Ombudsman
New South Wales

Abuse and neglect of vulnerable adults in NSW – the need for action

A special report to Parliament under section 31 of the Ombudsman Act 1974

2 November 2018

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New South Wales

2 November 2018

The Hon John Ajaka MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon Shelley E Hancock MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Madam Speaker

Pursuant to s31 of the *Ombudsman Act 1974*, I am providing you with a report titled *Abuse and neglect of vulnerable adults in NSW – the need for action*.

I draw your attention to the provisions of s31AA of the Ombudsman Act in relation to the tabling of this report and request that you make it public forthwith.

Yours sincerely

Michael Barnes
Ombudsman

Foreword

In July 2016, my office commenced a standing inquiry into the abuse and neglect of adults with disability in community settings, such as their family home. We began the inquiry as we were repeatedly and increasingly contacted about serious matters of alleged abuse and neglect of adults with disability, and because there is currently no other agency that is equipped to perform this role.

In particular, there is no other agency that has the powers to investigate allegations that do not reach a criminal threshold, and that can play a lead role to marshal a coordinated interagency response to address the critical issues.

This report is about the 206 reports of alleged abuse and neglect of adults with disability in the community that my office has handled in connection with the standing inquiry. As the case studies illustrate, the inquiry has identified highly vulnerable adults who are living in atrocious circumstances, and experiencing serious and ongoing abuse and neglect. The inquiry has shone a spotlight on the appalling living conditions of some of the most vulnerable members of our community, including some individuals who have been hidden from society and prevented from accessing the supports they need.

Our inquiry – and the powerful examples of the significant infringement of the rights of adults with disability by those they should be able to trust – has demonstrated the urgent need for better safeguards and protections for vulnerable adults in the community. While our standing inquiry has provided assistance, this role is temporary, and critical gaps remain. We agreed to continue our standing inquiry until 1 July 2019, to minimise the risks to adults with disability in the community while a longer-term option is identified and established; in my view, it is imperative that a comprehensive safeguarding approach for vulnerable adults is developed.

The NSW Law Reform Commission's recent recommendations from its review of the *Guardianship Act 1987*, including to establish an independent statutory position of a Public Advocate with investigative and related functions, are timely. They propose a way forward that both picks up the work that has been temporarily covered by the standing inquiry, and addresses the gaps that our inquiry is unable to address – including elder abuse. This report provides crucial evidence of why this is needed as a matter of priority.

As a State, we have led the way in the mandatory reporting and independent oversight of the abuse and neglect of people with disability in disability accommodation settings. However, it is unacceptable to seek to improve safeguards and protections for vulnerable adults from abuse and neglect only in connection with disability services. Our inquiry has shown that there is horrendous abuse occurring in family homes and other community settings that needs to be addressed.

Michael Barnes
Ombudsman

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Executive summary

In July 2016, the Ombudsman's office commenced a standing inquiry under section 11(1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* to examine and respond to allegations of abuse and neglect of adults with disability in community settings, such as the family home.

We started the inquiry:

- in recognition of the seriousness of the increasing number of matters that were being reported to us that raised concerns about the safety and welfare of adults with disability in the community, and
- in the absence of any other agency with the powers to investigate allegations that do not reach a criminal threshold or that otherwise require a coordinated interagency response.

The standing inquiry

Between August 2015 and October 2018, we received 358 contacts relating to the alleged abuse and neglect of adults with disability living in community settings. Most (206) of the matters involved reports of alleged abuse and neglect that required action as part of the standing inquiry.

The 206 reports do not relate to the conduct of service providers – they are about the conduct of the person's family and other informal supports, and members of the community.

Source of reports

We have an agreement with the National Disability Abuse and Neglect Hotline that it will refer matters to us that involve allegations of abuse and neglect of adults with disability in community settings in NSW. Of the 206 matters, 55 (27%) have been referred to us by the Hotline. The majority (143) of the other matters have been directly reported to us by external agencies or individuals.

The primary source of reports (whether via the Hotline or directly to our office) has been non-government disability providers, who have accounted for almost half (91) of all reports. Other main reporters include family members (34), NSW government or funded agencies (24), and community members (20).

The people involved

Alleged victims

Over half (110) of the matters reported to us in the standing inquiry have involved allegations of abuse or neglect of an adult with intellectual disability. More broadly, most reports have involved a person with some form of cognitive impairment.

However, there has been a range of matters in which the person has not had a cognitive impairment – including 11 matters that involved a person with a solely physical disability.

Subjects of allegation

Most of the subjects of allegation have had a close and personal relationship with the adult with disability – with most of the alleged abuse and neglect committed by their family members or their partner/spouse.

Over two-thirds (141) of the reports have been about the conduct of family members – mainly parents (99) and siblings (31). The adult with disability's partner/spouse has been the subject of allegation in 17% of matters (35). A smaller number of reports have involved community members (10) and ex-support staff of the adult with disability (4).

The reported allegations

Most of the reports have involved more than one type of abuse and/or neglect – most commonly neglect (78) and physical abuse (77). Allegations of ill-treatment featured in 56 reports, and one-quarter of reports involved alleged financial abuse of the adult with disability (52). Over 10% of reports included allegations of sexual abuse (24).

Our actions under the standing inquiry

Our actions in response to the reports typically involve undertaking inquiries with agencies that are currently, or have recently been, involved with the alleged victim; checking available intelligence on relevant parties (including police and child protection databases); bringing agencies together to facilitate the exchange of relevant information, discuss the existing risks, and agree on necessary actions; and monitoring the implementation of the agreed actions.

The standing inquiry has enabled our office to test, in a very practical sense, what needs to be done to provide an effective interagency response to these matters. Our handling of the 206 reports has highlighted that providing an effective interagency response can be relatively straightforward – provided that the agency taking the lead role has access to the right information, adequate powers, and the cooperation and support of key government and non-government stakeholders.

However, the Ombudsman's standing inquiry is a temporary measure, and will cease on 1 July 2019. In addition, there are critical gaps that are not addressed by the standing inquiry. In particular, we do not have the power to enter private residences to gain direct access to the alleged victim, and we are not competent or compellable to provide information to NCAT. The standing inquiry also does not encompass elder abuse.

The need for an effective safeguarding approach for vulnerable adults

In the context of the persuasive evidence provided by our standing inquiry, and the findings and recommendations from NSW and national inquiries into elder abuse, there is an urgent need for an effective, integrated framework and independent lead agency for responding to the abuse and neglect of *all* vulnerable adults in community settings in NSW.

We strongly support the recommendations of the NSW Law Reform Commission from its review of the *Guardianship Act 1987*, relating to the establishment of an independent statutory position of a Public Advocate to (among other things) investigate – of its own motion or in response to a complaint – cases of potential abuse and neglect of people who need decision-making assistance, with powers to:

- apply for and execute a search warrant if needed
- intervene in court or NCAT proceedings in certain cases
- require people and organisations to provide documents, answer questions, and attend compulsory conferences

- refer allegations to equivalent agencies in other jurisdictions
- exchange information with relevant bodies
- have read-only access to the police and child protection databases.

Our standing inquiry has highlighted some significant issues that should inform the development of a comprehensive safeguarding approach for vulnerable adults in NSW, and the work of the independent lead agency. In particular:

- There is a need for concerted guidance, service improvement, and capacity development with providers, agencies and the community in relation to the abuse and neglect of vulnerable adults in community settings – to ensure that matters are reported, and appropriate action is taken.
- There are significant opportunities to assist the work of police, through coordinating actions to assess and address the circumstances of the vulnerable adult, and providing a point of referral for police for guidance and support on specific matters. There is also a need to enhance police expertise in interviewing people with disability who have communication support needs and cognitive disability, to maximise their ability to give evidence and gain effective access to justice.
- All efforts should be taken to maximise the involvement of the vulnerable adult in the response that is provided to the alleged abuse and neglect – including through the provision of appropriate decision-making supports.
- There is a need for provisions for agencies that have responsibilities relating to the safety of vulnerable adults to be able to exchange information that promotes the safety of vulnerable adults – these agencies need to be able to share critical information with each other, and not have to rely on the Public Advocate to facilitate the exchange of information.

What is needed

From 1 July 2019, the NSW Ombudsman's office will no longer carry out its standing inquiry into the abuse and neglect of adults with disability in the community. Without an alternative option in place, this gap will present unacceptable risks to an already vulnerable and marginalised cohort of our community. There is a need for swift action to establish a comprehensive adult safeguarding approach that will both fill the looming gap in relation to adults with disability, and address the longstanding gap in relation to vulnerable older persons.

The recommendations of the NSW Law Reform Commission in relation to the establishment of an independent Public Advocate with investigative functions provide a timely and constructive way forward. However, there are a small number of supplementary steps that are required to provide an effective, integrated and person-centred approach to responding to the abuse and neglect of vulnerable adults in NSW – including information sharing provisions for relevant agencies, and enhanced options for decision-making assistance.

More broadly, the NSW Ombudsman's office would hope that this report acts as a trigger to the NSW Government to commit to a broad review, focused on establishing in NSW the strongest independent safeguarding and regulatory system in Australia for protecting vulnerable groups in our community.

Recommendations

It is recommended that the NSW Government should:

1. Implement the recommendations of the NSW Law Reform Commission in relation to the establishment of an independent statutory body to investigate and take appropriate action in relation to the suspected abuse and neglect of vulnerable adults in NSW, as outlined in its report on the *Review of the Guardianship Act 1987*.

2. As part of the establishment of the independent statutory body, and to support the development and implementation of an effective and integrated safeguarding approach for vulnerable adults in NSW:

    a. Introduce legislative provisions to enable agencies that have responsibilities relating to the safety of vulnerable adults to be able to exchange information that promotes the safety of vulnerable adults.

    b. Ensure that there are enhanced options for vulnerable adults to gain appropriate decision-making assistance. The recommendations of the NSW Law Reform Commission in relation to supported decision-making should be considered as part of this response.

3. Review the independent safeguarding and regulatory arrangements in NSW to identify opportunities to strengthen the system for protecting vulnerable groups in our community, with a view to considering the potential benefit of creating a single independent community services oversight body.

Chapter 1. Introduction

Examples of allegations reported to the NSW Ombudsman

- A young woman with intellectual and physical disability who is unable to verbally communicate and relies on a feeding tube for nutrition lives at home with her mother and her mother's partner. The mother uses cable ties, a dog leash and sheets to tie the young woman to her wheelchair and bed. The mother terminated the services of a previous disability in-home support provider who made a report to police about her restraining the young woman and leaving her alone in the house for the evening while she went out.

