Disability Services Commissioner

Annual Report 2023-2024

It's OK to complain

Disability Services Commissioner

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The Disability Services Commissioner is an independent oversight body resolving complaints and promoting the right of Victorians with disability to be free from violence, abuse, neglect and exploitation.

We acknowledge the Traditional Owners of country throughout Australia and recognise their continuing connection to land, waters and culture. We pay our respects to their Elders past and present.

This document is available in PDF and RTF formats on our website.

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Disability Services Commissioner

5 September 2024

Hon Lizzie Blandthorn MP
Deputy Leader of the Government in the Legislative Council
Minister for Children
Minister for Disability
Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Minister,
I am pleased to present the Disability Services Commissioner's annual report for the year ending 30 June 2024.

The annual report includes reporting pursuant to s19 of the *Disability Act* 2006 and a report on any matters my office has inquired into or investigated in relation to the provision of services (including abuse and neglect) identified in the Ministerial Referral from May 2023.

Yours sincerely,

J Jackson-Hall

Jen Jackson-Hall
Disability Services Commissioner

Disability Services Commissioner

L30, 570 Bourke Street
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Message from the Commissioner

It is an honour to present my first report as the Governor in Council appointed Disability Services Commissioner in Victoria.

We continued during 2023–2024, our 17th year, providing oversight of disability services delivered under the *Disability Act* 2006 (the Act). Our purpose, functions and powers are outlined in the Act. Although we now work with a small number of disability service providers, we continue to be driven by pursuing the best possible outcomes and service improvements for people with disability. We also continued the oversight role requested in the Ministerial Referral for 2023–2024.

Our jurisdiction includes a total of 154 services and was relatively unchanged during 2023–2024. It included 131 registered disability service providers. During the year there were seven new providers registered by the Department of Families, Fairness and Housing (DFFH) and 11 providers had their registration ceased. A further 37 providers had their registration ceased at the end of the year on 30 June 2024. Our jurisdiction also covered 23 disability advocacy agencies funded by DFFH. Two of those advocacy agencies merged this year.

It has been five years since the NDIS Quality and Safeguards Commission (NDIS Commission) commenced in Victoria, which marked the beginning of significant change and the reduction of the work of my office. We observed disability services transition to the National Disability Insurance Scheme (NDIS). We worked over this time to understand the challenges and successes of the remaining state funded disability services in the new context.

This year has seen the publication of the final report for both the Disability Royal Commission and the NDIS Review. In Victoria, significant project work was also undertaken to establish the Social Services Regulator (SSR) that commenced on 1 July 2024. These outcomes and developments have had a range of impacts on the disability community and have further changed the landscape for service delivery.

My office continued to communicate with DFFH and the Transport Accident Commission (TAC) as the funding bodies relevant to our jurisdiction. I thank Dan Stubbs, Victorian Disability Worker Commissioner, for working as a proactive co-regulator and for the positive and focussed way his team has worked with my office.

A similar pattern from recent years has continued, with many enquiries and complaints made to my office that are not in our jurisdiction or scope – that is, those we do not have the legislative authority to handle. We acknowledge the complexity for people with disability and their networks to find the right oversight body or complaint mechanism. Our aim has been to promote the concept of 'no wrong door' for complaints and we have worked consistently to make warm written referrals to the right place. I thank the other complaint bodies we work with for accepting our referrals and for responding to and resolving complex matters.

It was identified five years ago that our historic records would need to be archived. We worked with the Public Records Office of Victoria and Records Management Services within DFFH to ensure our operational records have been managed according to the relevant Record Disposal Schedules. All case records have been digitised.

I thank my team for their dedication, effort and flexibility during the year. They have shown enormous capacity to handle change and stay focussed on their tasks.

Jen Jackson-Hall

Disability Services Commissioner

The work of office of the Disability Services Commissioner (DSC)

Providing information and supporting people to get to the right place.

DSC's website and phone system are configured to prioritise connecting the public to the correct body, where possible, to address their complaint or find the information they require.

Our website assists with detailing information, links to other complaint bodies, and describes what is in-scope.

Our 1800 service assists callers with connecting to the agency that best suits their needs, if not DSC, with a self-select menu option.

This year there was a total of 46,431 views of our website, and a total of 2,019 calls to our 1800 service.

Of the 2,019 calls, 700 callers to our service selected the call transfer function as follows:

- 375 callers selected the NDIS Commission
- 166 callers selected the Disability Gateway
- 159 callers selected the Victorian Disability Worker Commission.

