Disability Services Commissioner

2018 annual report

Including *A review of disability service provision to people who have died 2017–18*

Disability Services Commissioner
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Disability Services Commissioner

1 August 2018

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

Dear Minister,

Pursuant to s. 19 of the *Disability Act 2006*, I am pleased to provide you with the annual report for the Disability Services Commissioner for the financial year 2017–18.

As requested by your referral in September 2017, this year's report also includes our first *Annual review of disability service provision to people who have died 2017–18*.

Yours sincerely,

Dr Lynne Coulson Barr
Acting 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 of the cases to protect the identity of the people to whom they refer.

Abbreviations, acronyms and definitions

ACR	Annual Complaints Reporting
assessment	The initial stage after a person has made a complaint and we have determined that the issues are within scope. We have 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 contacts us 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
CCIM	Critical Client Incident Management
CIMS	Client Incident Management System
CVB	Community Visitors Board
DHHS	Department of Health and Human Services
DSS	Commonwealth Department of Social Services
disability services	As defined in s.3 of the Act. It means a service specifically for the support of persons with a disability which 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 who has entered into a contract with the Secretary of DHHS under s.10 of the Act to provide services to a person with a disability • 'funded service provider' means a person who provide services to a person with a disability; and receives funding from the Secretary of DHHS under s.9 of the Act for the purpose of providing those services • 'prescribed service provider' means a person who provides services to a person with a disability specifically for the support of that person; and who is specifically declared as a 'prescribed service provider' for the purposes of the Act
finalised	A matter that has been completed or closed
incident reports	Matters referred to us from DHHS as per the referral from the Minister
in scope	Matters that we have the authority to handle
justified	Justified means that the information and evidence we received confirmed there was merit in raising, investigating and addressing the issue
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
Notices of Advice	Advice that we provide on any matter regarding complaints, accountability investigations, and the prevention and response to abuse and neglect in disability services. These can be provided to disability service providers, the Minister and the Secretary to DHHS
Notice to Take Action	A notice that we have issued to a disability service provider after an investigation. This notice specifies actions that the disability service provider is required to undertake to resolve issues identified during the investigation
open	A matter still active or in progress
out of scope	Matters that we do not have the authority to handle
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 incident
referrals	Matters referred to us from a variety of sources including the Minister, the Secretary to DHHS, State Coroner or the Community Visitors Board
service providers	See 'disability service providers'
shared supported accommodation	A type of accommodation that provides housing and support services for people with a disability. This is typically in the community in a group home where rostered staff are available to provide care and support to people with disability who reside there. DHHS and non-government organisations manage shared supported accommodation
the Act	*Disability Act 2006*
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
the Minister	Minister for Housing, Disability and Ageing
the Secretary	The Secretary of DHHS

Message from the Disability Services Commissioner

As we progress towards the full rollout of the National Disability Insurance Scheme (NDIS), now more than ever the disability sector needs to ensure that the voices of people with a disability are heard, and that effective safeguards are in place to uphold people's rights.

Strengthening Victorian safeguards for the rights of people with a disability

In August 2017, the Victorian Government passed the *Disability Amendment Act 2017* which further strengthened safeguarding arrangements for disability services funded under the *Disability Act 2006* (the Act).

Developed in response to recommendations arising from the Parliament of Victoria's Inquiry into Abuse in Disability Services, the changes to the Act resulted in an expansion of the powers my office has to provide oversight of Victorian disability services. These expanded powers include the ability to initiate an investigation, on either an individual or systemic level, where we believe abuse and neglect may be occurring. The powers also include the ability to initiate an investigation into a matter arising from a referral to our office, the authority to conduct unannounced site inspections of disability services as part of an investigation, and providing advice to the sector on better responding to and preventing abuse and neglect. Examples of how we have been able to use these expanded powers are outlined in this report.

In addition to the above, at the request of the Minister for Housing, Disability and Ageing (the Minister), my office's review of major impact incident reports has been expanded to include inquiring into and, at my discretion, investigating the provision of supports to people who have died while in receipt of disability services. While focusing on person-centred supports and giving people control and choice over their supports is commendable, people's right to be supported in ways that maximise their wellbeing and safety is the foundation for all other supports. Our work in this area has identified significant areas of concern, and is captured in our inaugural *Annual review of disability service provision to people who have died 2017–18*, which forms part of this report.

While the introduction of the electronic Client Incident Management System (CIMS) by the Department of Health and Human Services (DHHS) is also to be commended, implementation issues arising from the change have led to delays and gaps in information from incident reports being provided to our office. This has had a correlating impact on our ability to provide timely and effective oversight of critical incidents. Our office will continue to work with DHHS to resolve these issues so that the intended level of safeguarding exists for people with disability.

Establishment of the NDIS Quality and Safeguards Commission

The establishment of the NDIS Quality and Safeguards Commission (the Commission) is a critical element of the rollout of the NDIS. While 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.

Throughout 2017–18, my office provided significant input into the work undertaken by the Commonwealth Department of Social Services (DSS) in establishing the new Commission. Drawing on the knowledge and experience we have gained over the past 11 years, we reviewed and contributed to the development of the new Commission's approach to complaint resolution, investigations, incident review, data collection and expectations of disability service providers and their approach to complaints management.

We look forward to working with the Commission in preparation for the transition of Victorian safeguarding arrangements to that office in July 2019.

Reflections

As I have often said, I consider the opportunity to have been Disability Services Commissioner a privilege and an opportunity to make a positive difference in the lives of some of the most vulnerable people in our community. As such, it is with mixed emotions that I have decided to retire from the role effective as of July 2018.

I am proud of our office's achievements over the past 11 years. Long before the NDIS introduced the concept of choice and control, our office helped to ensure that the voices of people with a disability were heard by their disability service provider. This is confirmed by the growth in enquiries and complaints to my office from 311 in 2007–08 to 1,482 this year.

Similarly, our work with disability service providers has led to a more positive, transparent approach to their handling and reporting of complaints, increasing from 992 in 2007–08 to 2,919 in 2017–18. I acknowledge the commitment of service providers in responding positively to feedback from people with disability, their families and other key supports, and my office.

In closing, I thank those Members of Parliament who have served as Minister responsible for disability services, and for their support of our work over the years.

I thank the Hon. Martin Foley, Minister for Housing, Disability and Ageing, as well as Georgina Frost, President of the Disability Services Board, and the other board members, for their continued support of our work. I acknowledge and express my appreciation to Dr Lynne Coulson Barr for the time she acted as Commissioner while I was on leave. I congratulate Miranda Bruyniks on her appointment as Complaints Commissioner with the NDIS Quality and Safeguards Commission, and thank her for her service as Deputy Commissioner for some three-and-a-half years. I also thank all of the staff who have contributed to the work of the office over the past 11 years.

The disability sector is at a pivotal point in its history. There are many opportunities and challenges ahead. I leave confident in the knowledge that there are many committed people across the sector, and that there are increasingly effective safeguards in place to promote and protect the rights and wellbeing of the people with a disability who it is our privilege to serve.

Laurie Harkin AM
Disability Services Commissioner

30 June 2018

From the President of the Disability Services Board

The Disability Services Board met bimonthly to consider the issues facing people with disability and the wider sector, particularly as they transition to the National Disability Insurance Scheme (NDIS).

This year, the board provided valuable insight into the various quality and safeguarding issues needing consideration to prepare for Victoria's transition from the Disability Services Commissioner to the NDIS Quality and Safeguards Commission in July 2019.

In performing its role, the board consulted with various stakeholders including the Office of the Public Advocate, the Department of Premier and Cabinet, the Victorian Disability Advisory Council, the Victorian Advocacy League for Individuals with Disability, the Department of Health and Human Services and National Disability Services.

On behalf of the board, I would like to thank Laurie Harkin AM and wish him well on his retirement from the role of Disability Services Commissioner.

