



Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Disability services



Final Report
Volume 10

September 2023

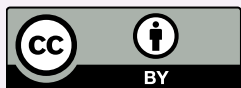
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Final Report

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Disability services

Acknowledgement of Country

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission) acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, seas and waters of Australia, and pays respect to all First Nations Elders past, present and emerging.

We recognise their care for people and country. In particular, we acknowledge the Traditional Custodians of the lands on which our offices are based: the Gadigal people of the Eora Nation where our Sydney office stands, the Jagera and Turrbal people as Traditional Owners and Custodians of the lands on which the city of Brisbane is located and the Ngunnawal and Ngambri peoples upon whose land the city of Canberra is located.

We pay our respects to all First Nations people with disability and recognise the distinct contributions they make to Australian life and to the outcome of this inquiry.

Acknowledgement of people with disability

The Royal Commission acknowledges people with disability who fought and campaigned long and hard for the establishment of this Royal Commission.

We acknowledge the courage and generosity of people with lived experience of disability who shared their knowledge and experiences of violence, abuse, neglect and exploitation with the Royal Commission. Their contributions to the Royal Commission have been indispensable in framing recommendations designed to achieve a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

Content warnings

This report contains information about violence, abuse, neglect and exploitation that may be distressing to readers.

The report contains first-hand accounts of violence, abuse, neglect and exploitation. As a result, some direct quotes in the report may contain language that may be offensive to some people.

First Nations readers should be aware that some information in this report may have been provided by or refer to First Nations people who have passed away.

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Key terms

agency-managed participants

Participants in the National Disability Insurance Scheme (NDIS) who have their plans managed by the National Disability Insurance Agency (NDIA).

block funding

Funding that is provided through a contract between governments and disability service providers. It is generally fixed-term funding provided to organisations to deliver an agreed amount or type of service for specific cohorts or in specific geographical areas.

capacity building supports

Supports and services that help NDIS participants build independence. These supports and services may relate to social, community and civic participation, employment, relationships, health and wellbeing, choice and control, lifelong learning and daily activities. They may also include support coordination services.

capital supports

Higher-cost pieces of assistive technology, equipment, and home or vehicle modifications for which NDIS participants can receive funding.

care and support workforce

A collective term for the paid workers who provide a range of essential services across Australia's aged-care, disability support and veteran care systems.

community visitor scheme

Community visitors (also known as 'Official Community Visitors', 'Official Visitors' or 'Official Visitors Disability' depending on the jurisdiction) are appointed individuals who visit people living in prescribed accommodation to independently monitor the services and facilities provided and assist with resolving issues or complaints. All states and territories except Western Australia and Tasmania have a community visitor scheme (CVS) for people with disability.

complainant

A person who has made a complaint. This may be the person affected by the issues the complaint is about, or a third party (such as a family member or an advocate).

complaint

A complaint includes a disclosure, concern, grievance, information or allegation about violence against, or abuse, neglect or exploitation of, a person with disability.

core supports

Supports and services that help NDIS participants with everyday activities and disability-related needs in categories such as daily activities, consumables, community participation and transport.

digital platforms

Businesses that provide online services, including connecting support workers with NDIS participants. They are also referred to as 'platform providers'.

disability representative organisation (DRO)

A peak organisation providing systemic advocacy and representation for people with disability.

disability sector

Collective term to describe disability service providers and workers, disability peak and advocacy bodies, disabled people's organisations (DPOs), disability representative organisations (DROs) and others involved in or affected by how disability services are designed and delivered.

disability services

Services that people with disability use because of their disability. Disability services are not offered or provided to the general public.

disability service provider

Individuals and government and non-government (including for profit and not-for-profit) organisations that provide disability services.

disability support workforce

A collective term for paid workers who provide direct and indirect support to people with disability, including daily living. They may be employees, contractors or self-employed.

disabled people's organisation (DPO)

An organisation where the majority of members, as well as those on the governing body, are people with disability.

incident

Commonly used to describe an event (such as alleged or known abuse or neglect) that occurs in a disability service provider or other setting. An incident may be the subject of a complaint or report.

intermediary services

Services that support people with disability to use individualised funding packages under the NDIS. Support coordination and plan management are intermediary services.

investigation

A fact-finding process where information is gathered, assessed and weighed up in order to establish the facts and make findings. An investigation may be conducted internally by the organisation or service provider that has received a complaint, or by an external investigator appointed to do so on their behalf. An investigation may also be conducted by a regulatory or oversight body. Police may conduct an investigation if a complaint or report raises criminal allegations.

local area coordinators (LACs)

Local organisations working in partnership with the NDIA to help people with disability and their families and carers access and navigate the NDIS.

mainstream services

Services provided to the Australian public, whether or not they have a disability. Examples include health, education, justice, housing, child protection, employment services, and transport.

market

Supply of disability supports, Specialist Disability Accommodation (SDA) housing and allied health services under the NDIS to meet demand from NDIS participants.

market concentration

A measure of the percentage of a market (or the market share) that is held by a small number of organisations.

market steward

The NDIA is the market steward for the NDIS marketplace. Market stewardship recognises that when governments implement policies to increase consumer choice and adopt market-based delivery, they must also oversee how the marketplace develops. If the marketplace is not working as intended, a responsible market steward identifies what action, if any, should be taken to improve the marketplace so policy objectives can be realised.

NDIS participant

A person with disability who meets the access criteria set out in the *National Disability Insurance Scheme Act 2013* (Cth) to become a participant in the NDIS.

NDIS plan

A written plan that sets out an NDIS participant's goals and the supports needed to achieve these goals. The plan is based on a participant's disability support needs, and includes information about NDIS funding and how it can be used.

NDIS provider

A person who or entity that provides supports or services to NDIS participants. We use this term in accordance with the meaning set out in section 9 of the *National Disability Insurance Scheme Act 2013* (Cth).

plan-managed participant

An NDIS participant whose plans are administered by a plan manager. A plan manager will help pay providers and manage funding from the participant's NDIS plan.

plan manager

A registered plan management provider. Plan managers support active participants to manage their NDIS funding.

registered provider

A person who or provider of supports that has registered as a provider with the NDIS Quality and Safeguards Commission.

self-managed participant

An NDIS participant who manages their own plan, choosing where to allocate NDIS funding for services that help them to achieve their plan goals.

Specialist Disability Accommodation (SDA)

A type of NDIS funding in an NDIS participant's plan for specialist housing rather than for supports. SDA funding is paid directly to SDA providers to cover building and maintenance costs.

supports

Actions, practices, strategies or resources that promote participation and inclusion of a person or people with disability in society.

support coordination

An intermediary service designed to assist NDIS participants to make the best use of their NDIS funding. There are three levels of support coordination: support connection, coordination of supports, and specialist support coordination.

support worker

A person who is employed or engaged to provide disability supports and services to a person with disability.

supported accommodation

A type of housing that also provides care and support services.

supported decision-making

Processes and approaches that assist people to make decisions, including by giving them the tools they need to make the decision for themselves. Supported decision-making does not mean deciding for or on behalf of another person.

Supported Independent Living (SIL)

A type of NDIS funding for home and living supports. SIL is for people with higher support needs who need some level of help at home all the time.

unregistered provider

A provider of disability services that is not registered with the NDIS Quality and Safeguards Commission. An unregistered provider can support plan-managed NDIS participants and self-managed NDIS participants.

worker

Anyone providing paid supports, including staff employed by service providers, as well as contractors, casual workers and self-employed workers (see support worker).

Summary

People with disability have the right to live and participate in safe and inclusive environments, free from violence, abuse, neglect and exploitation. Over the course of this Royal Commission we have heard harrowing evidence from people with disability and their family members about maltreatment, such as that occurring in, or in connection with, the delivery of disability services. The evidence given at hearings and accounts shared in submissions and private sessions described failures by disability service providers to prevent violence, abuse, neglect and exploitation, or to respond effectively to complaints and incidents. It also revealed deficiencies in organisational cultures, systems, policies and practices that contributed to violence, abuse, neglect and exploitation within disability services. It suggested that many people with disability are not assisted to develop lives in which they interact and participate with others in the community. They are not supported to learn and develop the skills essential to daily living and which are needed to live and participate in the community.

We approached our inquiry from a human rights perspective, examining the responsibilities of disability service providers and the changes to systems, processes, policy and practices required to better prevent and respond to violence, abuse, neglect and exploitation.

The evidence collected indicates that the nature and extent of violence, abuse, neglect and exploitation associated with disability services are wide ranging. These forms of maltreatment take place both episodically and routinely. They occur in people's homes, in places where people go to receive disability services – such as day programs – and when services are provided in the community. Services provided in the community include support to undertake everyday activities, such as grocery shopping or going to the movies.

The risks of exposure to violence, abuse, neglect and exploitation increase when people with disability are isolated, dependent and deprived of choice and control over services and where and how those services are delivered. These risks also increase when people with disability have limited capacity to raise concerns about the design, delivery, quality and safety of essential services and supports.

Several of our public hearings focused on particular case studies or themes related to the experiences of people with disability using disability services. We found that safe, high-quality disability service provision requires providers to take measures to prevent maltreatment and to respond effectively when incidents occur.

Given that the disability services examined in our public hearings are largely funded through the National Disability Insurance Scheme (NDIS), this volume also considers the role of the regulation and oversight of NDIS-funded disability services in preventing and responding to violence, abuse, neglect and exploitation. In particular, we discuss the functions and responsibilities of the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission (NDIS Commission).

Although much of our analysis addresses the changes required to policy, practice and systems within disability services, we do not make recommendations to disability providers in this *Final report*. This is because there is no single provider or peak body with authority to receive, respond to or be accountable for the implementation of recommendations. Instead, consistent with our terms of reference, we discuss aspects of promising practice drawn from our examination of systemic issues. We refer to practices that have been implemented by some providers involved in our public hearings to demonstrate that, with encouragement, measures can be taken to reduce the risk of violence, abuse, neglect and exploitation within disability services. All providers should use this information to strengthen the quality and safety of their service delivery.

The NDIS Commission holds many of the levers to address identified practice deficiencies and strengthen sector-wide practice. For this reason, recommendations directed to the NDIS Commission are aimed at lifting the quality and safety of services, as well as enhancing its operation.

The NDIS Commission also has a critical role to play in identifying systemic issues and practice trends detected through its oversight and sharing this information with the disability sector. This role extends to working with people with disability, advocates and service providers to ensure that adequate guidance and resources are developed to improve safeguarding practices by frontline workers all the way up to a provider's governing body. The NDIS Commission is uniquely placed to identify and share the many good practices of providers, including new and innovative models for managing complaints and incidents. A priority for the NDIS Commission should be regularly interacting with stakeholders to remain in touch with the challenges being faced 'on the ground' by NDIS participants and providers alike.

This volume is divided into two parts, Part A and Part B.

Part A: Disability service providers

This part sets out what people with disability and their supporters told us about their experiences of violence, abuse, neglect and exploitation when accessing or receiving disability services. It examines what providers can and should do to prevent and respond to these types of maltreatment.

Chapter 1 outlines the framework for the funding and provision of disability services in Australia, building on information contained in previous volumes. It discusses the diversity of the disability services market and introduces the regulatory environment created with the introduction of the NDIS.

Chapter 2 summarises the types of violence, abuse, neglect and exploitation in disability services we heard about through the course of our inquiry. It gives an overview of our public hearings related to disability services and refers to the impacts that maltreatment can have on people with disability and their supporters.

Chapter 3 examines measures to prevent violence against, and/or abuse, neglect and exploitation of people with disability who use disability services. It discusses what service providers should do to embed human rights into service delivery and the need to strengthen choice and control for service users. It also considers the role of service provider governance arrangements in preventing violence, abuse, neglect and exploitation, as well as the importance of providers recruiting, training and supporting their workers to deliver safe, high-quality disability services.

Chapter 4 examines what we have heard about how providers respond to incidents of and complaints about violence, abuse, neglect and exploitation. It highlights the elements of provider practice that encourage or discourage people with disability and their supporters from speaking up, and discusses how providers manage, investigate and report on incidents, feedback and complaints. It also discusses the need for providers to consider forms of redress for service users who have experienced violence, abuse, neglect or exploitation.

Chapter 5 considers systemic issues that affect how people with disability access safe, high-quality disability services. It outlines the need for measures to address structural workforce challenges, such as the increasing casualisation and fragmentation of the workforce, and examines different views on the value of a national worker registration scheme. It discusses the systemic changes required to ensure people with disability, whose circumstances put them at heightened risk of maltreatment, can realise their goals. It also examines the role of the NDIA as market steward and the continuing debate about access to services from providers of last resort.

Part B: NDIS Quality and Safeguards Commission

This part examines key issues arising from the evidence about the NDIS Commission's role in preventing, identifying and responding to violence, abuse, neglect and exploitation in disability services. It also sets out areas where the NDIS Commission's functions, performance and resourcing need to be strengthened or developed.

Chapters 6 and 7 provide information about the role and functions of the NDIS Commission, and its key achievements and challenges. These chapters also provide an overview of the issues we have identified and how our recommendations address these issues.

Chapter 8 outlines the reportable incidents function of the NDIS Commission, relevant data and critical issues. It examines the efficacy of current reporting practices and explores streamlining incident oversight processes so they are geared towards investing greater effort on matters and individuals identified as being at heightened risk of violence, abuse, neglect and exploitation. It refers to the role of the NDIS Commission in informing the disability sector about systemic issues and practice trends, and explores stronger obligations for providers to lift the quality of investigative practices.

Chapter 9 discusses the complaints function of the NDIS Commission, relevant data and critical issues. It examines the NDIS Commission's role in guiding disability service providers to improve complaint handling policies, procedures and practices, and the accessibility and performance of the NDIS Commission's own complaints processes.

Chapter 10 describes the provider registration function and what the registration data is telling us. It sets out the provider registration framework and quality audit process, and discusses the need for increased information sharing between the NDIS Commission and quality auditors. It also examines gaps and ambiguities in the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) (*Practice Standards*).

Chapter 11 outlines the behaviour support function and the NDIS Commission's role in overseeing the use of behaviour support and restrictive practices by registered disability service providers. It focuses on the need for measures to improve access to high-quality behaviour support practitioners.

Chapter 12 sets out the broad range of compliance powers and how these have been used to address non-compliance by NDIS providers. It stresses the importance of increasing site visits to, and face-to-face engagement with, people with disability and NDIS providers to better inform the use of the NDIS Commission's proactive compliance, investigation and enforcement powers.

Chapter 13 discusses the value of the data the NDIS Commission receives and identifies shortfalls in its current capacity to collect, analyse and use that data to inform operational decisions. It examines the adequacy of legislative arrangements between the NDIS Commission and other oversight bodies, and mechanisms to share information and promote the safety of people with disability who may be at greater risk of violence, abuse, neglect and exploitation.

Chapter 14 outlines the NDIS Commission's statutory obligations to build the capacity of NDIS participants to understand their rights and of disability service providers to meet their compliance obligations. It examines how the NDIS Commission can strengthen its connections with, and understanding of issues facing, First Nations people. It discusses what more the NDIS Commission can do to share data analysis and insights from its oversight activities with providers to promote improvements in the quality and safety of services.

Chapter 15 describes the NDIS Commission's role in the 'NDIS Worker Screening Check', which commenced in February 2021, and identifies opportunities to strengthen the operation of the process.

Chapter 16 discusses the NDIS Commission's current resourcing arrangements and the challenges it is experiencing in meeting the demands of its increasingly high workload. It also discusses the need for the adequacy of the NDIS Commission's resources to be reviewed.

Recommendations

Part A: Disability service providers

Recommendation 10.1 Embedding human rights

The NDIS Quality and Safeguards Commission (NDIS Commission) should commission a capacity-building program to support disability service providers to embed human rights in the design and delivery of their services. The program should be co-designed with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

The program should:

- develop opportunities for dialogue between providers and people with disability to address challenges and share promising practices
- develop tools, resources and training packages that reflect the diversity of people with disability and disability service providers across Australia
- focus on practical, implementable strategies that lead to better outcomes for people with disability
- be grounded in the principles of the *Convention on the Rights of Persons with Disabilities*, and reflect our findings, the NDIS Review, and the NDIS Commission's own motion inquiries and recent Safeguarding Policy Implementation Plan
- enable providers to prepare for, or demonstrate compliance with, current and future legislative and registration requirements associated with the rights of people with disability. This includes responsibilities under the *Disability Discrimination Act 1992* (Cth) and the Disability Rights Act (if enacted).

The National Disability Insurance Agency, and state and territory governments involved in providing, regulating or conducting oversight of disability services not funded under the National Disability Insurance Scheme, should actively participate in all stages of the program.

The program should begin by 1 July 2025.

Recommendation 10.2 Independent support coordination

To address potential conflicts of interest, the Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, create or amend an NDIS Rule to make clear that it is not appropriate for a provider of support coordination to be the provider of any other funded supports in an NDIS participant's plan.

Exceptions to the Rule should be developed in consultation with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

Exceptions may include situations where there are limited alternative service options for NDIS participants due to thin disability service markets, or where there are limited culturally appropriate or specialised services available.

Recommendation 10.3 Adequate support coordination

The National Disability Insurance Agency should ensure that participants in the National Disability Insurance Scheme (NDIS) identified as being at heightened risk of violence, abuse, neglect or exploitation, particularly those living in supported accommodation, have funding for support coordination included in their NDIS plans.

Funding for support coordination should reflect the NDIS participant's support and communication needs. Funding for hours of support coordination should also be sufficient to facilitate face-to-face contact at least monthly.

NDIS participant plans should be updated by 30 September 2025.