Enquiries logged

An enquiry is recorded by DSC when we have contact with a person who is seeking information or advice about their concerns or situation. This year we received 417 new enquiries compared to 403 the previous year.

When a matter raised is out-of-scope, we provide assistance with contact information for other safeguarding or complaints bodies who may help. We track the number of times we provide the details in such instances and this year we provided the contact details for other bodies 731 times. We often provide multiple contact details for an enquiry. These numbers show how complex it can be to navigate complaints systems.

There is a large variety of matters brought to DSC which are out-of-scope. This is due to people being unsure where to go and who to speak to about their concerns.

This year we recorded 94 instances where we encouraged a person to think about contacting a disability advocacy agency.

Where we have directed people to

*Table 1: Top three Commonwealth bodies we directed people to**

NDIS Quality and Safeguards Commission	112
National Disability Insurance Agency	46
Commonwealth Ombudsman	28

**Some enquiries involved directing people to more than one safeguarding body.*

*Table 2: Top three Victorian bodies we directed people to**

Victorian Equal Opportunity and Human Rights Commission	45
Victorian Ombudsman	40
Victorian Disability Worker Commission	25

**Some enquiries involved directing people to more than one safeguarding body.*

Case Study

The importance of answers

Peter* described a situation where his daughter, who lives with disability, had sustained an injury. It had been reported to Victoria Police and investigated by the NDIS funded service provider. He said he did not know what the outcome had been for the disability worker and was worried it had not been taken seriously enough. We directed Peter to the Victorian Disability Worker Commission.

* *For privacy purposes names and details have been changed.*

Complaints

Consistent with the Act and the Australian Standard for complaints handling, DSC defines a complaint as:

> ***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.***

We take complaints about a disability service which is defined in the Act. It means a service specifically for the support of persons with disability which is provided by a disability service provider.

This year we received a total of 69 new complaints in comparison to the previous year where we received 55 new complaints. From the 69 complaints we assessed that seven were in-scope and 62 were out-of-scope.

DSC carried over two complaints into this year to complete our assessment and resolution work.

Three complaints have been carried forward into 2024–2025.

Practice challenge:

Up-to-date complaints material

DSC encourages all organisations to review their complaints material for simplicity, accessibility, availability, and helpfulness.

- **Is the complaint procedure easy to locate and understand? People want to know what will happen.**
- **Is support offered to someone who wants to make a complaint? It can be frightening.**
- **Has training been given to staff? Workers with resources and confidence can resolve complaints.**

These documents assist the review of complaint material:

- **Social Services Regulator Guidance material – *Standard 4: Feedback and complaints.*** www.vic.gov.au/social-services-regulator-social-services-standards
- **DSC's publication *10 useful tips for an effective complaints policy and procedure.*** www.odsc.vic.gov.au/wp-content/uploads/Checklist_10_tips_for_complaints.pdf

Out-of-scope complaints that required referral to another body

From the 62 out-of-scope complaints received this year, a total of 71 warm written referrals were made. The previous year we made 53 warm written referrals. This year we made 20 referrals to the NDIS Commission compared with 22 the previous year.

*Table 3: Summary of written referrals made to other bodies**

NDIS Quality and Safeguards Commission	20
National Disability Insurance Agency (including fraud matters)	13
Department of Families, Fairness and Housing**	13
Transport Accident Commission	4
Victorian Disability Worker Commission	4
State Trustees	3
Community Visitor Program – Office of the Public Advocate	2
Home and Community Care – Department of Health	2
Health Complaints Commissioner	2
Advocacy service	1
Commonwealth Ombudsman	1
Consumer Affairs Victoria	1
Conference organiser	1
Health care provider	1
Chief Executive Officer of a disability service	1
Victorian Equal Opportunity and Human Rights Commission	1
Victoria Police	1
TOTAL	**71**

* *In some cases, more than one written referral may be required.*

** *DFFH referrals included to the Intensive Support Team and Victorians Ineligible for NDIS Program, Supported Residential Services unit in the Human Services Regulator, Homes Victoria and the performance Monitoring Team.*

Case Study:

Connecting with the right organisations

Anne* made a complaint to DSC. Harry,* Anne's brother is in his 20's and lives in country Victoria and has Supported Independent Living services. Harry is an Aboriginal person. He has autism and other disabilities. The State Trustees administer Harry's personal finances. Harry had made attempts to change his NDIS support coordinator but told his sister that no one was listening to him.