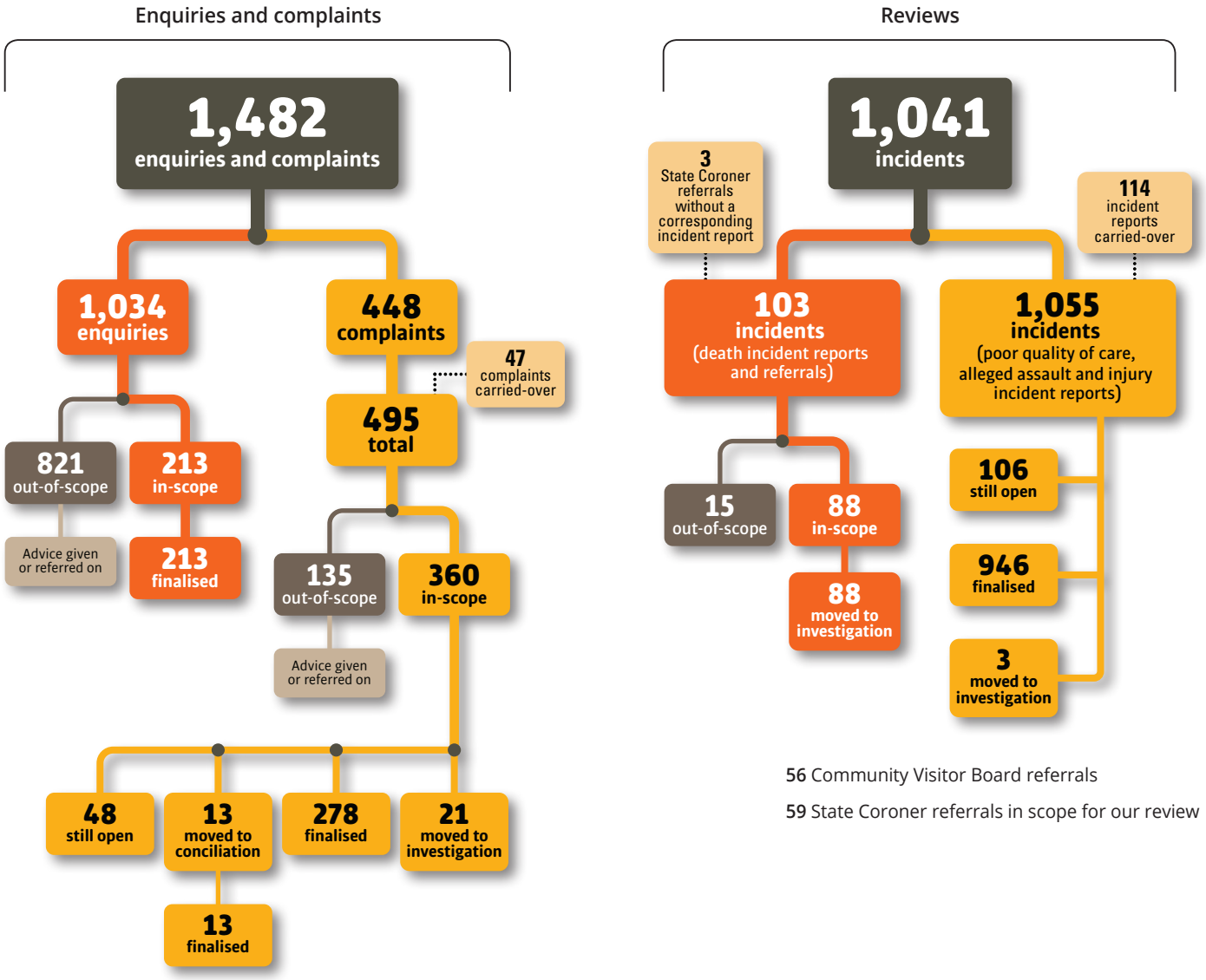
Laurie's prodigious knowledge and understanding of the disability sector has guided the board's discussions and work since its establishment in 2008. Over the past 10 years, the board has worked collaboratively with Laurie and his office to improve the lives of Victorians with a disability. We have witnessed the success of campaigns to pursue transparency when dealing with abuse of Victorians with a disability, to help people find their voice, and to understand that it is 'OK to complain' when it comes to disability services and supports.

Georgina Frost
President

Members

- Georgina Frost (President)
- Christian Astourian
- Chris Asquini
- Karen Cusack
- Glenn Foard
- Helen Kostiuk
- Jill Linklater
- Rocca Salcedo Mesa
- Llewlleyn Prain
- Dr Ruth Webber
- Bryan Woodford OAM

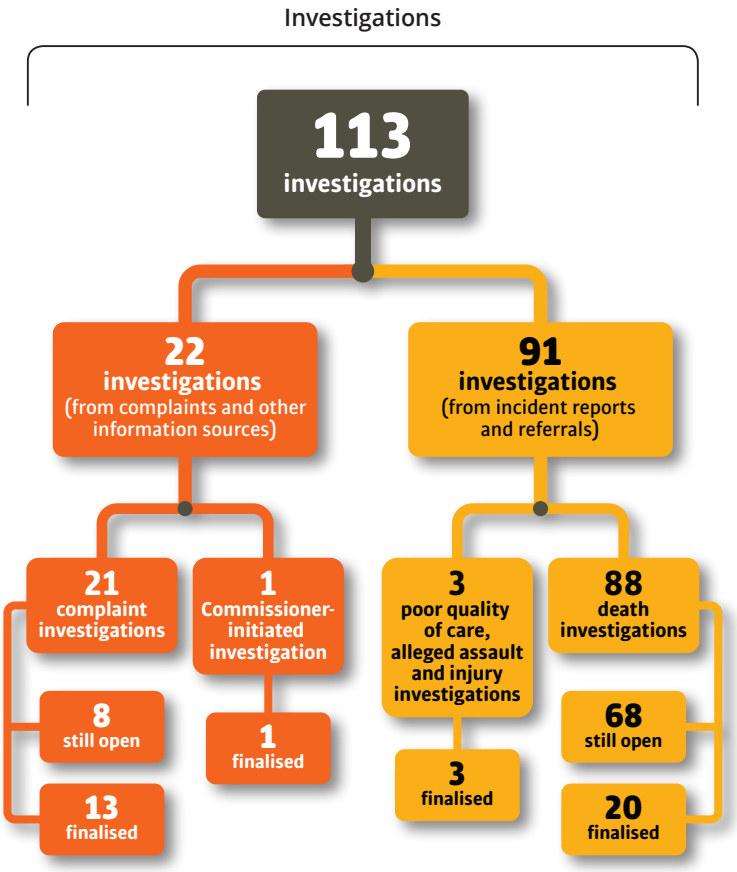
Our year in summary



56 Community Visitor Board referrals

59 State Coroner referrals in scope for our review

Highlights from 2017–18



4 inspections of disability service premises conducted by Authorised Officers

18 Notices to Take Action issued

56 referrals from the Community Visitor Board

59 referrals from the State Coroner in scope for our review

120 presentations or information sessions

2,919 complaints reported by service providers in Annual Complaints Reporting data

4,525 people reached through education and information activities

Enquiries and complaints

We support people with disability and their families to raise their concerns about the services provided by disability service providers. As part of this, one of our core functions is dealing with enquiries and complaints.

Resolving enquiries sometimes involves providing advice and coaching to people to give them the confidence to address issues directly with their provider.

When we respond to complaints, we do what we can to make it easier for people to speak up and get a good outcome. Once we receive a complaint, we assess it, and engage with the person making the complaint and their service provider to identify the best way to address concerns.

Most complaints are resolved at this initial assessment stage.

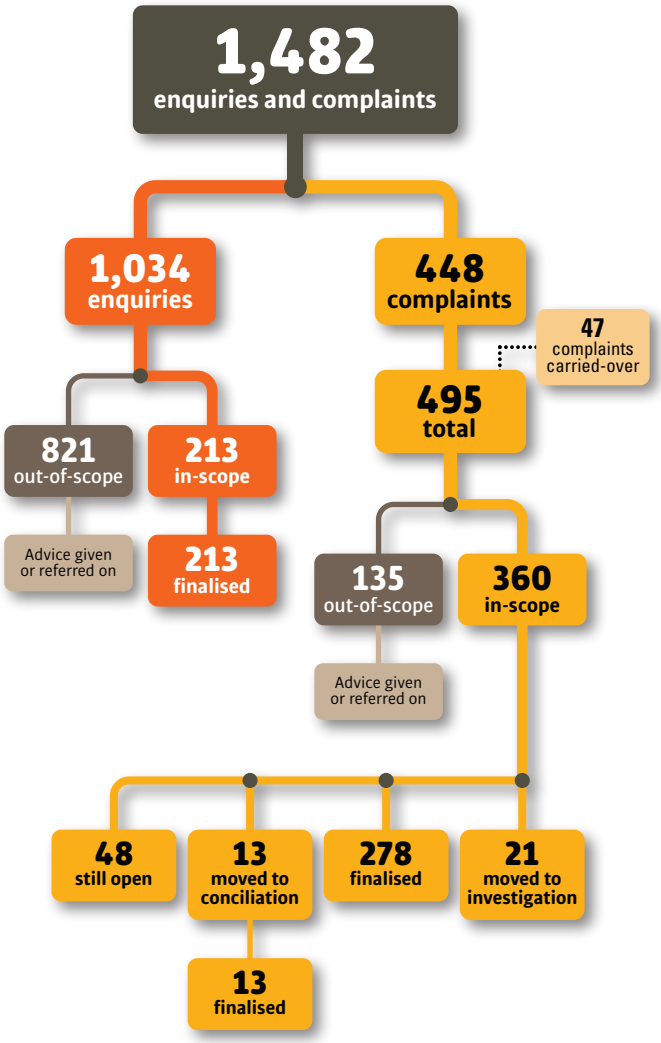
In some cases, we work with the parties involved via conciliation to ensure that people feel heard, and to facilitate outcomes.

In other cases, where conciliation is not appropriate or it has failed, we may undertake investigations. This includes when:

- there is a risk to a person, such as abuse or neglect, that could not be addressed during the assessment stage
- there is an inappropriate response to an identified risk (see p. 20).

Sometimes, we cannot help with a complaint because it is outside the scope of our legislated authority. In these instances, we have a 'no wrong door' philosophy, which means we provide people with information about who can help them. Sometimes, we make referrals directly to the appropriate agency.

Figure 1: Year at a glance – enquiries and complaints



In-scope: *matters that we have the authority to handle.*
Out-of-scope: *matters that we do not have the authority to handle.*

Figure 2: Total number of enquiries and complaints by year

Note: carry-over not included.

Who and how we help

2017–18 was our busiest year yet.

Figure 2 shows that the number of new complaints and enquiries we received increased by 26 per cent from last year. This reaffirms the need that people with a disability, family, friends, carers and staff have for advice, information and complaints resolution to assist in having their concerns addressed.

Within this, new complaints to our office increased by 76 per cent, while enquiries increased by 12 per cent.

The proportions of new in and out-of-scope and complaints are shown in Figure 3. Proportionately, they have not changed dramatically from the previous year.

However, the actual number of out-of-scope enquiries and complaints has increased. We received 821 out-of-scope enquiries, an increase of 175. We also received 135 out-of-scope complaints – an increase of 117 (see Figure 4).

The increase in out-of-scope enquiries and complaints reinforces the need for information or referral services during periods of significant change. This is especially so as the NDIS rolls out, and other changes to the disability services sector take place.

Who contacts us

Just over one-quarter of those who contacted us for in-scope enquiries and complaints throughout the year were people with disability or service users.

The important role that families play in supporting and safeguarding people with disability is reinforced by the fact that 55 per cent of the people who contacted us with concerns were a parent, guardian or family member (see Figure 5).