Recommendation 10.4 Quality of support coordination

The NDIS Quality and Safeguards Commission should examine the quality and consistency of support coordination, with a particular focus on National Disability Insurance Scheme participants who:

- live in remote and very remote locations
- are First Nations people with disability
- are culturally and linguistically diverse
- are navigating state or territory housing, health or criminal justice systems
- are experiencing housing insecurity or homelessness
- are living in supported accommodation
- are attending day programs or working in Australian Disability Enterprises.

The examination may be part of the proposed own motion inquiry on support coordination.

Recommendation 10.5 Advocacy

- a. The National Disability Insurance Agency (NDIA) should develop a program to connect National Disability Insurance Scheme (NDIS) participants living in supported accommodation with an appropriate disability advocacy organisation. The program should be co-designed with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

The program should:

- promote advocacy in the course of NDIS planning processes
- increase awareness of the role of advocacy in disability services among NDIS participants and their families and supporters
- strengthen advocacy referral processes when participants and their families and supporters raise concerns, make complaints or report incidents
- foster relationships between NDIS participants, their families and supporters, and disability advocacy organisations
- strengthen collaboration between disability service providers and disability advocacy organisations to enable advocates to maintain periodic contact with people with disability so they can identify potential or emerging issues.

The program should commence by January 2025.

Following an evaluation of the program's impact and outcomes, the NDIA should consider expanding the program to reach other groups of people with disability who are identified as being at heightened risk of violence, abuse, neglect or exploitation.

- b. The NDIS Quality and Safeguards Commission, when reviewing complaints and reportable incidents, should also actively promote the value of independent advocacy for NDIS participants identified as being at heightened risk of violence, abuse, neglect or exploitation, and/or those who live in supported accommodation.

Recommendation 10.6 Supported decision-making in disability services

The NDIS Quality and Safeguards Commissioner should amend the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) to reflect that each participant:

- is entitled to support to make everyday life decisions including what services they receive, in what way and from whom
- has opportunities to make decisions about their goals and aspirations
- is supported to develop their decision-making skills
- is supported to communicate their will and preferences
- has the right to choose their own supporter.

Amendments should be completed by 30 June 2025.

Recommendation 10.7 Practical guidance on supported decision-making

The NDIS Quality and Safeguards Commission should co-design – with people with disability, disabled people’s organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies – a practice guide on supported decision-making for service providers. This should be consistent with the NDIS Supported Decision Making Policy and the supported decision-making principles outlined in Recommendation 6.6.

Recommendation 10.8 A national disability support worker registration scheme

The Australian Government should establish a national disability support worker registration scheme by 1 July 2028.

Consultation about the scope and elements of the national disability support worker registration scheme should begin as soon as possible. The consultations should include people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, support workers and their representative bodies, disability service providers, state and territory governments, and peak and regulatory bodies.

The design of the scheme should consider:

- the definition of 'disability support worker'
- a code of conduct and minimum standards for registered disability support workers, including support coordinators
- mandating the NDIS Worker Screening Check for all disability support workers
- recognition and accreditation of workers' qualifications, experience, capabilities and skills
- continuing professional development requirements for disability support workers
- automatic registration for disability support workers who are registered with other relevant professional bodies
- a First Nations workforce pathway to address barriers to First Nations workers entering the sector
- an accessible portal to enable people with disability and their supporters to view the profiles and registration status of disability support workers
- portable training and leave entitlements.

Recommendation 10.9 The Social, Community, Home Care and Disability Services Industry Award

Organisations entitled to represent the industrial interests of members of the disability support workforce covered by the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2010, along with the Australian Government and employers, should consider a joint application to vary the modern award in accordance with section 158 of the *Fair Work Act 2009* (Cth).

This would seek to ensure equal remuneration of workers for work of equal or comparable value in accordance with section 302 of the *Fair Work Act 2009* (Cth), paying particular attention to employers' continued use of Schedule E and the 'work value' of contemporary disability support work.

Recommendation 10.10 Provider of last resort

The Australian Government should urgently engage with state and territory governments about funding and arrangements for a provider of last resort scheme. It should also consult with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies about how such a scheme could operate.

The scheme should be designed to address:

- failed or thin markets, particularly for First Nations people with disability in remote or very remote areas, and consider the use of block funding to guarantee service provision in those communities
- access to services for:
 - people in crisis situations
 - people at risk of losing their accommodation and disability services
 - people whose needs cannot be adequately met by existing services
- access to case management for people with disability at heightened risk of violence, abuse, neglect or exploitation
- clarity about which agency has the lead coordinating role.

The Australian Government should put forward a proposal for discussion to the Disability Reform Ministers Council in 2024.

Part B: NDIS Quality and Safeguards Commission

Recommendation 10.11 Internal procedures for monitoring reportable incidents

The NDIS Quality and Safeguards Commission should improve its internal procedures for monitoring reportable incidents, paying particular attention to:

- a. communicating feedback about the quality of providers' handling of incidents
- b. seeking clarification from providers, National Disability Insurance Scheme participants and their families when deficiencies or evidentiary gaps are identified, particularly where participants have been harmed or are at immediate risk of harm
- c. the efficiency of the online portal used by providers to report incidents.

Recommendation 10.12 Introduction of class or kind determinations

The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) to:

- a. introduce 'class or kind' determinations exempting certain registered providers from notifying less serious types or categories of reportable incidents where they have demonstrated a satisfactory level of competence in managing and investigating incidents
- b. enable the NDIS Quality and Safeguards Commission to conduct audits to assess compliance with class or kind determinations.

Recommendation 10.13 Creating an independent investigators panel

The NDIS Quality and Safeguards Commission (NDIS Commission) should establish a panel of independent investigators with strong credentials in relation to safeguarding, human rights and investigative practice. The NDIS Commission should seek regular feedback from providers about the quality of independent investigators' work.

Recommendation 10.14 Developing model policies and procedures

The NDIS Quality and Safeguards Commission should develop model procedures for National Disability Insurance Scheme (NDIS) providers, including:

- a. for frontline workers about recognising and reporting incidents, with clear definitions around what incidents must be reported and when
- b. for incident management, incorporating guidance on undertaking causal reviews of incidents and preventive action, as well as implementing wider system improvements
- c. for complaints, articulating person-centred approaches for managing and resolving complaints and providing feedback, and requiring supports for a participant who needs to participate in a complaints process
- d. that address the need to consider the impact or harm caused to a participant and provide guidance on forms of redress that should be offered to people with disability involved in incidents and complaints.

These procedures should be developed in consultation with people with disability, family members, advocates and NDIS providers.

Recommendation 10.15 Complaint handling and investigative practice guideline

- a. The NDIS Quality and Safeguards Commissioner should issue a guideline, by notifiable instrument, addressing accessible and responsive complaint handling and investigative practice. The guideline should:
 - outline the core components of an accessible and responsive complaint handling and investigative practice involving people with disability, consistent with Recommendation 11.5
 - be co-designed by people with disability and their representative organisations and involve consultation with National Disability Insurance Scheme (NDIS) provider representatives.
- b. The Minister for the NDIS should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) and *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to include recognition of, and a requirement for compliance with, the guideline.

Recommendation 10.16 Requirement to consider redress

- a. The Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) and *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to include a requirement for NDIS providers to consider redress and forms of support to an NDIS participant where the NDIS Quality and Safeguards Commission (NDIS Commission) forms the view that the service provider bears responsibility for the violence, abuse, neglect or exploitation experienced by the NDIS participant.
- b. The NDIS Commission should:
 - provide practical advice on suitable forms of redress when making the guideline on accessible and responsive complaint handling and investigative practice (see Recommendation 10.15)
 - consider whether it has power to incorporate in enforceable undertakings a requirement that service providers afford redress to NDIS participants in appropriate cases. If not, it should seek the necessary powers and be prepared to use them where appropriate.

Recommendation 10.17 Access to safeguarding indicators and expertise

In developing and publishing guidance about best practice governance models for National Disability Insurance Scheme (NDIS) providers, the NDIS Quality and Safeguards Commission should:

- a. include safeguarding indicators for use by NDIS providers based on the sample indicators outlined in Table 10.8.3
- b. provide guidance encouraging governing bodies of NDIS providers to have regular access to specialist safeguarding advice in considering issues arising from complaints and incidents.

Recommendation 10.18 Improved complaint handling procedures and responses

The NDIS Quality and Safeguards Commission should:

- a. ensure complainants are updated appropriately throughout key stages of the complaint process and their expectations managed
- b. ensure triage and streamlining models effectively prioritise complaints requiring a more immediate response
- c. clearly define risk categories, timeframes and procedures for handling these complaints
- d. establish realistic and achievable metrics for measuring its performance with respect to timeframes.

Recommendation 10.19 Requirement to investigate certain complaints

The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to empower the NDIS Quality and Safeguards Commission to require a provider to carry out an investigation into a complaint and report on its contact with the complainant and its findings.

Recommendation 10.20 Making complaint processes accessible

The NDIS Quality and Safeguards Commission should further enhance the accessibility of its complaint handling processes, having regard to the following steps:

- a. making information simple and easy to navigate
- b. adopting a 'no wrong door' approach
- c. accommodating people's preferred means of communication and making other adjustments as needed
- d. assisting people to secure advocacy and other supports
- e. identifying people at risk of abuse
- f. implementing a strategy for 'hard to reach' groups
- g. ensuring complainants are involved in complaint processes and when this is not possible, recording the reasons for their non-involvement
- h. examining whether providers are supporting people with disability to access advocates when they make a complaint and where providers conduct investigations.

Recommendation 10.21 Registration and audit process

- a. To enhance the registration process, the NDIS Quality and Safeguards Commission (NDIS Commission) should:
 - develop and implement a framework for sharing relevant information with quality auditors
 - conduct a comprehensive review of the provider registration process focused on:
 - simplifying the process for smaller providers seeking to renew their registration
 - improving the NDIS Commission's operating system (COS) portal and online application forms used to submit registration applications
 - removing any duplication of requirements for cohorts of practitioners or organisations working within multiple schemes and for recognising other forms of accreditation
 - identifying areas where there are workforce shortages or 'thin provider markets', and encouraging the use of easier and more cost-effective certification audit processes in these areas
 - assessing whether the number of approved quality auditors accredited for remote auditing and assessment should be increased
 - collect and publish de-identified data about quality audit outcomes to inform best practice
 - alert quality auditors to known systemic issues across the NDIS provider market.
- b. The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) to clarify the NDIS Commission is able to share relevant information with quality auditors.

Recommendation 10.22 Strengthened regulatory requirements

- a. The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the Core Module of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) to issue further standards that address complaint handling and incident management.
- b. The NDIS Quality and Safeguards Commissioner should amend the Core Module of the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) to strengthen the requirements relating to complaints and incidents (see Table 10.10.2), accountable governance (see Table 10.10.3), and worker capacity and training (see Table 10.10.4).

Recommendation 10.23 Publishing data about the unregistered provider market

The NDIS Quality and Safeguards Commission (NDIS Commission) should collect and publish data relating to trends and risks identified within the unregistered provider market, including a breakdown of:

- the number of complaints received involving unregistered providers
- quality and safety issues identified by the NDIS Commission through its oversight of complaints in relation to unregistered providers
- the number of compliance matters and investigations commenced by the NDIS Commission in relation to unregistered providers
- the number of unregistered providers involved in contraventions identified by the NDIS Commission and the type of breach identified
- the number and type of compliance and enforcement actions taken in relation to unregistered providers
- the number of workers engaged by unregistered providers involved in complaints, compliance matters or investigations without a worker screening clearance at the time of the alleged conduct or issue.

Recommendation 10.24 Improved access to behaviour support practitioners

The NDIS Quality and Safeguards Commission should, by December 2024, improve access to behaviour support practitioners by:

- a. providing incentives for practitioners and National Disability Insurance Scheme providers to provide behaviour support services, including in regional and remote areas in which ‘thin markets’ operate
- b. forming a partnership with First Nations leaders from the disability and employment services sectors to develop a recruitment strategy targeting First Nations people and others with experience in working with First Nations communities to address behaviour support shortages in regional and remote areas
- c. exploring with behaviour support practitioners, service providers and people with disability, the merits of an ‘on-the-job’ professional development and accreditation model for behaviour support practitioners
- d. creating a publicly accessible list of all individual behaviour support practitioners.

Recommendation 10.25 Strengthened monitoring, compliance and enforcement

The NDIS Quality and Safeguards Commission should review its compliance and enforcement policy and in doing so have regard to:

- a. where appropriate, transitioning its primary compliance approach from educational and capacity building strategies to stronger compliance and enforcement activities
- b. increasing its face-to-face engagement with National Disability Insurance Scheme (NDIS) participants who are at greater risk of experiencing violence, abuse, neglect and exploitation, and site visits to speak with providers and workers
- c. increasing the use of its enforcement powers and monitoring tools in relation to NDIS providers that:
 - have a history of non-compliance or repeatedly fail to meet their obligations to provide safe and quality supports and services
 - have demonstrated a disregard for the safety of people with disability
 - have caused serious harm to a person or people with disability
- d. the availability of enforceable undertakings and compliance notices to address non-compliance by NDIS providers.

Recommendation 10.26 Expanded data reporting and publication

- a. In addition to data currently published, the NDIS Quality and Safeguards Commission should publish in quarterly activity reports and annual reports:
 - ‘disaggregated data’ relating to complaints, reportable incidents and behaviour support, having regard to suggested data in Table 10.13.1
 - a comprehensive analysis of data trends, identifying systemic issues relating to the quality and safety of National Disability Insurance Scheme (NDIS) supports and services
 - ‘operational performance data’ relating to complaints, reportable incidents, compliance and enforcement, having regard to the suggestions in Table 10.13.2.
- b. The Minister for the NDIS should, in consultation with states and territories, amend the reporting requirements in the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) to enable provider investigation outcome data to be collected on a routine basis from NDIS providers.

Recommendation 10.27 Strengthened intelligence capacity

The NDIS Quality and Safeguards Commission (NDIS Commission) should establish a dedicated intelligence unit within the NDIS Commission to enhance its capacity to collect intelligence, identify and respond to higher risk participants, take action relating to providers where necessary and identify systemic issues.

Recommendation 10.28 Information sharing between prescribed bodies

- a. The Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) to include safeguarding bodies with the type of functions described in Table 10.13.3 as ‘prescribed bodies’ for the purposes of section 67A(1)(db) of the *National Disability Insurance Scheme Act 2013* (Cth).
- b. States and territories should introduce legislative and administrative arrangements that would allow prescribed bodies in each jurisdiction to exchange risk-related information with the NDIS Quality and Safeguards Commission, where the exchange of information will promote the safety of NDIS participants who may be at risk of experiencing violence, abuse, neglect or exploitation.

Recommendation 10.29 Establishing a First Nations Unit

The NDIS Quality and Safeguards Commission should establish a dedicated First Nations Unit to develop its engagement with and understanding of the issues facing First Nations participants in the National Disability Insurance Scheme, particularly in regional and remote communities.

Recommendation 10.30 Engagement and capacity building activities

The NDIS Quality and Safeguards Commission should enhance its engagement and capacity building activities with National Disability Insurance Scheme (NDIS) providers by:

- a. routinely sharing data analysis and insights from its oversight activities with NDIS providers to promote improvements in the quality and safety of services
- b. facilitating regular industry forums and communities of practice to raise and address critical safeguarding practice issues and share best practice
- c. expanding its training offerings to NDIS providers, particularly in relation to fulfilling their obligations to recognise, report and investigate incidents and deal appropriately with complaints
- d. developing a training and resources hub for use by people with disability and their supporters, as well as the NDIS provider workforce.

Recommendation 10.31 Continuous monitoring of criminal charges

The Australian Government and state and territory governments should amend the Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme to clarify the role of the Australian Federal Police (or other national bodies) in monitoring new charges relating to disability support workers who hold a clearance, and sharing information with state and territory worker screening units.

Recommendation 10.32 Operational framework to guide worker screening

The NDIS Quality and Safeguards Commission (NDIS Commission) should, in consultation with state and territory worker screening units, develop an operational framework to guide the efficient and effective provision of information to worker screening units to inform their assessments. In doing so, it should establish criteria to inform the provision of initial monitoring advice to screening bodies to promote consistency and help better inform initial screening actions. Such advice could include:

- date of the incident
- duration of alleged conduct (if applicable)
- description, nature and circumstances of the matter
- whether the police are involved (noting that the screening unit will only be alerted via the monitoring system at the point at which charges are laid)
- critical information relating to the available evidence (for example, an investigation report from an employer)
- relevant information relating to the NDIS Commission's oversight of the matter (for example, whether the matter is open, closed, substantiated or not and whether further outcomes are pending).

Recommendation 10.33 Reviewing information sharing arrangements

As part of the National Disability Insurance Scheme worker screening review, the Australian Government and state and territory governments, should consider the adequacy of information sharing arrangements with regard to:

- a. the ability of worker screening units to obtain relevant risk-related information from bodies outside of their operating jurisdiction to inform their assessments
- b. the ability of the NDIS Quality and Safeguards Commission and worker screening units to obtain and share relevant risk-related information (such as misconduct and disciplinary investigation outcomes) held by other safeguarding and complaint handling bodies to inform worker screening decisions.