Anne was concerned around instances of abuse and neglect. She said Harry's NDIS funds were not being used to adequately meet his support needs. He was paying for items that she felt the house should provide. Anne explained that Harry requires support with personal care and medical appointments. He also requires support to enable him to participate in the community. Harry was spending most of his days playing video games and sleeping. She said Harry was no longer visiting her. Anne wondered if his workers were supporting him to reach his goals and meet his cultural needs. DSC consulted with several organisations about Anne's complaint. DSC made referrals to the NDIS Commission, the State Trustees and an advocacy agency.

** For privacy purposes names and details have been changed.*

Record keeping

The importance of keeping comprehensive records that enable people with disability to receive the care they require was highlighted in several of DSC's complaints, incident reviews, and death reviews completed in 2022–2023. This year DSC shared resources on reliable record keeping with providers to increase their skills and focus on this topic. We also shared the material with the TAC, DFFH and other complaint bodies.

In-scope complaints

DSC handled nine in-scope complaints this year, two of which were carried over from the previous year. The nine complaints were about TAC funded disability services, DFFH funded forensic services and disability advocacy.

How were complaints resolved through DSC's process

Resolution of a complaint is when the person who made the complaint (and the person receiving services) decide that the issues/s have been addressed.

We finalised seven in-scope complaints this year. Six complaints were resolved. In one complaint the complainant did not provide feedback on the answers and actions undertaken by the service, so this was recorded as not resolved.

Our approach to the resolution of complaints is person centred. This means we are flexible in our approach so we can respond to individual needs and consider what is both important to, and important for, the person receiving services. We coach both the service provider and the person with disability to identify ways to resolve the complaint. Coaching people with disability, can be empowering, and assists to develop self-advocacy skills.

The 4As of successful complaint resolution: Acknowledgement, Answer, Action, Apology were successfully utilised by service providers to resolve complaints. This year 86 per cent of complaints included an apology as an outcome. An apology has the power to ensure people feel heard, respected, and understood. A sincere apology can rebuild relationships and help re-establish confidence in service provision. Service providers apologised in ways that a complainant felt most valuable to them; for some that meant in person and for others it was in writing.

Due to the small number of complaints further analysis of outcomes is not covered in any more detail.

Case Study

The importance of support planning

As a result of a transport accident, Mateo* receives disability services funded by the TAC. Mateo is originally from South America and has no family in Australia. Mateo's Occupational Therapist contacted DSC to complain that his disability workers are not following his personal care routine and that on occasions he has sustained bruising which she said is consistent with incorrect hoisting. DSC arranged a call with Mateo using an interpreter. Mateo said that many of his disability workers are new, and they rush through his routine, especially in the evening. Mateo tried to explain what to do but due to language barriers, some workers are unable to meet his needs and preferences. Mateo said that sometimes he will refuse personal care.

DSC provided coaching relating to best practice support planning and responsive complaints handling to the service provider. The disability workers were provided with training on manual handling connected to Mateo's care. The support plan was updated to include photographs and information about what is important to and for Mateo. DSC sent a letter, in Spanish, to Mateo about the outcome of the complaint.

** For privacy purposes names and details have been changed.*

Practice challenge:

Support planning

The importance of providing support that encompasses the needs of the whole person (personal, physical, health, communication and cultural) has been identified in all areas of DSC's work. When services are proactive in their planning, it can prevent small issues becoming major, for people, their workers and providers.

Good support planning not only contributes to people feeling safe and respected, it also:

- actively engages the person receiving support in the development of the plan
- captures goals and strategies. It ensures that support enables the person to participate in their community (including diverse communities)
- records their needs and how they like their support provided
- is responsive and is updated when changes occur.

DSC encourages people, workers and service providers to deeply value support plans.

At the forefront of every person's plan should be the question: what is important to and for the person?

Ministerial Referral

In 2023–2024 the Ministerial Referral under section 128I(2) of the Act continued. The Ministerial Referral requests that DSC inquire into and, at the Commissioner's discretion, investigate matters including incidents of abuse, neglect and deaths of people accessing state funded disability services. The Ministerial Referral enables regulation across several statutory authorities including Office of the Public Advocate and the Coroners Court of Victoria.

We publish the referral on the DSC website: https://odsc.vic.gov.au/about-us/legislation/

Incident reports received

We inquired into incident reports received from DFFH including deaths (where the deceased was a person with a disability receiving services at the time of their death), major impact incidents of assault, injury and poor quality of care.