- A man in his 20s with psychosocial disability is living with his father in accommodation that is filthy and infested with cockroaches to the extent that housing officers say is the worst they have seen. The man has not left the residence in over three years, and his father controls his medication and money, and blocks his access to services. The man is an NDIS participant, but his father only temporarily links him in with NDIS supports when external parties ask questions.

- A young man with intellectual disability lives at home with his parent. He shows signs of neglect, including poor hygiene, weight loss, and limited access to food. He has unexplained bruising, does not have access to medical treatment for his health issues, his parent has stopped him from seeing his psychiatrist, and he turns up to his day program in a sedated state. The young man does not have any access to his own money, and it is suspected he is exposed to domestic violence and drug use in the home.

These are just some of the over 200 allegations of abuse and neglect of adults with disability by family members or other community members that have been reported to the Ombudsman's office in the last three years.

This report concerns these appalling cases of abuse and neglect of adults with disability that resulted in the NSW Ombudsman commencing an ongoing standing inquiry to both examine and respond to these human rights infringements. The report demonstrates that there is a gap in the existing safeguards in NSW that leaves vulnerable adults without adequate protection, and it outlines what is urgently required to address this gap.

1.1. Background to the standing inquiry

In December 2014, the *Ombudsman Act 1974* was amended to introduce the Disability Reportable Incidents scheme, which requires the Department of Family and Community Services (FACS) and funded disability providers to notify the NSW Ombudsman of serious incidents of abuse, neglect and ill-treatment of people with disability living in supported group accommodation. The Disability Reportable Incidents scheme was the first legislated scheme in Australia for the reporting and independent oversight of allegations of abuse and neglect in disability services.

In 2015, disability providers became accustomed to reporting allegations to our office, as well as contacting us to discuss related practice issues in their accommodation services. From August 2015, disability providers also started raising concerns with us about their clients in community settings – such as a client who attended a day program and showed signs of neglect, and a client of an in-home support service who appeared to be subject to abuse and/or neglect by their family member(s).

We continued to receive an increasing number of contacts about these types of matters, coinciding with the progressive withdrawal of FACS from the provision of specialist disability services. Consequently, in July 2016, the Community and Disability Services Commissioner/ Deputy Ombudsman commenced a standing inquiry under s11(1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) to examine and respond to allegations of abuse and neglect of adults with disability in the community, such as the family home.[1] While many of the individuals have contact with disability services, the inquiry does not include allegations about staff members or relate to the conduct of disability service providers – these matters only relate to alleged abuse and neglect of adults with disability in private or community settings by family, informal carers, and other community members.

The decision to commence the standing inquiry reflected the seriousness of the matters that were being reported to our office, and the fact that there is no other agency with the powers to adequately investigate these types of allegations. Our inquiry has also shown that there is an urgent need for an agency to play a lead role in these types of matters, to ensure that the information held by various agencies is considered holistically, and to arrange for a coordinated interagency response to address matters that involve fundamental breaches of the human rights of vulnerable adults.

Case study 1

A member of the public contacted us to raise concerns about the circumstances of a young man with intellectual disability and autism who lived next door.

The young man lived in a converted garage at the back of his family's house, and the neighbour reported that the young man was left at home unsupervised and extremely distressed for most of the day. The young man was observed to wander the backyard for hours, slapping his face, biting himself, crying out, and banging on the door to the main house. The man's family was seen by the neighbour to hit him with a broom to move him away if he approached visitors to the home.

The neighbour told us that the room the young man lived in was squalid, attracting blowflies; the stench of human faeces reached the neighbouring properties; and the accommodation had been assessed as requiring forensic cleaning. The neighbour reported that the young man was not allowed inside the family home, and his family would leave food outside on a table for him, where the dog would access it. We were told that this situation had been going on for many years; even as a child, the young man would be dropped home from school by a bus and locked in the backyard unattended. The neighbour had previously made complaints to FACS and police about the young man's living conditions.

We checked the child protection and police intelligence systems and found a long history of concerns – including multiple reports of domestic violence, allegations of unexplained bruising and sexual abuse of the young man, and child protection reports relating to concerns of neglect. Police, Community Services and Ageing, Disability and Home Care (ADHC) had identified concerns about the living environment and provision of care, and police officers had sent photographs to Community Services of the young man's living conditions, including cockroach infestations and faeces in his bed and on the walls. While Community Services and ADHC had previously discussed the potential need for a

[1] Section 11(1)(e) of CS CRAMA enables the Ombudsman to inquire, on his own initiative, into matters affecting persons receiving, or eligible to receive, community services. Under CS CRAMA, 'community service' means services rendered under the community welfare legislation (such as the *Community Welfare Act 1987*, the *Disability Inclusion Act 2014*, and the *Guardianship Act 1987*) or a service rendered by a person or organisation that is covered by an arrangement between a NSW Minister and a State or Commonwealth Minister, under which arrangement the State or Commonwealth Minister agrees to the person or organisation being a service provider for the purposes of CS CRAMA.

guardianship application, they held the view that there was insufficient evidence to warrant this action.

We convened an interagency meeting with FACS, police and the Public Guardian. During the meeting, and after discussing the current circumstances and risks in play for the young man, it was agreed that FACS would submit a report to the NSW Civil and Administrative Tribunal (NCAT) detailing the concerns, relying on the consolidated brief of information that we had compiled from the holdings of the involved agencies. NCAT subsequently appointed the Public Guardian for the young man for 12 months for decisions about his accommodation, health care, and medical and dental treatment consent.

Chapter 2. The standing inquiry

Between August 2015 and October 2018, the NSW Ombudsman received 358 contacts about alleged abuse and neglect of adults with disability living in community settings. Of these 358 contacts:

- 103 (28.8%) were enquiries – in these matters, we have typically provided information and advice to service providers and other callers about available options. For example, we have discussed with disability providers the actions they could take in response to signs of suspected neglect.
- 49 (13.7%) involved complaints about the actions of disability providers – in these matters, the issues have primarily related to the provider failing to take action in response to concerns, or providing an inadequate or inappropriate response.
- 206 (57.5%) involved reports of alleged abuse and neglect of adults with disability in the community, which we handled under the standing inquiry (or in the lead-up to the inquiry).

This report is focused on the 206 reports of abuse and neglect involving people with disability in community settings that have been handled by our office in connection with the standing inquiry. At the outset, it is important to recognise that:

1. The 206 reports **do not relate to the conduct of service providers** – they are about the conduct of the person's family and other informal supports, and members of the community.
2. The Ombudsman's office has received the 206 reports without actively promoting the standing inquiry. As a result, and based on the Ombudsman's experience with the Disability Reportable Incidents scheme, the number of matters reported to date is unlikely to represent the prevalence of incidences of this kind across the community.[2]
3. The Ombudsman only has jurisdiction to look at matters involving adults with disability. For this reason, although the findings from our inquiry are also relevant to vulnerable older persons, the specific matters discussed in this report relating to the standing inquiry only pertain to vulnerable adults with disability.

Examples of allegations reported to the NSW Ombudsman

- A woman with intellectual disability and autism has arrived at her day program with bruising and a black eye. The explanation provided by her family is inconsistent with the injuries. The disability provider has recorded evidence of bruising and other injuries to the woman over a number of years, and documented the woman pointing to her bruising and saying 'mum' and 'dad'. The woman asks staff if they are going to 'hit' her after engaging in particular behaviour, and asks where the 'stick' is to hit her.

[2] In this regard, we note that when we established the Disability Reportable Incidents scheme, the reporting rate (then 50 notifications per month) was around 50% higher than our original estimate. Based on a comparison between the Disability Reportable Incidents scheme and our complaints data, the notification of matters via the mandatory reportable incidents scheme was over 10 times the number of matters we received via complaints.

- Two women with intellectual disability and mental illness live at home with their parent. Their sibling, who no longer lives at home, told us that the parent physically assaults the adult sisters by pulling their hair, restraining them, beating their heads against the wall, and throwing objects at them. The sibling also reported that the parent overmedicates the sisters to manage their behaviour, verbally abuses them, withholds money, and isolates the sisters by locking them in the house for extended periods.

- A man with quadriplegia lives with his sister, who is his primary carer. A disability in-home support provider contacted us and advised that the man has disclosed that his sister takes his money, and has coerced him into signing over his share of the house to her. The man had also disclosed that he is subject to constant verbal abuse by his sister, and that after workers from the in-home support service have left for the day, he is shut in his room and given no assistance.

2.1. Source of reports

2.1.1. Referral of matters

Since 2016, we have had an agreement with the National Disability Abuse and Neglect Hotline under which it refers to our office matters involving allegations or concerns about the abuse and neglect of adults with disability in community settings in NSW (with the consent of the reporter). The agreement provides the Hotline with a central agency to refer matters to, and provides our office with key details to inform our contact with the reporter – including enabling us to conduct initial checks of our information holdings to identify any previous contact with the reporter and other involved parties.

Of the 206 matters, 55 (27%) have been referred to us by the Hotline.

In a small number of cases (8), we have identified concerns about individuals in community settings through our other functions, such as through our handling of disability reportable incidents, complaints, or project work.

The other 143 matters (69%) have been directly reported to us by external agencies or individuals.

2.1.2. Reporters

As identified in Table 1, while we have received reports from a diverse range of sources, the primary source has been non-government disability providers. Disability providers have accounted for almost half (44%) of all matters – in the main, it has been day program/community participation providers (28), in-home support providers (19), and NDIS support coordinators (14) raising concerns about the abuse and neglect of their clients.

Family members – mainly siblings (15) and parents (11) – have raised 34 matters. NSW or Commonwealth government (or funded) agencies, such as agencies providing health, education, housing, and local area coordination services, have reported 32 matters. Neighbours have accounted for half of the 20 reports by community members.