Service providers and staff members also play an important role in safeguarding people's rights. They raised a combined 18 per cent of the enquiries and complaints brought to our office.

Figure 3: Overall proportion of in and out-of-scope enquiries and complaints

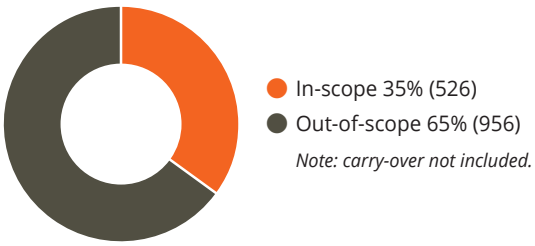


Figure 4: Proportion of in and out-of-scope enquiries and complaints

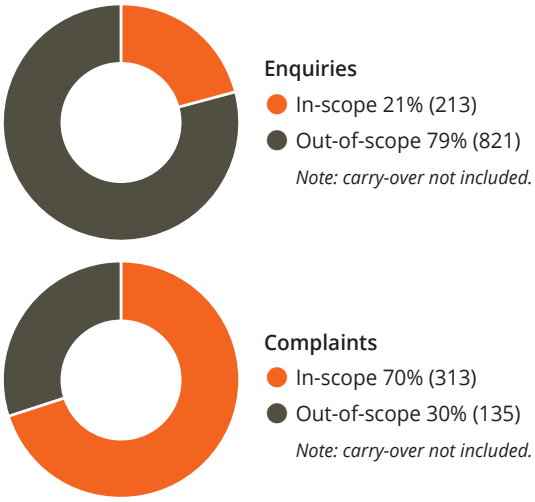
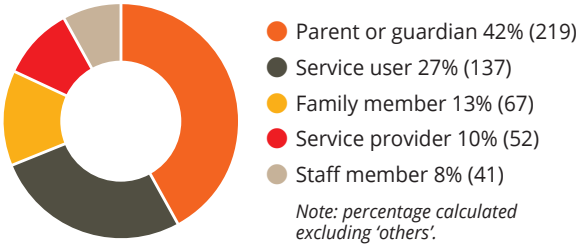


Figure 5: Top five sources of all in-scope enquiries and complaints



Enquiries and complaints

What people's concerns are

Most frequently, the complaints we received were about services provided to people with an intellectual disability at 53 per cent (see Figure 6).

When people contacted us, the most common disability service types they were concerned about were shared supported accommodation (49 per cent) and day services (14 per cent). The progressive rollout of the NDIS across Victoria has seen enquiries and complaints about support coordination and case management rise from 6 per cent last year to 10 per cent this year (see Figure 7).

Service quality remains the main issue of concern for most people.

A total of 57 per cent of in-scope complaints related to concerns about the quality of services provided to people with a disability. People also frequently raised concerns about the quality of communication that they received from service providers (42 per cent) (see Figure 8).

More specifically, people sought our help about how information is provided (26 per cent); whether communications and the services provided are person centred (24 per cent); and the behaviour and attitudes of staff (20 per cent) (see Figure 9).

Concerns about the NDIS

More people contacted us about the NDIS this year.

There were 480 enquiries and complaints related to the NDIS, compared with 124 the year before. This is a 287 per cent increase, and the pattern aligns with the increasing number of Victorians entering the scheme.

Some of the NDIS enquiries and complaints we receive are outside the scope of our work. For example, we cannot assist with complaints relating to the outcome of an NDIS plan.

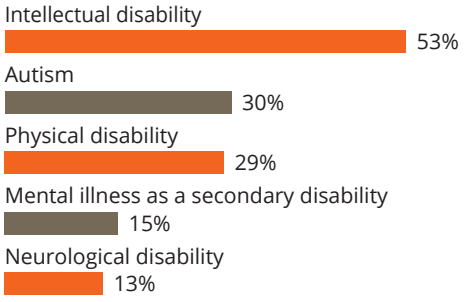
The higher number of out-of-scope enquiries (67 per cent) compared with last year emphasises the complexity of existing complaints systems for NDIS supports and services. It provides a strong case for improving NDIS participants' knowledge of how to speak up at all stages of their NDIS journey (see Figure 10 on p. 14).

We worked with the National Disability Insurance Agency (NDIA) during the year to address this through community information sessions (see p. 28).

We will continue to work with the NDIA and the NDIS Quality and Safeguards Commission to ensure that people are provided with information and assistance for making complaints about services and supports under the NDIS.

287% **increase in NDIS-related enquiries and complaints from the previous year**

Figure 6: Top five disability types of services subject to in-scope enquiries and complaints



Note: percentage calculated excluding 'unknown'. More than one disability type may be selected.

Figure 7: Top five service types raised for in-scope enquiries and complaints

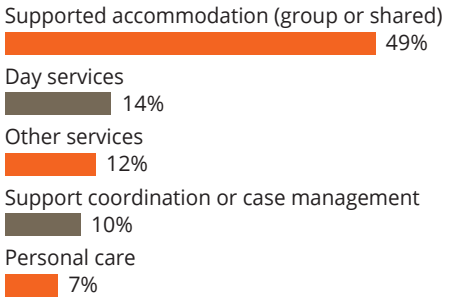
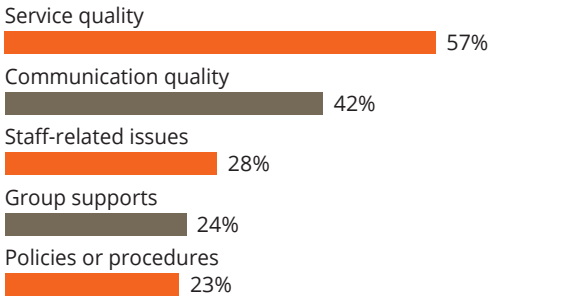


Figure 8: Top five issues raised for in-scope complaints



Note: more than one type of issue may be selected.

How we respond

Our resolution rates are based on feedback from the person who raised the complaint.

Our rate for fully resolving in-scope complaints increased five per cent from last year (see Figure 11 on p. 14).

This year, a slightly larger proportion of complaints were considered 'not resolved' by the person raising the complaint. Reasons for this include the complexity of the issues raised, and the interpersonal dynamics of the parties involved. We continue to review our practices in line with the changing nature of the issues raised.

Time taken to respond

Our experience tells us that a timely response to complaints is more likely to result in a positive outcome.

Despite the significant increase in the number of complaints we received this year, our average time (45.4 days) for assessing a complaint remains well under the 90 days required under the Act.

Where we believe the issues raised are not suitable for resolution in the initial assessment phase of the complaint process, we may decide to deal with the complaint via conciliation or investigation.

The average number of days to assess a complaint and decide to conciliate decreased to 44.8 days from 65 days previously.

The days taken to assess a complaint and decide to investigate increased slightly to 23.5 days from 21 days previously. This is despite a significant increase in case load.

Actions arising out of complaints

We resolve many complaints by working with people with a disability and service providers during the assessment stage of our process.

To help parties come to an agreement about an outcome, we use the four As:

- acknowledgment
- answers
- actions
- apology.

When a service provider agrees to actions arising out of a complaint, we ask them to advise us when they are completed.

In 2017–18, we requested 47 service providers report back to us on completed actions before we closed a complaint.

If we identify specific actions that disability service providers should complete to ensure that people receiving services obtain quality outcomes, we issue a Notice of Advice.

In 2017–18, we issued 16 Notices of Advice to service providers about matters arising from complaints.

We formally request that service providers who are issued a Notice of Advice report back to us about the actions they have completed.

Figure 12 (see p. 14) shows the top six ways we resolved in-scope complaints in 2017–18.

Figure 9: Sub-issues raised for in-scope complaints

Note: more than one issue may be selected.

Enquiries and complaints

Feedback from people about our service

We always request feedback from people involved in our complaints process.

The majority of people advised us they were satisfied with the process we conducted.

People told us the following:

'Your support made a big difference. I think we will be able to work together if issues arise.'

'I felt both heard and understood.'

'Grateful to have your service. People can actually get results.'

'The outcome was good. Your staff handled the issue with care.'

'It was a very thorough process. We were kept updated on progress.'

We use feedback on improvements to improve our practice. This year, based on the feedback we received, we were more proactive in following up with service providers to ensure that they informed us when planned, agreed actions were completed.

45.4 average number of days in assessment

44.8 average number of days before deciding to conciliate

23.5 average number of days before deciding to investigate

16 Notices of Advice sent

Figure 10: Percentage of in and out-of-scope new NDIS enquiries and complaints

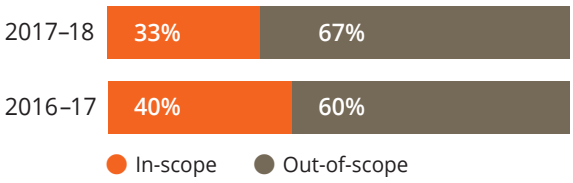


Figure 11: Resolution rates for in-scope complaints

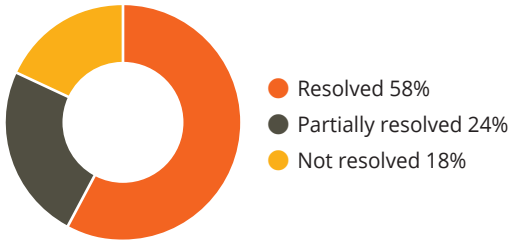
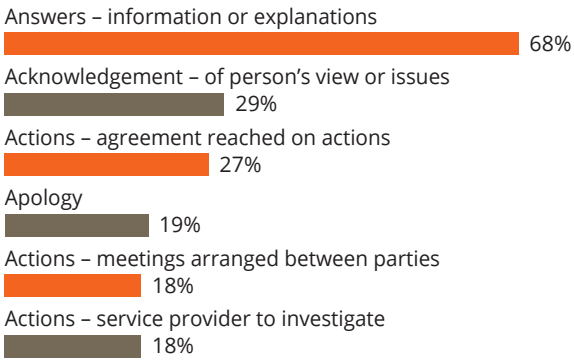


Figure 12: Top six ways in-scope complaints are resolved using the four As



Note: more than one method may be selected.