Part A: Disability service providers

Key points

- People with disability experience and are exposed to violence, abuse, neglect and exploitation within disability services. This can include neglect of their right to develop or acquire skills and to participate in the community. It can cause lasting trauma and harm. It can also lead to a breakdown in the confidence and trust people with disability, their families and advocates should have in disability services.
- Respect for human rights must be embedded in the design and delivery of disability services. Effective leadership and governance are required to ensure organisational cultures reflect this.
- Disability service providers should encourage and welcome feedback, concerns and complaints. They should address the barriers people with disability face when raising concerns, making complaints and reporting incidents.
- Service providers should understand the effects of trauma, and provide traumainformed and culturally safe supports to people who have reported or been exposed to violence, abuse, neglect or exploitation.
- Service providers should consider and offer redress on their own initiative when it is clear that a person with disability has experienced harm as a consequence of violence, abuse, neglect or exploitation for which providers are responsible. It should not be left to people with disability or their supporters to ask for redress in those circumstances.
- Effective recruitment, training and supervision of skilled disability support workers by disability service providers, as well as measures to ensure workforce continuity, are all essential to meet the needs of people with disability and to prevent violence, abuse, neglect and exploitation.
- A national worker registration scheme would provide a framework to professionalise and stabilise the disability sector workforce.
- The market approach to disability services has not worked for everyone. Urgent work is required to address service delivery gaps in all jurisdictions.
- The NDIS Quality and Safeguards Commission has a key role in preventing and responding to violence, abuse, neglect and exploitation in disability services.

1. Introduction

This chapter examines violence, abuse, neglect and exploitation in disability services. It includes a brief background to the National Disability Insurance Scheme (NDIS), and describes new language, roles and systems associated with NDIS funding. Building on Volume 3, *Nature and extent of violence, abuse, neglect and exploitation* and Volume 5, *Governing for inclusion*, it describes the objectives and principles of the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*). It then provides information about the disability service providers NDIS participants can use to receive services and supports. This illustrates the size, growth and diversity of the disability services market and the payments made to disability providers.

The chapter also outlines the different roles and responsibilities of the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission (NDIS Commission). It discusses the NDIA's role as market steward and introduces the various oversight functions of the NDIS Commission.

On 18 October 2022, the Minister for the National Disability Insurance Scheme announced a review of the NDIS (NDIS Review) to improve the wellbeing of Australians with disability and the sustainability of the scheme. The NDIS Review is being conducted by an Independent Review Panel. Volume 5, provides further information about the NDIS Review, including the terms of reference.

The NDIS Review will examine the design, operation and sustainability of the NDIS and ways to build a more responsive, supportive and sustainable market and workforce. The evidence we have heard about violence, abuse, neglect and exploitation in disability services is closely connected with a number of focus areas of the NDIS Review. The Australian Government has confirmed that the Review Panel is considering the proceedings of this Royal Commission and will have 'careful regard' to our findings. The report of the Review Panel is scheduled to be delivered by October 2023, shortly after the publication of this *Final report*. Throughout this volume we identify areas for consideration by the Australian Government as it implements any reforms recommended by the Review Panel.

1.1. Disability services

Services are the things that get us to square one. They might eliminate pain or provide certain access or assistance, but they rarely by themselves bring happiness. Happiness comes from our relationships, our sense of belonging, our capacity to contribute and the pursuit of our special interests.¹

In the course of our inquiries, we have used the term ‘disability services’ to refer to the particular services people with disability use because of their disability. They are distinct from the ‘mainstream’ or ‘generic’ services all people use over the course of their lives, such as education, healthcare, transport, employment or accommodation services. Disability services may support a person with disability to access and use mainstream services, or they may be specifically designed and used as a service to support people with disability.

We have consistently heard from witnesses that high-quality disability services are crucial for people with disability, particularly those with high support needs, to participate fully in the community and realise their fundamental human rights.² For example, in Public hearing 13, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)’, ‘Eliza’ told us about her sister ‘Melissa’, a young woman with Prader-Willi Syndrome.³ Eliza said:

What Melissa would like, and I would like too, is for her to have an ordinary life that is safe, predictable and enjoyable for her. ... The model that would facilitate this wonderful, ordinary life would involve a small group of highly trained and committed individuals, focused on Melissa and helping each other to support her.⁴

It is important to recognise that not all people with disability require or use disability services. The 2011 Productivity Commission *Disability Care and Support* Inquiry report, which preceded the introduction of the NDIS, estimated that around 411,000 out of a total of approximately 3.8 million people with disability in Australia would be funded through the NDIS.⁵ The Productivity Commission also said:

It will be important for the [NDIS] not to respond to problems or shortfalls in mainstream services by providing its own substitute services. To do so would weaken the incentives of government to properly fund mainstream services for people with a disability, shifting the cost to another part of government ... This ‘pass the parcel’ approach would undermine the sustainability of the [NDIS] and the capacity of people with a disability to access mainstream services.⁶

In addition, not all disability services are funded through the NDIS. There are other schemes for funding and providing such services, including the Disability Employment Services (DES) program discussed in Volume 7, *Inclusive education, employment and housing*, and the National Injury Insurance Scheme.⁷ However, the focus of this volume is on those services now largely funded through the NDIS.

1.2. Disability services under the NDIS

I should have the same power to shape my life as anybody else, but for years I had very little.⁸

Before the introduction of the NDIS, disability services in Australia were predominantly funded and provided by state and territory governments. The Royal Commission has heard how the provision of disability services fundamentally changed with the *NDIS Act* and the rollout of the NDIS beginning in 2016.⁹ Volume 5, provides background information on the NDIS, including a description of the objects and principles of the *NDIS Act* and individual plans under the NDIS.

Individuals who meet particular eligibility requirements can apply to participate in the NDIS and are provided with an individual support plan. To be eligible, a person must meet residency requirements, disability or early intervention requirements, and be under 65 years of age at the time of requesting access to the scheme.¹⁰ Volume 3, describes the characteristics and demographics of people with disability who are NDIS participants.

The *NDIS Act* establishes the NDIA as the independent agency responsible for delivering the NDIS.¹¹ Subject to meeting the access requirements set out in the *NDIS Act*, the CEO of the NDIA approves the funding of ‘reasonable and necessary’ supports for NDIS participants as set out in their individual NDIS plans.¹²

The *NDIS Act* envisages NDIS participants will be involved in the preparation of their NDIS plans.¹³ One of the stated objects of the *NDIS Act* is to ‘enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports’.¹⁴ Another object of the *NDIS Act* is to ‘promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the community’.¹⁵

Several witnesses told us about how the introduction of the NDIS affected their services and supports. Some witnesses said individualised NDIS funding packages positively affected their or their family members’ lives.¹⁶ Others spoke of the challenges they or others have faced in transitioning to or navigating the complexities of the NDIS system and ensuring they or their family members have access to safe and high-quality disability services.¹⁷

After an NDIS participant receives their NDIS plan, which sets out the funding available to them for services and supports to assist in achieving the goals stated in the plan, they can use that funding to purchase those services from one or more disability service providers.

Funded services and supports under the NDIS

NDIS participants can have three types of support budgets in their plans:¹⁸

- **core supports** include everyday activities and disability-related needs, such as Supported Independent Living (SIL), personal care, household cleaning, yard maintenance, a support worker to assist with participation in social and community activities, consumables (continence products) and transport to work or other places to pursue plan goals
- **capital supports** include higher-cost items such as assistive technology; equipment for mobility; personal care; communication and recreational inclusion; vehicle modifications; home modifications and Specialist Disability Accommodation (SDA)
- **capacity building supports** include assessments, training or therapy to help an NDIS participant build their independence and skills to find and maintain an appropriate place to live, find and keep a job, participate in the community and improve their relationships, health and wellbeing or learning. They also include support coordination to use a plan or plan management to manage funding in a plan.

NDIS plan management options

NDIS participants can manage their NDIS plans and funding in several ways:

- **Self-managed** participants (or their nominees) manage part or all of their NDIS funding themselves. They choose and pay providers directly for their services and supports.
- **Plan-managed** participants still choose who delivers their services and supports but employ a plan manager to pay providers on their behalf. The NDIA adds extra funding to employ a plan manager to the participant's plan.
- **NDIA-managed** (agency-managed) participants still choose their provider(s), but the NDIA pays the provider(s) directly after services have been delivered.

Participants may choose a combination of plan management options, using different methods for different aspects of the supports funded in their plans.¹⁹

The NDIA publishes quarterly information about NDIS participants and methods of plan management. In December 2022, the NDIA reported a 'significant shift in plan management' with an increasing number of participants choosing to be plan-managed rather than NDIA-managed.²⁰

Table 10.1.1: Trends in National Disability Insurance Scheme plan management types between 2020 and 2022²¹

Plan management types
Participants self-managing all or part of their plan has been stable at approximately 30%
Participants using a plan manager has increased from 45% to 58%
Participants with agency-managed plans has decreased from 24% to 12%

Intermediary services

Intermediary services were created to support participants to navigate the NDIS. During our public hearings, we heard they play an important role in supporting people with disability to access the NDIS and best use their individualised funding packages.

Support coordinators

Support coordinators are ‘service intermediaries’ who assist NDIS participants with procuring, establishing and coordinating service arrangements with providers.²² In Public hearing 32, ‘Service providers revisited’, Mr Jess Harper, CEO of Disability Intermediaries Australia Limited (DIA), told us that the role of support coordinators is to enable NDIS participants to be ‘informed consumers’.²³

Support coordination can be funded in a participant’s NDIS plan as a form of capacity-building support.²⁴ The participant can use that funding to pay for support coordination offered by a disability service provider as part of a suite of services, or by an independent support coordinator who only offers support coordination services.

The inclusion of support coordination in a participant’s plan is not universal or automatic. Mr Harper told us that the original intention of the NDIS was for 40 per cent of participants to have support coordination in their plans, but a recent survey found demand for support coordination continues to grow with 55 per cent of approved NDIS plans in the first quarter of 2022–23 containing funding for support coordination.²⁵

There are three levels of support coordination:²⁶

Level 1: Support connection assists participants to understand their NDIS plans, connect with service providers and achieve the most out of their plans.

Level 2: Coordination of supports is funded when there is greater complexity in the support environment and/or the participant’s circumstances. Level 2 support coordinators assist participants to understand their plans, reduce barriers to engage and maintain supports, design support approaches, establish supports and monitor the supports.

Level 3: Specialist support coordination is the highest level of support coordination. Level 3 uses expert or specialist approaches and is funded when NDIS participants have specific high and/or complex support needs, or where risks have been identified that require active specialised management.

Specialist support coordination can only be delivered by support coordinators who are registered NDIS providers.²⁷

A report published by DIA in 2022, which draws on data from the NDIA and the NDIS Commission, states that as at March 2022, there were 1,624 support coordination providers actively operating across Australia. Sixty per cent of these were registered providers and 40 per cent were unregistered providers.²⁸

Plan managers

Plan managers are financial intermediaries for NDIS participants who have chosen not to self-manage their NDIS funding nor to have the NDIA do so. They assist NDIS participants to manage their NDIS budgets, funding claims and administration.²⁹

A participant's plan manager claims for funds from the NDIA against an invoice or receipt and disburses those funds to providers for the supports and services the participant has received.³⁰ Plan managers must be registered NDIS providers.³¹

1.3. Disability service providers

The term 'disability service provider' encompasses a range of organisations that deliver disability services. Some providers may be government or non-government organisations. Some are small, supporting a single person with disability, while others are large, with thousands of workers, and operate in multiple states and territories. Some operate for profit while others are not-for-profit. We have heard that some providers offer multiple types of supports and services, while others focus on one particular form of support.³²

Table 10.1.2 indicates the different sizes and service offerings of several disability service providers involved in one or more of our public hearings. All are registered NDIS providers.

Table 10.1.2: Overview of selected service providers who have appeared before the Royal Commission

Service provider	Overview
Araluen Centre (Araluen)	As at 22 November 2022, Araluen provided support to 326 people with disability in Victoria. Araluen's services include SDA, SIL, day supports, support coordination, and group supports including hospitality and art programs. ³³
Australian Foundation for Disability (Afford)	In the year ending 30 June 2022, Afford provided services to 6,550 people with disability under the NDIS and the Disability Employment Service (DES) program. This number decreased to 4,790 by November 2022. The majority of its disability services were delivered to people in New South Wales followed by Queensland, Victoria, South Australia and Western Australia. Afford's services include SIL, community services, support coordination, and employment services. ³⁴
BET Group Global (BET Group)	In 2022, BET Group provided services to 62 people with disability across South Australia and Victoria. BET Group's services include accommodation assistance; respite; assistance with daily life tasks in a group or shared living arrangement, and participation in community, social and civic activities. ³⁵
Coastal Residential Services Inc. (CRS)	In 2022, CRS provided services to 20 people with disability on the north-west coast of Tasmania. ³⁶ CRS provides day services, support coordination, supported accommodation assistance, community access and individual support. ³⁷
Endeavour Foundation (Endeavour)	In the year ending 30 June 2022, Endeavour provided services to 3,029 people with disability, primarily in Queensland. Endeavour's services include SIL, day programs and supported employment. ³⁸
Life Without Barriers (LWB)	As at 30 June 2022, LWB provided services to 5,213 people with disability across all Australian states and territories, including SIL, support coordination, and assistance in the home and community with daily living skills. ³⁹
Minda	As at 22 November 2022, Minda provided services to 1,087 people with disability primarily in South Australia. Minda's services include SIL, short-term accommodation, advocacy and supported employment. ⁴⁰
Scope (Australia) Ltd (Scope)	As at 22 December 2022, Scope supported 5,433 people with disability with services including SIL, SDA, support coordination, communication services, mobility services, and day and lifestyle options, as well as allied health and DES. Scope operates across Australia with most users based in Victoria, followed by users in New South Wales. ⁴¹
Summer Housing	Summer Housing was established to replicate and scale housing demonstration projects carried out by the Summer Foundation. As at November 2022, Summer Housing supported 172 people with disability, mainly in New South Wales, Queensland and Victoria followed by South Australia, the Australian Capital Territory and Western Australia. Summer Housing only provides accommodation services to people with high support needs. ⁴²

Service provider	Overview
Sunnyfield Disability Services (Sunnyfield)	In the financial year ending 30 June 2022, Sunnyfield provided disability services to 1,962 people, predominantly in New South Wales, followed by the Australian Capital Territory, Queensland and Victoria. The majority of its service users are people with intellectual disability and people with autism. Sunnyfield's services include supported accommodation services. ⁴³
The Disability Trust	In the financial year ending 30 June 2022, The Disability Trust provided services to 4,991 people with disability, the majority of whom have a primary disability of intellectual disability. Most of its disability services were delivered to people in New South Wales followed by the Australian Capital Territory, Victoria and Queensland. ⁴⁴
Yooralla	As at 28 November 2022, Yooralla provided services to 2,758 people with disability in Victoria. Yooralla's services include community hubs and supports, positive behaviour support, respite, support coordination and supported accommodation. ⁴⁵

In addition to the differences in size, service offerings and location of disability service providers, the revenue they receive from the provision of services funded through the NDIS also varies. For example, in the financial year ending on 30 June 2022, Afford, The Disability Trust and Sunnyfield reported receiving revenue from the NDIS of \$124,041,229, \$111,209,753 and \$92,273,000, respectively.⁴⁶ As indicated in Table 10.1.2, in the same period, they provided disability services to 6,650, 4,991 and 1,962 individuals, respectively.

The transition from block-funded services to individually funded NDIS participants created a disability services market. NDIS participants are consumers in that market, seeking a range of services and supports from providers who may be competing with each other to deliver them. This is a deliberate design feature of the NDIS, intended to give people with disability maximum choice and control over the services they receive.⁴⁷

In addition, NDIS participants may choose to use either registered providers or unregistered providers for most supports.

A provider *must* be registered with the NDIS Commission under section 73E of the *NDIS Act* to:

- deliver services and supports specified in 36 registration groups⁴⁸
- manage funding of supports under participants plans (plan managers)⁴⁹
- provide supports to NDIA-managed participants⁵⁰
- deliver SDA or specialist behaviour supports, or use a regulated restrictive practice for self-managed and plan-managed participants.⁵¹

In order to become registered, a provider must meet the requirements in Part 3A, Division 2 of the *NDIS Act* and the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 (Practice Standards)*. We discuss this process in Chapter 10, 'Provider registration'.

While not bound by the *Practice Standards*, unregistered providers and people working for unregistered providers who provide services and supports to people with disability who are funded through the NDIS are covered by the *National Disability Insurance Scheme (Code of Conduct) Rules 2018 (Cth) (Code of Conduct)*.⁵²

The NDIA publishes data about NDIS participants and service providers through its data insights web pages and in its quarterly reports to disability ministers.⁵³

In the second quarter of 2022–23, the NDIA reported there were 151,629 active providers of disability services in Australia.⁵⁴ It also reported that in the year ending 31 December 2022, there were a total of 573,342 NDIS participants.⁵⁵ In the same period, \$31 billion in supports had been provided to NDIS participants, 54 per cent of which went to the core daily activities support category, which includes participants receiving SIL services.⁵⁶

SIL funding refers to funding to support NDIS participants who have high support needs due to their disability and need support all or most of the time to live in their accommodation.⁵⁷ In the year ending 31 December 2022, a total of 29,812 NDIS participants had funding for SIL.⁵⁸ SIL supports may involve:⁵⁹

- help with personal care tasks
- help to build skills in areas such as meal preparation and cooking, cleaning and developing a routine
- help to action any behaviour support plans
- help to develop social skills
- support for supervision, personal safety and security
- support to administer medication (if needed)
- support to attend medical appointments
- community access that is not routine or regular
- support to get to and from community access activities, such as visiting friends and family outside the home.

Throughout this volume we also use the term ‘supported accommodation’ to refer to housing that includes disability supports. Some people with disability live in shared supported accommodation, which may be referred to as a ‘group home’.⁶⁰

Some people who have funding for SIL may also have funding for SDA. In the year ending 31 December 2022, 22,069 NDIS participants had funding for SDA.⁶¹

SDA is a capital subsidy that is used to provide accommodation for people who require specialist housing solutions associated with extreme functional impairment or very high support needs.⁶² SDA providers must be registered NDIS providers, and SDA funding is paid directly to the providers to cover the building and maintenance costs for accommodation.⁶³

Figure 10.1.1 shows the number of SDA providers as at 31 December in each year from 2019 to 2022. On 31 December 2022, there were 337 SDA providers nationally.

