

The top five issues raised for in-scope complaints about group homes include:

- service quality
- group supports
- staff related issues
- quality of communications
- policy and procedures.

We continue to see examples of incompatibility between people who live together, which raises significant questions about how to protect the rights of individuals in group homes and how to promote the right of all people to choose who they live with.

This year has seen the commencement of the transfer of DHHS operated group homes and respite services to five non-government organisations, an initiative that affects over 2,500 people with disability as well as their families and staff. This complex process represents a significant change for all involved, and DSC is continuing to work closely with DHHS and the five service providers to ensure we maintain our oversight of these services and that complaints and concerns are responded to in an appropriate and timely manner.

Some complaints can be finalised early in the resolution process through a conversation between both the person with disability and the service provider. The important thing is that service providers are committed to person-centred practices and acting on feedback received.

DSC will continue to share our learnings from working with people living and working in these houses with the NDIS Commission to minimise potential future disruption when regulatory oversight of these services is transitioned into the NDIS Commission.

CASE STUDY

Jemma: Issues in group homes

Jemma* lived in a group home and was having difficulties with a staff member at her house called Gareth. She called us with the support of a different staff member Ben, to make a complaint about Gareth. She told us that Gareth bossed her, her housemates, and other staff around. Gareth always spoke loudly, and it often gave Jemma a headache.

Jemma had spoken to managers in the past about Gareth but felt that there was no difference in his behaviour. Jemma said she was frustrated that nothing was being done about the complaints she had made to the managers.

With Jemma's consent, we spoke to her service provider immediately about her complaint. Annika, a senior manager, met with Jemma at her home on the same day to talk about her concerns. Jemma asked Annika to speak to Gareth about changing his behaviour.

Annika promised Jemma that she would speak to Gareth and make sure that he participated in training on respectful behaviours and utilising person-centred approaches. She also promised that she would make sure all staff at Jemma's house would do the same training. Annika gave Jemma her mobile number so that Jemma could call her directly in the future if she had any other complaints. She also thanked Ben for supporting Jemma to call our office.

Afterwards, Jemma told us that she was happy as Gareth had become a better worker and wasn't being bossy and loud anymore. She also liked knowing that she could always call Annika directly if she had any more complaints.

A few months after this complaint was resolved Jemma called back with a new complaint about a member of staff. The Resolutions Officer who answered her call was able to talk to Jemma about the strategies that were used to resolve the last complaint and reminded Jemma of Annika's offer to be available to help in these situations.

The conversation empowered Jemma, who decided that she could take the next step of calling Annika herself. Jemma called later to say that being able to call Annika had resolved the issues, and she felt confident that she could work with her service provider to resolve issues in the future.

**Names and details have been changed*

Enquiries and complaints

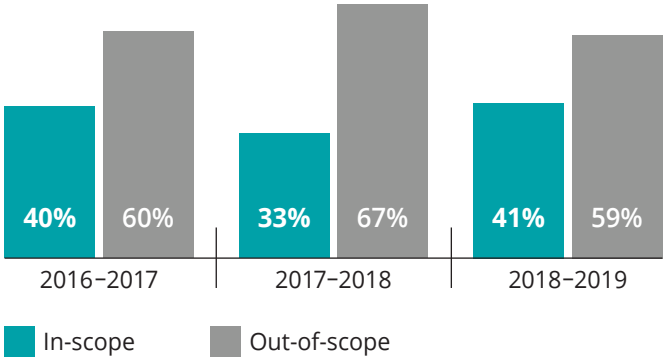
Enquiries and complaints about the NDIS

The total number of NDIS related enquiries and complaints increased significantly compared to last year (an increase of 78%), which is to be expected given the size and complexity of the scheme and that its rollout across Victoria is nearing completion. The NDIS related enquiries and complaints that were in-scope increased in number by 117% compared to last year.

162 NDIS related in-scope enquiries and complaints in 2018

352 **NDIS related in-scope enquiries and complaints in 2019**

Figure 2: Overall proportion of in and out-of-scope new NDIS-related enquiries and complaints



In-scope complaints about the NDIS included concerns about support coordination, and the frequency and quality of communication from Local Area Coordinators (LACs). Complaints about the quality of support coordination primarily related to a lack of staff experience and a lack of appropriate training, guidance and support for staff by service providers. This then has an impact on the person with disability, with some reporting gaps in service delivery.

Another common theme in complaints about support coordination appears to stem from differing levels of understanding from people with disability, service providers, and support coordinators themselves about what support coordination includes. People appear to need greater support to understand and navigate the transition from case management in pre-NDIS services to support coordination under the NDIS. Similarly, in many instances there is confusion about the change from a block funded model, where people received and paid for services as a whole, and the new arrangement whereby support coordination services are charged for in relation to hours of service used, including any and all actions or engagement undertaken by the support coordinator such as emails and calls. The way this will impact funding set aside for support coordination has not always been clearly explained. It will be important for the NDIA and organisations providing support coordination to continue to clarify the function, boundaries and fees related to the role and to inform people accordingly.

Out-of-scope NDIS concerns included the quality of planning, access to plan reviews, and the quality and frequency of communication with the NDIA. These matters were referred to the NDIA or Commonwealth Ombudsman where relevant.

Another area of ongoing concern is the confusion many people still appear to be experiencing about the NDIS and associated processes. These concerns have included difficulties in accessing information (including in formats required by the person with disability and their family) and difficulties in understanding where to go to report concerns about the planning process. To address this, DSC has continued to provide detailed information about NDIS complaint pathways, in both standard and plain English, on our website and in printed materials.

It will be important moving forward that all involved in the sector continue to focus on ensuring that people with disability, and where necessary their families and advocates, have easy access to information that assists them to understand NDIS processes and enable them to make informed decisions about their disability supports.

Out-of-scope enquiries

Throughout the year DSC received 890 out-of-scope enquiries and 65 out-of-scope complaints (and there was one carried over out-of-scope complaint). While these enquiries and complaints are not within our jurisdiction, DSC staff spend a significant amount of time researching issues raised, talking to the complainant and confirming who else might be able to assist.

A number of the out-of-scope enquiries and complaints we received were about unregistered service providers and included allegations of assault. Complaints about unregistered service providers fall outside our legislative jurisdiction, and we were unable to act on these complaints. Nor were the providers required to report the incidents through formal incident reporting channels (which would have enabled regulatory oversight of the provider's response). In these cases, we advised the person making a complaint to report assaults to Victoria Police, and if the person making the complaint provided consent, we used our information sharing powers to refer the case to other relevant bodies whenever possible.

While the NDIS offers many opportunities for people with disability, particularly in relation to choosing who they receive supports from, we continue to have concerns about the lack of safeguarding arrangements in place for unregistered service providers.

The NDIS Commission will be able to take complaints about unregistered service providers where the complaint relates to a potential breach of the NDIS Code of Conduct. In doing so the NDIS Commission will have the option of enacting its various powers such as compliance notices, enforceable undertakings, injunctions and banning providers from delivering services. However, whilst these are all important safeguards, unregistered providers will not have to undertake worker screening checks, report critical incidents or have to undergo independent quality audits against relevant disability practice standards.

We support people's right to choose their disability service provider, including an unregistered provider. However, we also think that with the current absence of proactive quality assurance measures for unregistered providers, it is critical that people should have ongoing access to clear, concise information about the comparative standards, safeguards and oversight in place for registered and unregistered providers.