Table 1. Reporters of standing inquiry matters

Reporter	Number	Percentage
NGO disability provider	91	44.2
Family member	34	16.5
NSW agency	24	11.7
Community member	20	9.7
Commonwealth agency	8	3.9
Internal referral	8	3.9
Private provider/practitioner	7	3.4
Alleged victim	6	2.9
Friend	5	2.4
Other	3	1.5
Total	**206**	**100**

Case study 2

A disability day program provider raised concerns with us about potential abuse and neglect by the family of a 19-year-old woman with a severe intellectual disability and autism. The disability provider advised that:

- the young woman consistently refused to return home, including screaming, barricading herself in the office, becoming highly distressed, and refusing to get out of the car when she arrived back home
- she showed signs of neglect, including attending the day program without any food or water, and having poor hygiene and dirty clothes
- she made statements that suggested that she had been subjected to sexual and physical abuse in the family home
- staff had witnessed her being verbally and physically abused by her parents, including the use of physical force that required intervention by staff, and
- staff had noticed bruising and a bite mark on her body.

Following advice from our office, the disability provider reported their concerns to police.

We obtained information from police and child protection databases, which showed a long history of concerns about the family, including allegations of neglect, aggressive and sexualised behaviour of the children, suspected sexual abuse, and disclosures by

the children regarding physical abuse. There had been limited involvement and response by child protection authorities and police, and there was still a sibling under 18 residing at the home.

Following extensive discussions between our office, the day program provider, the Public Guardian, and other involved disability providers about existing risks to the young woman, the day program provider submitted a guardianship application to NCAT.

At an urgent hearing, NCAT appointed the Public Guardian for 12 months. Immediately following the hearing, the young woman returned to the family home, and did not re-present to the day program. The Public Guardian subsequently attended the family home with police for a welfare check, and the young woman was removed and placed in respite, pending the availability of ongoing supported accommodation. Once the young woman was out of the home, the Public Guardian and service providers arranged a psychological assessment and medical review.

We concurrently made inquiries of FACS and the Department of Education about the circumstances of the younger sibling, and FACS closely examined what was happening in the home environment.

Our office facilitated the exchange of information between FACS and the Public Guardian, to ensure that the Public Guardian had all relevant information to inform its decision-making. We also provided a briefing to police, which incorporated the information we obtained from police and FACS, to make sure police had relevant background information to inform their actions.

2.2. The people involved

2.2.1. Alleged victims

Our inquiry function under CS CRAMA is tied to people who are 'receiving, or eligible to receive, community services'. In this context, our standing inquiry is focused on adults with disability.

Table 2 identifies the type of disability that was reported in relation to the alleged victim – either as their sole disability, or one of multiple impairments. People with intellectual disability have featured most often in the reported matters of abuse and neglect, represented in over half (53%) of all reports. More broadly, most reports have involved a person with some form of cognitive impairment.

However, it is important to note that there has been a range of matters in which the person has not had a cognitive impairment – including 11 matters that involved a person with a solely physical disability.

Table 2. Reported disability of the alleged victims

Disability	Sole disability reported (N)	Sole disability reported (%)	Disability reported with others (N)	Total matters (N)	Total matters (%)
Intellectual	63	31	47	110	53
Physical	11	5	25	36	17
Neurological	15	7	11	26	13
Psychosocial	8	4	18	26	13
Autism spectrum	6	3	19	25	12
Other cognitive	12	6	7	19	9
Acquired brain injury	4	2	12	16	8
Sensory	0	0	8	8	4
Insufficient information	6	3	0	6	3

2.2.2. Subjects of allegation

Table 3 identifies the relationship of the subject of allegation to the alleged victim in the 206 reported matters. Most (68%) of the reports have been about the conduct of family members – primarily parents (99) and siblings (31).

The person's partner/spouse has been the subject of allegation in 35 matters (17%) – mostly their current partner.

Members of the community have been the subject of allegation in 10 matters (5%), including neighbours (3); ex-support staff have been the subjects of allegation in four reports.

Table 3. Relationship of the subject of allegation to the alleged victim

Relationship to alleged victim	Number of matters	Percentage
Family member	141	68
Partner/spouse	35	17
Community member	10	5
Former staff member	4	2
Friend	2	1
Other	14	7
Total	**206**	**100**

2.3. The reported allegations

Examples of allegations reported to the NSW Ombudsman

- A disability provider contacted us to report the alleged neglect of a woman with an intellectual disability, epilepsy, and a feeding tube for nutrition, who lived at home with her mother and sibling. The provider reported that the woman's mother was unable to care for her properly, and that she was arriving at her day program showing signs of neglect, including rotting skin in her body creases, and an infestation of maggots at the site of her feeding tube.
- A woman with a cognitive impairment and who is reliant on full support for all daily activities lived in her own home. She received in-home support from an NDIS provider, with additional support from her brother, her informal carer. The woman's daughter reported abuse of her mother by her uncle, including verbal abuse, threats, and causing bruising to her breasts, face and body. The daughter and in-home support workers reported that the woman showed fear in the presence of her brother.
- A man with disability lives in a rural area, in a unit at the back of main house of the property, where his brother lives. The man's daughter and his advocate both contacted us to raise concerns about his circumstances. The man had disclosed physical and verbal abuse by his brother, but was reluctant to provide details and was highly distressed in providing the information. The brother was controlling the man's access to his money and identification, including Medicare and Centrelink cards. The man is an NDIS participant, but his brother was making all of the decisions about his day-to-day disability support, including ceasing services when the providers raised concerns or sought to link the man with an advocate.

The above matters handled under our standing inquiry provide examples of the types of allegations of abuse and neglect of adults with disability in the community that have been reported.

Most of the reports have concerned more than one type of alleged abuse and/or neglect. Overall, over one-third of matters have involved allegations of neglect (38%) and/or physical abuse (37%) of the adult with disability.

Matters of alleged ill-treatment (27% of reports) have included the subject of allegation blocking the person's access to supports; removing items or activities as punishment; and putting the person with physical disability to bed against their wishes at 6:30pm.

Alleged financial abuse (25% of reports) has included the family member taking all of the alleged victim's money; preventing the adult with disability from access to their own money; neighbours taking advantage of the person for money; and the family member taking the alleged victim's belongings.

Over 10% of matters (24) included allegations of sexual abuse of the adult with disability. Case studies 6 and 7 provide examples of sexual abuse matters that have been reported under the standing inquiry.

Table 4. Reported allegations

Alleged conduct	Sole issue reported (N)	Sole issue reported (%)	Issue reported with others (N)	Total matters (N)	Total matters (%)
Neglect	32	16	46	78	38
Physical abuse	32	16	45	77	37
Ill-treatment	16	8	40	56	27
Financial abuse	16	8	36	52	25
Emotional abuse	3	1	23	26	13
Verbal abuse	0	0	27	27	13
Sexual abuse	18	9	6	24	12

Examples of allegations reported to the NSW Ombudsman

- A support worker raised concerns with us about the abuse and neglect of a woman with psychosocial disability by her son, who was her primary carer. The worker told us that the man was failing to support the woman to shower and change her clothes, despite her having a broken arm; controlled the woman's access to her own finances; had punched a hole in the wall; and was growing marijuana in the house.

- A support coordinator contacted us to raise concerns about the circumstances of a young man with cerebral palsy and high physical support needs who lives with his family. The support coordinator reported that the young man had remained in bed for most of the five years since he had left school; his room, bed sheets and clothing are not cleaned and his mother will not let in-home support staff change the sheets; and his mother will not agree to the young man being showered. We were told that the young man is fed while lying down, which presents significant risks of choking and aspiration; and he is left in his room and isolated from the activities of the household and not included when the family go out.

- A family member told us that a man was abusing and neglecting his adult sister and mother. The man's sister has a physical disability and is reliant on daily care, and his mother has severe depression and is unable to care for herself and others. We were told that the man watches his sister while she is naked on her bed receiving personal care, and had been seen kissing and cuddling her inappropriately. The mother is reportedly afraid of the man, and he refuses to take her to medical and psychological appointments. The family member told us that in-home support staff had observed the behaviour but had not reported their concerns.

- We were contacted by the concerned neighbour of a man with cognitive impairment and a speech impediment who lives with his brother and his brother's family. The neighbour reported that the family is well-regarded in the community, but the neighbours have witnessed regular physical and verbal abuse of the man by his brother and sister-in-law – including him being hit on the head with the handle of an axe; hosed down in the garden; slapped in the face; and constantly yelled at. The neighbour is afraid to report the matter to police due to concerns about being identified as the reporter, and the associated risks of retribution.

2.4. Our actions in response to the reports

As highlighted by the case examples in this report, the nature of the matters that we have handled under the standing inquiry has been highly diverse – including in relation to the circumstances, support needs and decision-making ability of the adult with disability, the existing risks and protective factors, and the reported concerns.

While our actions, and the extent and duration of our involvement, has necessarily depended on the particular factors involved in the individual case, common elements of our response to these matters tend to include:

Obtaining available intelligence on relevant parties

We consider our own information holdings to ascertain any current or previous contact with, or intelligence on, any of the involved individuals. We also have read-only access to the NSW Police database (COPS)[3] and the NSW child protection databases (KiDS[4] and ChildStory), which enables us to quickly obtain relevant information about current or historical contact with police and child protection concerns. (See, for example, case studies 1-4, and 6).

Undertaking inquiries

In addition to the reporter, we also make inquiries with agencies or key individuals that are currently, or have recently been, involved with the adult with disability. Depending on the matter, this may include government and non-government agencies, oversight bodies, private practitioners, and members of the community.

Facilitating the exchange of information

At times, we identify critical information held by an agency that needs to be provided to other relevant bodies to enable appropriately informed actions to be taken to reduce the risk of harm and improve the safety of individuals. When necessary, we facilitate the exchange of the important information. For example, in some cases, the FACS child protection database has held information about the adult and their family that is relevant to the matter that has been reported to police; we have obtained consent from FACS to provide the relevant information to police.

[3] Computerised Operational Policing System (COPS)

[4] Key Information and Directory System (KiDS)

Providing guidance to agencies

In many cases, we provide guidance and advice to agencies about the actions they should take in response to identified or suspected abuse and neglect of individuals. Among other things, this has included providing guidance to agencies on: reporting to police, providing key information to other relevant agencies (such as the National Disability Insurance Agency – NDIA), supporting the person to obtain decision-making assistance and/or advocacy support, and supporting staff to identify and appropriately respond to instances of abuse and neglect.

Facilitating links to services, when required

In some cases, and in the absence of another appropriate party to do so, we have provided assistance to link the adult with disability to supports. In particular, this has included facilitating connections with services for advocacy support, and for assistance to access the NDIS.

Facilitating interagency discussions and plans for action

In certain cases, particularly where the matter is complex or the information points to a high level of risk for the person with disability, we bring agencies together to facilitate the sharing of relevant information, discuss the existing risks, and agree on necessary actions. (See, for example, case studies 1, 5 and 6).