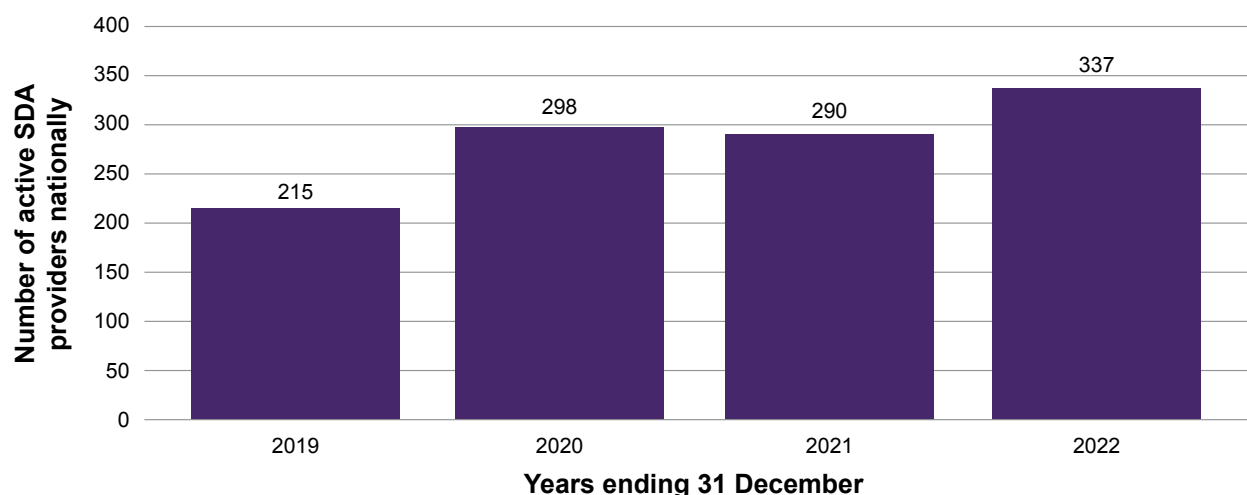


Figure 10.1.1: SDA providers for years ending 31 December 2019 to 2022

Note: Most available data is from 31 December 2022. Therefore, the SDA providers included in this Figure are active as of 31 December of each year to enable comparability.

Source: National Disability Insurance Agency, NDIS quarterly reports to disability ministers, Q1 2019–20 to Q2 2022–23 (2019 to 2022).

Market concentration and innovation

Market concentration measures the percentage of a market (market share) that is held between a small number of organisations.⁶⁴ Table 10.1.3 shows the concentration in the disability service provider market by remoteness rating.

Table 10.1.3: Market concentration by remoteness rating, December 2022

Remoteness rating	Market concentration (%) ^a
Major cities	25%
Population greater than 50,000	24%
Population between 15,000 and 50,000	22%
Population between 5,000 and 15,000	21%
Population less than 5,000	23%
Remote	46%
Very remote	48%

Note: There was a market concentration of 29 per cent in areas with a 'missing' remoteness rating.

Note: Market concentration is defined as the ratio between the top 10 providers over the six-month exposure period and the total payments to all providers over the period. The exposure period runs from nine months prior to the reporting date to three months prior to the reporting date. For example, data for the December 2022 reporting date is based on data from 1 April 2022 to 30 September 2022.

Source: National Disability Insurance Agency, NDIS quarterly reports to disability ministers: Q2 2022–23, Quarterly report, January 2023, p 108.

One of the functions of the NDIA is to develop and enhance the disability sector, including by facilitating innovation, research and contemporary best practice in the sector.⁶⁵

The rollout of the NDIS coincided with the growth in use of digital platform technologies and digital contracting.⁶⁶ Digital platforms or ‘platform providers’ have developed within the disability sector. The NDIS Commission describes ‘NDIS platform providers’ as ‘businesses that provide online platforms and online subscription services to connect workers with NDIS participants’.⁶⁷ At the time of preparation of this report, the NDIS Commission was conducting an Own Motion Inquiry into Platform Providers Operating in the NDIS Market.⁶⁸

In Public hearing 32, we heard from two digital platforms, Hireup and Mable, about how digital platforms operate in the disability sector to provide people with disability the tools to find, engage and manage support workers who fit their needs and share their interests.⁶⁹ While there are some aspects of their operations that are similar, there are also important differences between them.

Hireup is a registered NDIS provider that uses a digital platform to connect people with disability to support workers employed by Hireup.⁷⁰ In its 2020–21 annual report, Hireup said:

Alongside at least seven others, we’re part of a seismic shift in how support work is being organised and performed. We are doing away with traditional rosters and giving more flexibility and choice, both to people with disability and to their support workers.⁷¹

Mable is a conduit that connects people with disability to support workers, independent personal care, nurses and allied health professionals. It is not a service provider, nor does it require people or organisations offering services via its platform to be registered providers.⁷² Mable’s workforce is primarily comprised of individual contractors who are ‘people that are choosing to be self-employed’.⁷³

We heard that in September 2022, 9,897 support workers were using Mable’s platform and had delivered 383,264 hours of support to 14,899 clients. Of those 14,899 clients, around 58 per cent (slightly in excess of 8,500 people) were NDIS participants.⁷⁴

Hireup told us that on average, it provides services to 11,128 clients per month.⁷⁵ The vast majority of Hireup’s client base are NDIS participants.⁷⁶

1.4. Regulation and oversight

Role of the NDIA

Although the NDIA delivers the NDIS, it does not have statutory powers to regulate or oversee disability service providers. However, it does have a shared responsibility to ensure NDIS participants can obtain and retain safe, high-quality services.

Among other things, the NDIA has an important function to ‘promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and inclusion in the community’.⁷⁷ In accordance with this function, in 2016 the NDIA established its role as ‘market steward’ to create an ‘efficient and sustainable marketplace through a diverse and competitive range of suppliers who are able to meet the structural changes created by a consumer driven market’.⁷⁸

In October 2018, the NDIA released its Market Enablement Framework which sets out the processes and procedures the NDIA uses to assess market issues and ensure a functioning disability services market.⁷⁹ At Public hearing 32, ‘Service providers revisited’, NDIA General Manager, Provider and Market Development, Ms Gerrie Mitra, described the NDIA’s market stewardship activities, including:⁸⁰

- publishing improved supply and demand data
- monitoring pricing regulation and responsiveness
- using place-based market interventions where market challenges exist.

However, we have heard about areas where gaps remain in the service provider market for some cohorts of people with disability. We have discussed the particular gaps faced by First Nations people with disability in Volume 9, *First Nations people with disability*. In Chapter 5 of this volume, ‘Areas for systemic change’, we discuss other areas where there may be a need for increased action by the NDIA to respond to market deficiencies.

NDIS Quality and Safeguards Commission

The NDIS Commission was established by section 181A of the *NDIS Act* and comprises the NDIS Quality and Safeguards Commissioner (NDIS Commissioner) and Commission staff.⁸¹ Its objectives are underpinned by the principles of the NDIS Quality and Safeguarding Framework (NDIS Framework), which the Disability Reform Council released in 2016, and the *Convention on the Rights of Persons with Disabilities (CRPD)*.⁸²

The operation of the NDIS Commission rolled out in phases, starting in New South Wales and South Australia on 1 July 2018 and achieving national completion on 1 December 2020.⁸³

The core functions of the NDIS Commissioner include upholding the rights of people with disability; promoting the health, safety and wellbeing of people with disability; developing a

nationally consistent approach to managing quality and safeguards for people with disability who are receiving disability service and securing compliance with the *NDIS Act*.⁸⁴

In addition to these core functions, the NDIS Commissioner has functions related to the registration of providers and reportable incidents,⁸⁵ complaints⁸⁶ and behaviour support.⁸⁷ The NDIS Commissioner also operates and maintains an NDIS worker screening database.⁸⁸

In addition to the powers set out in the *NDIS Act*, a number of the NDIS Commission's activities are prescribed through a series of rules made under the *NDIS Act*.⁸⁹ For example, the *Practice Standards* specify the standards that registered providers must achieve in relation to the quality of supports and services.⁹⁰

The *Practice Standards* consist of 'modules' that apply to a provider based on the type of supports they are registered to deliver. Each standard is supported by a series of Quality Indicators set out in the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018 (Cth) (Quality Indicators)*.⁹¹ Throughout this volume we refer to these *Practice Standards* and the *Quality Indicators*.

The NDIS Commission can receive complaints about any issue connected with the supports or services provided by a registered or unregistered disability service provider.⁹² We discuss how it exercises this function in Chapter 9, 'Complaints'. In addition, registered NDIS providers are required to notify the NDIS Commission of 'reportable incidents' that occur in connection with the provision of supports or services, including incidents involving death or serious injury to, and abuse or neglect of, a person with disability.⁹³ We examine these obligations and the NDIS Commission's approach to reportable incidents in Chapters 4 and 8. We discuss the role, powers and functions of the NDIS Commission in detail in Part B.

Endnotes

- 1 Exhibit 14-53, 'Statement of Richard Bruggeman', 24 May 2021, at [40].
- 2 See, for example, Exhibit 13-3, 'Statement of Sophia', 29 April 2021, at [61]; Exhibit 20-64, 'Statement of Paul', 17 November 2021, at [158]; Exhibit 23-26, 'Statement of Suzie', 28 April 2022, at [100–102].
- 3 Names changed to protect identities.
- 4 Exhibit 13-2, 'Statement of Eliza', 29 April 2021, at [129].
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- 8 Exhibit 3-19, 'Statement of Sam Petersen', 27 November 2019, at [36].
- 9 Exhibit 4-20, 'Statement of James Simpson', 12 February 2020, at [105–106]; Exhibit 4-246, NSW.0017.0001.0001, [2.1–2.2].
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- 11 *National Disability Insurance Scheme Act 2013* (Cth) ch 6.
- 12 *National Disability Insurance Scheme Act 2013* (Cth) ss 33–34.
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- 16 Exhibit 6-12, 'Statement of Dariane McLean', 9 September 2020, at [38–45], [55]; Exhibit 20-20.04, 'Statement of Jennifer', 16 November 2021, at [27], [129]; Exhibit 3-10, 'Statement of Peter Gibilisco', 2 December 2019, at [44]; Exhibit 8-1, 'Statement of Ann', 23 November 2020, at [87].
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- 21 National Disability Insurance Agency, *NDIS quarterly report to disability ministers*, 31 December 2022, p 89.
- 22 Exhibit 32-6, 'Statement of Jess Harper', 6 February 2023, at [10].
- 23 Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-291 [35–41].
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- 25 Exhibit 32-6, 'Statement of Jess Harper', 6 February 2023, at [22–23].
- 26 Exhibit 32-6, 'Statement of Jess Harper', 6 February 2023, at [20].
- 27 Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-291 [16–21].
- 28 Exhibit 32-6.03, DIA.9999.0001.0217, p 40.
- 29 Exhibit 32-6, 'Statement of Jess Harper', 6 February 2023, at [10(b)].
- 30 Exhibit 32-6, 'Statement of Jess Harper', 6 February 2023, at [15].
- 31 Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-291, [7–10]; *National Disability Insurance Scheme Act 2013* (Cth) s 43.
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2. What we heard about violence, abuse, neglect and exploitation in disability services

Key points

- The Royal Commission heard evidence about violence, abuse, neglect and exploitation in disability services at five disability service provider hearings and several other hearings.
- 1,745 additional accounts of violence, abuse, neglect and exploitation in disability services were presented in submissions and private sessions.
- In some of our hearings, we examined case studies concerning disability providers or individual support workers misusing their positions of trust and power.
- We also heard about resident-to-resident violence, often in circumstances where people had no choice about where or with whom they lived.
- We found increased risks when people are forced to live together, with behaviour being a common means of communicating upset, frustration and distress.
- We examined the factors that expose people with disability to, or protect them from, violence, abuse, neglect and exploitation.
- Violence, abuse, neglect and exploitation can cause lasting trauma and harm.
- It can also lead to a breakdown in the confidence and trust that people with disability and their families and advocates must have in the disability providers who deliver essential services and supports.

Volume 3, *Nature and extent of violence, abuse, neglect and exploitation*, identifies numerous accounts from people with disability, family members of people with disability, advocates, paid support workers and others relating to disability services and supports. In some cases, these accounts include descriptions of incidents or events that constitute violence against, and/or abuse, neglect or exploitation of, people with disability.

Some of the information we received related to incidents or events that occurred many years ago, before the introduction of the NDIS and the changes to service funding and provision outlined in Chapter 1, 'Introduction'. However, we have also received descriptions of violence, abuse, neglect and exploitation after the commencement of the NDIS while NDIS participants have been receiving or seeking access to disability services and supports.

In addition to accounts of incidents of violence and abuse when receiving disability services, we also heard from people with disability and their families or supporters about how the day-to-day rights and general health and wellbeing of people with disability have been neglected. In some cases, the absence or shortage of appropriate services and supports may amount to forms of systemic neglect, such as the lack of culturally safe services for First Nations people with disability, as discussed in Volume 9, *First Nations people with disability*.

In this chapter, we outline what we heard about violence against, and abuse, neglect and exploitation of, people with disability when accessing or receiving disability services, and the effect this has on them and their supporters.

We draw on the evidence from public hearings, information from submissions and private sessions, and responses to issues papers. We also refer to the NDIS Quality and Safeguards Commission's (NDIS Commission's): *Own Motion Inquiry into aspects of supported accommodation Inquiry report (Own Motion Inquiry report)*, published in January 2023.¹

We examined in detail the experiences of people with disability using disability services, across several public hearings, through case studies relating to a small number of specific service providers:

- Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', held in May 2021.
- Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', held in June 2021.
- Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', held in December 2021.
- Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', held in May 2022.

The case studies were selected by reviewing submissions and other information received from people with disability and their supporters. The review identified numerous accounts of violence against, and abuse and neglect of, people with disability while receiving accommodation services or support to participate in the community. Many of these accounts referred to medium to large disability service providers. This informed our decision to focus the four hearings listed above on these types of settings and providers.

In addition, Public hearing 17, Part two, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', held in March 2022, examined the experiences of 'Niky', a young woman with Smith-Magenis Syndrome who was sexually assaulted in 2018 at a respite centre operated by a disability service provider.²

In Public hearing 32, 'Service providers revisited', held in February 2023, we examined common and recurrent themes arising across our inquiry related to the provision of disability services. We also heard from disability service providers involved in previous public hearings about changes to their policies and practices made as a consequence of those hearings.

2.1. Overview of public hearings

Volume 2, *About the Royal Commission*, summarises the 33 public hearings held over the course of our inquiry. In this section, we outline the hearings of particular relevance to our examination of violence, abuse, neglect and exploitation within disability services, which are referred to throughout this volume.

In addition to public hearings focused on disability service providers, two further hearings looked at the experiences of people with disability in specific disability service settings - group homes and Australian Disability Enterprises (ADEs). We also held a hearing focused on women and girls with disability and their experiences of family, domestic and sexual violence. This included an account of a sexual assault occurring at a day program in a respite centre.³

Public hearing 13

Public hearing 13 was the first service provider hearing. It focused on the experiences of 'Melissa', 'Carl' and 'Chen', people with disability living in supported accommodation operated by Sunnyfield Disability Services (Sunnyfield) in Western Sydney, referred to as 'the house in Western Sydney'.⁴

The case study examined Sunnyfield's role in and responsibility for preventing and responding to violence against, and abuse of, residents of the house in Western Sydney by two Sunnyfield employees (referred to as SP1 and SP2). The hearing also examined:

- Sunnyfield's governance, management and risk arrangements
- Sunnyfield's recruitment, supervision and management of staff working at the house in Western Sydney
- Sunnyfield's relationship with residents' families
- Sunnyfield's investigation of, and response to, allegations against SP1 and SP2 of abusing the residents of the house in Western Sydney
- the role and responsibilities of external oversight bodies, including the NSW Ombudsman and the NDIS Commission, to prevent violence, abuse, neglect and exploitation and to respond to complaints.

The Commissioners' *Report of Public hearing 13* included 24 findings and three recommendations.⁵ The findings covered a range of issues, including:⁶

- the exercise of choice and control over the services and supports received by residents of the house in Western Sydney
- Sunnyfield's governance and leadership structures and its approach to risk, including reputational risk
- recruitment and supervision of staff

- residency and service agreements
- incident management, including reporting and recording practices
- breakdowns in communication between Sunnyfield and the residents' families, and defensive and hostile responses to feedback and complaints.

The three recommendations directed at Sunnyfield included that:

- it should clarify in writing that it has withdrawn the eviction notice sent to 'Eliza', the sister and guardian of Melissa⁷
- it should discuss revising Melissa's service agreements with Eliza to ensure consistency with Melissa's rights and her exercise of choice and control⁸
- members of the Board and Sunnyfield's CEO should meet with Melissa, Carl and Chen, or their families, to apologise for its failures and to discuss redress and other matters.⁹

In advance of Public hearing 32, Sunnyfield responded to two notices to give information in writing. The first notice asked a series of questions concerning developments since Public hearing 13.¹⁰ The new Sunnyfield CEO, Mr Andrew Hyland, gave oral evidence at Public hearing 32 about some of those developments.¹¹ These matters are set out in Counsel Assisting's submissions following Public hearing 32.¹²

We accept Counsel Assisting's submission that there have been significant changes at Sunnyfield since Public hearing 13, including efforts to take responsibility for, and address, the deficiencies identified during that hearing.¹³ We discuss the issue of redress in more detail in Chapters 4 and 8.

Public hearing 14

The first part of Public hearing 14 examined the experiences of two people with disability – 'Mitchell'¹⁴ and Mr Daniel Rogers – who received accommodation services operated by the South Australian Department of Human Services (DHS) over approximately five years.