It is important to note that being an unregistered provider does not automatically imply a poor level of service delivery. Our concerns relate to the question of what the minimum acceptable level of regulatory oversight and quality assurance should be for any disability service provider.

CASE STUDY

Rose: Conciliating a complaint

We received a complaint from Rose* about her service provider. Rose prefers to communicate through text and emails as she is unable to communicate verbally.

In her complaint, Rose disclosed that she was concerned about four specific risks to her health and wellbeing:

1. the buzzer in her unit was not working so she would not be able to alert anyone if there was an incident
2. witnessing staff using the toilet and not washing their hands before preparing her food
3. incorrect medication had been administered
4. complaints to the service provider were not adequately responded to.

Rose was upset as she is very capable of directing her own care and providing feedback to her service provider, but she felt that all her attempts to communicate her needs to staff and the service provider had been ignored.

After a short assessment of the complaint, including a review of information provided by Rose and the service provider, DSC requested the service provider fix the buzzer as soon as possible and provide appropriate training for staff on hygiene, medication administration and complaints management.

When the buzzer was not fixed in a reasonable timeframe and staff training had not been organised, a Notice of Advice was issued to the provider requesting that the actions specified by our office be undertaken. The service provider responded quickly to the Notice of Advice by fixing the buzzer and providing verification that the relevant training had been organised for staff.

With both parties acknowledging a break-down in trust and communication in the relationship, a relationship that was ongoing with Rose expecting to remain living in the unit for the foreseeable future, we recommended conciliation as the approach most likely to resolve the remaining issues in Rose's complaint.

Conciliation allows each party to be heard, to seek to understand each other's views, to explore issues; and where possible, to reach agreements in a safe and facilitated meeting. We planned the conciliation to suit Rose's needs, including holding it in her home where she felt most comfortable, and allowing enough time for Rose to communicate using text-to-speech software.

The conciliation meeting provided an opportunity for Rose and the provider to communicate openly in a supported manner, and to reach a mutual agreement about each of the identified issues, including:

- Rose would communicate via email, at the time of the issue, with the house manager if she had concerns that she felt she could not address directly with staff
- unless urgent, if the house manager did not respond within three days, Rose would then contact the state manager.

It was also agreed that tone was very important in emails, and if there was ever any concern around tone, they would meet in person to address the issues.

Rose reported to us that following the conciliation process, the service provider was more responsive to communication from her, and that she felt a lot more confident in the ability of staff to respond to her needs. The service provider also reported improved communication between Rose and staff, resulting in a stronger and more trusting relationship.

**Names and details have been changed*

Oversight of critical incidents

Through successive Ministerial Referrals, DSC has provided increasing levels of oversight of Category One / Major Impact incident reports since 2012. From 2017 this has included the authority to enquire into and investigate any incidents relating to abuse, or neglect in the provision of services, and the provision of disability services to people who have died.

As mentioned in last year's annual report, the introduction of the electronic Client Incident Management System (CIMS) for non-government service providers in January 2018 resulted in delays and information gaps that reduced our ability to provide timely and effective oversight. DSC has continued to work with DHHS on the following concerns throughout 2018-19:

- the reduction in quality of information contained in incident reports
- the failure to adhere to mandated reporting timelines, and
- decision-making processes about the classification of incidents.

There has been a 35% decrease in the number of critical incidents reported by non-government services since the introduction of CIMS, from 540 incident reports in 2017–18 to 353 incident reports in 2018–19. During the same period, the number of incident reports from DHHS group homes, which still report via the earlier Critical Client Incident Management (CCIM) system, have declined by 16%, less than half of the decline for non-government providers.

Table 1: Incident types in government and non-government providers July 2018 to June 2019

	2017–18	**2018–19**	% change
CSO (non-government)			
Alleged sexual abuse/assault	125	**58**	**-54%**
Alleged physical abuse/assault	197	**135**	**-31%**
Alleged poor quality of care	70	**46**	**-34%**
Injury	96	**49**	**-49%**
Unexplained injury	23	**21**	**-9%**
New CIMS incident types (<3%)	29	**44**	**+52%**
DHHS (government)			
Alleged sexual abuse/assault	56	**14**	**-75%**
Alleged physical abuse/assault	136	**113**	**-17%**
Alleged poor quality of care	33	**33**	**–**
Injury	143	**138**	**-3%**
Unexplained injury	34	**40**	**+18%**

The CIMS system requires service providers to classify incidents as 'Major Impact' or 'Non-Major Impact', relying on a subjective decision by the service provider about the degree to which the incident has impacted a person. DSC has expressed concern that this classification system may negatively impact on people with disability, particularly those who are at increased risk of violence, abuse, neglect and exploitation. For example:

- people who have complex communication needs
- those whose capacity to understand their rights in relation to an incident is impacted by their level of cognitive functioning
- those who do not react to issues (through desensitisation or other) in ways that are typical of the broader community.

This approach has reduced our ability to accurately identify issues and trends in incident reporting, assess the quality of supports offered to people with disability after an incident, and potentially minimise critical issues of concern in the disability sector.

We have seen examples where incidents initially submitted as Major Impact by the provider were later reclassified as 'Non-Major' because the impacted person did not or could not verbalise any distress. In one of these cases, a person with disability was hit in the face but was then assessed as not having been adversely affected as they continued with activities at their day service. As a result, DSC was unable to identify if this was a one-off incident, or a trend.

Several months later our staff were made aware of concerns raised by a third party that the person in question had been the victim of physical assaults over a long period of time, but that the incidents had been reported as Non-Major impact and therefore did not have to be reported to our office. We have since followed up with the service provider to review their investigation of the assaults, their approach to the classification of incident reports, and the strategies adopted to ensure the person's safety and wellbeing.

Oversight of critical incidents

In summary, we have three primary concerns arising from our oversight of CIMS based incident reporting. Firstly, we are not confident that the number of incident reports submitted under CIMS accurately reflects the number of allegations of abuse in the disability sector. We welcome the actions by DHHS in April 2019 to cease reclassifying any Major Impact incident reports. However, the future classification and monitoring of incident reporting needs to be carefully considered in the context of ensuring that issues of concern can be addressed and required supports provided accordingly.

Our second concern relates to the increased regularity with which DSC staff need to request further information and/or clarification from service providers after receiving an incident report, as the level and quality of details provided in CIMS reports continues to be inadequate to carry out our oversight role. This request for further information happens in nearly three-quarters (73%) of all reports we review from CIMS. Most commonly, we are asking service providers to confirm that they have undertaken follow-up actions in response to the incidents, particularly around reporting to Victoria Police, seeking medical attention and specialist supports, and communication with people with disability and their families.

Another issue of concern relates to the timeliness of when incident reports are submitted via CIMS. Under the CIMS reporting guidelines, Major Impact incidents are required to be reported by non-government organisations to DHHS within 24 hours of the incident occurring, or within 24 hours of first becoming aware of the incident. Our data collection for CIMS incident reports show that only 20% of incident reports are submitted within the required reporting timeframe obligations.

The number of incident reports entered into CIMS more than 14 days after the incident has occurred is 25% of the total number of reports received. Almost one in ten (9%) of incident reports entered into CIMS have been received by DSC 30 to 90 days after the incident (this amounts to 29 CIMS incident reports).

These delays undermine the timeliness and effectiveness of our oversight of these incidents, which include the reporting of allegations of physical or sexual abuse. The delays also have the potential to further exacerbate any negative impact on the people with disability who are affected, particularly where the initial response has been inadequate.