DSC received five new incident reports in this cycle, which was the same number as reported last year. All reports received this year related to incidents that took place within a forensic residential service. Four were categorised as physical abuse and one categorised as injury. There were no deaths reported in this period. All five incident report reviews were finalised and closed. Two incident reviews carried over from last year were closed when DSC was satisfied that appropriate action had been taken.

The review process included clarifying issues, seeking further information or documentation. DSC determined what actions needed to be taken to address the situation, and/or whether to investigate the matter.

This year the outcome of our involvement included:

- a resident's Support Plan being reviewed by the service provider
- a recommendation to engage with the DFFH complex coordination team
- requesting the service to review how they were respecting the role of family and culture
- the service provider leading the completion of a functional behaviour assessment
- reviewing material for residents to support them to make a complaint after an incident.

This year DSC also consulted with the Victorian Senior Practitioner, the Victorian Disability Worker Commission and Victoria Police in relation to matters that came to our attention under this referral.

The importance of complaints information for residents in forensic residential services

DSC met with, and provided recommendations to, a forensic residential service provider in Victoria about the complaint material it supplied to residents. Importantly, people who reside in a forensic residential service need to know how and when to make a complaint.

We requested that their material be consistent in its terminology, timeframes, and concepts and that it used easy English and provided pictorial information to support the resident's understanding of concepts. We recommended that residents be given the opportunity to meet with an advocate for support across the steps in the complaint resolution process.

To assist the development of the complaint material, we shared resources including those listed on page 5 of this report.

Deaths referred by the Coroners Court of Victoria (CCOV)

The death review case we carried over from last year was completed. The report contained findings related to communication with family, updating support plans and assessment and planning for people with complex communication needs. The service provider accepted all the findings in our report and responded to our Notice to Take Action by implementing a complex care project and corresponding tools including training for staff.

DSC received one referral from CCOV of a death. We consulted with DFFH to establish whether the person received DFFH funded disability services. The case was deemed to be out-of-scope.

In a continuation of our working relationship with CCOV, the court provided DSC with copies of its draft and final coronial investigation reports and finding into the deaths for four cases for our review and consideration. On several occasions throughout the year, we liaised with CCOV staff to provide information about the parameters of the Ministerial Referral and the scope of DSC's jurisdiction.

Matters of abuse and neglect referred by the Community Visitors Board

DSC did not receive any referrals from the Community Visitors Board this year. We communicated with the Community Visitors program manager regularly and discussed jurisdiction on several occasions.

DSC made two referrals to the Community Visitors program in relation to circumstances for residents who live in Specialist Disability Accommodation dwellings. Both were connected to services that had been in DSC's jurisdiction until 2021 when they transferred to be fully NDIS funded.

Education and information

This year, DSC continued to provide information to people with disability, families, advocates and the Victorian disability sector about the importance of speaking up as a means of improving disability services.

DSC continued to maintain strong working relationships with other safeguarding bodies, meeting regularly to discuss emerging issues and trends, and to ensure responsive communication between organisations. Our targeted communications also continued throughout the year.

Disability and Palliative Care Forum

The importance of listening to people with a disability who also have a life limiting condition together with the professionals working in the field was emphasised at the National Disability Services 'Disability and Palliative Care Forum'. The best ways to support people with end of life and palliative care planning and access to services was discussed.

DSC subsequently shared this information with CCOV and other stakeholders to ensure that they knew of the valuable information coming from this forum. The information was also shared as a news item on our website on: https://nds.org.au/resources/all-resources/palliative-care-life-limiting-illness-and-support-for-people-with-a-disability

Presented at VALID's Having a Say Conference

DSC was invited by the Victorian Disability Worker Commission to join with them as co-presenters of a workshop on the importance of Support Planning at the Having a Say Conference. The session, with people with disability and their disability workers, encouraged discussion about setting goals, defining what is important to a person and developing support practices to guide consistent high-quality support.

Attended Advocacy Agency Annual General Meetings

The Commissioner and team members attended the annual meetings for several of the Victorian funded advocacy agencies. This allowed us to appreciate the work undertaken by disability advocacy agencies and the wide range of projects they are involved in.