'Victoria' and 'James', Mitchell's aunt and uncle, gave evidence about Mitchell's experiences living in different supported accommodation settings.¹⁵ They also gave evidence about the challenges of raising issues and concerns, and about the events surrounding the receipt of an anonymous letter threatening to harm Mitchell.¹⁶ The hearing examined what steps DHS took to investigate and respond to the threatening letter and why there was a delay in doing so.

The hearing also examined the experience of Mr Rogers when he lived in a house operated by DHS, referred to as 'N-Street'. His mother, Mrs Karen Rogers, gave evidence that she often had need to complain about her son's care. Of particular concern was Mr Rogers' admission to hospital with extensive bruising. Mrs Rogers did not believe support staff at N-Street were truthful about how the injuries had been sustained and about other incidents.¹⁷

The hearing examined DHS's practices and policies around the standard of care provided to Mr Rogers, its spending of and accounting for his money, and its communication with his family (including about health matters). The hearing also considered the adequacy of the steps taken by the South Australian Police and DHS to investigate the circumstances of Mr Rogers' physical injuries. DHS's internal reporting and complaints handling processes were also examined.

Following Public hearing 14, DHS announced that it had engaged a forensic investigator to examine Victoria and James's concerns about the letter. The DHS Chief Executive also issued formal letters of apology to Mitchell and Mr Rogers, and their families.¹⁸

The Commissioners' *Report of Public hearing 14* includes nine findings concerning the case studies relating to Mitchell and Mr Rogers. We found that DHS had failed to adopt a person-centred approach focusing on Mitchell's safety and wellbeing in its supported accommodation.¹⁹ We also found failures in how it responded to the threatening letter.²⁰ We made findings concerning deficiencies in DHS's response to Mr Rogers' injuries,²¹ and the lack of institutional accountability on the part of DHS for the problems experienced by Mitchell, Mr Rogers and their families.²²

The second part of Public hearing 14 examined the responses by DHS, the National Disability Insurance Agency (NDIA) and the NDIS Commission to the death, in 2020, of Ms Ann-Marie Smith who had lived with cerebral palsy.

The hearing focused primarily on the measures taken in response to investigations already conducted into Ms Smith's death, particularly:

- the reports of the Safeguarding Task Force commissioned by the South Australian Government²³
- the Honourable Alan Robertson SC's report, *Independent review of the adequacy of the regulation of supports and services provided to Ann-Marie Smith, an NDIS participant, who died on 6 April 2020*.²⁴

The hearing examined:

- how the NDIA and the NDIS Commission identify vulnerable NDIS participants
- the NDIS Commission's regulation of 'sole carers'
- the responsibility of local area coordinators and support coordinators for vulnerable NDIS participants' safety and wellbeing
- information-sharing arrangements between state and Australian government agencies, and between the NDIA and the NDIS Commission.

The Commissioners' *Report of Public hearing 14* included a series of observations about the responses to the two reports on the death of Ms Smith, but we did not make any findings.

Public hearing 17

Public hearing 17 examined violence against, and abuse of, women and girls with disability. The hearing included a case study about the experiences of Niky, who was sexually assaulted while attending a day program operated by Anglicare, a disability service provider in Queensland.²⁵

Key themes arising from the hearing related to: ²⁶

- harm prevention and response
- incident management policy and procedures
- provider investigations
- redress.

In the Commissioners' report we found that many aspects of Anglicare's response to, and handling of, Niky's allegation of sexual assault were inadequate. The response lacked a trauma-informed approach and failed to address the issues in a timely and appropriate manner.²⁷ We made six findings, which were accepted in substance by Anglicare and two recommendations.

Volume 8, *Criminal Justice and people with disability*, examines further experiences of family, domestic and sexual violence that we heard about during our inquiry.

Public hearing 20

Public hearing 20 examined two case studies involving people with disability who received Supported Independent Living (SIL) services from Life Without Barriers (LWB), a large, not-for-profit, registered disability service provider.²⁸

The first case study considered the experiences of 'Sophie' and 'Natalie' who received accommodation and support services from LWB in Lismore, New South Wales, until 2019 and 2020, respectively.²⁹ While living in the Lismore house, Sophie's goal was to pursue a relationship.³⁰ She was sexually assaulted while out on a date.³¹ We also received evidence about alleged sexual misconduct by a support worker towards Natalie.³² The hearing examined the supports provided by LWB to Sophie and Natalie before and after these incidents.

The second case study focused on the experiences of 'Robert' and 'Rebecca', who lived in a group home operated by LWB in Melbourne, referred to as the Melbourne house', from 2011 to 2020.³³ It examined conflict and resident-to-resident violence at the house over several years, and LWB's responsibility for preventing and responding to the violence. The Victorian Department of Families, Fairness and Housing also gave evidence about its responsibilities for the Melbourne house and its residents.³⁴

The hearing examined several issues, including:

- the quality of care provided to residents at the homes operated by LWB
- LWB's response when its clients were abused by a support worker or a third party, including whether it took adequate steps to prevent that abuse
- LWB's response to resident-to-resident violence in its homes and its reaction to concerns expressed by families and community visitors
- whether LWB's governance, structures, systems and culture may have affected the services and supports provided to the people with disability in the case studies
- whether residents had choice and control over where and with whom they lived
- the responses of external oversight bodies, the NDIS Commission and others to allegations of violence, abuse, neglect and exploitation, as well as measures taken to prevent such maltreatment of residents.

The Commissioners' *Report of Public hearing 20* included 34 findings which focused on:³⁵

- the right of people with disability to have intimate relationships and the importance of dignity of risk
- failures by LWB to respond promptly and appropriately to incidents
- the normalisation of interpersonal violence and conflict between residents of the Melbourne house, and failures to address the incompatibility of residents
- breakdowns in communication between LWB and residents, and between LWB and residents' families
- inadequacies in support and leadership for frontline staff from LWB's management, and in the training provided to those staff.

We also made six recommendations about:³⁶

- policy and procedure improvements to guide staff practice
- record keeping and incident reporting
- redress.

The Royal Commission provided an advance copy of the report of Public hearing 20 to LWB. Prior to Public hearing 32, LWB responded in writing to questions about progress with respect to changes and improvements in its policies and practices since Public hearing 20.³⁷ LWB's CEO, Ms Claire Robbs, gave oral evidence at Public hearing 32 about LWB's response to the recommendations contained in the report.³⁸ This evidence is set out in Counsel Assisting's submissions following Public hearing 32.³⁹

We accept Counsel Assisting's submission that LWB has taken steps to address the matters raised at Public hearing 20 although, at the time of Public hearing 32, it had not yet fully implemented all the recommendations in the hearing report.

Public hearing 23

Public hearing 23 focused on day program services provided by the Australian Foundation for Disability (Afford).

We examined the experiences of several young people with disability who attended an Afford day program in Mount Druitt, New South Wales, between 2018 and 2021. The experiences of 'Jason', 'Toby' and 'Simon' were described by their parents 'Sally', 'Suzie' and 'Rob', and 'Lilly', respectively.⁴⁰

We also examined the way Afford delivered services to its day program participants during the relevant period, and the quality and safety of those services. In particular, we considered Afford's response to the abuse of participants in the Mount Druitt day program by a support worker, Mr Daniel Nuumaalii.

The hearing also examined:

- whether Afford's structure, management, governance, policies and processes may have affected the safety and quality of the services it provided to people with disability
- Afford's systems and training for preventing, recording, reporting and responding to incidents of violence, abuse, neglect or exploitation
- how Afford handled complaints and communicated with participants' families
- recent organisational and governance changes made by Afford to prevent and respond to maltreatment of people with disability to whom it provides services
- how Afford charged for its day program services
- external oversight and regulation by the NDIS Commission and/or NDIA of the quality of Afford's services and Afford's charging of fees to participants' NDIS plans.

The Commissioners' *Report of Public hearing 23* included 29 findings focused on:⁴¹

- failures in communication between Afford, and day program participants and their families
- failures to adequately investigate the abuse by Mr Nuumaalii
- failures to respond appropriately to the people with disability affected by the abuse, and their families
- failures to ensure choice and control for day program participants over the services and supports they received
- lack of sufficient training and support for frontline staff and the effects of staff turnover
- complex service agreements
- onerous staff responsibilities for administrative tasks

-
- complaints and incident management, including inadequate training of staff
 - failures in governance, leadership and strategic planning
 - insufficient oversight of risk management.

We did not make any recommendations.

In preparation for Public hearing 32, Afford responded in writing to questions about its workforce and developments since Public hearing 23, particularly with respect to organisational governance.⁴² In addition, Afford CEO Ms Joanne Toohey gave oral evidence during Public hearing 32 and responded to questions about some of the findings in the *Report of Public hearing 23*, an advance copy of which had been provided to Afford.⁴³ These matters are set out in Counsel Assisting's submissions following Public hearing 32.⁴⁴

Following Public hearing 32, Afford told the Royal Commission that it 'acknowledges and accepts full responsibility for its failures in governance identified by the Royal Commission' and accepts that it must be held accountable. It reported that three board directors, including the Chair, Mr Mike Allen, had resigned with immediate effect on 19 February 2023.⁴⁵

We accept Counsel Assisting's submission that there have been significant changes at Afford since Ms Toohey's commencement as CEO in October 2021 and since Public hearing 23. We are satisfied that Afford's Board has accepted responsibility for the deficiencies and failures revealed during Public hearing 23. However, improvements to the safety and quality of services received by people with disability require more than changes to senior personnel. We examine this further in Chapters 3 and 4.

Group homes and ADEs

In addition to the case studies focusing on specific disability service providers, we examined the experiences of people in specific types of disability services.

Public hearing 3

Public hearing 3, 'The experience of living in a group home for people with disability', held in December 2019, examined the 'group home model' for the provision of accommodation and support services to people with disability, particularly in Victoria.

The key themes arising from the hearing included:

- the transition from large, institutional and segregated state-operated residential settings to group homes
- residents' lack of choice and control about where and with whom they live
- whether lack of choice and control in accommodation options contributes to violence against, and abuse, neglect and exploitation of, residents with disability

- the use of restrictive practices in group homes
- social attitudes, service cultures and staff practices that contribute to violence, abuse, neglect and exploitation, as well as other factors
- inadequacy of reporting mechanisms and oversight of service providers
- redress for people who may have experienced violence, abuse, neglect or exploitation while living in a group home
- alternative accommodation models to transition from group homes.

Several witnesses at the hearing raised concerns about the extent to which people with disability can exercise choice over where and with whom they live, and have control over their daily lives. This evidence is summarised in the Commissioners' *Report of Public hearing 3*.⁴⁶

In the Commissioners' *Report of Public hearing 3*, we observed that the introduction of group homes as an alternative to large institutions has not eliminated institutional forms of violence, abuse, neglect and exploitation experienced by people with disability, particularly people with significant intellectual disability.⁴⁷

We also heard about how a disability service provider, Yooralla, responded to sexual crimes committed by its staff against people with disability receiving its accommodation services.⁴⁸

While the Commissioners' *Report of Public hearing 3* did not include any adverse findings about any individual or Yooralla, we sought written responses from Yooralla in advance of Public hearing 32 about developments since Public hearing 3.⁴⁹ Yooralla CEO, Mr Terry Symonds, gave oral evidence during Public hearing 32 about further changes at the organisation.⁵⁰

We are satisfied that significant, positive changes have been made at Yooralla, with respect to matters of redress for people who have been subjected to violence or abuse, and to Yooralla's governance and operation.

Public hearing 22

We held Public hearing 22, 'The experience of people with disability working in Australian Disability Enterprises', between 11 and 13 April 2022. At the hearing, we examined supported employment services provided through ADEs.

ADEs largely employ people with cognitive disability, who work under supervision. We heard evidence that ADE employees can be financially and economically exploited and experience violence and abuse.⁵¹

The key themes arising during the hearing that directly affect people with disability working in ADEs were: ⁵²

- the application of human rights principles and the rights of people with disability working in ADEs

-
- genuine choice and control
 - vulnerability to, and experiences of, violence, abuse, neglect and exploitation in ADEs
 - payment of sub-minimum wages.

Volume 7, *Inclusive education, employment and housing*, examines issues related to meaningful and sustainable employment and the right to a safe and secure home.

Service providers revisited

Public hearing 32 took place in Brisbane from 13 to 17 February 2023 and re-examined issues and themes from previous public hearings concerning disability service providers. During the hearing, witnesses representing a number of disability service providers and digital platforms gave evidence through a series of themed panels.

The hearing inquired into:

- the extent to which people with disability using disability services have choice and control in the way these services are delivered (including where and with whom they live)
- how service providers are supporting decision-making by service users
- the circumstances in which service users self-advocate and/or access independent advocacy where required
- the extent to which service providers give effect to inclusive design principles in all aspects of their services
- the extent to which service providers deliver services in a culturally responsive and trauma-informed manner
- how policies and regulations governing the disability workforce support the provision of high-quality disability services including in relation to remuneration, conditions, training and worker screening arrangements
- how internal governance arrangements of disability service providers can reduce risks of violence against, and abuse, neglect and exploitation of, service users
- how service providers respond to, manage and investigate complaints and incidents – particularly those involving violence, abuse, neglect and/or exploitation – and provide options for redress.

As noted above, representatives of Yooralla, Sunnyfield, LWB and Afford provided further evidence about the steps taken in response to the findings and recommendations arising from previous hearings.

Following Public hearing 32, Counsel Assisting the Royal Commission prepared written submissions on the role and responsibilities of service providers to prevent and respond to violence, abuse, neglect and exploitation, as well as the related oversight roles of the NDIA

and the NDIS Commission.⁵³ On 31 March 2023, Counsel Assisting's submissions were provided to parties with leave to appear at Public hearing 32, and to witnesses who gave evidence.

National Disability Services (NDS), the peak body for non-government disability service providers, provided a substantive response on 21 April 2023.⁵⁴ It broadly agreed with Counsel Assisting's submissions and supported the proposed findings and recommendations. NDS particularly emphasised the critical importance of a stable, well-trained, capable and supported disability workforce in ensuring the delivery of safe and quality disability services, and the need for measures to address workforce shortages.⁵⁵

On 28 April 2023, the Australian Government provided a substantive response which also outlined activities, that are underway or planned, to address several issues discussed at the hearing, including:

- a comprehensive update to the Australian and New Zealand Standard (Workforce) Classification⁵⁶
- a proposed own motion inquiry on support coordination⁵⁷
- the development of a comprehensive NDIS Workforce Strategy to be informed by the NDIS Review⁵⁸
- the delivery of the NDIA's Homes and Living Demonstration Projects⁵⁹ and the alignment of the Home and Living Framework with the recently released *Convention on the Rights of Persons with Disability (CRPD)* guidelines on deinstitutionalisation⁶⁰
- publication of the National Disability Advocacy Framework 2023–2025 and the Disability Advocacy Work Plan.⁶¹

We address the views of the Australian Government within our analysis throughout this volume. There will not be a published report for Public hearing 32.

Other public hearings

The experiences of people with disability in disability services were also examined during public hearings focused on other issues, such as health care, justice and guardianship.

Public hearings 4 and 6

Public hearing 4, 'Health care and services for people with cognitive disability', and Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', held in February and September 2020, respectively, focused on the health of people with cognitive disability. Evidence presented at both hearings identified the need for better integration of health and disability services.⁶² At Public hearing 6, we heard how people with disability who exhibit 'behaviours of concern' are frequently administered psychotropic medication as a way to control or reduce these behaviours. Witnesses described how disability service providers and

workers who are not sufficiently skilled or trained in communicating with people with disability and in providing behaviour support, may resort to medication as a form of chemical restraint.⁶³ Following Public hearing 6, we found that environmental factors, including lack of choice, unsuitable living arrangements and social isolation, can have long-term effects on the health and wellbeing of people with cognitive disability.⁶⁴

Public hearings 5 and 12

Public hearing 5, 'Experiences of people with disability during the ongoing COVID-19 pandemic', and Public hearing 12, 'The experiences of people with disability, in the context of the Australian Government's approach to the COVID-19 vaccine rollout', held in August 2020 and May 2021, respectively, concerned the experiences of people with disability during the pandemic. People with disability and their families described the effects of the pandemic, and the Australian Government's response to it, including concerns about its effects on the delivery of disability services, particularly for people living in supported accommodation settings.⁶⁵

Volume 6, *Enabling autonomy and access*, examines the right to health care and treatment, and the reduction and elimination of restrictive practices. In Chapters 3 and 10 of this volume we examine the quality and safety of disability service provision, including the standards of practice required to prevent and respond to issues such as medical neglect within disability services.

Public hearings 11 and 15

Public hearing 15, 'People with cognitive disability and the criminal justice system: NDIS interface', took place in Brisbane on 12 and 13 August 2021. It followed up on issues which had been raised during Public hearing 11, 'The experiences of people with cognitive disability in the criminal justice system'.

Public hearing 15 examined the experiences of people with cognitive disability in the criminal justice system and their need for proper supports, including the interface between the NDIS (run by the Australian Government) and corrective services (run by state and territory governments).

The hearing focused on:

- the approach of the Australian Government and state and territory governments to the division of responsibility for providing supports and services to people with cognitive disability involved in the criminal justice system
- barriers for people with cognitive disability involved in the criminal justice system in accessing the NDIS, including when transitioning from custodial environments
- NDIS guidelines and policies as they relate to people with cognitive disability and the criminal justice system.

Volume 8 considers how people with disability can become enmeshed within the justice system due, in part, to a lack of disability services and supports. In Chapter 5 of this volume, 'Areas for systemic change', we discuss 'thin markets' as a structural barrier that limits access to disability services for people who have complex support needs.

