The Separation of Powers

The safeguarding framework must acknowledge the necessity of separating those responsibilities and powers that should rightly be that of the National Disability Authority (NDIA) and those that must come under the jurisdiction of a single national body independent of, and separate from, the NDIA. Therefore, the concept of a separation of powers must be applied and a separate national body established to take responsibility for and to have the authority to act in relation to the elements identified below.

The role and responsibilities of the NDIA must not be compromised by seeking to make it an, 'all things to all people' type entity. The NDIA must be allowed to do its legislated work of assessing eligibility and allocating funds without being loaded down by being required to also function as auditor, advocate, service reviewer, receiver of complaints and incident reports, and as a police force.

It would be short-sighted of those responsible for establishing the next steps for the NDIS to simply transplant that which is currently operating in particular state or territory jurisdictions, or pretend to establish something new by simply fiddling around the edges. Therefore, a new approach is required. The writers therefore propose the establishment of the National Disability Compliance Authority as below.

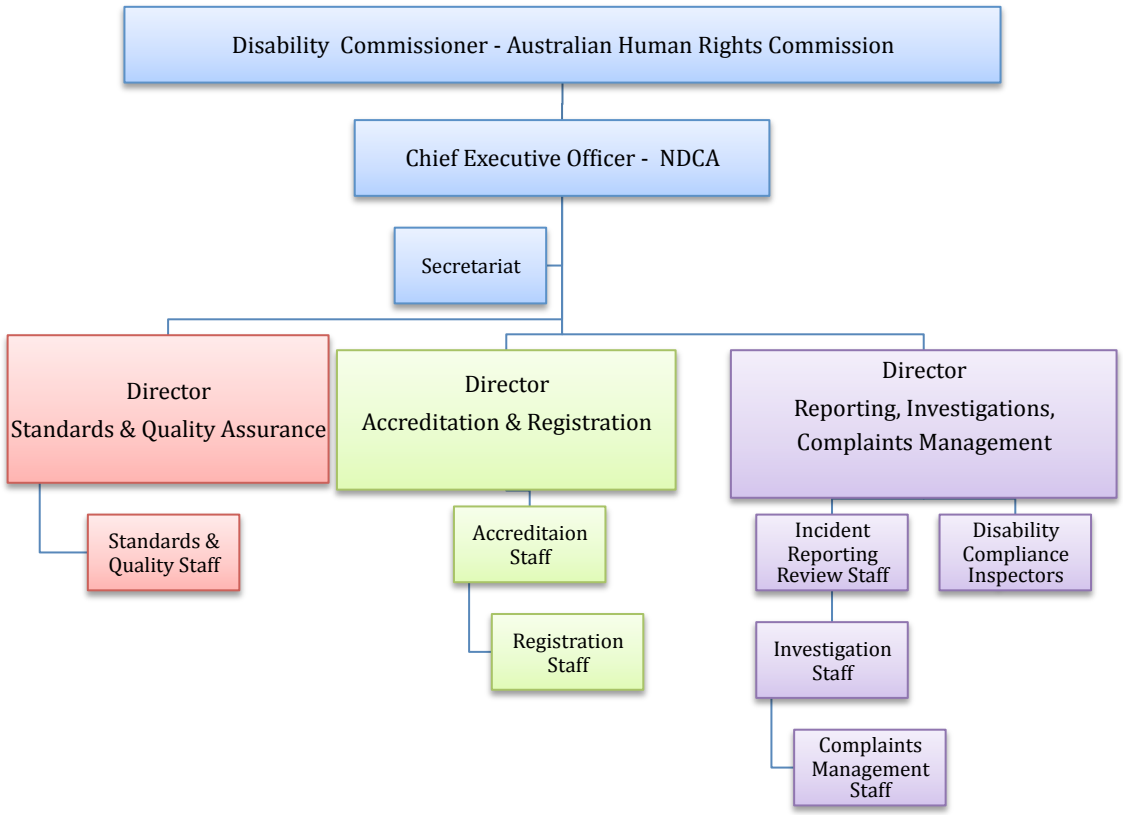
Name: **National Disability Compliance Authority (NDCA)**

Purpose: To uphold the rights of persons with disabilities to receive high quality supports and to live free from abuse, neglect, exploitation and violence, by having sole authority and responsibility for:

- Accreditation of entities funded through the NDIA
- Registration of individuals seeking to provide specialist disability services
- Monitoring standards and quality assurance
- Operating a national complaints mechanism
- Establishing and implementing a national inspectorial system.