Case study:

Resolving a communication breakdown through conciliation

Amira* lives in a group home in rural Victoria. Amira does not communicate verbally.

One of Amira's sisters contacted us to discuss her concerns. She was worried about how the service was supporting Amira. In particular she was concerned about:

- Amira's therapist being in Bendigo, a long way away
- the impact on Amira when staff provided her with inconsistent messages about why family members were unable to visit as agreed
- the service provider not ensuring that she and her siblings knew what was happening in Amira's life.

After receiving permission to speak with the service, we spoke with both parties. Everyone said they wanted the best outcome for Amira. They told us they had unsuccessfully tried to resolve things together in the past.

We were not concerned about Amira's safety, but it was clear that her family was very important to her. We were worried that a further breakdown in communication would affect Amira's access to family support and her overall wellbeing.

We brought the family and service provider together for a conciliation where they agreed to:

- develop a communication plan that included details of who to speak about key issues
- meet regularly over two months to confirm Amira's supports, including her access to therapy.

In the meeting, Amira's brother also told us that he did not understand how Amira's money was being spent. The service agreed to provide clearer documentation of Amira's personal expenses and a breakdown of her NDIS expenditure.

Amira's family and the service both told us that there was better communication between them as a result of the conciliation. There was increased understanding on how to best support Amira and ensure she was connected with her family.

** Names and details have been changed.*

Reviews

As we have done since 2012, we review incident reports that are forwarded to us from DHHS that relate to alleged assault, injury and poor quality of care.

The following disability services are required to report incidents:

- individual support services (day services, flexible support packages, individual support packages, outreach support, respite)
- information, planning and capacity building services (case management, access)
- targeted services (behaviour intervention services, independent living training)
- residential services (residential institutions, shared supported accommodation)
- Victorian approved NDIS providers of disability and psychosocial supports.

Once received from DHHS, we review these incident reports so that we can:

- identify, assess and understand any issues in the disability services being provided
- provide advice and recommend actions the service provider should take to improve the services being provided, including any actions that may assist in the prevention, reporting, investigation, and review of the incident.

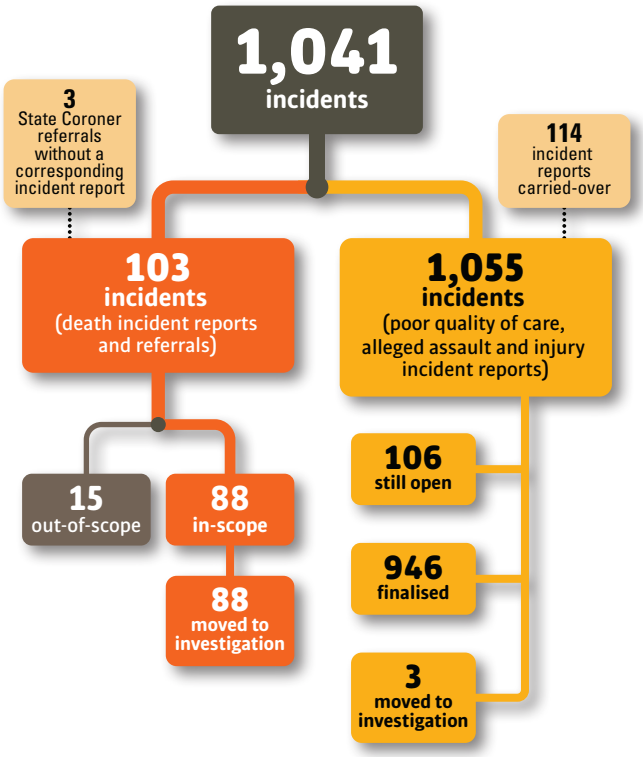
In September 2017, the Minister requested that we also commence reviewing:

- incident reports received from DHHS relating to persons who have died and were receiving disability services at the time of their death
- referrals from the State Coroner where the person who died was receiving disability services at the time of their death
- referrals from the Community Visitors Board (CVB) about matters of alleged abuse and neglect.

Our expanded powers in reviewing critical incidents has increased our capacity to identify and initiate practice and service improvements at both organisation and sector level.

It has also further strengthened Victoria's oversight framework and protections available to people with disability.

Figure 13: Year at a glance – reviews



Referrals: *matters referred to us from a variety of sources including the Minister, the Secretary to DHHS, State Coroner or the Community Visitors Board.*

Incident reports: *matters referred to us from DHHS as per the referral from the Minister.*

Referrals

In 2017–18, we received a combined 115 referrals from the State Coroner and the Community Visitors Board (CVB).

Reviewing Community Visitor Board referrals

We reviewed 56 referrals that we received from the CVB.

Of these, 19 had already been reviewed by us through incident reports (see Figure 14).

We inquired into the remaining 37 referrals by liaising with DHHS. We decided not to investigate these matters after ensuring they were being appropriately handled through other processes.

Reviewing State Coroner referrals

Of the 59 referrals that were in scope for our review from the State Coroner regarding the deaths of people receiving disability services, 56 were also subject to an incident report from DHHS (see Figure 15).

These, and the three referrals not captured by incident reports, were subsequently investigated as part of our review into disability service provision to people with disability who have died (see *Annual review of disability service provision to people who have died 2017–18*).

Incident reports

As per our referral from the Minister, we reviewed 1,041 new incidents, including deaths, and assaults, injuries and poor quality of care alleged in 2017–18.

The majority of incident reports (941) relating to alleged assaults, injuries or poor quality of care were reviewed, but did not progress to investigation.

In these instances, we often sought further information from disability services or provided advice on the steps they could take to address an issue, or to stop it from happening again.

Three incidents relating to alleged assault, injury or poor quality of care, and all 85 deaths went to investigation (see p. 25).

Changes to incident reporting

DHHS has two incident reporting systems: Critical Client Incident Management (CCIM) and the Client Incident Management System (CIMS).

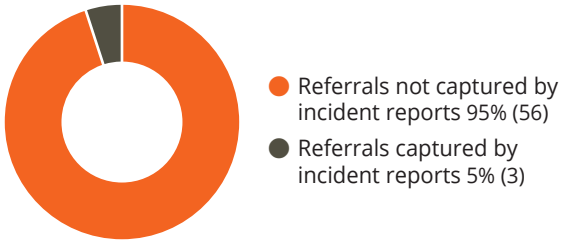
The CCIM system ceased being used by non-government funded service providers from 15 January 2018, when it was replaced with CIMS. DHHS-delivered services continue to use the CCIM reporting system.

The introduction of CIMS led to increased interactions (broadly up 70 per cent from 40 per cent last year) with DHHS and service providers to ensure that all relevant incidents are appropriately captured, reported, investigated, reviewed and addressed.

As with any significant change, there have been unforeseen issues arising from the implementation of CIMS. Delays and gaps in the provision of information about incidents have undermined our ability to provide timely and effective oversight. We have worked with DHHS to identify and address our concerns and we will continue to do so in 2018–19.

Figure 14: Referrals from the Community Visitors Board

Figure 15: In-scope referrals from the State Coroner



Trends in incidents

Alleged physical assault (32 per cent), injury (23 per cent) and alleged sexual assault (17 per cent) continued to be the highest proportion of reported incidents (see Figure 16).

Overall, our data indicated that a higher proportion of allegations of physical abuse or assault were made by or on behalf of males. Conversely, a higher proportion of allegations of sexual abuse or assault were made by or on behalf of females. Of the in-scope deaths we were notified about, more males than females died in disability services in 2017–18 (see Figure 17).

Our data also re-emphasises the importance of ensuring the safety of all people using and working in disability services.

It continues to be a concern that the highest percentage of alleged physical assault incidents (58 per cent) were staff to client. While there has been a decrease of 38 per cent from the year before, it is not clear if this is due to a reduction of abuse and neglect of people in disability services or underreporting (see Figure 18).

It is also concerning that 22 per cent of allegations of sexual assault were staff to client.

The highest proportion of alleged sexual assault was 'other to client' (41 per cent), an increase of 7 per cent from the year before. 'Other' is a category that may include family members, friends, members of the public, or service providers that are not providing disability services (see Figure 18).

Figure 16: Incident reports on deaths, alleged assaults, injuries and poor quality of care

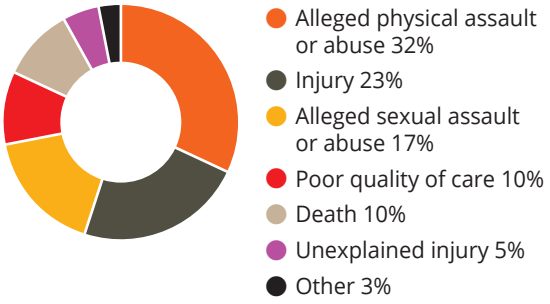


Figure 17: Incident reports on deaths, alleged assaults, injuries and poor quality of care by gender

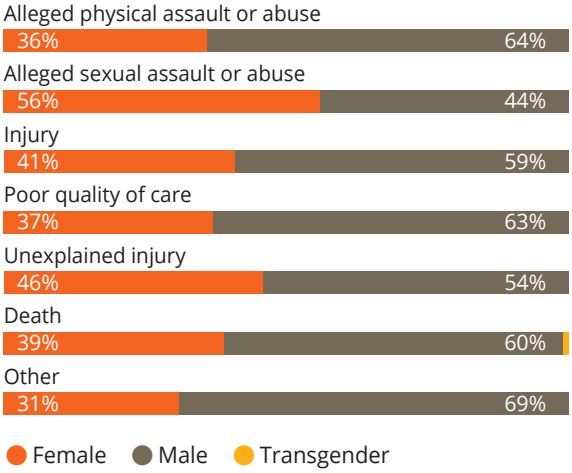
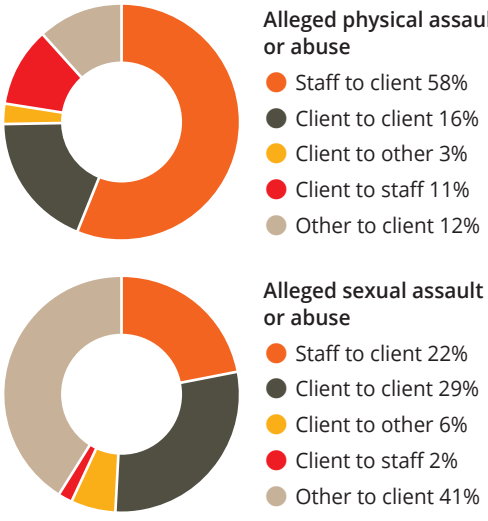


Figure 18: Incidents relating to alleged physical and sexual assault



Case study:

Working with others to prevent neglect

We received an incident report from a service provider who was concerned about the wellbeing of one of their clients, **Natalie***, who lived with her family.