Public hearing 25

In Public hearing 25, ‘The operation of the NDIS for First Nations people with disability in remote and very remote communities’, held in July 2022, witnesses told us of a severe shortage of disability service providers (thin markets) in First Nations communities and how available services may not be culturally safe. Witnesses with disability described either receiving no services at all or having to go ‘off Country’, moving away from family and community supports, to access essential services and supports.⁶⁶

Volume 9 examines the experiences of First Nations people with disability in more detail.

Public hearing 26

Public hearing 26, ‘Homelessness, including experience in boarding houses, hostels and other arrangements’, held in August and September 2022, examined the importance of safe and secure housing for people with disability. People with disability and their families described their experiences of homelessness and insecure housing, and the effects of those experiences on their lives.⁶⁷ We also heard how people with disability who have insecure housing may be vulnerable to exploitation by disability service providers, and received evidence about people with disability living in squalid conditions.⁶⁸

Volume 7 examines homelessness and insecure housing in more detail. Chapter 5 of this volume also discusses the safeguards required to support people with disability at heightened risk and the need for ‘last resort’ service provision.

Public hearing 29

Public hearing 29, ‘The experience of violence against, and abuse, neglect and exploitation of people with disability from culturally and linguistically diverse communities’, held in October 2022, examined the experiences of a specific cohort – people from culturally and linguistically diverse communities – including members of the Deaf community. We heard about the challenges faced by people with disability from culturally and linguistically diverse backgrounds in navigating disability and other service systems in Australia, and the effect of language deprivation on choice and control for people who are Deaf.⁶⁹

Volume 6 examines these issues further.

Public hearing 30

Public hearing 30, ‘Guardianship, substituted and supported decision-making’, held in November 2022, examined the effects of guardianship and administration laws and policies on the rights of people with disability, with a particular focus on substitute decision-making. We heard about people with disability being subject to guardianship and administration orders, and substitute decision-making affecting where and how disability services are delivered and received.⁷⁰

These issues are explored in more detail in Volume 6. In Chapter 3 of this volume, 'Preventing violence, abuse, neglect and exploitation in disability services', we discuss what disability service providers can do to support decision-making by service users, and the need for independent advocacy and support coordination.

Other sources

While only a small number of case studies could be examined in detail through our public hearings, our inquiry has also been informed by the information provided to us in written and oral submissions, responses to issues papers, and at private sessions. We have also considered research reports and findings contained in reports of previous inquiries.⁷¹

At 17 February 2023, we had received 1,745 accounts of violence, abuse, neglect and exploitation, specifically related to disability services, through submissions or private sessions. This was 12 per cent of the total accounts received by the Royal Commission. As set out in Table 10.2.1, the majority of the 1,745 accounts related to some form of violence or abuse. In some cases, they related to incidents or events that occurred prior to the introduction of the NDIS and/or in the course of disability services provided by a state or territory government. In other cases, accounts related to more recent incidents or events involving a particular service provider or more than one provider.

Table 10.2.1: Accounts of violence, abuse, systemic abuse, neglect and exploitation

Source	Violence and/or abuse	Systemic abuse	Neglect	Exploitation
Accounts/experiences	948	734	863	370
Percentage	54%	42%	49%	21%

Note: Total percentage is greater than 100 per cent because some accounts describe multiple forms of violence, abuse, neglect and exploitation.

Note: 'Systemic abuse' refers broadly to indirect forms of violence that are built into social structures and that prevent people from meeting their basic needs or fulfilling their potential. This encompasses and is synonymous with systemic neglect.

Note: Volume 2 provides further information about the Royal Commission's internal data.

NDIS Quality and Safeguards Commission Own motion inquiry

The NDIS Commission published its *Own Motion Inquiry* report in January 2023.⁷² It examined the nature of complaints and reportable incidents received by the NDIS Commission from 1 July 2018 to 30 September 2022 connected to supported accommodation services (specifically, group homes) operated by seven large disability service providers. The NDIS Commission subsequently published an Action Plan documenting its planned response to implement changes arising from the inquiry.⁷³

The issues outlined in the *Own Motion Inquiry* report were broadly consistent with the issues raised in our public hearings and in written submissions and private sessions concerning violence, abuse, neglect and exploitation in disability services. Significantly, the *Own Motion Inquiry* report emphasised that people with disability living in supported accommodation settings are often dependent on others for most aspects of their daily living needs. They also ‘may have few protective mechanisms available to them, both to identify risks to them and act on those risks to avoid harm’.⁷⁴

In relation to the 6,269 reportable incidents examined as part of the Own Motion Inquiry, the NDIS Commission made the following observations:

- 85 per cent of reportable incidents notified by the seven providers occurred in group home settings.⁷⁵
- The most common reportable incident type in a group home was serious injury, followed by abuse and neglect of a person with disability. These three incident types made up over 75 per cent of all incidents examined in the inquiry.⁷⁶
- A significant number of incidents concerned misconduct of workers, including exercising undue influence over a person with disability, and verbal and psychological abuse of a person with disability.⁷⁷
- A significant number of incidents were associated with participant-on-participant altercations. These incidents were mainly low-level physical or verbal abuse, with patterns of incidents occurring over a long period of time.⁷⁸

2.2. Types of violence, abuse, neglect and exploitation in disability services

In this section, we describe some of the types of violence, abuse, neglect and exploitation we heard about in the course of our inquiry. Many of the examples we refer to, particularly those arising from our public hearings, relate to people with disability receiving supported accommodation from medium to large service providers. As indicated in the NDIS Commission’s *Own Motion Inquiry* report, a significant proportion of people with disability who receive supported accommodation live with intellectual disability, cognitive impairment or communication barriers.⁷⁹ In the context of group homes, this can heighten their risk of exposure to violence, abuse, neglect and exploitation. We explore this in Volume 7.

Our service provider hearings examined specific incidents of violence or abuse and how individual disability service providers responded to those incidents. During these and other public hearings, we also heard evidence about poor-quality, unsafe or inadequate services and supports for people with disability.⁸⁰

Based on the evidence presented, supplemented by information provided in written submissions and at private sessions, we consider that poor-quality, unsafe or inadequate services or supports, individually or cumulatively, can constitute neglect of the physical, emotional, social and cultural

wellbeing and development of a person or group of people with disability. In addition, our hearings have indicated that people with disability are more vulnerable to other forms of violence and abuse when they receive poor-quality, unsafe or inadequate services and supports.

Violence and abuse

The terms ‘violence’ and ‘abuse’, as we have defined them, may overlap or be used interchangeably by people describing their own or others’ experiences. For this reason, we deal with examples of violence and abuse together. We recognise that a person’s experience can extend beyond a single category and may be indicative of violence and abuse, as well as neglect and/or exploitation. As outlined above, we heard about various types of violence and abuse experienced by people with disability while receiving disability services and supports across a number of public hearings.

For example, at Public hearing 22, disability services provider, Bedford, acknowledged that employees with disability had experienced violence and abuse in its workplace. It told us:

The most common instances of [violence, abuse, neglect and exploitation] occurring between employees with disability in our workplace are instances of yelling and/or verbal taunts, physical abuse (such as a slap) and inappropriate sexual conduct (such as unwanted kissing or touching).⁸¹

In addition, responses to our *Group homes issues paper* detailed physical assaults, sexual assaults and verbal abuse involving support staff, volunteers, community members and other residents in group homes.⁸²

These types of violence and abuse are not unique to the disability services sector and can and do occur regularly in other settings, as set out in Volume 3.

However, the relationship between those providing disability services and supports and the people with disability receiving those services and supports creates a particular risk of violence and abuse. For people with disability relying on daily living supports and personal care, the relationship with support workers and service providers requires considerable trust and confidence. This is especially the case for people with disability who may be isolated or living in segregated or separate settings. In addition, support workers and service providers can hold significant power within the relationship, notwithstanding the move towards greater choice and control for people with disability through the NDIS. We discuss this power imbalance further in Chapter 3.

Violence and abuse by support workers

At Public hearing 3, AAG described how the staff of one group home inflicted punishments on her daughter, AAF, using a ‘tick-chart’ that listed behaviours and consequences for those behaviours. She said this was designed to humiliate and deprive AAF of the things she liked or wanted, depending on the level of ‘severity’ of her behaviour. These included punishments such

as taking AAF to McDonald's and making her sit and watch others eat food that she liked.⁸³ AAG also spoke of instances at a different home when AAF was locked outside without dinner, had her dinner thrown in the bin and had her property taken away by support workers.⁸⁴

Based on the evidence presented during Public hearing 13, we found that two former Sunnyfield workers had perpetrated violence and abuse against people with disability living in the house in Western Sydney.⁸⁵ For example, Carl, one of the residents, was subjected to hair pulling; being tipped out of a lounge chair, pushed and kicked; being dragged by a vehicle harness strap; and being purposely frightened by a support worker.⁸⁶ Another resident, Melissa, was dragged by her wrists down a hall while she was naked.⁸⁷

At Public hearing 14, we heard about threats made against Mitchell, who lives with autism and intellectual disability, while he was living in supported accommodation run by DHS. His aunt and uncle, Victoria and James, received an anonymous letter that included explicit references to possible forms of violence and abuse that could be inflicted on Mitchell.⁸⁸ Due to the nature of the threats and the writer's knowledge of Mitchell, the family held serious concerns the letter may be from a support worker. We found that DHS did not take appropriate measures to find the source of an apparently serious threat to the safety and wellbeing of a person with disability in its care. This caused significant distress to Victoria and James and led to them losing trust and confidence in DHS.⁸⁹

Mrs Karen Rogers, mother of Mr Daniel Rogers who lives with autism and an intellectual disability and has limited speech, said she observed bruises on her son's inner arm in October 2018 while he was living in a group home run by DHS.⁹⁰ In February 2019, Mr Rogers sustained a large, unexplained bruise on his back. A locum doctor recommended Mr Rogers be admitted to hospital, where he underwent a computed tomography (CT) scan to check for internal damage or bleeding. Mrs Rogers said she was shocked when she arrived at the hospital and saw the extent of the bruising, which extended from Mr Rogers' spine to his front.⁹¹ The photographs of the bruising Mrs Rogers took that night were in evidence.⁹²

At Public hearing 20, we heard Sophie was assaulted by a support worker during an incident at an LWB group home. This occurred in the months following her being subjected to a serious sexual assault by a third party, and shortly before she was due to give evidence at the criminal trial.⁹³ During an internal investigation, an LWB worker admitted to pushing Sophie and causing her to fall.⁹⁴ Despite this, Sophie was not given an opportunity to report the incident to the police.⁹⁵

At Public hearing 23, we examined Afford's response to abuse of participants in a Mount Druitt day program by disability support worker, Mr Daniel Nuumaalii. Mr Nuumaalii recorded intimate images and videos of several day program participants, including of Jason during personal care in the bathroom at Jason's home and in public toilets.⁹⁶ He also shared those images with others.⁹⁷ In addition to his criminal conviction for these offences, Mr Nuumaalii was found to have assaulted Jason by blowing e-cigarette smoke into his face and slapping him.⁹⁸ While these offences did not occur in a group home setting, they highlight the risks of violence and abuse when people with disability who experience communication barriers are provided with one-on-one, unsupervised supports by workers.

At Public hearing 17, we heard that ‘Chloe’ was sexually assaulted by her support worker and heard about violence against her dog.⁹⁹

Chloe said:

I can’t trust anyone anymore. It’s been about six years of hell. I’m scared to be in my own house because he raped me in my bedroom, my lounge room and the kitchen, and I can’t move without help. I’m scared he’s going to come back to my house and kill me. One of my dogs has never been the same. She’s now on anti-depressants. She bites strangers who come near me. She’s terrified as well. But I am a survivor. I’m glad to be alive, and I’m becoming more confident to leave the house and to be in the community.¹⁰⁰

Most accounts of violence, abuse, neglect and exploitation we received through submissions and private sessions involved a paid support worker.¹⁰¹

We heard repeated accounts of support workers behaving in violent and abusive ways towards people with disability in closed settings, such as group homes, where there is limited supervision by others and/or where residents experience communication barriers. As noted above, the NDIS Commission’s *Own Motion Inquiry* report observed that people with disability can have heightened exposure to violence, abuse, neglect and exploitation in these settings.¹⁰² It also found that complaints about alleged abuse and neglect were mostly about verbal abuse, disrespectful behaviour and/or conduct, and support workers exercising undue influence over people with disability.¹⁰³ Similarly, a significant number of reportable incidents notified to the NDIS Commission related to the conduct of workers. These commonly involved support workers exercising undue influence over, or verbally or psychologically abusing, a person with disability.¹⁰⁴ We examine reportable incidents in Chapter 8 of this volume, ‘Reportable incidents’. In Chapter 9, ‘Complaints’, we further examine the NDIS Commission’s complaints data.

Resident-to-resident violence and abuse

We also heard about people with disability experiencing violence and abuse at the hands of other people with disability when they are in group accommodation and other congregated settings.

We examined this form of violence and abuse through one of the case studies at Public hearing 20. At the hearing, we heard about the considerable conflict between residents of the Melbourne house when it was operated by LWB which, at times, escalated into violent incidents. On one occasion, a resident, Rebecca, was dragged by her hair across the carpet by another resident. Her hair was pulled from her scalp, and she sustained a carpet burn on her knee.¹⁰⁵ In the Commissioners’ *Report of Public hearing 20*, we found that other types of interpersonal violence and conflict between residents included objects being thrown or used to strike others, as well as physical assaults that resulted in bruises, cuts and wounds, and, on at least one occasion, a fracture.¹⁰⁶ We also found that LWB, despite being aware of the adverse effects of the interpersonal violence on the residents, did not take sufficient, timely or adequate action to reduce or eliminate such violence and conflict.¹⁰⁷

Similarly, at Public hearing 3, AAG said AAF was regularly beaten by two male residents at a group home and that she frequently had things thrown at her by another resident. AAG said the risk of violence was so great that, at one point, a staff member had to sit outside AAF's room at night to ensure she would not be attacked.¹⁰⁸

We received similar accounts of resident-to-resident violence in written submissions. For example, one person described how her sister was physically attacked and strangled on several occasions by another resident in her group home. She explained that when she complained to the service provider, they did not respond appropriately.¹⁰⁹ Another person said that she had experienced living with 'violent others' and described how she had to remain in those circumstances. She said that the selection of compatible residents is often 'really poorly made'. She referred to the inadequacy of staff training in this respect.¹¹⁰

Other government inquiries and disability research reports have also identified resident-to-resident violence as a significant concern.¹¹¹ For example, the Victorian Office of the Public Advocate's 2019 report, *I'm too scared to come out of my room*, noted high rates of violence between co-residents in group homes.¹¹² It found:

Ten percent of the 1,041 incidents reported to the Victorian Disability Services Commissioner in 2017–2018 related to allegations of physical or sexual assault or abuse between co-residents in disability services.¹¹³

Sexual abuse

When sexual abuse or misconduct occurs during the provision of disability services or supports, it not only violates the person's autonomy, dignity and sense of safety, but also breaches the trust of the person affected and of their supporters.

At Public hearing 3, Dr Peter Gibilisco gave evidence of a support worker at a group home attempting to grope him on two occasions while he was sleeping. Dr Gibilisco said that he resisted and struggled against the support worker on both occasions.¹¹⁴ We also heard about the sexual abuse of a number of people with disability by Yooralla support workers, which resulted in criminal convictions and lengthy prison terms.¹¹⁵

At Public hearing 17, Chloe told us about one of her male support workers who was initially 'very charming' but who went on to physically and sexually assault her repeatedly in her own home. Upon finding out that she was pregnant, Chloe said the worker assaulted her, causing her to miscarry.¹¹⁶

In the same hearing, we heard about Niky's experience of being sexually assaulted by another participant during a day program at an Anglicare respite centre in Queensland.¹¹⁷ Niky's mother told us that Anglicare did not offer support to Niky or her family after the assault.¹¹⁸ In addition, Anglicare did not discuss or provide feedback on the incident or the outcome of its investigation into it, and did not make any apology to Niky or her parents until two years after the sexual assault occurred.¹¹⁹

At Public hearing 20, we heard about an LWB support worker's sexual misconduct towards Natalie, a young woman with cerebral palsy and intellectual disability, while she was living in a group home in northern New South Wales.¹²⁰ In this case, the support worker's sexual misconduct occurred on a number of occasions while providing Natalie with personal care supports. Other support workers witnessed the behaviour, which made them feel uncomfortable, and they reported it to their managers.¹²¹

We also heard from Sophie, a young woman with cerebral palsy and left-side hemiplegia, who lived in the same group home as Natalie. Sophie was violently sexually assaulted by a man she met online, resulting in hospitalisation.¹²² Despite the severity of the assault against Sophie and her preparing to give evidence at the criminal trial in the aftermath, we found that LWB staff did not provide adequate support to her and did not respond appropriately to her changing needs over the following 18 months.¹²³

Restrictive practices

The NDIS Commission has acknowledged that restrictive practices can be a form of – and risk factor for – violence against, and abuse, neglect and exploitation of, people with disability, and are commonly used against people with cognitive disability, including autism.¹²⁴

None of the cases studies examined in our four service provider hearings focused on restrictive practices. However, in our public hearings and in private sessions and written submissions, we heard about restrictive practices being used while delivering disability services. We recognise that people with disability who have high support needs, including those living in supported accommodation settings, may be particularly impacted by the use of restrictive practices.