Investigating disability services

In the 2018-19 reporting period, DSC commenced seven systemic investigations following information being received through a variety of channels including complaints, incident reports, information from Office of the Public Advocate (OPA) Community Visitors and others.

The August 2017 amendments to the Act have increased DSC's powers and functions and allowed our work to become more intelligence driven. Greater collaboration and information sharing is now possible with external stakeholders such as Victoria Police, the Coroners Court of Victoria, OPA and the Community Visitors Board (CVB). This has allowed us to become more strategic in identifying potentially concerning situations and service providers, and informs our decision making about how best to handle each matter. This has also provided opportunities to promote our presence, and the positive impacts we can have for both people with a disability and staff when concerns are raised with us.

DSC provides Victoria Police with expert advice on working with people with disability and understanding the nature of disability services through our participation in the Police Managers Qualifying Program and training days for their SOCIT (Sexual Offences and Child Abuse Investigation Teams) officers.

Authorised Officers

One of the powers afforded to our office in August 2017 was the authority to undertake Authorised Officer visits which are unannounced inspections of disability services. Sending Authorised Officers to a disability service during an investigation achieves several objectives. Firstly, it gives us a point-in-time indication of how things are working within a service on a day-to-day basis. It allows us to speak to people with disability and staff, and to gather information in a timely manner which has often been critical to informing any subsequent decision as to whether further investigation is required.

Secondly, and perhaps more strategically, sending an Authorised Officer to a disability service sends a very visible message to the service provider, to staff, and to people with disability who are supported by the service that we take complaints about people's safety and wellbeing seriously. It reminds people of the oversight and safeguards in place across the sector; that people can and do complain about their disability services; and that disability service providers and their staff need to ensure that they are providing high quality supports at all times.

We conducted 22 Authorised Officer visits at 21 different sites this year as part of the investigation process for seven different matters involving six service providers.

Wherever possible, we endeavour to take an educative, rather than punitive, approach in our investigations. We have seen encouraging results from this approach in the past 12 months, with many providers engaging positively throughout the investigation process and taking actions and improving services before our investigation concludes.

For some of our investigations, even when the issues are found to be justified we are finding that we do not need to issue a Notice to Take Action as the service provider has already engaged and taken appropriate action during the investigation process. This is a positive step, as it means that improvements to services are happening in a more timely manner, with more immediate benefits for people with disability.

It is also important that oversight and safeguarding bodies throughout the human services sector work together wherever necessary to ensure there are comprehensive safeguards for all people. During the 2018-19 financial year, we conducted joint investigations with the Health Complaints Commission and Mental Health Complaints Commissioner respectively into allegations which extended across each of our jurisdictions. One of these investigations was ongoing at the end of the reporting period. The other resulted in a joint referral of the issues uncovered to the NDIA.

'I am so appreciative that you have become involved. It is really nice to have a body that will listen and take the issues forward. It is comforting to know that you guys are there to show service providers they are accountable.'

Person who made a complaint that led to an investigation

CASE STUDY

Investigating Beth's injury

Beth* is a 38-year-old woman with significant intellectual and physical disabilities who requires one-to-one support with all her daily activities. She lives in a group home with three other people, all of whom also have high support needs.

Whilst supporting Beth at the local swimming pool, Beth's family observed significant bruising on Beth's thigh. The family reported the bruising to the service provider and took her to the hospital where it was found that the injury could have been caused by staff dragging her along a carpet.

DSC received a complaint from the family and subsequently sought and obtained the incident report. Following a review of this report, DSC was concerned about the severity of Beth's injury and that the service:

- had not sought medical attention for Beth
- did not report the initial injury to Beth's family
- had not detailed any planned changes to Beth's physical care following the incident
- submitted the original incident report as Category 2/Minor Impact, rather than Category 1/Major Impact, before we requested that it be recategorised
- had not acknowledged the concerns by Beth's family that the cause could have been a staff to client assault.

Based on our concerns about this incident, and past patterns of incidents and complaints received by DSC in relation to the same service provider, we commenced a systemic investigation. During the investigation, we discovered that:

- Beth and several of the other people living in the group home had no verbal communication, however there were no communication plans for any clients
- although Beth had had numerous falls, a falls assessment had never been organised
- rosters and records showed that the group home residents frequently did not receive the level of staff support they were supposed to receive
- there had been several other incidents in Beth's house that had either not been reported or had been reported as a Category 2/Minor Impact incidents which we believed should have been submitted as Category 1/Major Impact incidents.

As part of the investigation process, we interviewed people who lived in the group home, family members, staff and senior management. We examined documents, conducted Authorised Officer inspections of the disability service, and shared information with external organisations including Victoria Police and the Senior Practitioner.

Following this investigation, an Action Plan was produced that outlined several recommendations and actions to address the shortcomings of the service provided at the group home. These actions included:

- fostering a culture where training was provided to all staff
- supervisors being made accountable for undertaking reviews of all incidents
- reviewing staffing levels in the house
- revising the organisation's processes for communicating with families.

**Names and details have been changed*

Review of disability service provision to people who have died

In our second year[1] investigating deaths reported to our office by DHHS and the State Coroner, it is disappointing to note that many of the issues that we highlighted in our inaugural 2017–18 *Review of disability service provision to people who have died* are still evident.

There continue to be deaths attributed or provisionally attributed to choking on food or aspiration pneumonia. People who should have had mealtime support plans had not been assessed for, nor had plans. Some who had them were not supported as they should have been. We are increasingly concerned that service providers and staff are not always aware of the serious risks people with disability can face at mealtimes, sometimes with terrible consequences, including potentially avoidable deaths.

The quality of health planning and record keeping by service providers still varies greatly, resulting in gaps in critical information meant to ensure that all staff provide appropriate and safe support to people. This is another area of practice that service providers and regulatory bodies need to focus on if we are to ensure people's safety and wellbeing.

Our work in this area also continues to identify an ongoing lack of communication assessments and plans to support people with complex communication needs, who require support to communicate their specific needs including alerting others of their deteriorating health. Communication is a fundamental human right that is not always being supported in disability services. In one example, a person who had lived in the same group home for 28 years had never had a communication assessment done. If we are to make the most of the principle of control and choice under the NDIS, it goes without saying that at minimum people with complex communication needs should be supported to communicate as effectively as they can.

During 2018–19 we received 99 (in-scope) notifications of people who had died while in receipt of disability supports, completed 37 investigations, and issued 23 NTTA to service providers to improve their services. We also issued nine Notices of Advice to the Secretary of the Department of Health and Human Services (DHHS) to address systemic issues identified through our investigations.

More information about our work in this area, including actions we have taken to influence future supports and oversight, can be found in our *Review of disability service provision to people who have died 2018–19*. DSC urges all people with disability, families, carers, service providers and regulatory bodies to read this Review to understand the issues of concern, and the actions that must be taken to improve the safety and wellbeing of all people with disability who are in receipt of disability supports.

1. While deaths were reported to us over an eleven-month period in 2017–18, we began conducting investigations in November 2017.

Education, information and training

We continue to provide information to people with disability and their families on speaking up about disability services, and to deliver training on positive complaints cultures to the sector. We have done this for 12 years through a range of forums, expos, network meetings, workshops, campaigns and conferences.

Through our engagement with people with disability, their families, supporters, carers and others, DSC is continuing to evolve the way we distribute our content to ensure the key message 'It's OK to complain!' is heard and seen by as many people in the disability sector as possible.