Promoted the Abuse and Neglect Hotline

The Final Report from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability identified that people were not aware of the National Abuse and Neglect Hotline. We encouraged service providers to promote the hotline to the people who access their services. We also shared information about the hotline in our newsletter and social media at: https://odsc.vic.gov.au/2023/11/24/do-you-know-about-the-national-disability-abuse-and-neglect-hotline/

Notices of Advice

DSC defines a Notice of Advice as:

A formal advice that we provide on any matter regarding complaints, investigations, and the prevention and response to abuse and neglect in disability services. These can be provided to disability service providers, complainants, the Minister and the Secretary of DFFH.

Notice of Advice regarding a complaints system

This year one Notice of Advice was issued to a service provider about the workings of their complaints system. All registered disability service providers are required under the Act to submit an Annual Complaints Report (ACR) each year in July. The Notice was issued to a provider due to problems identified in relation to how complaints were recorded and the reducing number of complaints in the service provider's complaints system. Our Notice requested that the organisation review the workings of its complaints recording system and specifically the handling of complaints from 1 July 2022 to 30 June 2023. Following the Notice, the organisation acknowledged DSC's concerns about the adequacy of its complaints handling and recording systems. The organisation then reviewed its complaints process and developed a complaints management policy and flowchart. It provided training to staff and implemented an oversight system to ensure that complaints were reviewed by management. The organisation also developed a 'lessons learned' staff meeting framework that enabled complaints to be reviewed and considered as part of its quality and continuous service improvement model. At the end of the process, the service management stated:

"We are committed to continuously improving our services and appreciate the guidance provided by the Disability Services Commissioner. The implementation of the actions identified in the review is already underway. We are focused on enhancing our complaints system and ensuring thorough completion of the Annual Complaints Report. Our team is dedicated to providing the best service possible, and this process has been invaluable in furthering our commitment to excellence."

Notice of Advice regarding information on how to complain

Last year DSC communicated with the biggest Specialist Disability Accommodation (SDA) provider in Victoria about the content of the complaint material attached to the SDA Residency Agreement they were using. It included both incorrect content and information that could be misleading to residents, families and administrators. This needed to be improved so that there is clear and direct information about how to make a complaint about an SDA service.

This year we reviewed the content of the complaints material and found that it had not been updated. We subsequently issued a Notice of Advice in relation to the SDA Residency Agreement which contained information about complaint pathways.

In March 2024, the provider explained that they had updated their complaints material. The information had been placed on their website with an 'Easy English' version of the Agreement. DSC is pleased that these SDA residents will now have access to the applicable complaints and organisational information and will know that 'It's OK to complain'.

Annual Complaints Reporting (ACR) from the sector

The Act outlines that all registered and regulated Victorian disability service providers must:

1. **Institute and operate a system to receive and resolve complaints about services provided**
2. **Provide an annual report to DSC on complaints received including number, type and outcomes of complaints**
3. **Take steps to ensure that there are no adverse effects on a person who has made a complaint, or a person with disability on whose behalf a complaint was made.**

This part of our report covers what disability service providers told us about the complaints made directly to them. The complaint information submitted to DSC through the ACR process was for disability services funded by DFFH or TAC. These complaints are not about NDIS services.

Which services needed to complete a report this year?

There were 145 providers included in the ACR data collection process. A small number of these providers hold more than one registration under the Act. Providers with registration for part of the cycle were still required to report for the part of the year they held registration.

What were the numbers reported?

DSC received a report from each of the 145 disability service providers.

This year 40 service providers (28 per cent of service providers required to report) submitted 195 in-scope complaints in total.

This data includes 88 complaints carried over from the previous year. Seventy-two per cent of service providers (or 105 providers) who submitted their reports indicated that they did not receive any in-scope complaints (known as a NIL report).

Half of the complaints reported were in relation to DFFH funded services, and the other half were in relation to TAC-funded services.

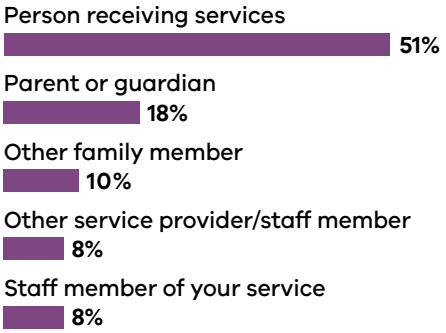
Reported in-scope complaints have been in decline over the previous three years:

- 2020–2021 with 460 complaints
- 2021–2022 with 335 complaints
- 2022–2023 with 235 complaints.

Who made complaints to their service provider?