The report revealed that Natalie was living in significant squalor. She was not being supported to go to the bathroom properly. Natalie was sometimes being left alone for hours at a time, and her appointments with her occupational therapist were missed frequently as her family refused to take her.

Like the service provider, we were concerned about Natalie and the neglect she was experiencing.

Since our concerns related to the care and support being given to Natalie by her family rather than her disability service provider, we had no authority to commence an investigation. Nevertheless, we brought the matter to the attention of DHHS, who put in place support services for Natalie and arranged a new place for her to live.

The support provided included:

- a cleaner to ensure Natalie's home environment did not deteriorate while her new living arrangements were put in place
- the regular purchase and supply of continence aids
- additional support workers to provide Natalie with support options for daily living.

Natalie is now happily residing in a supported accommodation service. She regularly visits her occupational therapist, and goes out into the community.

** Names and details have been changed.*

Investigations

Investigations are another important part of our work.

This year we continued to investigate complaints that we deemed unsuitable for conciliation, or where conciliation failed and we identified that further action was required.

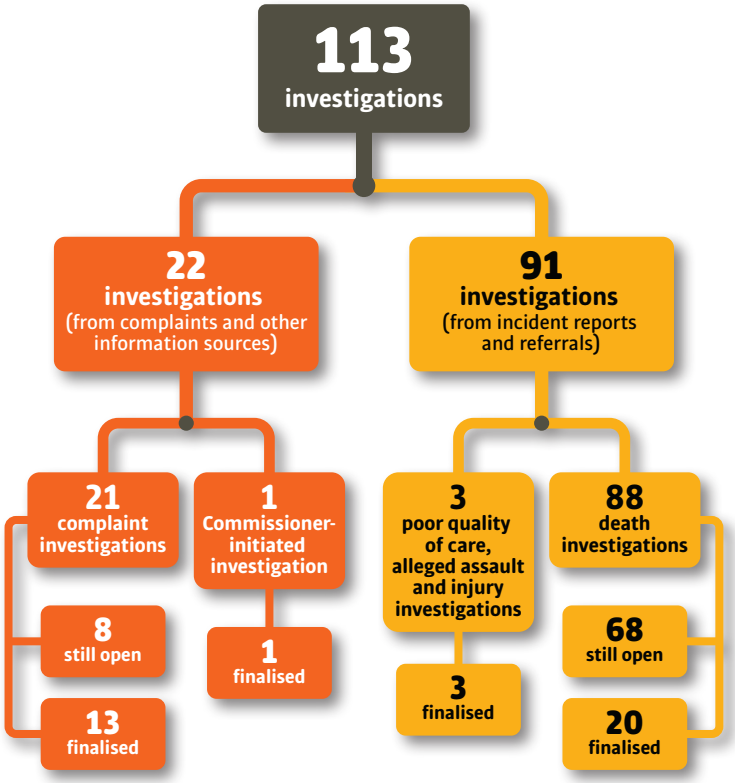
The expansion of our powers this year meant that we also had the discretion to commence investigating any matter regarding the provision of disability services arising from our review of client incident reports and referrals from the State Coroner and CVB (see p. 25).

The amendments gave us scope for the first time to conduct Commissioner-initiated investigations into disability service provision.

We can now conduct these investigations if we have concerns about the abuse or neglect of a person with a disability, or if there are allegations of persistent or recurring systemic issues about abuse or neglect in the provision of disability services. In the past we could only do this if we first received a complaint.

As part of our new investigation powers, the Act's changes have also given us the power to visit and inspect the premises of a Victorian disability service without notifying the provider we are investigating in advance.

Figure 19: Our year at a glance – investigations



130.3 average number of days to complete investigations from complaints

83% of issues investigated in complaint investigations were justified

9 Notices to Take Action were issued as a result of our complaint investigations

Complaints and other information sources

In 2017–18, we undertook investigations of 21 matters arising from complaints. We also conducted one Commissioner-initiated investigation based on information received from multiple sources (see p. 23).

Investigating complaints

As of 30 June 2018, we had completed 13 investigations arising from complaints.

Of the eight investigations that remain open, six are still being investigated, and two are awaiting service providers to report on the action that they have taken in response to a Notice to Take Action (see Figure 20).

The time taken to close investigations arising from a complaint was 130.3 days. This is down from 209 days in 2016–17.

There are usually several issues being investigated in one matter. Of the issues we investigated, we found 29 of 35 (83 per cent) issues raised were justified, meaning that the information and evidence we received confirmed there was merit in raising, investigating and addressing the issue.

We issued nine Notices to Take Action to service providers based on the findings of our investigations. Some of the actions required included training staff and improving communications with family members of a person with disability.

Our data also reconfirms the importance of disability service providers focusing on the needs of individuals.

In addition to alleged sexual or physical abuse or assault (48 per cent), matters relating to providing a person-centred approach to choice and communication (48 per cent) and service delivery (38 per cent) were key issues of investigative concern this year (see Figure 21).

The role of informal and formal supports cannot be underestimated. A variety of people play a vital role in preventing and responding to abuse and neglect.

Allegations of assault or abuse may be made by people with disability, their family or friends, or even support workers.

In 2017–18, a combined 71 per cent of complaints that were investigated were made by a parent, guardian or another family member. Another combined 23 per cent of investigated complaints were made by staff and service providers.

We note that only 6 per cent of complaints were made by people with disability. They therefore continue to be significantly underrepresented in raising complaints about issues that lead to investigation (see Figure 22).

We encourage the NDIS Quality and Safeguards Commission and broader sector to be mindful of this when establishing and monitoring services under the NDIS.

Figure 20: Status of investigations arising from complaints

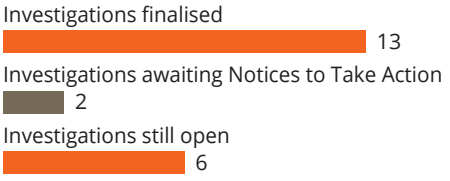
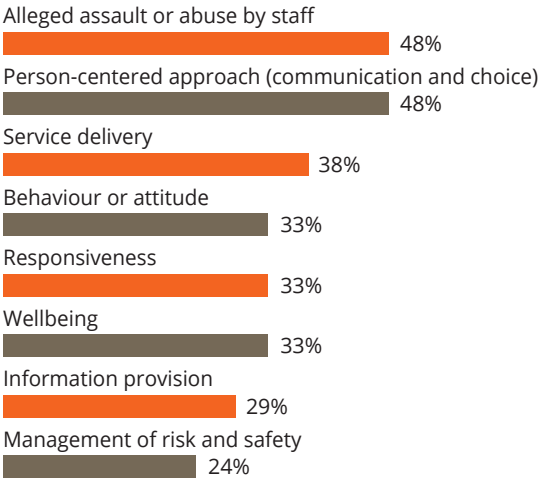
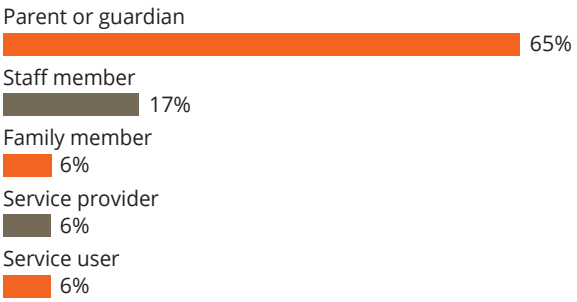


Figure 21: Top eight issues raised for in-scope complaint investigations



Note: more than one issue may be selected.

Figure 22: Top five sources of complaints that were investigated



Case study:

Luca's burn

Georgio* contacted us to make a complaint about an untreated burn his son **Luca** had sustained while under the care of a disability service provider in temporary accommodation.

Georgio was shocked and dismayed about the burn, which was sustained while Luca was being supported in the shower.

He was also upset about the service's response. The service had not notified him about the incident, and he only found out what had happened once Luca had returned home a few days later.

We commenced an investigation into this complaint because the matter was not suitable for conciliation. We found that the service provider and staff had:

- failed to ensure that appropriate facilities (including temperature-controlled showers) were available at Luca's accommodation
- burned Luca's leg with overly hot water. While accidental, it was preventable with the right showering facilities or better staff supervision
- failed to treat the injury and subsequently monitor it
- failed to notify the family about the injury when it occurred, or next steps
- failed to appropriately investigate or report the incident for several days after it had occurred
- failed to communicate appropriately with Georgio or Luca during and after the incident.

We asked the service what they had done to prevent such issues from occurring again.

They told us they had issued first and final warnings to the staff involved, conducted workplace health and safety and risk management training, developed a checklist to ensure that all accommodation venues have temperature-controlled facilities, and updated their policies on communicating with families in the future.

