Safeguarding the rights of people with disability in Victoria through death reviews

Young people in residential aged care – 31 August 2018

Maggie Whitmore
DSC powers and functions

1. Resolve complaints about Victorian disability services
2. Oversight of critical incident reports
3. Conduct research into improving complaints systems
4. Deliver education and information about complaints
5. Receive an annual report of complaints from all registered disability service providers
DSC new powers and functions

- Oversight of Category 1 incident reports - assault, injury and poor quality care
- Authorised Officers to inspect premises in response to reports of abuse or neglect
- Review of deaths in disability services
- Commissioner initiated investigations into abuse and neglect
- Education and resources in relation to the prevention and reporting of abuse
Investigations of adequacy of disability services to people who have died

- Investigations typically include a review of factors such as:
  - Health and support planning
  - Risk management
  - Service provider policies and procedures
  - Service provider actions and responses

- Will include reviewing service records, interviewing staff and may include reviewing hospital and GP records

- Have established an MOU to work and share information with the Victorian State Coroner
What we learnt from the research

- **New South Wales Ombudsman 2013** *Report of reviewable deaths in 2010 and 2011: volume 2 – deaths of people with disabilities in care*

- **Office of the Public Advocate 2016** *Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland – a systemic advocacy report*

- **Parliament of Victoria**, *Family and Community Development Committee, Inquiry into abuse in disability services: final report, State Government of Victoria*

- **Heslop P et al. 2013, op. cit.**; **MENCAP 2007**, *Death by indifference: following up the Treat me right! report,*
Our approach to investigations

Investigations are:
• Person centred

• Utilise and consider the principles of the
  – Disability Services Act 2006,
  – the Charter of Human Rights and Responsibilities Act 2006
  – The United Nations’ Convention of the Rights of Persons with Disabilities
Process of investigations

• Request for information
• Phase one investigations
• Phase two investigations
Outcomes of investigations

- Notice to Take Action
- Advice to the Secretary and/or Minister
- Advice to the service provider
Annual report: review of disability service provision to people who have died
“When people not used to speaking out are heard by people not used to listening then real change can be made.” - John O’Brien