Despite our efforts, we still encounter people with disability who have been using services for many years who may know about their right to complain but are not confident to do so. We have heard of situations where people have reported that they have been treated differently by staff after having made a complaint to DSC, and situations where people have delayed making a complaint until the situation reaches breaking point, because they have been afraid of either retribution or the loss of their supports.

This sense of fear has also been expressed by disability support staff and family members from their unique perspectives. For staff, fear of losing their job, or retribution from management or co-workers, all played a part in not wanting to speak up. For family members, fear that their loved one may be worse off if a complaint is raised, fear that nothing will change or that they will lose their family member's disability supports, and an ingrained sense of gratitude impeded their willingness to complain.

This reporting period, DSC presented to disability service providers on 59 occasions, including at the National Disability Services regional forums where we discussed key themes from our 2017–18 *Review of disability service provision to people who have died* and delivered information about our Building Safe and Respectful Cultures (BSRC) project on abuse prevention.

We continued to partner with the NDIA in delivering community information sessions across the state, including in Swan Hill, Shepparton, Mildura, Kinglake, Bairnsdale, Orbost and Yarram. We also worked closely with DHHS, NDS, VALID, Women with Disabilities Victoria and the Diverse Communities and Intersectionality Working Group. We attended expos and forums, participated in panels at conferences, and presented and participated in groups and networks including those for culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities.

Over and above the learning derived from complaints and investigations, education and information strategies are critical elements of achieving lasting improvements in the disability sector. Given the continued evidence of poor practice, abuse and neglect occurring in the sector, it is imperative that there continues to be a strong and ongoing focus on achieving cultural change through education and training.

Education, training and information needs to be a continual process to regularly reinforce the key message – It's OK to complain!

As part of our efforts to enhance understanding about people's right to make a complaint, we continued our sponsorship of the Having a Say Conference and ArtAbility. At the Having a Say conference we had information stalls, showcased some of the initial findings of our BSRC project, supported come-and-try activities and delivered presentations and a music workshop to a crowd of enthusiastic participants.

Promoting messages about positive complaints culture needs to be repeated in various ways to get traction throughout the community. We used art and music as alternative ways for our office to engage with, and have conversations that matter with people interested in our service. Artists from ArtGusto facilitated wrap art workshops by the Geelong waterfront as part of *the together project* and as an extension of our 'ask me' campaign launched on International Day of People with Disability (IDPWD). Making art together was an opportunity to open up conversations between people with disability, families, friends, support workers and broader community members around the key questions of what makes us all feel safe, happy and respected.

Building Safe and Respectful Cultures

While there is much work being undertaken in the secondary and tertiary prevention areas, primary prevention is still not given the focus it deserves. Primary prevention is a complementary approach that works towards stopping abuse, neglect and exploitation before it starts.

Building Safe and Respectful Cultures (BSRC) was a pilot research project that aimed to:

- learn more about the role of culture in disability services in promoting safety and respect
- improve our understanding of multi-tiered approaches in preventing harm
- identify some practical approaches that might be useful now and in the future.

It was important that our research methodology reflected the aims of the project: creating safe and respectful cultures, building meaningful relationships, the empowerment of people with disability, and bringing people together (including having people with a disability, family members, staff and senior managers participate in sessions together).

DSC led the project, and the research was conducted by community researchers (people with lived experience of disability); an international team of academics; Associate Professor Sally Robinson, Dr Melissa Murphy, Dr Peter Oakes, and DSC staff. The work undertaken by the community researchers was vital for the project's success.

The research report was launched on 25 June 2019 by the Minister for Disability Ageing and Carers. the Hon. Luke Donnellan MP

While the pilot project was modest in scope, the findings will resonate and be relevant to all disability service providers. The core concepts can and should become actions for change that can be applied to all disability service settings.

We believe it will further inform the dialogue about the importance of culture in preventing violence, abuse, and neglect in disability services, especially as the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* commences.

We would like to thank all involved in this project for their commitment to contributing to the development of organisational cultures that can better safeguard the safety and wellbeing of people with disability.

The final BSRC research report was released in June 2019 and can be found on our website.

> 'The whole project has been fantastic and life-changing. It's like I've woken up.'
>
> Fran, community researcher

The Minister for Disability Ageing and Carers. the Hon. Luke Donnellan MP, Community Researchers; Peta Ferguson, William Ward Boas, Francesca Lee, Disability Services Commissioner Arthur Rogers at the launch of the Building Safe and Respectful Cultures research project in June 2019.

CASE STUDY

Music as part of research

Music allows us to express ourselves in different ways. It doesn't rely on words, and it is accessible to anyone. This pilot project explored the different ways that people communicate with each other, and the ways in which the traditional power dynamics might be shifted and changed in a different context.

Similarly, the research explored the benefit of mutually rewarding relationships which were fundamental to building safe and respectful cultures. For people with disability, this supported their identity development, being embraced as a person of worth and value, and enhanced their confidence to speak up about issues concerning service provision.

Music workshops hosted as part of the project enabled participants to build relationships between those who use the service, family members and staff. Participants also found ways to express ideas and feelings to share something about themselves with other people.

Shared music experiences for this project, although therapeutic and enjoyable for those who participated, were also shown to have the potential to connect people in meaningful and mutual ways.

Following the music workshops we received feedback from a participating service provider about a staff member who used what he'd learnt in a music session to help him communicate with a person with disability whom he was taking out for the day. When Joe*, with whom he was working, started becoming anxious and upset by what was going on around him and was not able to calm down, he had remembered that there was a song that Joe had really connected with at the workshop. He sang the song to Joe, who started to sing with him. Through this process of singing together, they were better able to participate in a shared activity, and Joe was able to relax and calm down.

"I would say that the biggest thing would be Joe's increase in communication through the music, because we know that increasing his communication decreases behaviours of concern, and it also increases his ability to tell us what's going on. Anything that goes wrong, Joe can't communicate it, so by having anything, no matter what it is, that helps him increase his communication, this means that if there was ever anything to go wrong then he is better equipped to tell us."

**Names and details have been changed*

Annual Complaints Reporting (ACR) from Disability Service Providers

All registered and regulated Victorian disability service providers are required by legislation to report annually to our office on the number and types of complaints they receive and how these complaints are resolved. As a result, we now have 12 years of longitudinal complaints data which allows us to identify trends and areas for improvement to inform government and influence policy.

Complaints to disability service providers

In 2018–19 the number of disability services providers in Victoria rose sharply from 557 in 2017–18 to 816, an increase of 46%. This follows strong increases in the number of providers in previous years from 346 in 2015–16 and 435 in 2016–17. There was also a large increase in the number of providers that ceased delivering disability services this year (largely due to their registration being revoked or having lapsed), from 30 providers in 2017–18 to 77 providers in 2018–19. This year 90% of service providers (or 739 providers) submitted a complaint report to DSC in 2018–19, down from 99% in 2017–18.

A total of 3,638 complaints were reported to DSC in 2018–19, including 3,273 new complaints and 365 complaints carried over from the previous year (see Figure 3). This represents an increase of 719 complaints (or 25%) from the 2,919 complaints reported in 2017–18 and is by far the highest number of complaints reported since DSC was established in 2007. This continues the strong upward trend in complaint numbers over time, which have risen by an average of 13% per year since 2007.