Monitoring the implementation of agreed actions by agencies or individuals

In many matters, we monitor the implementation of agreed actions by agencies or individuals to improve the safety and welfare of the alleged victim – irrespective of whether the actions were agreed in an interagency meeting or in separate discussions with our office. We tend to monitor the situation until we can see that the actions are well in-train, or feel confident that the involved agencies will take appropriate additional actions if the situation changes.

Case study 3

A health worker contacted us to raise concerns about the circumstances of a woman who resides at home with her husband and adult son. The woman has a total mobility impairment and relies on her husband for her care, but does not have a cognitive impairment. We were advised that another health worker had conducted a home visit several weeks earlier and had significant concerns about the strong smell of faeces in the home; dried faeces on a recliner chair and on the back of the woman; very dark urine observed in her catheter bag; water bottles full of urine scattered about the room; and green pus observed to be oozing from a pressure wound on her back. During the home visit, the husband had refused the woman's request for water, and had refused to give her any pain medication. The man told the health worker that his wife had not been washed for two weeks; the health worker's assessment was that the timeframe was much longer.

Our review of police intelligence identified allegations of domestic violence spanning a five-year period – including allegations of financial, emotional and physical abuse. In one incident, the woman's husband allegedly kicked her repeatedly in the groin after she had an episode of incontinence. He was charged with common assault and an AVO was obtained. In another incident, the woman had attempted to leave her husband; however, he had chased her in his vehicle and snapped off her windscreen wiper. He was charged with malicious damage.

We provided a brief of information to police, noting a possible offence of failure to provide the necessities of life under s 44 of the *Crimes Act 1900*. In response, police Domestic Violence Liaison Officers visited the woman at her home and formed a view that no offence had occurred; police did not take further action.

We made enquiries with the disability provider who was providing in-home support twice a week. The provider told us that:

- the woman sits in her recliner chair all day and all night, which places her at very high risk of pressure sores
- the woman is only showered once a week as her husband had refused to allow hoists or other equipment into the home to enable staff to shower her
- equipment was not in place to enable staff to change the woman's continence aid, which resulted in her sitting in her faeces for a week before her husband returned from his work trip and changed the continence aid.

The provider advised that its staff never spoke to the woman alone; her husband was always present and would speak over the top of her. The provider told us that it was withdrawing support in light of the existing risks, and referred the woman to another service. The provider agreed to provide information to the NDIA about its concerns.

We contacted the new in-home support provider, who advised that its staff had not been informed about the complexities of the case prior to commencing service provision. Staff had significant concerns about the woman's poor hygiene, and noted that she appeared to be in significant pain and was fearful of staff advising her husband about her pain. The provider told us that the woman had been taken to hospital due to her pain. In hospital, doctors expressed grave concerns for the woman's welfare and skin integrity, but she discharged herself from hospital against medical advice. The provider agreed to bring staff's concerns to the attention of the NDIA.

We spoke to hospital staff, who advised that NSW Health had reported its concerns to the NDIA. While the woman's husband had told hospital staff and the disability providers that there was not enough funding in her NDIS plan, our enquiries with the NDIA identified that the woman had over $70,000 of unspent funds.

We provided a briefing to the NDIA on the concerns that had been raised with our office, and the NDIA subsequently asked a local area coordinator to contact the woman to help her to implement her plan. Given the complexity of this matter and the significant risks in play for the woman, we escalated the matter in the NDIA, and the Agency appointed an NDIS support coordinator.

After the woman left hospital, her husband engaged a different in-home support provider, whose staff were not aware of the pre-existing concerns. The new provider also identified a range of concerns, including about the woman's hygiene and personal care. Staff were also concerned that the woman was receiving strong doses of pain medication, which were not the dosage prescribed by her doctor. When the woman showed signs that she was in pain, staff offered to call an ambulance; however, the woman declined as her husband had threatened that she would be taken to a nursing home. After staff raised concerns with the family, the husband told the provider that he had decided to cease its service. We advised the provider that, as the woman is the NDIS participant and has decision-making ability, staff should seek her views and consent prior to ceasing service. When the provider spoke with the woman, she advised that she did not want to end their support, but she felt that she did not have a choice as she believed it was what her husband wanted.

We contacted the NDIA again to ensure that the allocated support coordinator had been advised of all relevant background information, including the need to consult and take direction from the woman about her supports, and to confer with the woman alone to ensure her wishes were heard.

The support coordinator was able to develop rapport with the woman, and the woman was recognised as the decision maker in relation to her supports and the only person who could cancel them. The support coordinator engaged a new in-home support provider, and an occupational therapist and physiotherapist reviewed her manual handling and pressure care. An occupational therapist was also engaged in relation to home modifications. We followed up with the providers to ensure that the woman had regular access to hospital to have her catheter changed, and monitoring of her pressure areas.

2.5. Factors that have assisted our work under the standing inquiry

Our handling of the 206 matters relating to the alleged abuse and neglect of adults with disability in community settings has highlighted that providing an effective interagency response to this issue can be relatively straightforward – provided that the agency taking the lead role has access to the right information, adequate powers and the cooperation and support of key government and non-government stakeholders. In this regard, the following factors have been key to our office being able to respond to these matters:

- We are able to inquire into matters of our own motion. While the majority of the matters have been reported to us, we are not reliant on having a complainant, and we are able to act on information irrespective of its source.
- We have the power to require agencies to provide us with information and documents. Our power to compel the provision of information both assists us to obtain vital intelligence, and provides protection for parties from privacy requirements.
- Our role as an independent watchdog agency and our standing and pre-existing relationships with agencies has meant that we have had good cooperation from agencies – including participation and active engagement in interagency meetings, and implementation of agreed actions. In particular, our longstanding professional relationship with senior officers in NSW Police, FACS and Public Guardian has been of significant assistance in responding to these matters.
- Our direct access to the police and child protection databases has been critical to identifying risks and gaining an important overview of the broader issues in play for the adult with disability and their family.

Case study 4

A day program provider contacted us with concerns about a young man with intellectual disability. Several months earlier, the young man had presented at the day program with a black eye, and said that his stepfather had punched him. The provider had discussed the allegation with the young man's mother, who told the service to ignore the disclosure as he tended to make things up. We advised the provider to make a report to police.

In response to the report, police attended the day program and spoke with staff and the young man, but were unable to obtain a statement from him. Police arranged for the young man to attend the police station with his stepfather and mother, and reached the view that the young man was unable to make a statement due to his disability. They spoke with his mother, who told police that the young man could become 'attention seeking', and said that he had previously made allegations against others, which had been investigated by FACS and found to be false.

We reviewed the child protection database and identified multiple child protection reports in relation to the young man, relating to significant injuries on numerous occasions over several years – including facial bruising, a large scratch that appeared to have been made by a pen on his back, and bruising to his legs. The young man had indicated that all of the injuries had been caused by his stepfather; there were no reports of the young person attributing the injuries to any other person. None of the reports had been reported to police. Following discussion with our office, FACS provided information to police about the allegations that pertained to a potential criminal offence.

We provided detailed feedback to the day program provider on its record keeping; its response to the young man's disclosures, including the delay in reporting to police and discussing the allegation with the young man's mother (and partner of the subject of allegation) prior to reporting to police; and its related guidance for staff.

2.6. Why the standing inquiry is a temporary measure

Our standing inquiry has enabled the Ombudsman's office to play an important role in relation to the abuse and neglect of adults with disability in community settings, and to test, in a very practical sense, what needs to be done to provide an effective interagency response to these matters. However, the standing inquiry is – and was always intended to be – a temporary measure until a longer term and more comprehensive option could be established.

There are two main reasons why the standing inquiry is necessarily temporary:

1. From 1 July 2019, our community services jurisdiction will be much more limited.

The Ombudsman's inquiry function only extends to matters affecting service providers and persons receiving, or eligible to receive, community services.[5] The main way that we pick up adults with disability under our inquiry function is through an arrangement between the Commonwealth and NSW that provides for NDIS support providers to be 'service providers' under CS CRAMA. That arrangement has been extended on a temporary basis until 1 July 2019.

While the arrangement could theoretically continue to be extended by the responsible Ministers beyond 1 July 2019, this would be impractical. In this regard, we note that, in the wake of the introduction of the NDIS Quality and Safeguards Commission, the Ombudsman's contact and connection to disability providers will increasingly be limited to the operation of the Official Community Visitor (OCV) scheme.[6] It is important that the lead agency for handling these matters has a meaningful and continuing connection to the disability sector.

2. There are critical gaps that are not addressed by the standing inquiry.

Notably, the standing inquiry only pertains to adults with disability who receive, or are eligible to receive, community services. It does not include all vulnerable adults – in particular, it does not include older persons who are not eligible for community services and, therefore, excludes most matters involving elder abuse.

In addition, the Ombudsman's legislation does not enable us to undertake certain activities that are vital to providing a comprehensive adult safeguarding approach, including:

- **We do not have the power to enter private residences to gain direct access to the alleged victim. In certain matters involving significant risk to the alleged victim, this is essential.**
- **We are not competent or compellable to give evidence or produce any document in any legal proceedings in respect of any information we obtain in the course of our work.[7] As a result, we are unable to give evidence in NCAT hearings, and our information is unable to be used in the proceedings. This has presented significant challenges and unintended consequences in the standing inquiry.**

  In particular, at times, our office has been the only party who has had the full picture of the alleged conduct and the concerns of multiple parties. We have had to rely on involved agencies to provide a full account to NCAT (which they have not done), and/or we have provided NCAT with the contact details of relevant parties who could provide key information to inform the hearing (who have not been contacted by NCAT). As a consequence, there have been at least three matters that, in the absence of all the relevant evidence being before

[5] Under CS CRAMA, 'community service' means a service rendered under the community welfare legislation (such as the *Disability Inclusion Act 2014*, and the *Guardianship Act 1987*), or a service rendered by a person or organisation that is covered by an arrangement between a NSW Minister and a State or Commonwealth Minister, under which arrangement the State or Commonwealth Minister agrees to the person or organisation being a service provider for the purposes of CS CRAMA.

[6] At the moment, the NDIS Quality and Safeguarding Framework does not include a community visitor scheme. At the time of writing, a multilateral review of existing community visitor schemes in relation to people with disability is underway, examining the intersection of the schemes with the NDIS, with a final report due in December 2018. The outcomes of the review will inform the future operation of the NSW OCV scheme in relation to people with disability.