Jurisdiction: All individuals across Australia who are registered and entities that are accredited to provide specialist disability services and supports to people with disabilities.

Structure:



Note: Location and Reporting of the NDCA

The writers argue that locating the **NDCA** under the Australian Human Right Commission with reporting to the Disability Commissioner will give the Australian Human Rights Commission 'real teeth', while at the same time emphasising the link between human rights and the rights of people with disabilities to be free from abuse, neglect, exploitation and violence.

What Is Meant By Safeguards?

Although different interpretations may exist as to what is meant by safeguards, the writers submit that it is unarguable that in the context of people with disabilities they must be:

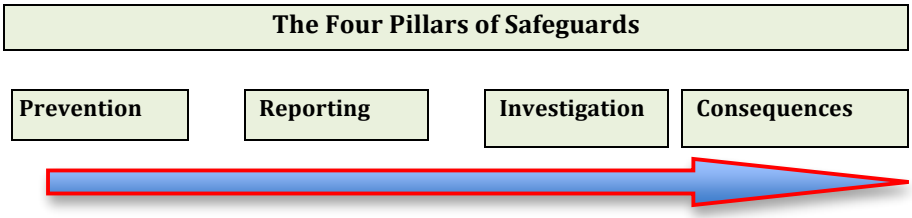
> ***Measures established and actions applied to uphold the rights of people with disabilities, to protect them from harm and to prevent something undesirable happening to them.***

Thus, safeguards must protect people with disabilities from neglect, abuse, violence and exploitation. Given this, it must also be recognised that neglect, abuse, violence and exploitation can come in many forms and particularly abuse and neglect can be perpetrated either as a direct action, or by an inaction, by a person or entity charged with providing a duty of care to persons with a disability.

Given the duty of care imperative, it therefore stands to reason that safeguards must, at the very least, include preventative measures. However, no matter how stringent preventative measures might be, their effectiveness cannot be totally guaranteed.

The Four Pillars of a Safeguard System

Given that prevention must be the first pillar in a safeguard system, what then are the other pillars and what measures or activities must be incorporated into each of the four pillars identified in the diagram below?



Pillar 1: Prevention

- Much has being written about safeguards, yet the focus has significantly been on the reporting of incidents and complaints. While acknowledging complaints reporting and management, and incident reporting are integral to a safeguards hierarchy, nonetheless the first pillar must be prevention.
- Therefore, there are a number of preventative strategies that must be written into any future safeguard document. Further, these must be mandated as an automatic requirement and therefore not subject to 'ifs, buts or maybes'.

Innovation in Prevention

In Victoria much has been made of the role played by Community Visitors since their inception in 1986. If one were to listen uncritically to the white noise that surrounds the commentary about the role of Community Visitors allegedly addressing abuse, neglect, exploitation and violence, one could be forgiven for believing they are white knights in shining armour. However, in terms of prevention, the facts speak for themselves. On their own admission in the 2014 Community Visitors Annual Report, Community Visitors note that despite concerns about abuse and neglect having been 'a continuing theme in recent years' abuse and neglect represent 'a systemic problem.' Further, and as expressed by the Public Advocate, this is only the 'tip of the iceberg'.