In line with recent years, the increase in the number of complaints reported in 2018–19 was predominantly due to an increase in complaints from existing service providers[2] (81% of all complaints reported). The continued increase in the number of complaints reported by these service providers is evidence of the improving complaints culture that exists within these organisations and the growing awareness that exists of the link between concerns raised by services users and delivering quality person-centred disability supports. It also reinforces the importance of the sustained education and training program for disability service providers undertaken by our office.

Though there was an increase of 259 in the number of service providers in 2018-19, only 11% of new service providers reported complaints (totalling 140 of all complaints reported). Further, in this reporting period, just over half (54%) of service providers reported that they did not receive any complaints and 52 % of these 'NIL returns' were recorded by new providers.

This is similar to the 53% of complaints reported in 2017–18, but above the 51% received in 2016–17 and 47% in 2015–16.

It is not possible to be definitive about the reason for the low reporting trend amongst new providers. However, based on conversations DSC has had, for the majority of new providers it appears that they are placing low value on developing and refining their feedback and complaints systems.

As the disability sector continues to mature into a customer driven sector under the NDIS, we hope that the attitude of service providers to feedback and complaints will continue to improve until there is recognition of, and transparency about, their importance to the delivery of high-quality services.

2 Existing service providers are providers who were registered to provide disability services prior to 2018–19 and previously participated in the Annual Complaint Reporting process.

Annual Complaints Reporting (ACR) from Disability Service Providers

What were complaints reported by service providers about?

The rollout of the NDIS in Victoria and change in the funding source for disability services has resulted in a change in the nature of complaints over recent years. The proportion of complaints relating to NDIS funded services rose to 78% in 2018–19 (from 44% in 2017-18), while the proportion relating to DHHS funded services declined to 21% (from 52%), in line with the transition to NDIS funded services. Only 3% of complaints related to services funded by the Transport Accident Commission (TAC), while 1% of complaints related to services with other funding sources.*

The type of services subject to complaints varied significantly between NDIS and DHHS-funded services. While 35% of complaints relating to DHHS-funded services were about group homes, this accounted for only 10% of complaints from NDIS-funded services. In contrast, complaints about NDIS-funded services were much more likely to be about participation in community, social and civic activities (21%, compared with 9% from DHHS-funded services), coordination of support (12%, compared with 5% from DHHS-funded services) and planning (9%, compared with 1% from DHHS-funded services). A breakdown of complaints by service type for both NDIS-funded services and DHHS-funded services is shown in Figure 17.

The two most common complaint issues were again related to workforce and/or staff issues (45%) and service delivery and quality standards issues (42%), though it is of note that this is the first time since the ACR process began that workforce related complaints were more common than service quality related complaints. Otherwise, the issues raised in complaints in 2018–19 were broadly in line with previous years. Complaints related to communication from service providers made up 31% of complaints, while complaints were less likely to be related to access to services, (14%), service providers' policies and procedures (9%) and relationship and compatibility issues (8%). An overview of the issues raised in complaints is shown in Figure 18.

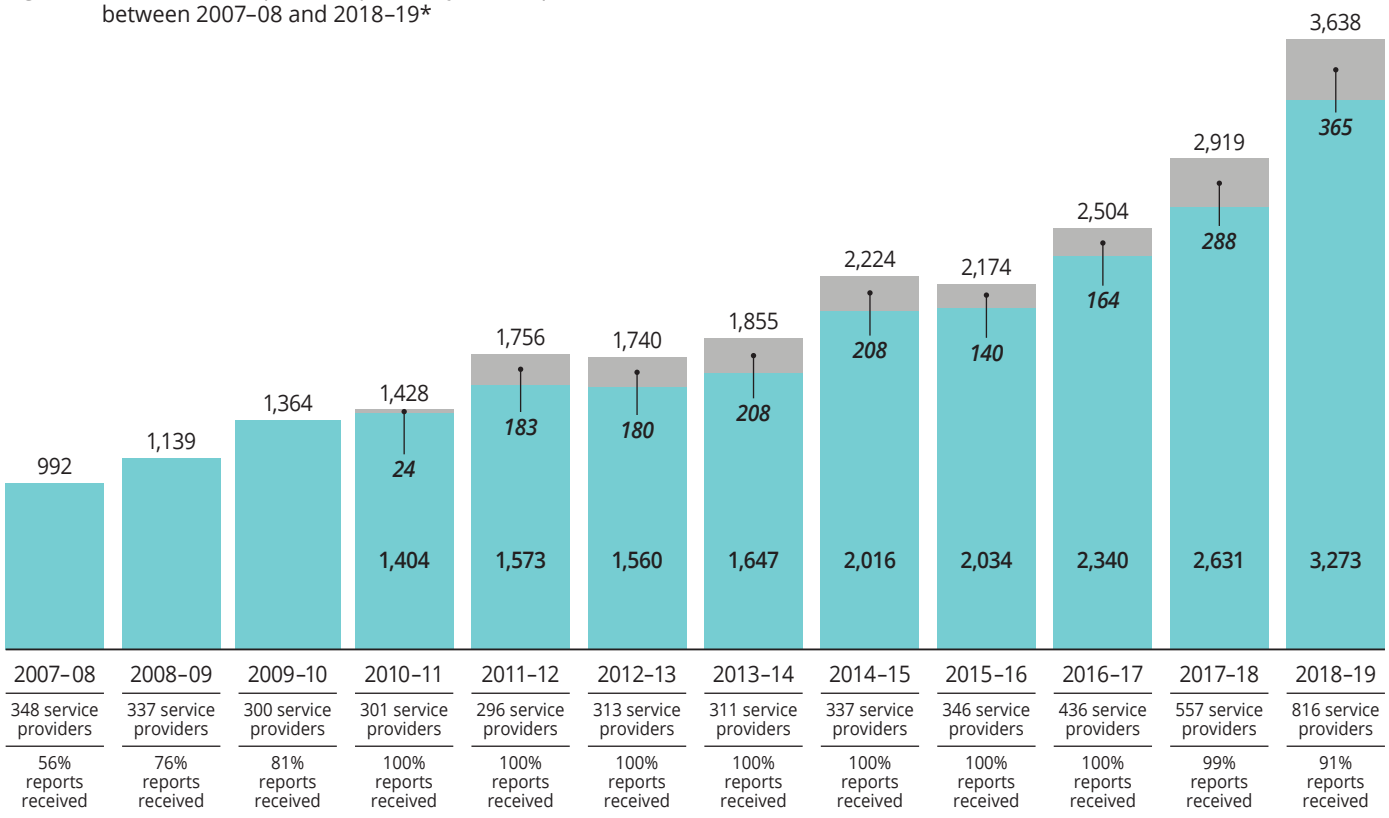
28%

of complaints were made by the person receiving service.

An accessible complaints system empowers people to speak for themselves when something isn't right.

* Multiple responses are possible for this question, so figures may not add up to 100%.

Figure 3: Number of complaints reported by service providers between 2007–08 and 2018–19*



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

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

Annual Complaints Reporting (ACR) from the sector

Who made complaints to service providers?

Consistent with previous years, complaints were most commonly made by family members (54%), again reinforcing the critical role families have in safeguarding the rights of people with a disability. Patterns in complaints received from people receiving services (28%) and support staff (7%) were similar to previous years (see Figure 16).

Service providers responding to complaints

DSC uses the Four As model to respond to complaints and feedback, and encourages all service providers to use the same model. The Four As are:

- Acknowledgement
- Answers
- Actions
- Apology.