[7] Section 35(1) of the Ombudsman Act.

them, have resulted in NCAT appointing the subject(s) of allegation as the guardian of the alleged victim.

It is crucial that these and other gaps are addressed through a comprehensive adult safeguarding approach in NSW, informed by the lessons and issues from the standing inquiry.

Case study 5

In 2012, FACS removed 12 children from an extended family, a group comprised of some 40 adults and children living communally in inadequate conditions on a farm in regional NSW.[8] At the time of their removal, the children were neglected and malnourished. The family was living in unhygienic and squalid conditions, and were found to have multiple, untreated medical and dental concerns. Some of the family members were developmentally delayed; others were cognitively impaired.

While the children were removed and placed under the parental responsibility of the Minister until the age of 18 years, there were barriers in agencies being able to act to safeguard the adult family members who had a cognitive impairment. In particular, the absence of an investigative function meant that the Public Guardian did not have direct access to the individuals to ascertain whether they were in need of guardianship or other protection or supports.

In part, the inability of agencies to respond effectively to this matter – particularly the significant number of vulnerable adults in the family with disability – was linked to the lack of authority and responsibility by any particular agency to provide a well-calibrated, coordinated response. By the time we commenced our standing inquiry, the family had dispersed across the country.

This year, police arrested eight adult family members in regional areas of NSW, South Australia, and Western Australia, on charges including perjury, sexual intercourse with minors, indecent assault, common assault, and incest. Following the arrests, NSW Police contacted our office to seek assistance in relation to some of the adults remaining on the properties whom police had identified were in need of disability and/or health supports. With the consent of police, we provided information to the Public Guardian, who had been appointed in relation to one of the adults in NSW, and the Public Advocates in SA and WA, to enable them to make relevant inquiries and take appropriate action. We also held an interagency meeting with the Public Guardian, FACS and police to discuss the actions that were required to safeguard the adults in NSW, and to ensure that relevant agencies in SA and WA had relevant information relating to the adults who had previously been in residential care in NSW.

[8] *DFaCS (NSW) and the Colt Children* [2013] NSWChC 5

Chapter 3. A safeguarding approach for vulnerable adults

There is a need for a coordinated approach and local response by NSW agencies to the abuse and neglect of its vulnerable citizens. In addition to the matters handled by our office under the standing inquiry in relation to the abuse and neglect of adults with disability in the community, there are well-documented, similar issues concerning elder abuse. There is an urgent need for an effective, integrated framework and independent lead agency for responding to the abuse and neglect of *all* vulnerable adults in NSW.

In November 2016, we held a public forum on *Addressing the abuse, neglect and exploitation of people with disability*. The forum was attended by over 500 people with disability and their supporters, service providers, government agencies and others. Forum participants noted the critical need for an effective framework to respond to this particular issue for those who are vulnerable and living in the community. In response, we gave a commitment to do what we could to advocate for a more robust framework for this particularly vulnerable cohort.

In 2016/17, we provided a briefing paper to the NSW Department of Premier and Cabinet (DPC) and FACS on our work as part of the standing inquiry, and proposed the establishment of a NSW Public Advocate as a solution to the gaps that had been identified. We emphasised the important need for a Public Advocate (or equivalent) to investigate allegations of abuse and neglect of vulnerable adults – including adults with disability and older people – and to take the lead in facilitating and coordinating the response to safeguard individuals. We noted that establishing a Public Advocate is consistent with recommendations from NSW and national inquiries into elder abuse – including the NSW Legislative Council GPSC2 inquiry into *Elder abuse in New South Wales* (June 2016),[9] and the Australian Law Reform Commission's inquiry into *Protecting the Rights of Older Australians from Abuse* (June 2017)[10] – and our submissions to the NSW Law Reform Commission's (NSWLRC) review of the *Guardianship Act 1987* (Guardianship Act).[11]

Against this background, and in the context of the cogent evidence of need outlined in this report, we strongly support the recommendations of the NSWLRC relating to the establishment of an independent statutory position of the Public Advocate to (among other things) investigate – of its own motion or in response to a complaint – cases of suspected abuse and neglect of people who need decision-making assistance. However, the standing inquiry has shown the importance of having a broad reading of 'decision-making assistance'. In this regard, we note that while some of the alleged victims in the matters reported to us have had some level of decision-making ability, their living situation (and relationship with the subject of allegation) effectively prevented them from exercising it – they needed decision-making assistance. In addition, in some matters, information about the vulnerable adult's need for decision-making assistance will not be known at the outset – for example, where the person is isolated and does not have access to services. There needs to be adequate scope for the Public Advocate to look into these matters to establish the person's circumstances and need for assistance.

[9] The NSW Legislative Council GPSC2 inquiry report included the recommendation that the NSW Government should introduce legislation to establish a Public Advocate along the lines of the Victorian model, with powers to investigate complaints and allegations about abuse, neglect and exploitation of vulnerable adults, to initiate its own investigations where it considers this warranted, and to promote and protect the rights of vulnerable adults at risk of abuse. The NSW Government's response to the report's recommendations in January 2017 indicated that more analysis was required of the appropriateness of the application of the Victorian model in the NSW context, and that legislative change in this area should be deferred until the recommendations of the NSW Law Reform Commission's review of the *Guardianship Act 1987*.

[10] The Australian Law Reform Commission's inquiry report includes recommendations for adult safeguarding laws to be enacted in each state and territory, with adult safeguarding agencies to have the statutory duty to make inquiries in relation to 'at risk adults' (including of their own motion); to have coercive information-gathering powers; and to have a range of options for responding to the suspected abuse or neglect, including coordinating services, and collaborative work with government agencies and other bodies to stop the abuse and support the adult.

[11] See: preliminary-submission-to-the-nsw-law-reform-commissions-review-of-the-guardianship-act-1987, and nsw-ombudsman-letter-to-nswlrc-re-draft-proposals-from-review-of-guardianship-act-1987-5-february-2018

Importantly, the NSWLRC recommendations appropriately recognise the need for the Public Advocate to be able to intervene in court or NCAT proceedings in certain cases, and to have powers to:

- apply for and execute a search warrant if needed
- require people and organisations to provide documents, answer questions and attend compulsory conferences
- refer allegations to equivalent agencies in other jurisdictions
- exchange information with relevant bodies (including NCAT, our office, the NDIS Commission, the NDIA and relevant NGOs)
- have read-only access to the police and child protection databases.

The work of the Public Advocate would not duplicate the work of others. Instead, it would act when there are gaps and assist agencies in working in a coordinated and complementary way (in accordance with their current mandates and existing duty of care obligations).

3.1. Elder abuse

As previously noted, multiple NSW and national Inquiries have examined matters relating to the abuse and neglect of older persons, and have consistently identified the need for a Public Advocate or other adult safeguarding body in NSW to, among other things, receive and investigate allegations, coordinate an interagency response, and take other action as needed to improve the safety and outcomes of this cohort of vulnerable adults.

There are differences between some aspects of the reported matters of alleged abuse and neglect involving adults with disability, and those involving older persons. For example, while the main subjects of allegation in matters involving adults with disability in the standing inquiry have been parents and siblings, the primary alleged perpetrators of the abuse of older persons are the person's adult children.[12] However, the broad issues of substance are the same, and it is in the public interest for these matters to be handled within the one agency as part of an integrated approach to safeguarding vulnerable adults.

The following examples provided by the NSW Elder Abuse Helpline and Resource Unit identify reported issues that are similar to those reported under our standing inquiry in relation to adults with disability.

Examples of matters reported to the NSW Elder Abuse Helpline[13]

- A woman with declining memory and poor mobility experienced the loss of her husband a few months before the report to the Helpline. Before he died, her husband asked his best friend to look after her. The woman is reliant on the friend for help with transport and help around the house. The friend has offered to help the woman, but only in exchange for sexual favours.
- A man has been diagnosed with dementia, and his family has hired a private carer. Without any clinical recommendation or guidance, the man's untrained carer 'manages' his bowel care by manually extracting faeces. When the man screamed in pain from this process, the carer scalded him with hot water and held a face cloth over his mouth, telling him to 'shut up'.

[12] Data from the NSW Elder Abuse Helpline and Resource Unit for the financial years 2013-14 to 2016-17 shows that adult children have consistently been the primary alleged perpetrators of abuse against older persons. For example, in 2016-17, adult children were the suspected abuser of the older person in 49.4% of reported matters. Source: https://public.tableau.com/profile/facs.statistics#!/vizhome/ElderAbuseHelplineandResourceUnit/Elderabuse

[13] Source: NSW Elder Abuse Helpline and Resource Unit, 24 October 2018

- An older woman lives with a disability that prevents her using her hands and leaves her bedbound. She relies on her husband to provide food, and to feed her. When upset with her, her husband restricts food for up to a few days at a time.
- A man was in hospital due to a collapsed lung, broken ribs and significant bruising. On admission, he told hospital staff that he had had a fall. However, he later disclosed to the social worker that he had in fact been pushed over and kicked by his adult son.

These examples illustrate the significant consistency in the underlying issues involving the alleged abuse and neglect of adults with disability and older persons, such as alleged abuse at the hands of family members; and power imbalance and reliance of the vulnerable adult on the support of the subject of allegation.

The findings from a coronial inquest in 2018 into the death of an older woman from circumstances involving elder neglect reinforce the need to address the existing gaps in the response to the abuse of vulnerable adults in NSW, and highlight the grim and irreparable consequences if action is not taken to identify and respond to these matters:

Inquest into a death associated with elder neglect

In May 2018, the Coroners Court of NSW handed down the findings from its inquest into the death of an 83-year-old woman from the combined effects of severe malnutrition and infection.[14] The evidence before the inquest included that, among other things:

- three days before her death, paramedics found the woman in an emaciated state, lying on a dirty wet bed with urine and faeces, which paramedics concluded had accumulated over a number of days
- the woman was found to be malnourished and dehydrated, with muscle wastage and in considerable pain from multiple pressure sores, including one on the sacral area of her lower back that had been there for seven months, and which was considered likely to have infected the underlying bone
- hospital staff believed that the woman had been the victim of elder neglect.

The inquest identified that the woman's daughter, her primary carer, was struggling to care for herself, and was not up to caring for her elderly mother alone. The inquest heard that at the time of the woman's hospital admission, her daughter was unkempt, dirty and confused, and unable to explain to hospital staff why she did not attempt to get medical assistance for her mother earlier.