Based on this information, we chose not to issue a Notice to Take Action in this instance.

While the incident should never have occurred, our investigation confirmed that the organisation had taken appropriate actions to:

- reduce the potential for such injuries to occur in the future
- ensure better follow up in the future if such injuries did occur.

** Names and details have been changed.*

Commissioner-initiated investigations

In 2017–18, the Commissioner received information about possible abuse and neglect in a group home. Our information came from a range of sources, including people who were reluctant to make a formal complaint.

The Commissioner decided to investigate the disability service provider responsible for this home by using the new Commissioner-initiated investigation powers available under the Act.

Based on the information available to us, part of our initial investigation of these concerns included sending Authorised Officers to visit and inspect the premises.

Our investigation found that the allegations of abuse and neglect were justified.

To try to prevent future incidents of abuse or neglect, we issued the service provider with a Notice to Take Action to:

- conduct client communication and behaviour assessments to find ways in which people with a disability are better able to indicate their needs without frustration
- work with the Senior Practitioner – Disability to review their restrictive interventions
- update and train staff on their incident review policy so that incidents are reported to DHHS as required
- work with families to identify meaningful activities for residents and record these strategies for all staff to use
- improve the home's ambience to reflect the needs and interests of its residents and provide them with a stimulating environment.

The investigation highlights the value of our new powers to investigate when we have concerns and information, but have received no formal complaint.

Inspecting premises

An Authorised Officer is a staff member from our office who has been delegated the authority to visit and inspect a disability service.

We can decide to send Authorised Officers to the premises of a disability service provider if we are investigating the disability services being provided there.

There are always at least two Authorised Officers at every visit and inspection. They can visit a service at any time of the day or night without notice.

A staff member who provides disability services that are being investigated must provide the Authorised Officers with reasonable assistance during a visit and inspection.

Authorised Officers can also interview people with a disability and their family if they agree.

4 visits by Authorised Officers

8 Authorised Officers appointed

Case study:

How our Authorised Officers helped Robert

Robert* told us that staff from his disability service regularly lock him in his bedroom in the afternoon and evenings. He also told us that he has to sleep on a mattress on the floor.

Given the allegations of abuse and neglect, we referred the matter to investigation. We also sent two Authorised Officers to Robert's group home soon after he contacted us to assess whether he was being properly supported.

Upon arrival at the group home, our Authorised Officers informed the person in charge of the service of the reason for the visit.

Our Authorised Officers gathered information and evidence. This included taking photos of the lock on Robert's bedroom door and of his mattress on the floor. They also interviewed staff.

We then met with the disability service to discuss the evidence we had gathered.

We issued the service with a Notice to Take Action requiring that they:

- develop a plan to better support Robert
- arrange for Robert to have a proper bed
- take the lock off Robert's door.

We told the disability service provider to report back to us on what they had done. At the end of our investigation, Robert told us that he felt more comfortable about living in his home.

** Names and details have been changed.*

Incident reports and referrals

In 2017–18, 91 incidents spanning the spectrum of deaths, alleged assault, injury and poor quality of care were moved to investigation.

Investigating provision of disability services to people who have died

In 2017–18 we commenced investigations into disability service provision for 88 people who had died while receiving a disability service.

Of these 20 investigations were completed this year. The remaining 68 investigations will be carried over into 2018–19.

We issued eight Notices to Take Action to service providers.

For further analysis of these investigations see the *Annual review of disability service provision to people who have died 2017–18*.

Investigating poor quality of care, alleged assault or injury incidents

We investigated and finalised three incidents relating to assault, injury and poor-quality care.

These incidents were referred to investigation to better identify and understand any issues that may have arisen in preventing, identifying, reporting, investigating or responding to these incidents.

In each case, we chose not to issue Notices to Take Action, as we were satisfied that the service providers had taken adequate steps to protect the interests of people with disability in these instances.

8 **Notices to Take Action were issued for investigations of the provision of disability services to people who have died**

Working with partners to keep people safe

The State Coroner notifies us about people who have died and were receiving Victorian disability services at the time of their death. This is so we can investigate the disability services provided. We signed a memorandum of understanding with the State Coroner in August 2017.

We have a protocol with Victoria Police that guides how we work with them to ensure the safety and welfare of people with disability. We signed this protocol in September 2017.

Our protocol with the Office of the Public Advocate and the Community Visitors Board sets out how we exchange information about issues and concerns about the provision of disability services to persons with a disability with the Public Advocate, and community visitors. We finalised an updated version of this protocol in May 2018.

We also signed an updated protocol with the Transport Accident Commission in May 2018. This protocol outlines how, in cooperation with TAC, we provide an independent complaints process to TAC clients receiving disability services.

4 **protocols or memorandums of understanding signed**

Case study:

Investigating the follow-up to Nancy's alleged assault

We received a report about an incident where a staff member allegedly slapped and grabbed **Nancy*** in response to 'escalating' behaviour. This alleged assault was witnessed by another staff member.

When we reviewed the incident report, we were concerned about the service provider's response. In particular, we were worried that it had taken several months to report and respond to the incident.

We decided to investigate the incident to better understand the circumstances of the alleged assault and the disability service provider's response to this allegation.

Our goal was to identify if any additional actions should be taken to improve the disability services being provided, including whether any further actions would be required to safeguard Nancy's wellbeing.

After notifying the organisation of our investigation, we asked for all relevant documents, statements, interviews and witnesses. The service provided us with this information.

As we progressed with our investigation, we found that the witness of the incident had failed to report the matter in a timely manner.

Upon learning of the incident, the service provider immediately:

- reported the incident
- stood down the staff member who allegedly assaulted Nancy
- counselled the staff member who witnessed the alleged assault on their obligations
- retrained all staff so they understood their requirements to report any such incidents immediately in the future
- offered support to Nancy, including medical and counselling assistance.

The service provider highlighted the importance of reporting incidents immediately so support could be provided to the person with a disability, and so that investigations could be conducted to ensure the rights of the person with disability were protected.

Based on the information provided, we found that while the service provider's response to the alleged assault was initially delayed, they had reported it as soon as they became aware. They had also immediately implemented a number of detailed actions and responses to support Nancy, prevent such occurrences from happening again, and to ensure that staff met their duty of care obligations in the future. As a result, we did not issue a Notice to Take Action.

Our work with the service provider during the investigation resulted in all issues being addressed prior to the investigation's completion.

** Names and details have been changed.*

Education and information

Our Capacity Development team continued to reach out in 2017–18 and inform people with a disability, families, carers and service providers about a positive complaints culture.

Amendments to the Act also empowered us to provide education and information to the Victorian disability sector in preventing and responding effectively to allegations of abuse and neglect.

Community and sector outreach

Educating people on speaking up

We continued to distribute information to people with disability and the wider sector about ways to speak up and make a complaint (see Figure 23).

Our resources come in a range of formats, including information in plain English and other accessible formats.

Informing people about our new powers

We updated our website (see Figure 24), and created a number of new information sheets to explain our new powers.

We spoke to more than 4,500 people with disability, families, carers and services. We explained our new powers, and how these would help enhance the rights of people with disability (see Figure 25).

We achieved this reach through our participation in 120 presentations and multiple expos (see Figure 26).

A major highlight was our 10th presence at, and continued sponsorship of, VALID's Having a Say conference in Geelong. At this year's conference, we hosted art workshops about rights and led discussions about what a safe and happy service looks like.

Working with diverse communities

We worked with the Aborigines Advancement League and artist Gary Saunders on developing a culturally meaningful brochure for our office.

The new 'It's OK to complain' brochure and magnet were released in the lead-up to Reconciliation Week. They are available for order on our website.

To further connect with the culturally and linguistically diverse communities across Victoria, we provided key resources in Vietnamese and Polish, and provided additional web content in three new languages – Japanese, Swahili and Somali – bringing our total to 23 languages. We visited and presented to Vietnamese, Polish, Afghan and other multicultural communities throughout the year.

Our staff have all completed cultural competency and complex communication needs training to further enhance our office's capacity to respond to the diverse needs of people who contact our office.

Training the sector

Another highlight was delivering sessions at safeguarding forums coordinated by the Transport Accident Commission.

We also delivered 16 training sessions to NDIS Local Area Coordinators across the state, to assist them with responding effectively to complaints.

Figure 23: Number of products we distributed

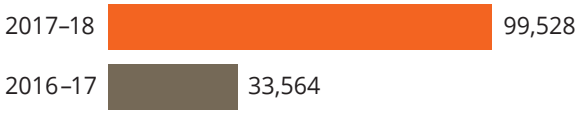


Figure 24: Number of visits to our website

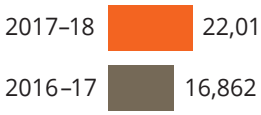
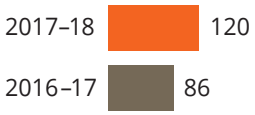


Figure 25: Number of people we reached

Figure 26: Number of presentations and expos



Education and information

Preventing and responding to abuse and neglect

As a result of the 2017 changes to the Act, our role now also includes providing information and education, and conducting research about preventing and responding to allegations of abuse and neglect in the provision of disability services. This year we have focused on:

- information and research
- a pilot program on early indicators of concern
- collaborating with the sector on key initiatives and projects.

Information and research

We commissioned a La Trobe University literature review of best practice support in disability services for the prevention of abuse of people with disability. This review highlights the value in moving from a 'response-to-risk' approach to a broader framework. The review is now available on our website.

As part of our inaugural forum about preventing and responding to abuse in September 2017 (see p. 29), we invited Professor Peter Oakes from the University of Staffordshire in the United Kingdom to share his work on early indicators of concern regarding the risk of abuse in disability services.