The most common complaint outcome achieved in 2018–19 across the Four As outcome categories was an acknowledgement of the person's views or issues (74%). The next most common outcome was some form of action taken to resolve the complaint (56%). Most frequently, these actions related to performance management or disciplinary action (21%), a change or improvement to communication (19%) or a change or appointment of a worker or case manager (16%). Answers or explanations were provided to respondents in 52% of cases, while an apology from the service provider was provided in 47% of complaints. See Figures 20 for more information.

As shown in Figure 19, service providers indicated that 97% of complaints have been resolved to at least some degree.

Feedback from disability service providers learning from complaints

Learning from complaints is an essential part of quality improvement. Providers who are willing to engage and learn from feedback and complaints are more likely to be able to deliver services that directly meet the needs of the people being supported. Some of the reflections voluntarily reported by service providers via the ACR tool included:

'Last minute communication contributed to the complaint. Learnings are that services must be proactive and ensure families are communicated to in a timely manner if changes to services are to happen.'

'The importance of providing/receiving written confirmation following conversations to ensure that communication is clearly understood.'

'That families/significant others should be consulted about important matters in their family member's life.'

'It is important that staff are mindful of how information is communicated to families. Staff also need to be mindful of their tone and manage their stress reactions about a client's behaviour before communicating with families.'

'Identify participant expectations and requirements with communication at the intake or review stage. Spot check, communication methods to ensure effectiveness.'

'Having a variety of carers from different cultural and linguistic backgrounds improves the chances of finding a good match for the clients.'

Appendices

Appendix 1: Complaints handled by Disability Services Commissioner

Figure 4: Total number of enquiries and complaints by year *(excludes carry over)**

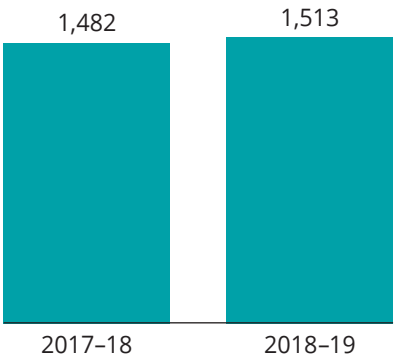


Figure 5: Overall proportion of in-scope and out-of-scope enquiries and complaints *(excludes carry over)**

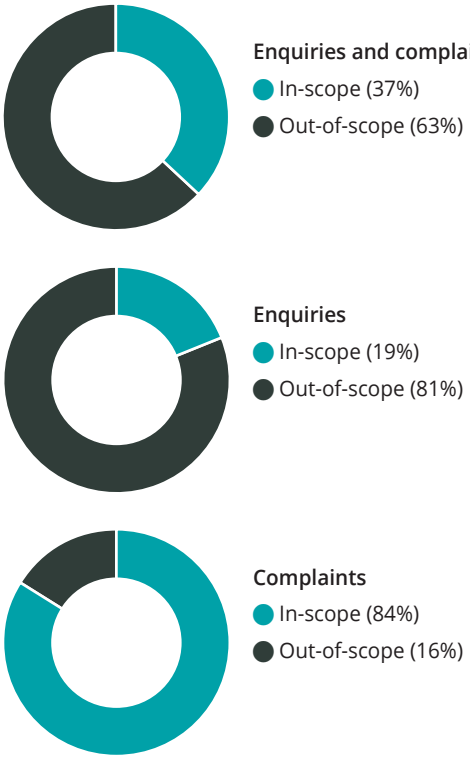


Figure 6: Who contacts us (in-scope)*

Families, parents and guardians have continued to be the primary source of complaints, showing the important role that families play in supporting and safeguarding people with disabilities.

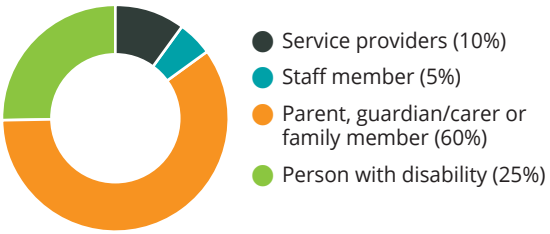


Figure 7: Most common disability types reported in in-scope enquiries and complaints*

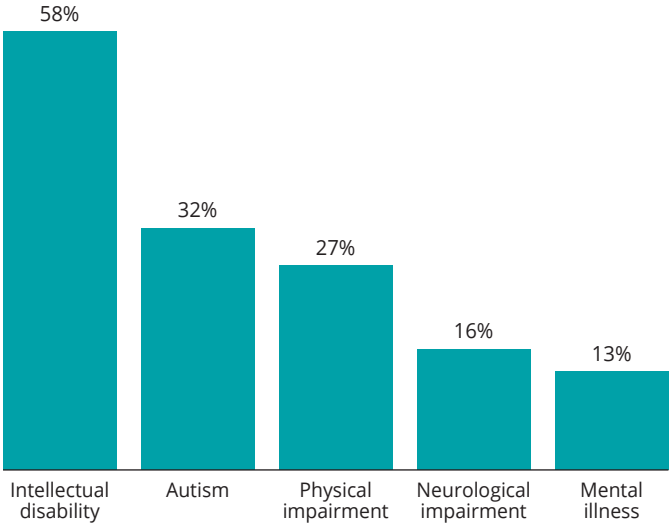


Table 2: Enquiries/complaints received relating to people with more than one disability*