At Public hearing 6, several witnesses expressed concern about the overuse and misuse of psychotropic medication as a form of chemical restraint (a restrictive practice), in response to behaviours of concern, during disability service delivery. ABF told us about how her brother ABG's behaviours of concern were managed after he moved into supported accommodation. She observed that his behaviours escalated while his social, household and other skills regressed, which resulted in the use of psychotropic medication to restrain him.¹²⁵ She said:

I am mostly worried that he now has a reputation of being a violent individual ... I have seen people who are fearful of him, ignore and isolate him, grab him as well as yell at him rather than listening to and observing him in order to identify what he is attempting to communicate.¹²⁶

Ms Dariane McLean described her son's experiences when living in several group homes in Victoria where he was physically restrained, placed in restricted environments and medicated in response to his behaviours.¹²⁷ Other witnesses expressed concerns about service provider staff administering psychotropic medication to people with disability in response to behaviours when doctors had prescribed the medication to be used 'pro re nata', or 'as needed'.¹²⁸ Restrictive practices are discussed further in *Volume 6*.

Neglect

When a service provider or disability support worker fails to provide the conditions necessary for the physical, emotional, social and cultural wellbeing and development of a person with disability to whom they are providing services, this amounts to neglect. Like violence and abuse, neglect can take many forms. In the context of service provision, neglect may refer to a single incident, or may comprise a series of omissions or deficiencies in service quality that negatively impact the wellbeing and development of a person with disability. Sam Petersen, a person with disability who provided evidence at Public hearings 3 and 32, re-characterised neglect as ‘slow violence’ when disability service providers continually fail to meet the needs of people with disability.¹²⁹

The overall absence or shortage of available services and supports can amount to a form of systemic neglect. Culturally unsafe services for First Nations people with disability are discussed in Volume 9.

Market failure was also commonly cited as a reason for the absence or shortage of services. For example, at Public hearing 25, Ms Beth Walker, Public Guardian and Trustee of the Northern Territory Office of the Public Guardian, observed that the principle of choice and control cannot be realised in remote settings where the market for disability services is thin or does not exist.¹³⁰ Ms Emily Carter, a Gooniyandi-Kija woman and CEO of Marninwarntikura Women’s Resource Centre (MWRC), and Dr Lauren Rice, Research Fellow, University of Sydney, explained that MWRC is in a difficult position as it helps people apply to the NDIS ‘knowing they will likely be unable to use their plans because there are no services available and will feel let down’.¹³¹ Similarly, at Public hearings 11 and 15, we heard that people with cognitive disability in the criminal justice system face barriers as a result of gaps between their needs and services available in the market.¹³²

Examples of neglect

Following Public hearing 14, we found there was sufficient evidence to conclude that Mr Rogers experienced neglect while living at a residence operated by DHS, which was referred to as ‘N-street’ for the purpose of the hearing.¹³³

Mr Rogers’ mother gave evidence that the standards around her son’s grooming and hygiene were quite variable while living at N-street. From about 2017, she became more concerned. She observed him dressed in clothes that did not belong to him and, at times, he smelled, often of faeces, and had bad breath.¹³⁴ From at least 2019, Mrs Rogers said the house was not well maintained, having dirty floors and walls.¹³⁵

On one occasion, support staff at the residence forgot about a holiday Mr Rogers was taking with his family to Melbourne, despite receiving a reminder the week before. Staff packed his bag with another resident’s clothes and failed to include enough medication to last the week.¹³⁶

In the Commissioners’ *Report of Public hearing 14*, we found Mr Rogers’ poor personal hygiene and grooming, the lack of care about his clothing and his choices about his purchases, and the

unsatisfactory state of cleanliness and maintenance of the home, reflected the absence of a person-centred approach by DHS at N-Street. The combination of these experiences affected Mr Rogers' wellbeing and development, and amounted to neglect.¹³⁷

At Public hearing 20, we heard that in March 2020, when she lived in supported accommodation operated by LWB, Natalie was hospitalised after crying and exhibiting significant pain. She was then diagnosed with chronic distention and a large faecal mass in her rectum requiring manual disimpaction under general anaesthetic.¹³⁸ In the Commissioners' *Report of Public hearing 20* we found there was a failure by LWB staff to keep proper records in relation to the administration of Movicol, and bowel charts for Natalie.¹³⁹ We also observed that a service provider's failure to properly document these types of matters may jeopardise a client's health and potentially risk their life and, for this reason, is capable of constituting neglect.¹⁴⁰

At Public hearing 20, we also heard evidence that LWB did not adequately clean and maintain the Melbourne house, despite many requests and complaints from residents' family members. For example, Robert's father 'Paul' described how the spa bath at the property was broken for many months despite Robert's known preference to use the spa bath every day.¹⁴¹ Paul raised his concern that the continued delay in its repair would adversely impact Robert's behaviour.¹⁴² On another occasion, the oven stopped working and it took LWB a total of five weeks to fix it.¹⁴³

At Public hearing 23, we received evidence about the quality of services provided by Afford to participants in the Mount Druitt day program. For example, Lilly expressed concerns that participants in the day program, including her son Simon, were not being shown age-appropriate content and were watching television designed for children. She also told us they were not being supported to develop their independent living skills, such as brushing their hair and cleaning their teeth.¹⁴⁴ We also heard that some participants were not being encouraged or supported to use non-verbal forms of communication, or augmented or alternative communication devices.¹⁴⁵

In addition, we heard from former Afford workers about overcrowding in the day program and their concerns about its impact on the safety and quality of services they were able to deliver.¹⁴⁶ These former workers also described how the ratios of support that Afford provided to day program participants were not always in line with the participants' needs and funded supports. 'Erynn' recalled an occasion when she was required to provide support to four clients with high support needs, including personal care, and said she considered it 'lucky that nothing went wrong'.¹⁴⁷

Similar concerns about the adequacy of staffing, and the impact on the residents of the house in Western Sydney, were raised by witnesses at Public hearing 13.¹⁴⁸ For example, Eliza said that even after Melissa's funding for 2:1 supports in the community had been added to her plan, there were not enough staff members who were sufficiently trained to support Melissa to go out safely.¹⁴⁹

Neglect of basic hygiene and intimate care for people with disability receiving disability services was a common theme in written submissions and accounts provided to us during private sessions. For example, some people told us about being left in undergarments¹⁵⁰ or having to wear soiled incontinence aids for extended periods of time.¹⁵¹ In one submission, a support worker told us how a client with high needs was regularly not provided with adequate assistance

in relation to his physical hygiene. For example, the client was left unattended on multiple occasions in soiled clothes for more than eight hours.¹⁵²

Structural and systemic forms of neglect

In *Our vision for an inclusive Australia* and Volume 3, we discuss how entrenched attitudes and assumptions about people with disability can result in exclusion, negatively affecting their physical, emotional, social and cultural wellbeing and development. These attitudes and assumptions can be demonstrated by those providing services and supports to people with disability, as well by the broader community. For example, at Public hearing 20, we heard that despite Sophie's clear interest in pursuing intimate and sexual relationships, LWB did not sufficiently support her in achieving this goal or in obtaining appropriate sex and relationship education. On the contrary, LWB developed an 'interim safety plan', referred to at the hearing as the 'Relationship Rules', which restricted her freedom, privacy and confidentiality.¹⁵³ Sophie gave evidence that she hated the rules because she is an adult, not a child.¹⁵⁴

Similarly, in a written submission to us, a woman with a physical disability described how she was routinely prevented from having guests stay at her group home. She explained that her partner had been stopped from sleeping over and her friends were not welcome to visit the house, causing a deterioration in her relationships.¹⁵⁵

These experiences are consistent with observations made by advocacy group, Women With Disabilities Australia, regarding sexual and reproductive rights. It said:

Women and girls with disability express desires for romantic, sexual and intimate relationships but report limited opportunities and difficulty negotiating relationships, often due to lack of support and paternalistic attitudes ... Attitudes toward women and girls with disabilities' expression of their sexualities remain restrictive and laws against sexual exploitation are often interpreted as a prohibition of consensual relationships.¹⁵⁶

In Volume 9, we discuss the significant structural barriers impacting First Nations people's access to and use of NDIS-funded services and supports in remote communities. While the structural factors at play are beyond the responsibility of individual service providers, the sector as a whole must be increasingly mindful of how the needs of First Nations people with disability are recognised and addressed, particularly in terms of the cultural competency of their service delivery.

Similarly, we have heard that people with disability from culturally and linguistically diverse backgrounds often encounter a range of barriers to accessing, navigating and benefiting from mainstream and disability services.¹⁵⁷ During Public hearing 29, we heard evidence about measures required to improve the responsiveness of service systems for people with disability from culturally and linguistically diverse backgrounds, to ensure their specific needs are not overlooked. These include increasing the cultural competency and safety of service providers, and using trauma-informed approaches in service delivery and planning processes.¹⁵⁸

Neglect associated with systems gaps

The quality of supports provided by other service systems, such as for health and education, influence the health and wellbeing of people with disability, and the broader context within which disability services are provided. At Public hearing 4, we examined the health care experiences of people with cognitive disability. As we observed in the Commissioners' report of the hearing, significant barriers affect the quality of health care provided, leading to people with cognitive disability receiving poor-quality or inappropriate health care, with often serious and sometimes tragic consequences.¹⁵⁹ We found people with cognitive disability are subjected to neglect in the Australian health system.¹⁶⁰

During Public hearing 4, Mr Jim Simpson, Senior Advocate with the Council for Intellectual Disability, explained the complementary role of disability services to support people with cognitive disability in leading healthy lifestyles. This includes being alert to signs of illness; facilitating access to, and communication with, appropriate health professionals; and supporting action on recommended treatment.¹⁶¹ Among other things, Mr Simpson expressed concern about how the introduction of the NDIS had affected the interface between health provision and disability service provision to people with intellectual disability.¹⁶²

Additionally, in circumstances where people with cognitive disability rely on service providers and workers for significant daily support, we heard that poor communication and coordination between health care providers and disability service providers can adversely affect the health and wellbeing of people with disability.¹⁶³ This is consistent with the NDIS Commission's *Own Motion Inquiry* report, which noted:

The interface with health and the supported accommodation services is not effective for many people is reflected in high levels of incidents and complaints. Incidents arise in relation to the transition of participants from the health system to the disability support system, from inadequate access to health care resulting in accelerated deterioration where a person has a chronic condition, and poor-quality end of life support. Providers are trying new approaches to address these interface issues; however, it is apparent that a system level approach would be beneficial.¹⁶⁴

The interdependence of service systems, including some examples of mainstream interface issues, is considered further in Volume 5, *Governing for inclusion*.

Exploitation

The case studies examined during the service provider hearings did not focus on issues about exploitation of people with disability, although we have received accounts of potential financial or economic exploitation by service providers or support workers.

At the service provider hearings, some witnesses expressed concern about the way their, or their family member's, money was spent by service providers, or about the lack of transparency and comprehensible systems to account for invoices or spending. For example, at Public hearing 14,

Mrs Rogers told us that she did not receive bank statements or have access to records about how her son's money was managed or spent by DHS while her son resided at N-Street.¹⁶⁵ At Public hearing 23, Suzie, Sally and Lilly described being unable to understand how amounts invoiced by Afford had been calculated, and Suzie and Lilly received bills for activities that had not taken place or had already been paid for.¹⁶⁶ While we do not suggest these are examples of deliberate financial exploitation, we observe that there are opportunities for disability service providers and their staff to misappropriate funds from people with disability, particularly people with cognitive disability who may not have the support of families or advocates.

At Public hearing 17, Chloe described how a support worker tricked her into thinking she was special. She said he would frequently take her out to buy her 'some nice things', but would also buy something for himself and use her bank card to pay for it. She said the worker would take her phone home with him, so she was not able to contact anyone.¹⁶⁷

Of the 1,745 accounts we received through submissions and private sessions concerning violence, abuse, neglect and exploitation specifically related to disability services, 370 described an experience of exploitation. A large majority of these related to financial exploitation, such as providers or workers receiving payment for services and supports that were not delivered, or theft of money or property.¹⁶⁸

In addition, in responses to our *Group homes issues paper*, we heard about allegations of financial exploitation of people with disability in group homes. These included staff stealing money from residents and service providers misusing their clients' NDIS funding.¹⁶⁹

2.3. Impacts of violence, abuse, neglect and exploitation in disability services

Lasting harm

The impacts of violence against, and abuse, neglect and exploitation of, people with disability are significant. The economic costs associated with poorer health, education, employment and social outcomes are set out in Volume 3.

In examining disability service provision, during public hearings and private sessions we heard accounts of how violence, abuse, neglect and exploitation in disability services adversely affect people with disability. These impacts will depend on a range of factors, including the nature of the violence, abuse, neglect or exploitation, and the individual circumstances of the person affected. In addition, while some impacts may be immediate and obvious, others may not develop until later and may be less evident.

For example, in a written submission to us, Deafblind Australia said that violence perpetrated by support workers can inflict complex and lasting harm, attributable to the relationship that a person has with the worker, including physical proximity and the worker's involvement in their personal affairs.¹⁷⁰

From the accounts we have heard, the effects of violence, abuse, neglect and exploitation can be both short term and long term. They affect a person's behaviour, mental health, physical health, quality of life, participation in the community and communication with others. Following are some examples provided by witnesses during our public hearings:

- Dr Gibilisco said he did not feel 'safe and comfortable' following a support worker's attempt to grope him at night and that, while he had informed management about not allowing people to come into his room, they had not taken any action.¹⁷¹
- AAG described how AAF lived in fear of being punished or suffering consequences for things that occurred, including for trivial things that were not her fault. AAG stated that 'AAF is psychologically damaged' and is 'damage she will never recover from'.¹⁷²
- AAG also stated that AAF was traumatised by events that took place at a group home where she was subjected to physical violence by two residents of the home.¹⁷³
- 'Sophia' told us about Carl's increased anxiety in the house in Western Sydney, and how he began exhibiting more behaviours of concern that sometimes resulted in injury to himself.¹⁷⁴
- Chloe described the impacts of a physical and sexual assault by her support worker, including being unable to trust anyone, feeling scared in her own home, fearing for her life and fearing potential reprisal by the support worker.¹⁷⁵
- Rebecca's mother, 'Catherine', told us that interpersonal violence between residents at the Melbourne house operated by LWB negatively affected Rebecca's physical health and general demeanour.¹⁷⁶ Rebecca experienced stress-related bowel problems, exhibited signs of anxiety, became more aggressive, started smearing her faeces, and limited her participation in the group home.¹⁷⁷
- Sophie told us she 'felt sad and hurt' when she was unable to talk to support workers about being sexually assaulted by a man she had met online.¹⁷⁸ She also said that, in the lead-up to the criminal trial, she feared 'she would not be accepted by society', felt 'hurt, betrayed and fearful' and became withdrawn.¹⁷⁹
- Sally said that after Jason began to receive supports from Mr Nuumaalii, Jason became anxious when he was about to be left alone with Mr Nuumaalii. He developed a twitch in his neck and head around the same time. After the abuse was uncovered, Jason was diagnosed with anxiety.¹⁸⁰

Families and supporters lose confidence and trust

We have heard that for many families of people with high support needs, the decision to place trust in a service provider for daily supports and personal care is a very difficult one. When concerns about the safety or quality of services are realised or incidents of violence and abuse occur, families can experience trauma, stress, a heightened sense of guilt, loss of trust, and fear. We heard about the following examples:

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- Mrs Rogers described the two years prior to Public hearing 14 as an ‘incredibly difficult and traumatic time for all of Daniel’s family’. She also said that it was distressing not knowing how to help her son ‘as we were never able to understand the trauma that he has been through’.¹⁸¹
 - Sally told us that Jason’s family was left ‘physically sick with shock, disbelief and disgust’ after his abuse by Mr Nuumaalii became known. She said they lost so much trust in people, particularly the people and organisations they had relied on to support Jason, and Jason’s sister had to receive counselling.¹⁸²
 - Similarly, Suzie said she and her husband, Rob, developed a ‘deep mistrust of people we did not know being involved in Toby’s care’ and that this happened quite often because of the high turnover of workers at Afford.¹⁸³
 - Sophia described her loss of trust in Sunnyfield after she was made aware of events at the house in Western Sydney involving Carl. She said she felt increasingly helpless, as she could not care for Carl at home.¹⁸⁴
 - In a private session, ‘Marion’ told us she has become hypervigilant as a parent following the abuse of her daughter by a male support worker.¹⁸⁵ She does not allow her daughter to spend the night in respite care. Marion also worries about her daughter’s future, particularly as she herself gets older and less able to care for her full time.¹⁸⁶

We examine what providers should do to better respond to incidents of, and complaints about, violence, abuse, neglect and exploitation in Chapters 4, 8 and 9.

Endnotes

- 1 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023.
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- 6 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, pp 3–7, Findings 1 to 24.
- 7 Name changed to protect identity. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Recommendation 1.
- 8 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Recommendation 2.
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- 10 Exhibit 32-54, SUN.9999.0005.0019; Exhibit 32-74, SUN.9999.0006.0001.
- 11 Transcript, Andrew Hyland, Public hearing 32, 14 February 2023, P-175–189.
- 12 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 36 [107] – 41 [124].
- 13 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 41 [124].
- 14 Name changed to protect identity.
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- 17 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-94 [9–25], P-96 [33]–P-97 [2]; Exhibit 14-5, ‘Statement of Karen Rogers’, 5 May 2021, at [40–55].
- 18 Submissions by the State of South Australia in response to Counsel Assisting’s submissions in Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, Annexure A, pp 16–17.
- 19 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)*, June 2022, p 30, Finding 5.
- 20 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)*, June 2022, p 27, Finding 1.
- 21 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)*, June 2022, p46, Finding 6.
- 22 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)*, June 2022, p48, Finding 9.
- 23 Exhibit 14-214, SAG.0002.0023.0092; Exhibit 14-215, CTD.7200.0004.4115; Exhibit 14-217, SAG.0002.0023.0114.
- 24 Exhibit 14-216, DRC.2000.0008.0673.

25 Exhibit 17-28.1, 'Statement of Carolyn Cumming', 18 February 2022, at [11], [21];
Exhibit 17-27.2, TRA.3000.0005.0045, p 3.