Professor Oakes highlighted the significance of workplace culture and noticing early indicators of concern. He has devised a simple tool to record concerns and observe interactions to help identify patterns that may signal an environment where abuse is more likely to occur. This tool is also available on our website.

Pilot program on early indicators of concern

We have commenced a participatory research project to test an early indicators of concern tool across various disability support settings.

The goal is to build an evidence base and then share the learnings with the broader sector through training and resource development.

Assisted by people with a disability who are represented on a Project Advisory Group and community researchers, Professor Oakes, Associate Professor Sally Robinson from Southern Cross University, Felicity Baker and Melissa Murphy from the University of Melbourne will help guide the research.

The pilot will involve three disability service providers that support people with an intellectual disability or acquired brain injury. It will trial a multilevel approach to addressing early indicators of concern that includes:

- training staff and families on indicators of concern
- conducting music workshops to promote positive and equal communication and a shared sense of community
- upskilling staff to provide effective supervision.

The findings of this research will be shared across the sector in collaboration with people with disability.

Supporting people on their NDIS journey

We can take complaints about NDIS planning conducted by Local Area Coordinators.

Until the NDIS Quality and Safeguards Commission launches in Victoria in July 2019 we also handle complaints about disability services funded under the NDIS if they are registered under the Act. We are not able to take complaints about unregistered NDIS service providers.

We worked with the NDIA throughout the year to co-present at their community information and implementation sessions across Victoria.

We informed people of their rights and recourse options, and how we can help resolve complaints and enquiries about the provision of disability services funded under the NDIS. We also highlighted the value in speaking up so that disability services and the NDIA continue to improve their services to people with disability.

61 co-presentations with the National Disability Insurance Agency (NDIA)

16 training sessions to NDIS Local Area Coordinators

Our work with the sector

Throughout the year, we also contributed to activities that were designed to prevent and improve responses to abuse and neglect. This included:

- sharing our knowledge of complaints and abuse prevention with the Future Social Service Institute as they review their Certificate III and IV Disability Support Worker courses
- supporting the Office of the Victorian Skills Commissioner in the development of the accredited course *Introduction to the National Disability Insurance Scheme* through participation in the Project Steering Committee, which our Deputy Commissioner chaired. The course, launched on 15 June 2018 exclusively for the Victorian TAFE network, will ensure students gain the requisite entry level skills, knowledge and understanding to work effectively alongside NDIS participants. It includes syllabus on the importance of recognising and responding appropriately to violence, abuse, and neglect
- providing significant input on the Family Safety Victoria (FSV) 10 Year Inclusion and Equity Statement, and joining FSV's Diverse Communities and Intersectionality Working Group. We also worked with FSV to:
  - advise on risk management and ways to establish inclusive processes in their Victoria-wide safety hubs
  - deliver sessions on the issues and barriers faced by people with disability who are trying to access the broader family violence system
- joining Women with Disabilities Victoria's advisory group to develop resources with women with disabilities about safety from violence and abuse
- contributing to the Speak Up and Be Safe from Abuse project developed by SCOPE to support people with complex communication needs to report abuse, and to build capacity of service providers to support people who have experienced or are at risk of abuse
- working with the Lifeline DV Alert program team to ensure their accredited training is relevant to the broader disability sector.

Organisations we collaborated with

In 2017–18 we worked with the following organisations on issues relating to abuse and neglect:

- Office of the Victorian Skills Commissioner
- Lifeline Australia
- Women with Disabilities Victoria
- National Disability Services (Victoria)
- Future Social Service Institute
- SCOPE
- VALID
- Action on Disability within Ethnic Communities (ADEC)
- Balit Naurrum
- Family Safety Victoria
- Commonwealth Department of Social Services.

Statewide forum on abuse and neglect

In September 2017 our major statewide forum on best practice in abuse prevention and response included more than a dozen speakers. Including people with a disability, service providers and sector specialists, we covered topics such as:

- **early indicators of concern for people with learning disabilities**
- **strategies for preventing abuse and neglect**
- **approaches for safeguarding the rights of people with a disability without a guardian**
- **international perspectives on safeguarding**
- **the role of Victoria's disability workforce in responding to abuse.**

Lyn Rowe presented a popular session examining ways that support workers can make people feel safe in a service.

Touching on issues of respect, control, inappropriate behaviour and best practice in responding to abuse, Lyn reminded us of a critical component of preventing and responding to abuse: see the person, not the disability.

400+ forum attendees

Annual Complaints Reporting (ACR) from the sector

Under ss.105 and 106B of the Act, Victoria's disability service providers are required to provide us with an annual report about the number and type of complaints they have received throughout the year, and the outcome of those complaints.

This reporting allows us all to better understand the issues raised about the quality of the services being provided to people with disability in Victoria, and how these issues are being addressed. It also provides enhanced transparency about the disability sector.

Complaints reported to us by service providers

In 2017–18, service providers reported a total of 2,919 complaints to us (see Figure 27). This is the highest number of reported complaints since we commenced in 2007–08.

The majority of these were new complaints (2,631) service providers received throughout the year, an increase of 12 per cent from the year before.

Disability service providers also reported that they carried over also almost double the number of reported complaints from the previous year (288 compared with 164 in 2016–17).

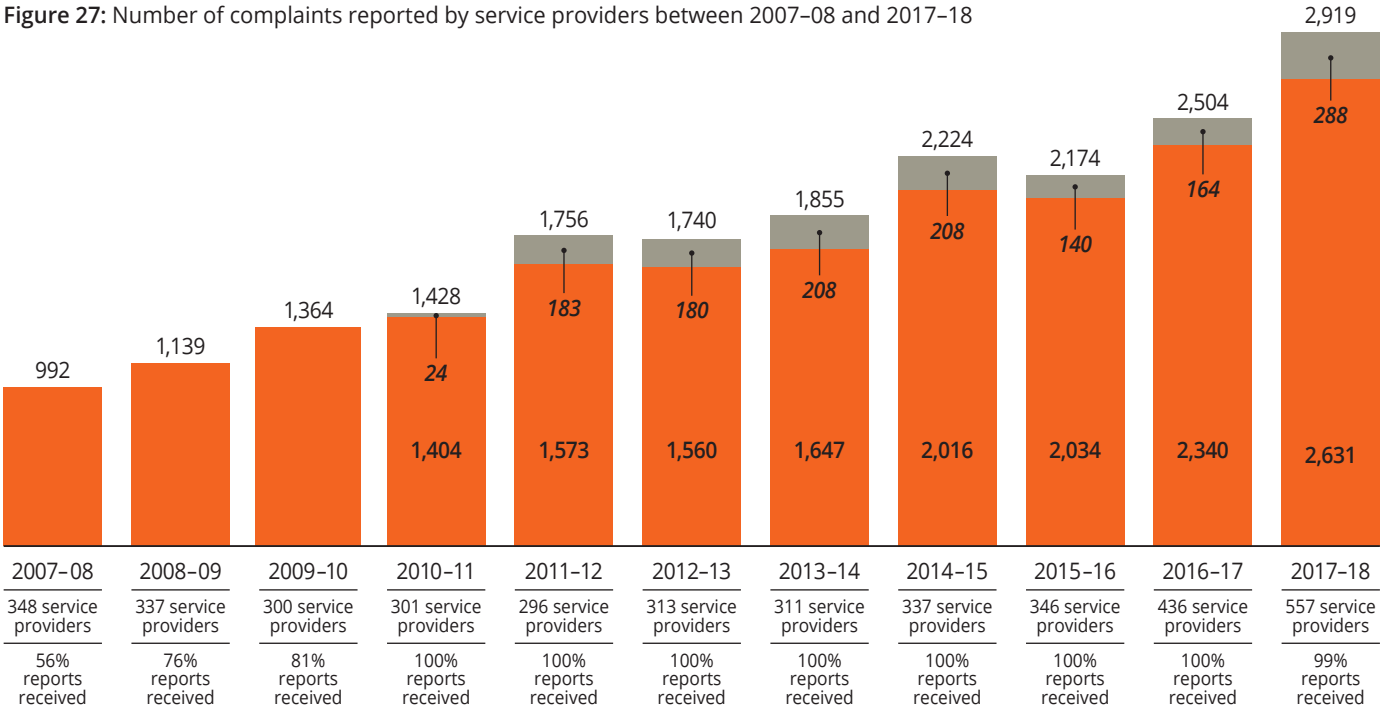
Similar to 2016–17, the increase in the number of complaints reported in 2017–18 was largely due to an increase in complaints from existing service providers (87 per cent of the increase, compared with 82 per cent in 2016–17). Only a small proportion is due to the contribution of complaints made to new service providers.

The continued increase in the number of complaints among existing service providers suggests ongoing improvement in the complaint reporting culture. It also reinforces the positive influence of the long-term education and training work conducted by our office, and the benefits of exposure to a stable and mature mandatory complaint reporting process. Conversely, it is noteworthy that the new NDIS providers reporting low numbers of complaints have yet to engage with the training and resources we offer in any meaningful way.

Just over half (53 per cent) of all service providers reported that they did not receive any complaints in 2017–18. This continues an upward trend from 51 per cent in 2016–17 and 47 per cent in 2015–16. Of these 'nil' returns 53 per cent were recorded by providers who also submitted 'nil' returns in 2016–17. A large proportion of 'nil' returns (38 per cent) were also recorded by new providers.

As with previous years, and mindful of the inherent complexity in providing disability services, we will seek to engage with service providers who have submitted 'nil' returns to better understand the operational context which has led to no complaints being received from people with a disability or their families.

Figure 27: Number of complaints reported by service providers between 2007–08 and 2017–18



Note: data on complaints carried forward prior to 2010–11 is not available.

Comparison with last year's data

Compared with last year's ACR data, the issues raised in complaints reported by service providers are broadly proportionate to those in 2016–17.