1 disability	72%
2 disabilities	21%
3 disabilities	6%
4 disabilities	1%

**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Appendices

Figure 8: Top five service types reported in in-scope enquiries and complaints*

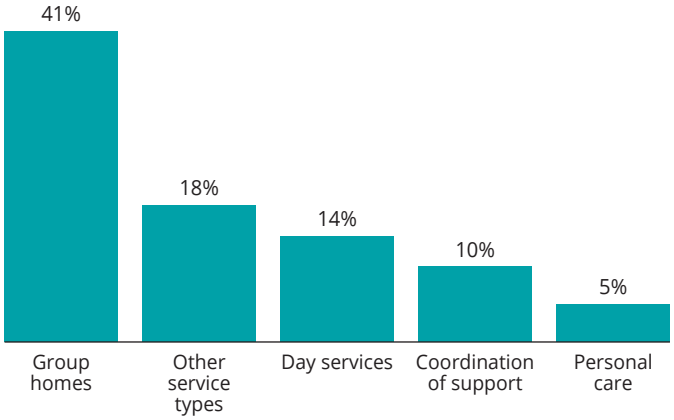


Figure 9: Top five issues raised for in-scope complaints*

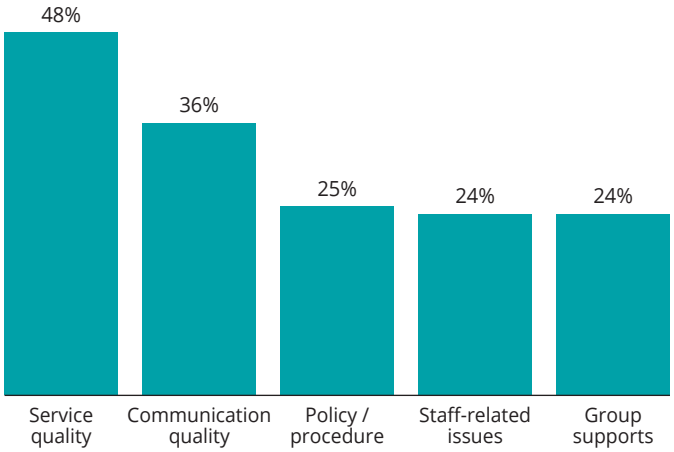


Figure 10: Breakdown of issues raised for in-scope complaints*

Service quality

Delivery 21%

Person-centred approach / communication and choice 15%

Support planning and implementation 14%

Well-being 13%

Communication quality

Information provision 20%

Responsiveness 17%

Policy / procedure

Fees and charges 9%

Incident/s management 7%

Cessation of services 5%

Staff-related issues

Behaviour / attitude 14%

Knowledge / skill 6%

Alleged assault / abuse 6%

Group supports

Management of risks and safety 14%

Impact on individuals 12%

Alleged assault / abuse by person with disability 5%

**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Figure 11: Resolution rates for in-scope complaints*

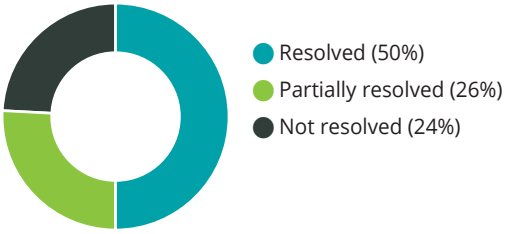


Figure 12: Top ways in-scope complaints are resolved*

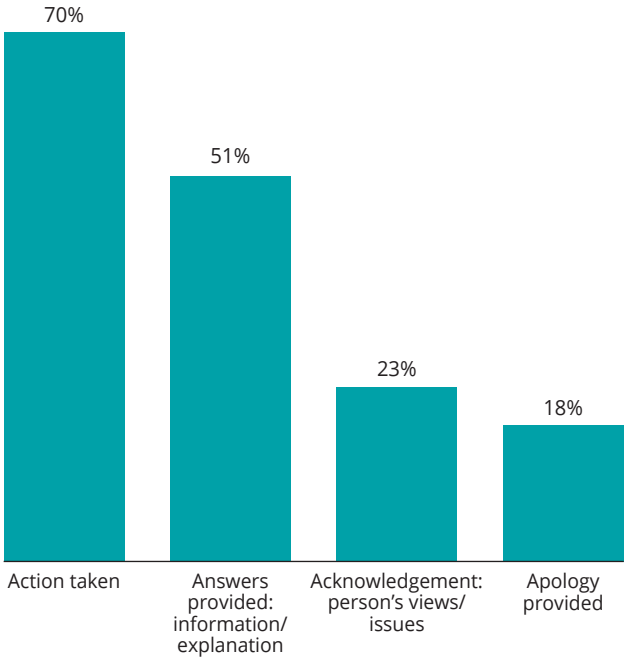


Table 3: Top ways in-scope complaints are resolved – breakdown by Four As as indicated on Resolve*

Action Taken	
Agreement reached on actions	19%
Change to way in which support/service provided	14%
Meetings/reviews arranged by provider with service user/ participant	13%
Service provider investigation undertaken/ to be undertaken about incident/issues.	12%
Communication issues addressed/misunderstandings resolved	10%
DSC advice/suggestions on ways to resolve	10%
Policy/procedural change proposed or made	8%
Support plan/person centred plan to be developed/reviewed	5%
Training/input provided to staff	5%
Independent assessment or opinion sought/obtained	5%
Reimbursment/waiver or reduction of fees/ compensation – in kind or monetary	5%
Answers provided: information/explanations	
Answers provided including information or explanations	51%
Acknowledgement: person's views/issues	
Acknowledgement of person's views/issues	23%
Apology provided	
Apology provided	18%

**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Appendices

Appendix 2: Incident report data

Figure 13: Incident reports on deaths, alleged assaults, injuries and poor quality of care*

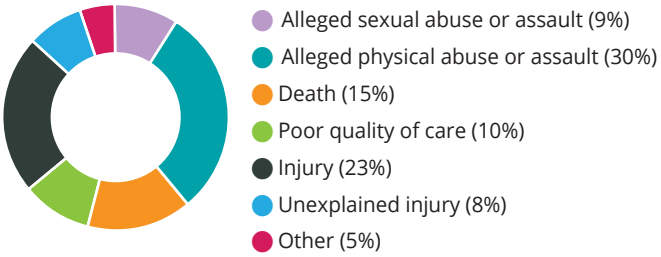


Figure 14: Gender profile of incident reports*

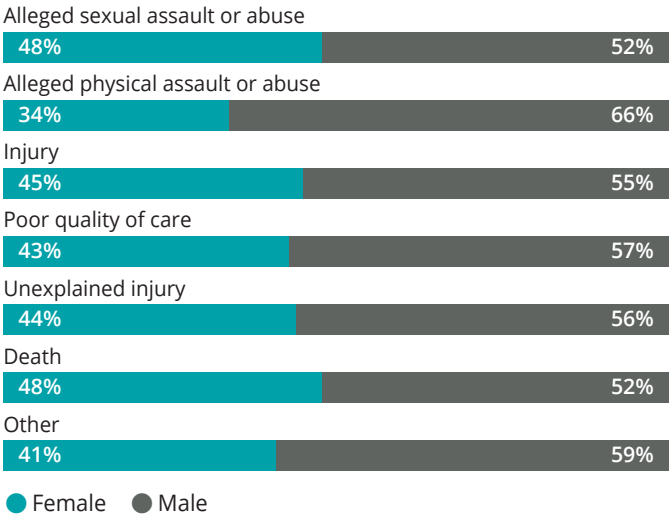


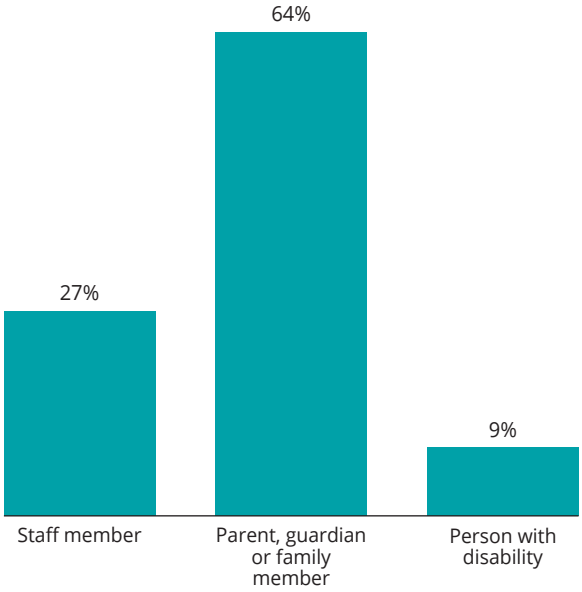
Table 4: Incidents relating to alleged physical or sexual assault*

	2017–18	2018–19
Alleged sexual assault or abuse		
Client to client	29%	**38%**
Client to other	6%	**4%**
Client to staff	2%	**1%**
Other to client	41%	**19%**
Staff to client	22%	**38%**
Alleged physical assault or abuse		
Client to client	16%	**15%**
Client to other	3%	**2%**
Client to staff	11%	**4%**
Other to client	12%	**8%**
Staff to client	58%	**71%**

**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Appendix 3: Investigations data

Figure 15: Top three sources of complaints that were investigated*



Appendix 4: Annual Complaints Reporting Data

The following figures reflect information arising from complaints reported to us by disability service providers through the ACR process. Some results look similar to our own data, while others help highlight the difference between the types of complaints brought to our office compared to those directly raised with a person's service provider

Figure 16: Top five sources of enquiries and complaints reported by service providers*