Therefore, despite Victoria's Disability Act 2006 providing Community Visitors with the authority to visit residential facilities and inquire into particular aspects of a facility's operation, the outcomes of these powers effectively stop there. It must also be emphasised that they do not have the power to visit specialist disability service providers. Therefore, the volunteer Community Visitors, despite being well-meaning and no doubt carrying out their role in accordance with the legislation, have clearly been ineffectual in actually preventing abuse, neglect, exploitation and violence.

Thus - Should Community Visitors be part of the NDIS safeguarding framework? **NO!**

Equal Rights and Equal Protection

Given Victoria's safeguards have not worked, what sense does it make to simply implant them into the NDIS system? None. Therefore, the writers propose an approach that more appropriately and more effectively reflects equal rights and equal protection for people with disabilities. In order to meet this objective, the writers have considered protections given to employees when compared and contrasted to the rights and protections given to people with disabilities.

The disability sector is high on the rhetoric of rights. One only has to listen to the policy makers, the academics and watchdogs as well as the advocacy organisations. Yet, activating these high sounding rights in funded specialist residential and day services is far from convincing.

By contrast, employees in Victoria have their right to be able to work in an environment that is safe and free from abuse, neglect, exploitation and violence unequivocally enshrined in action-based law through Victoria's Occupational Health and Safety Act 2004 (OH&S Act). The mandated provisions of this legislation contrasts significantly, in terms of rights applicable to employees, to the much softer approach applied to clients in the disability sector through the Disability Act 2006 and policy statements as applying to the rights of people with disabilities.

Critically, employees have the right to appoint health and safety representatives within local work areas whereby these representatives have significant powers designated to them, including the imposition of what is known as a Provisional Improvement Notice (PIN). Contravention of a PIN is deemed as an offence under the legislation. Also significantly, the OH&S Act provides for Workplace Inspectors, who not only have the authority to visit workplaces at any time, but also to impose PINs, which may require particular rectification of irregularities or defects in the workplace. In addition, the OH&S Act specifically prohibits discrimination against employees and emphasises the enforcement authority of Workplace Inspectors. This Act also gives Workplace Inspectors the authority to give directions. They can also serve infringement notices that can lead to prosecution action and require compliance with particular mandated codes and orders.

In addition to the provisions of the OH&S Act and the rights and protections afforded to employees, noting that the writers have no dispute with this, employees having the protection of WorkSafe, whereby matters of dispute can be taken and judgements made that require employers to meet certain findings of the WorkSafe authority. By contrast, none of these definitive requirements are imposed on accredited service providers in Victoria, and none of the protections afforded workers are afforded to people with disabilities supported through accredited agencies.

As such, the writers propose the incorporation of an approach based on OH&S and WorkSafe provisions but as applying to the rights and protection of people with disabilities to be able to receive services and support free of abuse, neglect, exploitation and violence. Therefore, they highlight the need to establish **Disability Compliance Officers** as paid employees of the **NDCA**, who have the legislative authority to go beyond the powers of inspection, as currently available to Community Visitors and to go beyond the power of waiting for complaints to be made, as is the case with the Disability Services Commissioner (DSC), and having the authority to be proactive and focussed on prevention and compliance.

Pillar 2: Reporting

Victoria has long had an incident reporting system established under the authority of the now Department of Health Human Services (DHHS) and as applied to services managed by DHHS as well as agencies funded by that department. In terms of complaint mechanisms, the creation of the DSC under the Disability Act 2006 established a complaints process managed by that office. This was extended to what might be called 'internal complaints' within service agencies, whereby all registered service providers are required to have a complaints mechanism and are required to report annually to the DSC in relation to the complaints managed by them.

Essentially, incident reporting to DHHS and complaints made to the DSC are both forms of reporting. In effect, incident reporting is primarily an internal process, whereas the making of complaints, as applying to the DSC is an external process.