The top two issues in reported complaints are service quality (47 per cent) and workforce and staff related issues (46 per cent), with communication quality coming third at 30 per cent (see Figure 30 in Appendix 1). The top two sub-issues are dissatisfaction with staff behaviour and attitude (21 per cent) and dissatisfaction with service quality – both at 21 per cent (see Table 1 in Appendix 1).

This differs from the complaints we receive where the primary issues we handle fall into the categories of service quality (57 per cent) and communication quality (42 per cent) (see Figure 8 on p. 12). This makes sense in a context where people come to us in the event that an issue – such as perceived quality of service or communication – cannot be resolved directly with a service provider.

The information that service providers have shared about reported complaints reconfirms again the importance of connections in the community. A combined 51 per cent of reported complaints were made by family members (see Figure 28 in Appendix 1), a trend similar to ours (see Figure 5 on p. 11).

Service providers indicated that the large majority of complaints they received have been resolved at least to some degree (see Figure 33 in Appendix 1).

Consistent with the results of ACR data from previous years, the most common reported complaint outcome across the four As categories was an 'acknowledgment of the person's views and issues' at 72 per cent, followed by 'answers provided' at 52 per cent (see Figure 31 in Appendix 1).

When a service provider undertook an action to address a reported complaint, this commonly related to a change or improvement to communication, disciplinary actions or performance management of staff, change of existing support arrangement, and change or appointment of a worker or case manager (see Figure 31 and 32 in Appendix 1).

The ACR data again reinforces the value of having multiple avenues to manage complaints. People with disability, their family and others have options to resolve complaints internally, or to approach us or DHHS.

Appendix 1 presents additional data.

Growth in the Victorian disability sector

The number of registered disability service providers in Victoria increased by 28 per cent for the twelve month period 2017–18.

New entrants to the market ranged from single-person businesses to large interstate or international service providers.

Growth is even more marked over two years, increasing by 61 per cent since 2015–16.

In comparison, the increase in service providers for the four-year period from 2011–12 to 2015–16 was just 17 per cent. Virtually all new service providers are registered with the NDIS.

557 disability service providers

28% increase from 2016–17

Priorities for 2018–19

We will support people with disability to speak up and obtain better quality disability services through our complaints resolution, education and information, reviews and investigations.

With the NDIS Quality and Safeguards Commission (the Commission) commencing operations in Victoria on 1 July 2019, we will continue to work with the Commonwealth Department of Social Services and the new Commission to ensure that people with disabilities have effective, responsive quality and safeguarding options as these functions transition from our office to the new federal Commission.

We will continue our important work to review the deaths of people who were receiving disability services at the time of their death. This will include preparing a second annual review of disability service provision to people who have died. Prior to this, we will also share our learnings from the first review (see *Annual review of disability service provision to people who have died 2017–18*) with the disability services sector to:

- support improvements in service provision
- contribute to the prevention and reduction of abuse and neglect in disability services.

We will also release a 'train the trainer' package to disability service providers based on the four As complaints resolution training we have provided over the past seven years.

In addition, we will undertake our final Annual Complaints Reporting process for the sector.

The outcomes of our pilot program on preventing and responding to abuse and neglect, with its focus on early indicators of concern, will also be shared with the sector and the Commission.

Appendices

Appendix 1: Annual Complaints Reporting (ACR) 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.

Note: multiple responses are possible in the following data, so figures may not add up to 100 per cent.

Figure 28: Top five sources of enquiries and complaints reported by service providers

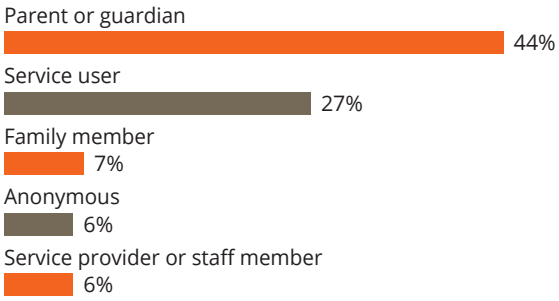


Figure 29: Reported complaints by service type and funding program

Note: percentage represents complaints from people funded to access the service through NDIS and DHHS that account for at least 5 per cent of matters.

Figure 30: Top five issues raised in reported complaints

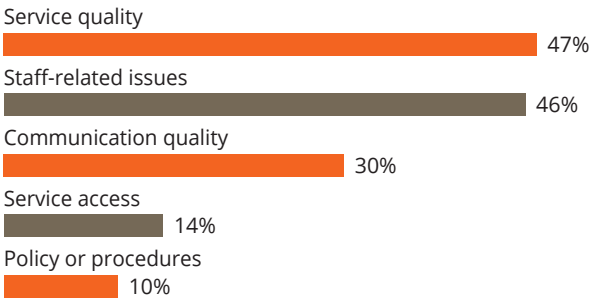


Table 1: Sub-issues raised in reported complaints

Sub-issues	%
Service quality	**47%**
Dissatisfaction with service quality provided	21%
Physical, psychological health and safety	14%
Insufficient service or support	13%
Lack of choice for service or activities	5%
Other matters	6%
Staff-related issues	**46%**
Staff behaviour and attitude	21%
Knowledge and skill of workers	12%
High turnover	7%
Other matters	6%
Discrimination, abuse, neglect, intimidation, assault or bullying	5%
Poor match between person and workers	4%
Communication quality	**30%**
Insufficient communication	18%
Poor quality communication	11%
Other matters	5%
Service access	**14%**
Cost of service or funding issues	5%
Wait time to access services	4%
Transport issues	3%
Other matters	3%
Service request refused – not considered priority for service access	<1%
Service request refused – not assessed as having disability	<1%
Policy or procedures	**9%**
Concerns about policy or procedures	5%
Complaint handling	2%
Other matters	2%
Privacy or confidentiality breach	1%
Relationships and compatibility	**8%**
Poor relationship or incompatible with other people accessing service	5%
Discrimination, abuse, neglect, intimidation, assault or bullying from other people accessing service	2%
Other matters regarding other people accessing service	2%
Other	**5%**

Appendices

Figure 31: Top six ways complaints were resolved using the four As

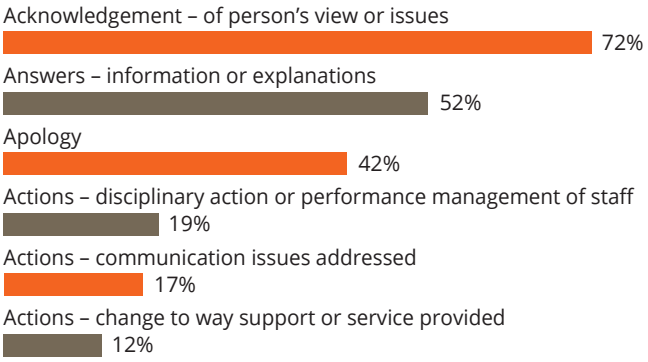


Figure 32: Actions taken as a result of the reported complaint

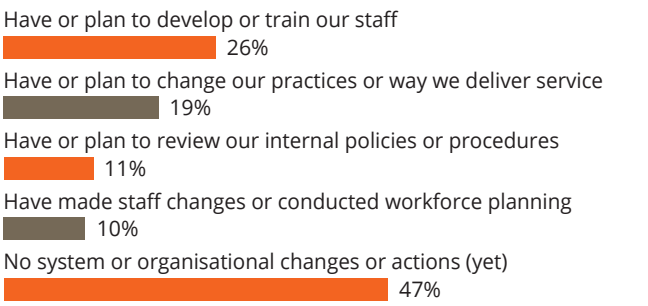


Figure 33: Resolution rates for reported complaints

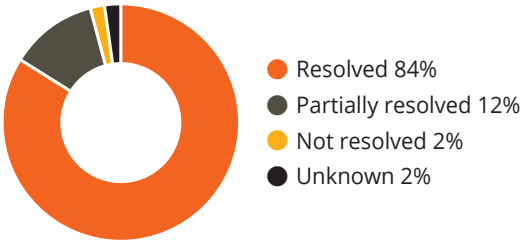


Table 2: Type of disability experienced by the person receiving service

Type of disability	2017–18 (n = 2,290)	2016–17 (n = 1,780)
Intellectual disability	51%	59%
Physical disability	21%	25%
Autism	18%	22%
Neurological disability	10%	13%
Acquired brain injury	9%	9%
Mental illness as a secondary disability	8%	9%
Sensory disability	7%	6%
Developmental delay	3%	6%
Other disability	9%	2%

Table 3: Age of person(s) receiving service

Age	2017–18 (n = 2,108)	2016–17 (n = 1,969)
35 or under years old	51%	52%
Over 35 years old	50%	48%

Table 4: Gender of people receiving service

Gender	2017–18 (n = 2,296)	2016–17 (n = 1,969)
Female	45%	44%
Male	56%	58%
Transgender	<1%	<1%

Appendix 2: Operations

Financial statement for the year ended 30 June 2018

DHHS provides financial services to our office.

The financial operations of our office 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 2017–18 is provided below.

Operating statement for the year ended 30 June 2018

Expenses from continuing activities	
Salaries	$ 3,498,597
Salary on-costs	$ 497,626
Supplies and consumables	$ 592,702
Indirect expenses *(includes depreciation and long-service leave)*	$ 138,445
Total expenses	**$ 4,727,370**

Staffing for the year ended 30 June 2018

31.5 full-time equivalent (FTE)

35 staff positions

Appendix 3: 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.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 2017–18, DSC received six requests under the FOI Act. Three requests were transferred to other agencies; two requests were granted in part, and the other was ongoing as at 30 June 2018.

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

Freedom of Information Officer
Disability Services Commissioner
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 gives consideration to human rights 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>.

Disability Services Commissioner
570 Bourke Street
Melbourne VIC 3000

Enquiries and complaints: 1800 677 342 (free call from landlines)

TTY: 1300 726 563

Office enquiries: 1300 728 187 (local call)

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