In her findings, Deputy Coroner O'Sullivan noted that, while the Elder Abuse Helpline and Resource Unit provides a valuable service, it is not an investigative body. Calling on police to undertake a welfare check in cases where there are concerns that the older person is being abused in their own home is not desirable. The Deputy Coroner noted that, while police 'might be able to identify and investigate examples of gross abuse or neglect, they are not the appropriate service to investigate more insidious and less obvious forms of elder abuse or neglect.' The inquest heard that it is important for a specialised service to have the capacity to enter the home of an older person and investigate arrangements for their care as a matter of last resort in cases where less intrusive forms of support or management have failed.

[14] Inquest into the death of Marcia Clark, Coronial file number: 2014/216538

The Deputy Coroner did not make recommendations in this matter, as she noted that detailed consideration was being given in NSW to 'establishing services that can support, educate, mediate and if necessary investigate situations where older people are at risk of abuse.' In this regard, the Deputy Coroner referred to the breadth of matters considered in the NSW Parliamentary Inquiry into elder abuse (and related government response), and the NSW Law Reform Commission's proposals to amend the Guardianship Act.

The NSW Elder Abuse Helpline and Resource Unit is funded by FACS and provides information, support and referrals relating to the abuse of older people in NSW. As noted in the above inquest findings, and in the NSW Legislative inquiry into elder abuse in NSW, the Elder Abuse Helpline is a well-respected and valued point of contact for information and guidance in relation to concerns about the abuse of older persons. However, the Helpline is not an investigative or case management agency. To provide an effective and integrated safeguarding approach in relation to vulnerable adults, there would be strong merit in integrating the work of the Elder Abuse Helpline and Resource Unit into the Public Advocate.

Chapter 4. Key issues from the standing inquiry

Our standing inquiry has identified a range of significant issues that need to be considered and addressed in the development of a comprehensive safeguarding approach for vulnerable adults in NSW, and establishment and operation of an independent lead agency.

4.1. Improving the response to abuse and neglect

4.1.1. The need for guidance

When we started the Disability Reportable Incidents scheme in December 2014, many disability providers had a poor understanding of the actions they needed to take to prevent and effectively respond to the abuse and neglect of clients in their supported accommodation services. Providers often lacked the knowledge and systems to provide a quality response – including fundamental aspects such as reporting criminal matters to police, and providing appropriate support to alleged victims. A substantial amount of our work in relation to the scheme has been dedicated to supporting providers to build their capacity to deliver a timely and effective response.[15] Over the four years, we have seen significant and sustained improvements in the practice of disability accommodation providers in relation to reportable incidents, including abuse and neglect.

Our standing inquiry has shown that there is a similar need for concerted guidance, service improvement, and capacity development in relation to the abuse and neglect of vulnerable adults in the community. In this regard, we have identified that:

- Matters are infrequently reported to police – even in circumstances where physical abuse has been witnessed, or there is serious and ongoing risk of harm to the adult with disability.
- Disability providers and other agencies are not clear about the actions they should take and their role in these matters. While some of the providers have detailed policies and procedures for staff in relation to allegations of abuse or neglect within their services, they lack guidance on what to do when the allegations involve external parties.
- The response of some providers has placed the adult with disability at increased risk. In particular, we have seen a range of providers who, at the time that they have reported the alleged abuse and neglect to our office, have indicated that they are ending (or have already ended) their provision of support to the person, citing the risks to their staff. In most of these cases, the information has identified that the actual risk to staff was low and the actions of the provider in withdrawing support unnecessarily placed the person with disability at greater risk.[16]

4.1.2. Factors affecting the response to matters involving families

The fact that the allegations typically relate to families and informal carers appears to affect the response of providers, agencies and community members. The matters we have handled under the standing inquiry demonstrate that there is an inclination to look the other way, not interfere, and to see the conduct as part of the family dynamic. Instances of physical abuse are viewed as harsh or tough behaviour rather than domestic violence and criminal conduct. We have considered multiple matters in which individuals and staff have witnessed the violence or abuse for years, and only reported it because something changed – for example, the person with

[15] See, for example, our Resource Guide and related guidance on the *Initial and early response to abuse and neglect in disability services* (https://www.ombo.nsw.gov.au/news-and-publications/publications/guidelines/disability-reportable-incidents); factsheets on key areas of practice in responding to disability reportable incidents (https://www.ombo.nsw.gov.au/news-and-publications/publications/fact-sheets/disability-reportable-incidents); and our training on handling serious incidents in the disability sector, and the initial and early response to abuse and neglect in disability services (https://www.ombo.nsw.gov.au/training-workshops-and-events/our-workshops/community-and-disability-services-training).

[16] In a range of these matters, we opened own motion complaints to examine the actions of the providers.

disability made a disclosure that forced the provider to act; or the severity of the injuries increased.

It is evident in some matters that the response to the abuse or neglect of the adult has been affected by the reporter's legitimate fear of physical retribution by the subject of allegation. This is particularly the case where the reporter has had a close connection to the family. However, the additional factor that tends to colour the response of disability providers is concern that the family will cancel the service – particularly when the provider knows that it is the only service involved with the person. It is a legitimate concern – we have handled a number of matters where the family or spouse has ceased services on multiple occasions due to providers asking questions or seeking to address the issues.

Carer and family stress is also a relevant factor. In many of the matters reported to us, the information included that the carer or family unit was under stress or struggling. In at least two matters, the abuse came to light as a result of the carer themselves disclosing to a disability provider or mainstream service. Parties have been reluctant to report abuse or neglect in these situations, recognising the broader context involved, and the need for the family members to obtain help.

Notwithstanding these factors, it is vital that action is taken by those who know about the abuse to bring it to light. Reporting the abuse and neglect of adults with disability can enable the provision of a thoughtful and person-centred response to the adult and their family to improve outcomes. However, failing to respond to the abuse cannot assist the person, and continues the denial of their human rights.

4.2. Contact with police

4.2.1. Involvement of police in the standing inquiry

Unsurprisingly, many of the matters of alleged abuse and neglect of adults with disability in the community reported to the Ombudsman involve contact with NSW Police. While the contact often relates to the current concerns, in some cases there has been a history of police contact – either in relation to the family (such as domestic violence incidents), or specific involved parties (such as the subject of allegation). Our access to the police database to gain a solid overview of relevant recent and previous contact with police has been critical to informing our understanding of existing risks for the vulnerable adult, the current status of police involvement in the matter(s), and the critical information held by other parties that needs to be provided to police.

In relation to the standing inquiry, police have provided constructive support. While some of the case studies illustrate the preparedness of police to do what they can in these often difficult situations, they also demonstrate, among other things, the need for police and other agencies to have an organisation that is empowered to coordinate action to address the dire circumstances of the involved vulnerable adult. In this regard, we are conscious that in many of these types of cases, a criminal prosecution is often not an option, and even where a prosecution is able to be commenced, this will not remove the need to address the ongoing vulnerabilities of the involved adults.

The establishment of a Public Advocate, with appropriate powers, would complement the work of police in these matters. For example, (and as noted in the coronial matter in Chapter 3), police are currently asked to undertake 'welfare checks' in response to concerns about the circumstances of individuals in the family home, but this is not always ideal, for a range of reasons. Police cannot necessarily enter the property and, if they are granted access, they don't always have the necessary clinical skills to look for signs of abuse or neglect (such as pressure sores, malnutrition, dehydration), or have the skills required to communicate effectively with the person with cognitive impairment about the situation. A Public Advocate – with appropriate skills and expertise in relation to vulnerable adults, and the power to gain direct access to the person to assess their need for protection and/or supports – would work collaboratively with police to provide an appropriately targeted and person-centred response.

The implementation of an appropriate safeguarding approach for vulnerable adults is likely to increase the call on police resources because it is expected that more criminal offences against vulnerable adults will be reported. However, the Public Advocate would also provide an important and accessible mechanism for police to refer concerns relating to vulnerable adults that do not reach a criminal threshold, and to obtain advice and support regarding further actions. We note that the NSW Elder Abuse Helpline and Resource Unit is valued by police for its advice, expertise and referrals. There is scope for a Public Advocate to build on the positive work of the Elder Abuse Helpline and Resource Unit to provide guidance and support to police to inform the response to vulnerable adults more broadly, and police practice.

4.2.2. Supporting frontline police in investigating crimes involving adults with disability

There are substantial barriers to people with disability – particularly people with cognitive impairment – engaging with the criminal justice system on an equal basis with others, including reporting to police and participating in investigations and court proceedings. To ensure allegations of abuse have the best chance of being effectively investigated and prosecuted, it is essential that investigators have the resources to assist them to interview people with cognitive impairment using an appropriate and sensitive approach.

Through our work, including the standing inquiry, we have identified the need to enhance police expertise in interviewing people with disability who have communication support needs and cognitive disability, to maximise their ability to give evidence and gain effective access to justice.

Guidance on interviewing people with cognitive disability and communication difficulties

We have engaged Professor Penny Cooper to develop – in collaboration with our office – a guide and related training package for disability providers on obtaining 'best evidence' from people with cognitive impairment, particularly those who are the subject of, or witnesses to, alleged abuse. Professor Cooper devised and delivers the national training and procedural guidance for registered witness intermediaries in the UK and also trained the first cohort of intermediaries employed by the child witness intermediary pilot scheme in NSW. The main role of registered intermediaries is to assist two-way communication between children or vulnerable adults and professionals involved in the investigation and trial stages of a case (including police officers, lawyers, judges and magistrates).

A version of the guide and training package will also be tailored specifically for use by NSW Police in their detective training course and their training to other police officers.

Specialised skills in the NSW Police

There will continue to be cases that require specialist skills, particularly when they involve interviewing people with a cognitive impairment and/or communication difficulties. This need has been recognised by the Child Abuse and Sex Crimes Squad via a number of cases where they have either directly conducted interviews with vulnerable adults and/or provided expert advice to Police Area Commands (PAC). For example, in one case, charges were laid against an offender – including for aggravated break and enter, and two counts of aggravated sexual assault – after the PAC engaged the Child Abuse and Sex Crimes Squad to interview the alleged victim, an adult with a cognitive impairment.