The person receiving the service (51 per cent) and parents or guardians of the person receiving the service (18 per cent) were the most common sources of complaints in 2023–2024. The share of complaints made by the person receiving services has notably increased since 2019–2020 (from 28 per cent in 2019–20, 32 per cent in 2020–2021, 40 per cent in 2021–2022 and 48 per cent in 2022–2023).

Figure 1: Top five sources of complaints

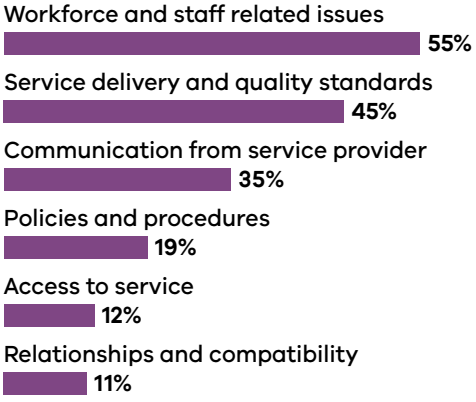


What type of services were the subject of complaints reported?

Thirty-one per cent of in-scope complaints reported in 2023–2024 were in relation to personal care, overtaking supported accommodation services (30 per cent of complaints) as the most common complaint service type. The proportion of complaints about supported accommodation services has significantly decreased following the transition of disability accommodation services to being fully NDIS funded (from 71 per cent in 2020–2021, down to 41 per cent in 2021–2022, and 25-30 per cent respectively in 2022–2023 and 2023–2024).

What were the issues in the complaints?

*Figure 2: Issues raised in complaints**



**Multiple responses are possible so figures may not add up to 100%.*

What outcomes were achieved from complaints and how were they resolved?

Like previous years, acknowledgement of the person's views or issues is the most frequent complaint outcome achieved in 2023–2024 across the 4As outcome categories (58 per cent).

*Table 4: Primary ways complaints were resolved using the 4As**

Acknowledgement of person's view or issue	58%
Action	48%
Communication issues addressed	23%
Disciplinary action or performance management of staff	19%
Change or appointment of worker	11%
Change to way in which support or service was provided	8%
Policy or procedural change proposed or made	5%
Answers provided – information or explanation	37%
Apology provided	30%

**Multiple responses are possible so figures may not add up to 100%.*

Practice challenge:

Good outcomes because of a complaint

DSC encourages disability services to consider the values that underpin how they respond to complaints.

We ask them how they show that they:

- Respect and value the knowledge, abilities and experiences of people with disability.
- Support people to make choices about their lives so that they can live the life they want to live.
- Act to achieve the best possible outcome for people with disability as an outcome of a complaint.

Reflections from service providers from complaints they handled

Within the ACR process disability service providers were asked what are the key lessons learnt from complaints?

The quotes below are a sample of answers provided:

"To explain some organisation limitations and include client in problem solving and provide options."

"Monitor the performance of staff."

"Better understanding of the resident's needs and implement practices that provide increased oversight and safeguards for vulnerable residents."

"Opportunities identified to improve the quality of care provided to vulnerable residents by agency staff."

Appendices

Appendix 1: Operations

Financial statement for the year ended 30 June 2024

DFFH provides financial services to DSC. The financial operations of DSC are consolidated into those of DFFH 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 2023–2024 is provided below.

Expenses	Amount
Salaries	$611,131
Supplies and consumables	$77,412
Contract staff costs	$33,000
Indirect expenses *(includes depreciation and long service leave expense gains or losses on revaluation)*	$16,414
Total expenses	**$737,957**

Staffing for the year ended 30 June 2024

Four VPS staff, 2.6 full-time equivalent (FTE) as at 30 June 2024.

Appendix 2: 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 is available at: www.odsc.vic.gov.au/about-us/privacypolicy/ and 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 DSC subject to certain exemptions. In 2023–2024, DSC did not receive any requests under the FOI Act.

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

Freedom of Information Officer
Disability Services Commissioner
Level 30, 570 Bourke Street
Naarm/Melbourne VIC 3000

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

Our website has more information about this process: www.odsc.vic.gov.au

***Charter of Human Rights and Responsibilities Act* 2006**

The *Charter of Human Rights and Responsibilities Act* 2006 (the Charter) sets out the basic rights, freedoms and responsibilities of all people in Victoria. It requires all public authorities, including DSC, 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

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: www.ibac.vic.gov.au

Disability Services Commissioner
Level 30, 570 Bourke Street
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1800 677 342 (free call from landlines)

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