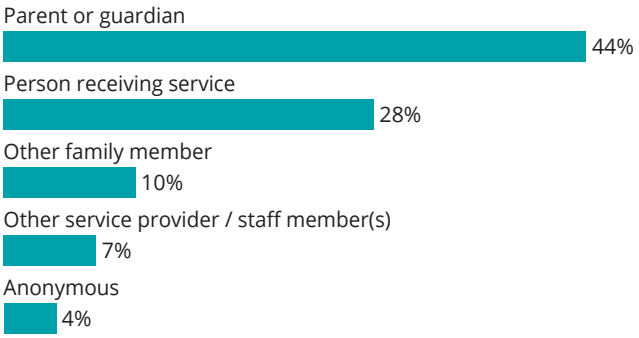
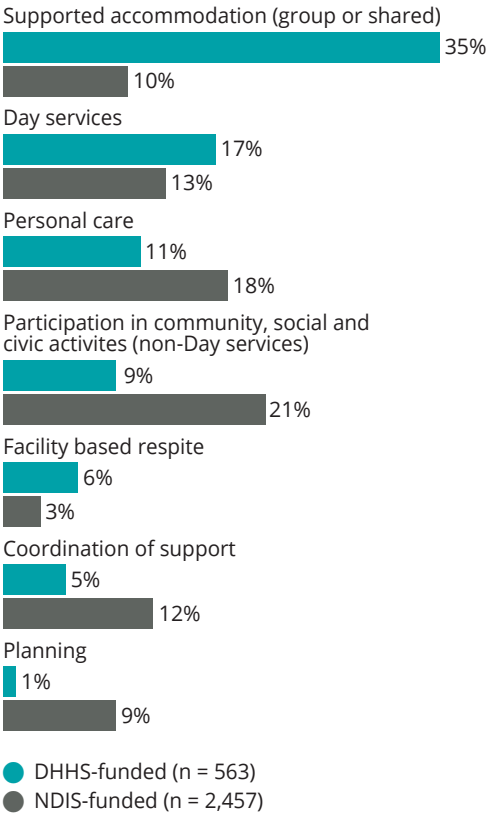


Figure 17: Reported complaints by service type and funding program*



**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Appendices

Figure 18: Top issues raised in ACR reported complaints*

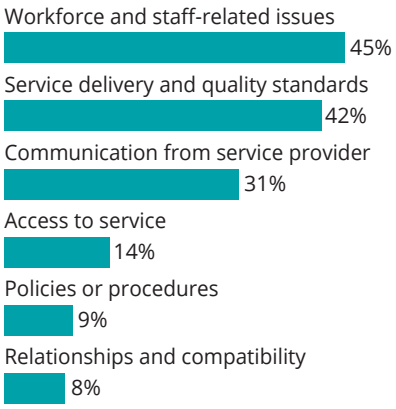
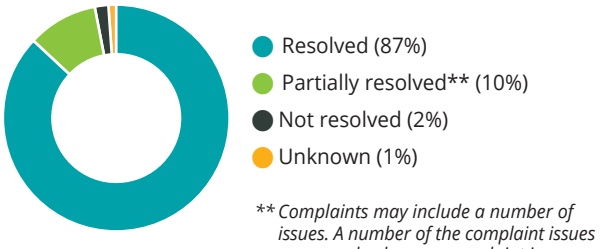


Figure 19: Resolution rates for reported complaints*



*** Complaints may include a number of issues. A number of the complaint issues were resolved; some complaint issues were not able to be resolved.*

Figure 20: Systems or organisation changes made as a result of the complaint*

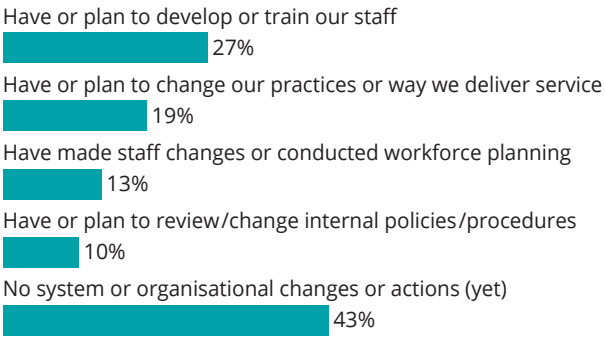


Table 5: Issues and sub-issues raised in ACR reported complaints*

Workforce and staff-related issues	**45%**
Staff behaviour and attitude	21%
Knowledge and skill of workers	12%
High turnover of workers or staff rostering / attendance	10%
Poor match between person and workers	5%
Discrimination, abuse, neglect, intimidation, assault or bullying	3%
Other staff-related issues	3%
Service quality	**42%**
Dissatisfaction with quality of service provided	23%
Perception of insufficient service or support provided	12%
Physical and psychological health and safety	9%
Lack of choice of service	3%
Other service delivery, quality or standards issues	3%
Communication from service provider	**31%**
Insufficient communication	19%
Poor quality communication	13%
Other communication issues	3%
Service access, access priority or compatibility	**14%**
Wait time to access services	5%
Cost of service or funding issues	4%
Transport issues	2%
Other service issues	3%
Policy or procedures	**9%**
Concerns about policy or procedures	4%
Complaints handling	2%
Privacy or confidentiality breach	2%
Other policy or procedure issues	2%
Relationships and compatibility	**8%**
Poor relationship or incompatible with other people accessing service	4%
Discrimination, abuse, neglect, intimidation, assault or bullying from other people accessing service	2%
Other relationship or compatibility issues	2%
Other	**4%**

**As multiple issues are possible in an enquiry / complaint, the total percentages may not equal 100%. In addition, issues with less than 5% have been excluded.*

Appendix 5: Operations

Financial statement for the year ended 30 June 2019

The Department of Health and Human Services (DHHS) provides financial services to Disability Services Commissioner (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 2018–19 is provided below.

Operating statement for the year ended 30 June 2019

Expenses from continuing activities

Salaries	$ 4,134,007
Salary On-costs	$ 549,760
Supplies and consumables	$ 581,641
Indirect expenses *(includes depreciation and long-service leave)*	$ 92,135
Total expenses	**$ 5,357,543**

Staffing for the year ended 30 June 2019

39 full-time equivalent (FTE)

53 staff positions

Appendix 6: 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.

DSC's privacy policy <http://www.odsc.vic.gov.au> explains how we deal with personal and health information.

Freedom of Information Act 1982

Victoria's *Freedom of Information Act 1982* (FOI Act) allows the public a right of access to information held by the Disability Services Commissioner subject to certain exemptions. In 2018–19, DSC received seven requests under the FOI Act.

Applications for access to information can be made in writing to:

Freedom of Information Officer
Disability Services Commissioner
Level 20, 570 Bourke Street
Melbourne VIC 3000

Email: odsc.foi@odsc.vic.gov.au

Our website <http://www.odsc.vic.gov.au> has more information about this process.

Charter of Human Rights and Responsibilities Act 2006

The *Charter of Human Rights and Responsibilities Act 2006* sets out the basic rights, freedoms and responsibilities of all people in Victoria. It requires all public authorities, including the Disability Services Commissioner, to act consistently with the human rights in the Charter.

DSC complies with the legislative requirements outlined in the Charter and uses a human rights approach when dealing with enquiries and complaints, conducting reviews and investigations, and delivering education and information to the sector.

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 3001

Phone: 1300 735 135

Fax: (03) 8635 4444

Email: info@ibac.vic.gov.au

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