In contrast, we have seen cases where, despite the efforts of area commands to investigate allegations of abuse involving a person with cognitive impairment, evidentiary problems have arisen. For example, our inquiry has shown that even in circumstances where police have shown outstanding initiative and engaged workers from within the disability sector to help them in obtaining evidence, those engaged can sometimes lack the specialist expertise required to assist police without prejudicing the interview process. In other cases, we have observed police diligently attempting to gather evidence from alleged victims with cognitive impairment or

communication difficulties, but investigators have been unaware of the options available to them to assist with the interview process.

While we believe that it is critical to enhance the skill-set of police across commands, it is not reasonable to expect all police to acquire a high level of expertise in obtaining 'best evidence' from people with complex communication needs. In this regard, it would appear that providing PACs with direct access to, and advice from, specialist interviewers would provide another important option, particularly for those more challenging cases.

We also note that the specialist interviewing skills of officers within the Child Abuse and Sex Crimes Squad can be a valuable asset for commands to draw on. However, due to the Squad's existing heavy workload, their availability can be limited. In our view, consideration should be given to expanding the Squad's remit to include a specialist team of investigators tasked with providing investigative advice and assistance to area commands in conducting interviews with adults with cognitive impairment and/or communication difficulties. We recognise that this suggestion has resourcing implications. However, as we have highlighted in previous public reports, improved arrest rates, reduced delays and attrition rates, and improving the overall experience of child victims, illustrates that when police are given additional, targeted support and resources, very significant positive outcomes can be achieved.

Case study 6

We received a report about a sexual relationship between a 65-year-old man and a 19-year-old woman with intellectual disability living in supported accommodation who was not able to provide informed consent to the relationship.

We made enquiries with the supported accommodation service and checked for relevant intelligence on the police and child protection databases relating to the involved individuals. We identified that the man had a long history of child sex abuse and was known to police and child protection agencies in two states. The records indicated that:

- the young woman and another woman with intellectual disability from the supported accommodation service had both made complaints to police in relation to alleged sexual assaults by the man
- one of the women alleged that the man had threated violence against her pet if she disclosed the assault to anyone
- the man had been convicted of the indecent assault of his daughter 13 years earlier, when she was a child, leading to him being placed on the Child Protection Register
- the man had sustained findings made against him by the Joint Investigation Response Team regarding sexual harm of his son when he was a child
- the man had previously been convicted of breaching his Child Protection Register reporting obligations, and had recently been charged again in relation to another breach of the conditions – associated with the man seeking out contact with parents with an intellectual disability to gain access to their children, and
- the man's daughter, now an adult, had an intellectual disability and had made three reports to police of sexual assault by her father. The investigations had been hampered by her subsequent refusal/delay in providing statements to police.

The disability accommodation provider had no awareness of the man's inclusion on the child protection register, or his history of sexual violence. The provider indicated that, while they discouraged the relationship, they felt powerless to stop it.

After extensive separate discussions, we held an interagency meeting with the disability accommodation service, police, and the Public Guardian. In the meeting, police officers raised concerns about the difficulties they had experienced in gaining access to the alleged victims at the accommodation service. The police and the accommodation provider agreed on communication arrangements. The provider also outlined the steps it would take to ensure

that staff were aware of the Apprehended Violence Order (AVO) that was in place to prevent the man from approaching the premises or communicating with the alleged victims.

Following the meeting, police worked with the provider to gain access to the alleged victims to discuss the supports they could receive to help them to give evidence, and to alleviate any fear the young women had of police. The improved interagency communication and support resulted in one of the young women agreeing to give a statement to police.

In the interagency meeting, we also discussed the possible use of a Child Protection Prohibition Order under the *Child Protection (Offenders Prohibition Orders) Act 2004*, AVOs, or access orders to prevent the man's contact with vulnerable women, including his daughter and the two other young women.

Police subsequently made an application for the man to be subject to a Prohibition Order, which contained significant prohibitions, preventing him from:

- having contact or approaching the young women involved
- having contact or approaching any female person with an intellectual disability
- having contact or approaching any female person under the care of the Public Guardian, and
- entering or loitering outside any premises that provides care for intellectually impaired persons.

The order was granted by consent. The man was subsequently convicted of a breach of the prohibition order and a failure to comply with his reporting obligations.

4.3. The involvement of the vulnerable adult

4.3.1. Empowering people with disability to identify and report abuse

It is critical that concerted and ongoing efforts are made to maximise the ability of more vulnerable members of the community, including people with cognitive impairment, to be able to speak up about abuse and other unacceptable situations.

In 2015-2018, our office ran a Rights Project for People with Disability, which included a focus on strengthening systems to prevent, identify and respond to the abuse and neglect of people with disability.[17] As part of this work, we developed and delivered a 'Speak Up' training workshop, designed to encourage people with disability to speak up when they would like a change in their lives or when something is not right, and to develop the skills to do so. We delivered 116 workshops to almost 1500 people with disability and support staff, and co-delivered the training with well-known self-advocates with intellectual disability.

Of the 206 reports of abuse and neglect we have handled under the standing inquiry, 29 (14%) have originated from a disclosure by the adult with disability to another person, mainly a disability provider. It is important to recognise that some of the disclosures have been made by adults with substantial cognitive impairment and/or communication difficulties. In some cases, the person has just pointed to an injury or body part and said key words; in other cases, the person has been able to provide more detailed information about the abuse and their experience. We have seen positive work by disability providers to recognise and respond to the disclosures of the adult they are supporting. The matters emphasise:

[17] In the transition to the NDIS, FACS funded a range of projects that were aimed at building capacity in people with disability to understand and exercise their rights in the context of the NDIS landscape. FACS provided $1 million to our office to conduct the Rights Project.

- Vulnerable adults will disclose abuse and neglect to people they are familiar with and/or trust – it is vital that people working with vulnerable adults are receptive and appropriately equipped to respond to potential disclosures.
- There is a vital need to maximise the ability of the adult to disclose and to give evidence, via access to decision-making supports, advocates, communication tools, and witness intermediaries.

Our standing inquiry identifies that there are significant opportunities to vastly improve the extent to which adults with disability report abuse, and the supports they are provided to help them to do so and to gain effective access to justice.

However, it does a disservice to vulnerable adults to provide information about how to exercise their rights without ensuring that appropriate supports are in place to help them to do so, and that services are adequately prepared and equipped to respond. We have undertaken substantial work with providers and mainstream agencies on identifying and effectively responding to the abuse and neglect of people with disability. However, a comprehensive and sophisticated approach across government and community to recognising and appropriately responding to signs of abuse and neglect of vulnerable adults is required. The recommendations of the NSWLRC for the establishment of a Public Advocate provide a useful mechanism for seeking to address these issues.

4.3.2. Maximising the involvement of the vulnerable adult

Providing an effective response to alleged abuse and neglect of vulnerable adults requires a coordinated and person-centred approach. While the particular response, and suite of options for improving the person's safety and welfare depends on the circumstances of the case, all matters must have a central focus on the adult at risk.

The decision-making ability of the adults with disability in the standing inquiry matters has varied – ranging from individuals with severe intellectual disability who have required a substitute decision-maker, to adults who have had decision-making ability. However, it is important to note that, for many of the individuals who have had decision-making ability, they have effectively been unable to exercise it due to the domestic violence situation, associated power imbalance, and control wielded by the subject of allegation.

It is important to recognise that investigating and making inquiries into reported concerns does not equate to removing or denying the autonomy of the vulnerable adult at the centre of the concerns. While for some individuals the response may include measures such as applications for guardianship, for others the response may be increased support for the individual and/or their carer (and external monitoring of what is happening); increased connections to external parties and the community; and assistance to understand their rights, and the available options for help and how to obtain it when needed.

It is vital that the presumption is always that the person has ability to make their own decisions, and that substitute decision-making is a last resort. Where there is evidence to suggest that the person is currently unable to make an informed decision in relation to the matter at hand, the first response should be the provision of decision-making support (in whatever form works best for the person).

From our involvement in matters, we consider that there is scope to ensure that decision-making support is provided or at least offered to individuals to maximise their ability to make (or at a minimum, inform) decisions and exercise their rights, will and preferences. Our experience with the standing inquiry has stressed the need for a comprehensive adult safeguarding approach that:

- provides appropriate powers and authority for the Public Advocate to gain direct access to the vulnerable adult to ascertain what is happening and what action may be required
- reflects the UN Convention on the Rights of Persons with Disability (UNCRPD), including the provision of appropriate measures to provide access by people with disability to the support they may require in exercising their legal capacity

- provides a spectrum of decision-making support options, including information provision and referral mechanisms; a range of more intensive supports to maximise the person's ability to make decisions (such as supported decision-making); and substitute decision-making
- enables the Public Advocate to work with the person and relevant agencies to provide a person-centred approach to responding to the alleged abuse and neglect, and to improving their safety and welfare.

We support the recommendations of the NSWLRC in relation to the development of a new framework for assisted decision-making in NSW – including:

- provision for supported decision-making arrangements as part of a suite of different assisted decision-making options
- provision for decision-making supporters to assist the person in communicating their decisions to others, and advocating for the implementation of the decision where necessary
- roles for a NSW Public Advocate in facilitating the development of support agreements; mediating disputes about assisted decision-making; administering and/or promoting decision-making assistance services and facilities; and setting guidelines for supporters and representatives.

In our view, decision-making support for vulnerable adults is a critical component of an appropriately person-centred response to allegations of abuse and neglect. For this and other reasons, we agree with the NSWLRC's recommendation that the investigative and related functions of the Public Advocate should be combined with the decision-making functions and role of the Public Guardian.

Independent advocacy

There is a vital continuing role for community advocates who work with and support people with disability and other individuals who require decision-making and advocacy assistance, and who advocate for broader, systemic issues across a range of life domains. Our office has seen the benefit of individual advocacy for people with disability, particularly for people without an informal support network, or where the person and their informal supports need assistance to raise and resolve concerns locally and at an early point.

It is important to recognise that the role of a Public Advocate should complement, not duplicate or replace, the role of community advocacy. In our view, community advocates would be an important stakeholder for the Public Advocate, including playing a key role in raising concerns about suspected abuse and neglect of individuals for the agency's investigation and action; and providing critical decision-making support.

4.4. The intersection with the NDIS

As outlined in this report, the matters we have handled under our standing inquiry into the alleged abuse and neglect of adults with disability in the community do not pertain to the conduct of service providers – they relate to the conduct of family or informal carers and other community members. While many of the alleged victims in the 206 matters are NDIS participants, as the allegations are typically not about the provision of supports by NDIS providers, they do not fall under the remit of the NDIS Quality and Safeguards Commission. Obviously, matters relating to elder abuse are also unconnected to the NDIS.