Despite incident reporting having been in place for over a quarter of a century, and the DSC having operated since mid-2007, there is clear evidence to suggest these processes have not been effective in stemming the tide of neglect, abuse, exploitation and violence in the disability sector in Victoria. Evidence of this in part resides in articles in The Age newspaper and the recent ABC Four Corners program (24/11/2014), which highlighted significant abuse, including rapes, in one of Victoria's largest disability service providers. The evidence also resides in the recent call by Victoria's Public Advocate for an inquiry into abuse and neglect.

The evidence also resides in the fact that prior to its election in November 2014 the newly elected government in Victoria announced its intention to undertake a broad-based inquiry into the disability sector. And further the evidence resides in the Victoria's Ombudsman undertaking an investigation, as well as a Senate Inquiry that is currently underway. Therefore, while it is important to acknowledge the existence of incident reporting and complaints management, given this indisputable evidence it is equally important to acknowledge that the current arrangements have not worked.

Pillar 3: Investigation

Although investigative powers already exist for Victoria's DSC, as evidenced through his annual reports he has failed to implement even one single investigation since 2010. Equally, although DHHS also has the power to investigate allegations of, for example, abuse and neglect or other types of

complaints as applying to its own service provision as well as those funded through the department, DHHS has failed to always exercise this authority.

The importance of the investigative process is to provide opportunity to the complainant as well as the respondent to state their case, and also to seek to determine whether or not the allegations can be substantiated. Therefore, not to investigate clearly denies the complainant his or her right to have a complaint addressed in a way that has a greater chance in determining the efficacy or otherwise of the complaint.

Therefore, it is essential that investigations be embraced as a crucial element of a safeguarding system. It is also important that the investigative process is independent of the funder and the service provider, and further that the outcomes of investigative process are transparent.

Pillar 4: Consequences
Although a range of consequences can be applied to individuals and entities who fail to meet their service and legislative obligations, it is rare for any significant consequences to be applied to individuals and entities who transgress, in a significant way, their service and legislative obligations. A glaring example of this failure is that of the Yooralla rapes. While it is true that two rapists were jailed as a consequence of their horrendous behaviour towards people with disabilities in their care, this action did not come about as a result of the Yooralla Board, Chief Executive Officer or indeed DHHS taking the initiative to bring these matters to the attention of the police.

The writers are also aware of a number of cases where DHHS and particular funded agencies have failed, and in some cases refused, to mete out appropriate consequences to staff who failed their duty of care towards those people with a disability in their care. In the case of the DSC, he has also failed to make any such recommendations. In terms of individuals who transgress significantly against people with disabilities, a range of options is available to managers. While acknowledging industrial agreements and Fairwork requirements may have some import, nonetheless, again it is reasonable to suggest that rarely have significant consequences been applied.

Financing and Distribution

If safeguarding is to be taken seriously and be effective, then it must go beyond the rhetoric and there must be full acknowledgment that the framework must be adequately funded. Regardless of whether the framework functions are located under the NDIA, contracted out or under a **NDCA** there will be a cost. However, a significant advantage associated with the functions being located under a separate **NDCA** entity is that this reduces the risk of compromising transparency. Also, while clearly separating funds as allocated for their specific purposes without the potential for cross–subsidisation or funds leakage.

Further, in terms of funding the **NDCA**, it would be incongruous to seek to deliver the NDIS program to the tune of $ 22 billion per annum when fully rolled-out, but then seeking to skimp on safeguarding functions.

In terms of distribution of the resources and people necessary to operationalise a safeguarding framework, again it is argued that regardless of whether the framework functions are located under the NDIA, contracted out or under the **NDCA,** distribution of the resources remains the same. Indeed, the writers contend that a Commonwealth funded and managed **NDCA** should presents no greater costs and there are a number of examples of Commonwealth managed functions already operating across Australia. Additionally, discontinuing individual jurisdictional controls, as through entities such as the DSC, the Public Advocate and government departments, present the opportunity for cost savings.

Concluding Comment

If a totally independent safeguarding agency is not established to be responsible for the four pillars as defined above, it is reasonable to suggest that abuse, neglect, exploitation and violence will continue unabated.

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