However, there are important areas of intersection between the NDIS and the standing inquiry, which are relevant to the broader safeguarding arrangements for vulnerable adults that are required in NSW.

4.4.1. Identifying and linking people to disability supports

Some of the matters that have been brought to our attention under the standing inquiry have involved adults with significant functional impairment and disability support needs who are not in receipt of any disability supports. Some people had previously received disability supports but had lost the connection. In other cases, the individuals had never been connected to specialist disability supports. The standing inquiry has identified individuals who have been largely hidden – they are not connected with disability supports, do not access other community services, and are not visible in their community.

One of the significant benefits of having an identified point of contact for matters relating to the alleged abuse and neglect of vulnerable adults is that it enables greater visibility of vulnerable adults who require assistance, and provides a mechanism for facilitating their access to critical supports. In this regard, we note that, under the inquiry, we have made and followed up referrals for individuals to obtain support to access the NDIS (and other necessary supports, such as advocacy services). However, a more comprehensive safeguarding approach for vulnerable adults is required to provide direct access to the person in their home to enable informed decisions about necessary supports and services, in discussion with the involved adult.

4.4.2. Working with the NDIA and related agencies

In relation to matters involving NDIS participants, in order to effectively conduct our inquiry we regularly obtain information from the NDIA about the person's plan, current and recent providers, nominees, and the types of supports that have been funded. In certain matters, we have also provided information to the NDIA (either directly, or through advising an involved agency to provide information) about the circumstances of the participant to inform the NDIA's actions. For example, we have provided information relating to current concerns and significant risks to the participant to enable the direct appointment of a support coordinator; a review of the plan; and an informed response to a family member's request to self-manage the participant's NDIS funds.

We support the NSWLRC recommendations for the Public Advocate to have statutory powers to exchange information with relevant bodies (including the NDIA and the NDIS Quality and Safeguards Commission) on matters affecting the safety of a person in need of decision-making assistance – such as information relating to allegations of abuse and neglect.

Ensuring that eligible people with disability are linked to specialist disability supports under the NDIS, and identifying and signalling where the participant needs specific or additional assistance to realise their plan (for example, to prevent a family member from blocking the participant's access to their NDIS supports), are important parts of the work under the standing inquiry – and need to continue as part of a broader safeguarding approach for vulnerable adults. In addition to upholding the rights of people with disability to live free from abuse and have effective access to justice, our work has underscored the importance of addressing these issues in order for people with disability – and the state of NSW – to fully realise the benefit of the NDIS.

4.5. Information sharing

We have also consistently argued that there needs to be provisions for agencies to be able to exchange information that relates to the promotion of the safety of adults with disability. We do not believe it is consistent with the rights of people with disability who are adults to be affected by a broad information exchange provision (such as that under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*). However, from our extensive experience and discussions with people with disability and their supporters, we are nevertheless convinced that it is essential that agencies dealing with allegations of abuse or neglect have the ability to exchange information consistent with their legislative obligations and existing common law duty of care responsibilities. In our view, there is a need for a legislative provision to enable agencies that have responsibilities relating to the safety of vulnerable adults to be able to provide and receive information that promotes the safety of vulnerable adults.

While the NSWLRC recommendations in relation to the Public Advocate include powers for the proposed agency to exchange information with relevant bodies (including relevant NGOs), this requires the Public Advocate to be at the centre of any information exchange. To enable an effective and integrated response to alleged abuse and neglect of vulnerable adults, it is vital that prescribed agencies are able to provide and receive information to promote and improve the safety of the alleged victim – without the Public Advocate having to facilitate all of the information exchange.

It is important to note that, while the matters in this report relate to abuse and neglect by family and community members, not disability providers, some of the cases have involved allegations against people who were former disability support workers of the alleged victim. The alleged abuse occurred when the subjects of allegation were no longer working with the adult with disability, but were typically still employed in the disability sector, such as in the below example. As illustrated in this case study, it is vital that providers are able to exchange information relating to the safety of vulnerable adults, including information relating to conduct outside of the service setting.

Case study 7

We were contacted by a disability provider, advising us of allegations that an ex-employee was engaging in a sexual relationship with a former client of the service. The former client is a young woman with intellectual disability and mental illness who lives independently in the community. The ex-employee had provided drop-in support to assist the young woman with shopping, cooking, and other activities in the community.

A member of the young woman's family had raised the allegations with the provider after seeing numerous sexually explicit text messages between the woman and ex-employee on the woman's mobile phone, and a text from the man telling the woman to delete the messages. Although the provider was no longer involved with the young woman or ex-employee, it was concerned that the ex-employee may have been engaged by other disability providers, and pose a risk to other vulnerable adults.

The ex-employee had gone on to work for three other disability providers. Information about the allegations was given to the providers; on each occasion, when the provider raised the allegations with the employee, he resigned. Our inquiries in relation to this matter identified problems with the probity checking processes of the two providers who employed the man after the allegations came to light. One of the providers had not conducted any referee checks, and the other had failed to conduct a referee check with a recent supervisor and to ask questions about any alleged misconduct, workplace investigations and/or disciplinary proceedings.

The introduction of the NDIS Worker Screening Check will provide greater safeguards for people with disability who are supported by NDIS registered providers, including addressing some of the issues associated with employees who move between registered providers in the wake of allegations. However, and in the context of matters of elder abuse, it is important to note the existing gap in relation to a worker screening system for aged care supports.

Chapter 5. What is needed

5.1. Improving safeguards for vulnerable adults in NSW

From 1 July 2019, the NSW Ombudsman's office will no longer carry out its standing inquiry into the abuse and neglect of adults with disability in the community. Our inquiry has produced powerful evidence of the need for swift action to establish a comprehensive adult safeguarding approach that can respond effectively to the abuse and neglect of vulnerable adults who are living in the community.

While NSW has led the way in Australia in relation to the mandatory reporting of the abuse and neglect of people with disability in disability service settings, this report highlights that we are lagging in our responsibilities to vulnerable adults residing in the community. We are at a critical juncture in NSW: this standing inquiry into the abuse and neglect of adults with disability, and previous inquiries that have been conducted into elder abuse, have shown that the current safeguards for these vulnerable adults is inadequate.

For these reasons, we fully support the recommendations of the NSWLRC in relation to the establishment of an independent statutory position with investigative functions. These recommendations pick up the work that we are currently performing under our standing inquiry, and address some critical gaps that our inquiry is unable to address – including providing powers to enable direct access to the adult at risk; enabling the Public Advocate to intervene in court or NCAT proceedings; and ensuring that the abuse of older vulnerable citizens also receive an appropriate response.

Our inquiry has also pointed to a number of related issues that will need to be addressed to provide an effective, integrated, and person-centred approach to responding to the abuse and neglect of vulnerable adults in NSW. In particular, there is a need for information sharing provisions in relation to agencies that have responsibilities relating to the safety of vulnerable adults; and access to ongoing decision-making assistance services, including advocacy services and broader supported decision-making capability.

It is also imperative that this work capitalises on the broader reforms that are currently being undertaken to enhance the provision of mainstream community supports to NSW citizens with disability. We expect that these reforms will result in a greater demand for services, such as police/justice and health, as part of NSW showing a stronger commitment to deliver on its United Nations Convention on the Rights of Persons with Disabilities and National Disability Strategy obligations. In this regard, we note that, among other things, the standing inquiry highlights the need for greater recognition that the abuse of vulnerable adults in the family home often constitutes domestic violence or another violation of an individual's human rights. Furthermore, there is an obvious nexus between this issue and the Premier's priority to reduce domestic violence reoffending.[18]

5.2. Broader considerations

More broadly, we also hope that this report acts as a trigger for the NSW Government to review the current independent safeguarding landscape, with the aim of putting in place the strongest independent safeguarding and regulatory system in Australia for protecting vulnerable groups within our community. In this regard, we note that:

[18] Reducing domestic violence reoffending is one of the 12 Premier's Priorities. https://www.nsw.gov.au/improving-nsw/premiers-priorities/

- there have already been proactive steps by the Government to improve the integration and streamlining of oversight arrangements for safeguarding children in NSW, via the recently announced plan to transfer responsibility for the oversight of workplace child abuse allegations from our office to the Office of the Children's Guardian (OCG)
- the combined impact of the transfer of our reportable conduct function, and the cessation of our disability work over the next 12 months, will mean that our remaining community services oversight role will be much more limited.

Against this background, there is a compelling case for the NSW Government to now consider what would constitute the best independent oversight and regulatory framework for protecting vulnerable groups in the community. In doing so, we again note our support for the proposed merger of our reportable conduct investigative, keep under scrutiny, and capacity building work with the OCG's child safe, out-of-home care accreditation and Working With Children Check functions (particularly given the significant overlap between both agencies' roles in these areas). However, despite the obvious benefits of this proposed merger, integrating these Ombudsman and OCG functions into one entity will unfortunately cause fragmentation between the proposed exercise of the OCG's new functions and those residual community service functions that will remain the responsibility of the Ombudsman (for example, our responsibilities to monitor, review, and inquire into the delivery of community services, as well as the exercise of our complaint handling, in-care review, child and disability death review, and community education responsibilities).

On a separate but related note, there are parallels between the type of work that the new Anti-slavery Commissioner would be required to undertake and the investigative and related activities of the Public Advocate.

This fragmentation could be addressed by the creation of a single independent community services oversight and regulatory body. This would remove duplication, inefficiency and current gaps in critical intelligence capability. In particular, a single body of this type would be well positioned to deliver:

- an integrated understanding of critical intelligence relating to individuals and agencies of concern
- the required synergies in our auditing, research, review and capacity building work with individual agencies and sectors
- a more efficient system for the agencies it would oversight and support — for example, these agencies would no longer have to respond separately to the same or similar issues, and it would minimise the risk of different oversight bodies imposing different demands, or taking a different position, on the same or similar issues
- greater efficiencies for other key stakeholder agencies, such as Police, FACS, NGO peaks and advocacy bodies, which are currently required to work extensively with two independent oversight agencies in this area — for example, there would be obvious risk minimisation and other benefits in there being only one independent safeguarding body having access to, and using the holdings from, the COPS and KiDS/ChildStory systems
- for members of the public generally, and for people directly involved in the 'system', a simpler pathway for accessing and navigating a single, independent oversight and regulatory body
- more effective and better targeted exercise of system review and capacity building activities.

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