26 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
*Report of Public hearing 17: The experience of women and girls with disability with a particular
focus on family, domestic and sexual violence: Niky case study*, May 2023.

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29 Names changed to protect identities.

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31 Exhibit 20-1, 'Statement of Sophie', 9 November 2021, at [80].

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33 Names changed to protect identities.

34 Exhibit 20-1280, 'Statement of Anne Lorraine Congleton', 22 November 2021; Exhibit 20-1281,
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35 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
*Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies)*, February 2023, pp 3–12.

36 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
*Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies)*, February 2023, p 12.

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39 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
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40 Names changed to protect identities. Exhibit 23-1, 'Statement of Sally', 26 April 2022;
Exhibit 23-26, 'Statement of Suzie', 28 April 2022; Exhibit 23-15, 'Statement of Lilly', 28 April 2022.

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43 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-205–229, P-233–238,
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45 Submission by Afford in response to Counsel Assisting's submissions in Public hearing 32,
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48 Exhibit 3-34, 'Statement of Sherene Devanesen', 28 November 2019; Exhibit 3-34.1,
YPL.9999.0001.0001; Transcript, Sherene Devanesen, Public hearing 3, 5 December 2019,
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50 Transcript, Terry Symonds, Public hearing 32, 16 February 2023, P-330–341.

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[6]; Exhibit 22-3, 'Statement of Kaite', 30 March 2022, at [42]; Exhibit 22-5, 'Statement of Tay',
5 April 2022, at [47].

52 Submissions of Counsel Assisting the Royal Commission following Public hearing 22,
3 March 2023, p 7 [10].

53 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
31 March 2023, Parts 6 and 7.

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- 54 Submissions by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069.
- 55 Submissions by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.
- 56 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 24.
- 57 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, [15].
- 58 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, [16].
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- 62 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Health care for people with cognitive disability*, October 2020, [361–376]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 6: Psychotropic medication, behaviour support and behaviours of concern*, June 2021, pp 148, 151.
- 63 Exhibit 6-5, 'Statement of ABF', 9 September 2020, at [21–23], [89–94]; Exhibit 6-6, 'Statement of Rosemary Atherton', 8 September 2020, at [31–32], [34]; Transcript, Keith McVilly, Public hearing 6, 24 September 2020, P-239 [20–45]; Exhibit 6-14, 'Statement of Professor Leanne Dowse', 7 September 2020, at [74–75].
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3. Preventing violence, abuse, neglect and exploitation in disability services

Key points

- Embedding human rights in disability services means ensuring, so far as practicable, service provider boards, managers and workers understand:
 - the nature and scope of the human rights of people with disability
 - how their decisions and practices can impair or enhance a person's rights
 - how to incorporate respect for human rights in practice at all levels of service provision on a day-to-day basis.
- Disability service provision based on respect for human rights is critical for people with disability to exercise choice and control.
- People with disability can be unduly limited in exercising choice and control while accessing and receiving disability services. Denial of choice can increase the risk of violence, abuse, neglect and exploitation.
- Access to independent support coordination, independent advocacy and informal supports enables people with disability to exercise choice and control.
- Disability service providers can also support people with disability to exercise choice and control by supporting decision-making by service users. This requires cultural change.
- The governance and leadership arrangements of service providers dictate organisational culture and practice. These arrangements also influence how providers embed a human rights culture and identify and manage risk, including the risk of violence against, and abuse, neglect and exploitation of, the people receiving their services.
- Reporting and good governance practices bring transparency and accountability to decision-making and decision makers.
- Investment in disability leadership and meaningful engagement with people with disability also strengthens transparency and accountability.
- Effective governance and leadership can create robust policies and procedures. These policies and procedures must be translated into the professional practice of workers and managers at every level to effect outcomes.
- Disability service providers should take practical steps to ensure that recruitment, training and supervision systems equip workers to deliver safe, high-quality services and supports.

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- Managers must be well supported to supervise workers who require additional training and performance management, and to respond to complaints and grievances.

Preventing violence against, and abuse, neglect and exploitation of, people with disability is a core objective of disability services. In this chapter we identify areas of promising practice for disability service providers to contribute to the prevention of violence, abuse, neglect and exploitation.

Service providers are primarily responsible for achieving this objective, but effective prevention requires a multi-layered approach, involving:

- people with disability, their advocates and/or their families and supporters, who should be active participants in decisions about the services and supports provided
- the directors and senior managers of service providers, who should work together to design, plan and deliver services in a manner that:
 - respects, protects and fulfils the human rights of people with disability
 - meets all regulatory requirements
 - creates a strong organisational culture
 - ensures governance practices are transparent and accountable
 - takes a preventative and planned approach, rather than a reactive and risk-averse approach
- the people delivering daily supports and services, such as support workers, supervisors, support coordinators or other professionals, who should be competent, capable, valued and supported
- those responsible for funding and overseeing the provision of disability services, who should ensure the standards and obligations imposed on service providers are monitored, reported and reviewed with the aim of continuous and ongoing improvement.

While this chapter focuses on prevention, the way service providers respond to incidents, feedback and complaints can also help prevent future instances of violence, abuse, neglect and exploitation. This illustrates the importance of service provider organisations having a culture that encourages communication and feedback from recipients of services and their advocates, families or supporters, and from staff working in these organisations. A common theme throughout our public hearings concerning disability services has been the detrimental effect of failures in communication and responses to informal concerns and feedback. We discuss this further in Chapter 4 of this volume, 'Responding to violence, abuse, neglect and exploitation in disability services'.

Our public hearings also demonstrated the critical need for disability providers to foster a culture that puts the human rights of people with disability at the forefront of service delivery. This requires an evolution from benevolent or charitable approaches and service provision that perpetuates outdated models, to approaches based on autonomy and social inclusion that drive innovation.¹

3.1. Embedding human rights

While my new place isn't perfect, it is so much better. For the most part I'm respected, and that is all I was asking for. The support actually is set up for me and it's a place of my own. I think the most important thing you can do is to truly listen, and support people with disability to drive the process of our lives.²

In Volume 4, *Realising the human rights of people with disability*, we discuss Australia's international obligations regarding the human rights of people with disability. In particular, we consider the rights articulated in the *Convention on the Rights of Persons with Disabilities (CRPD)*. One of the stated objectives of the *National Disability Insurance Scheme Act 2013 (Cth) (NDIS Act)* is, in conjunction with other laws, to give effect to Australia's obligations under core international human rights treaties, including the *CRPD*.³ We also refer to the role of non-government actors, such as disability service providers, in realising the human rights of people with disability and the three pillars of the *Guiding Principles on Business and Human Rights*, published by the Office of the United Nations High Commissioner for Human Rights in 2011 (*Guiding Principles*).⁴

As outlined in Chapter 1 of this volume, 'Introduction', the advent of the National Disability Insurance Scheme (NDIS) moved the provision of disability services from government agencies to a market-based system where for-profit and not-for-profit organisations compete to provide services to NDIS participants. This means that while the Australian Government has the responsibility to fulfil Australia's international legal obligations, disability service providers have an important role to play in respecting, protecting and fulfilling the rights of people with disability. This includes the right to live free from exploitation, violence and abuse (article 16 of the *CRPD*).

Disability service providers should also support the realisation of the general principles articulated in article 3 of the *CRPD*. These include respect for the inherent dignity, individual autonomy and independence of people with disability, and their full and effective participation and inclusion in society.

Giving people with disability choice and control over the services they receive is a core principle of the *NDIS Act* and a requirement of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 (Cth) (Practice Standards)*.⁵ We discuss the role of service providers in supporting people with disability to exercise choice and control below.

In its written response to Counsel Assisting's submissions following Public hearing 32, 'Service providers revisited', the peak body for non-government disability service providers in Australia, National Disability Services (NDS), agreed that disability services should advance the human rights of people with disability. It said providers have a responsibility to prevent and respond to

violence against, abuse, neglect and exploitation of people with disability in service provision.⁶ In oral evidence at Public hearing 32, Ms Laurie Leigh, CEO of NDS, referred to an e-module called Human Rights and You, developed by NDS in collaboration with people with disability and a disability advocacy organisation. The e-module is a training tool for service providers and support workers about human rights. Ms Leigh said it was intended as a helpful resource, particularly for smaller service providers and individual support workers, who may not have access to information and training on human rights.⁷ She was, however, unable to point to any data or research that demonstrates the effectiveness of this training in reducing incidents of violence, abuse, neglect and exploitation in settings run by service providers.⁸

Similar views about the role of disability service providers in advancing human rights were expressed by representatives of two service providers who gave evidence in Public hearing 32.⁹ The CEO of Melba Support Services Inc (Melba), Ms Hayley Dean, told us that Melba has made the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ‘part of our fabric as an organisation’, even though Melba is not a ‘public authority’ within the meaning of the Charter.¹⁰

Several other service providers told us that they also use the resources developed by NDS to train their staff on human rights.¹¹

A commitment to a human rights approach in disability services means ensuring, as far as is practicable, that boards, managers and workers understand:

- the nature and scope of human rights
- how their decisions and practices can impair a person’s rights
- how to incorporate respect for human rights in practice at all levels of service provision on a day-to-day basis.

During our public hearings, and in written submissions and private sessions, we heard about occasions when a human rights approach was clearly not applied in decision-making about the supports provided to people with disability. This raises issues about the effectiveness or application of current tools, resources and training, and stresses the importance of their ongoing evaluation. For example, in Public hearing 20, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)’, ‘Sophie’ said one of her goals was to have safe intimate and sexual relationships.¹² In the Commissioners’ report on the hearing, we found Life Without Barriers (LWB) took inadequate steps to assist Sophie in achieving this goal and imposed ‘Relationship Rules’ that did not sufficiently respect and support her right to intimate relationships.¹³

In Public hearing 23, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)’, witnesses, whose adult family members attended the Mount Druitt day program offered by Afford, described their concerns about the activities that were offered and the limitations on participation in the community. We found the activities offered at the day program were not suited to the ages and interests of the participants and did not foster their independent living skills.¹⁴

The evidence from service providers and people with disability, their families and supporters suggests there is a growing discourse around the need for respect for human rights to be embedded in daily service provision. However, we heard there are a range of challenges to achieving this in practice. These challenges include diversity among providers, their available resources, and their capacity to recruit, train and retain staff who have a practical understanding of rights-based models of practice.

We accept that service providers with a written human rights policy or framework have created a starting point. Implementing such policies or frameworks requires strong leadership, a commitment to skills development, and cooperation between staff and the people with disability purchasing services, their supporters and advocates. It also requires that providers continually reflect on and evaluate the quality of their services by working with people with disability, their families and supporters, and being transparent and accountable to service users when their rights are not respected. This should include consultation with disabled people's organisations (DPOs) and disability representative organisations (DROs).

The *Guiding Principles*¹⁵ provide information on how to:

- adopt, implement and integrate a human rights policy
- assess how services delivered impact human rights, directly and indirectly
- implement systems to monitor and report on human rights impacts and the performance of service providers
- improve transparency and communication about the human rights impacts of service provision
- develop accessible and appropriate procedures to address grievances and complaints.

We accept the submissions of Counsel Assisting following Public hearing 32, that the *Guiding Principles* provide a practical framework that can assist disability service providers to develop best practice approaches to implementing human rights, including those set out in the *CRPD*.¹⁶

In March 2023, the United Nations Special Rapporteur on the rights of persons with disabilities, Mr Gerard Quinn, presented a report to the United Nations Human Rights Council titled *Transformation of services for persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities*.¹⁷

Mr Quinn encouraged changing the way services are provided to people with disability. His approach is based on three core elements:

- supporting personal development and inclusion in the community¹⁸
- changing policy and legislation to dismantle institutionalisation and segregation, reflecting the departure from the medical model of disability¹⁹
- integrating businesses and the private sector as a whole, along with civil society and the State, as partners in social services and support.²⁰

Mr Quinn also noted that some elements of the service provider community around the world have accepted responsibility for the rights of people with disability. For example, he described a European Association of Service Providers for Persons with Disabilities initiative to recognise disability service providers that excel in advancing inclusion of people with disability as a 'highly imaginative practice'. He said it ought to be emulated in other regions around the world.²¹

Mr Quinn also proposed a series of recommendations.²² Among those directed at governments and businesses, including disability service providers, were to:

- hold providers accountable to standards by monitoring performance and supporting and nurturing new service provider organisations led by people with disability²³
- develop protocols on supported decision-making in the specific context of support services²⁴
- design a workforce development strategy that is realistic and supports decent wages and career development²⁵
- promote the participation of people with disability in the design of business models and provide opportunities for their career progression and involvement in decision-making²⁶
- ensure that independent feedback and complaint mechanisms are available to service users.²⁷

These reflect suggestions we received from people with disability, their families and supporters, as well as the views expressed by disability service providers involved in our public hearings.

During Public hearing 32, Counsel Assisting suggested there may be three elements to improving provider practice:²⁸

- making human rights legally enforceable
- creating and sharing resources to build capacity and awareness about human rights within the disability sector, including among service providers, workers, and people with disability who receive disability services
- increasing institutional capability in a way that is transparent and accountable.

The CEOs of Melba, Synapse and Scope Australia agreed with these elements.²⁹

In Volume 4, we discuss the need for a stronger, more comprehensive legal framework to more effectively respect, protect and fulfil the human rights of people with disability. We recommend the introduction of an Australian Disability Rights Act (DRA). We propose the DRA both enshrine rights and create positive duties for Australian Government public sector authorities and entities.

While all the Commissioners do not consider it practicable for the proposed legislation to apply immediately to non-government entities such as disability service providers, providers could voluntarily choose to be subject to the general public authority obligation, as set out in Recommendation 4.10(c). This could be considered on the basis that they receive payment for their services from public funding through the NDIS. We also recommend a review of the DRA

within five years of its commencement, including to extend its application to additional persons or entities, such as NDIS providers. Commissioners Bennett, Galbally and McEwin alternatively recommend that, rather than considering this question at the five-year review, the Australian Government should examine, as a priority, how to expand the duty holders under the DRA to include private sector providers delivering supports and services to NDIS participants.

In addition, we agree there should be increased support for disability service providers to build their internal capacity to provide person-centred, rights-based services. At Public hearing 32, the CEO of Scope Australia, Ms Kate MacRae, commented that a 'central repository of policy and contemporary practice' with respect to human rights would be useful. She noted this could reduce duplication of effort and resources and ensure broader awareness of innovative approaches.³⁰ Representatives of other service providers supported this and Ms Leigh suggested the NDS could take on this role as central repository.³¹ We encourage NDS, along with DROs and DPOs, to collaborate with the NDIS Quality and Safeguards Commission (NDIS Commission) to develop such a central repository.

Recommendation 10.1 Embedding human rights

The NDIS Quality and Safeguards Commission (NDIS Commission) should commission a capacity-building program to support disability service providers to embed human rights in the design and delivery of their services. The program should be co-designed with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

The program should:

- develop opportunities for dialogue between providers and people with disability to address challenges and share promising practices
- develop tools, resources and training packages that reflect the diversity of people with disability and disability service providers across Australia
- focus on practical, implementable strategies that lead to better outcomes for people with disability
- be grounded in the principles of the *Convention on the Rights of Persons with Disabilities*, and reflect our findings, the NDIS Review, and the NDIS Commission's own motion inquiries and recent Safeguarding Policy Implementation Plan
- enable providers to prepare for, or demonstrate compliance with, current and future legislative and registration requirements associated with the rights of people with disability. This includes responsibilities under the *Disability Discrimination Act 1992* (Cth) and the Disability Rights Act (if enacted).

The National Disability Insurance Agency and state and territory governments involved in providing, regulating or conducting oversight of disability services not funded under the National Disability Insurance Scheme, should actively participate in all stages of the program.

The program should begin by 1 July 2025.

3.2. Exercising choice and control

If you are not given the same opportunities and the same choices as people who do not have a disability, then your life becomes difficult.³²

One object of the *NDIS Act* is to give effect to Australia's obligations under the *CRPD* by enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports. This is reflected in NDIS policy.³³ The *Practice Standards* also require that registered service providers enable participants to exercise informed choice and control.³⁴

Despite this, we heard that the choice and control of people with disability who are NDIS participants can be restricted or inhibited in a variety of ways while accessing and receiving disability services. This can increase the risk they will experience violence, abuse, neglect and exploitation.

Structural or systemic inhibitors include:

- the absence of disability services in remote and very remote communities, particularly culturally safe services for First Nations people with disability. This is discussed further in Chapter 5 of this volume, 'Areas for systemic change', and in Volume 9, *First Nations people with disability*
- the lack of appropriate housing options for people with disability, particularly those with high or complex support needs, leaving people with little choice but to live in congregate settings or with people to whom they may not be suited. This is discussed in Volume 7, *Inclusive education, employment and housing*
- funding arrangements for Supported Independent Living (SIL) and Specialist Disability Accommodation (SDA) that may contribute to people with disability who are living in supported accommodation being unable to exercise choice and control over their supports

to the same extent as other NDIS participants.³⁵ For example, the NDIS Commission's inquiry report, *Own Motion Inquiry into aspects of supported accommodation* (*Own Motion Inquiry* report) found there are 'limited levers for providers to assist people to make changes where they wish ... or to easily adjust support arrangements as a person's needs change'.³⁶

We have heard about how service provider practice can support or limit the exercise of choice and control by people with disability, particularly in supported accommodation services. In the Commissioners' *Report of Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)'*, we observed that:

a person-centred approach to service delivery requires the person with disability to be at the centre of decision-making and to have control over the services they receive. These services and supports should be directed to enhancing a person's choice and control over where and how they live. The person-centred approach is based on recognising and respecting a person's dignity and human rights.³⁷

The role of support coordinators and independent advocates

Under the NDIS, support coordinators can facilitate choice and control for people with disability over the services and supports they receive. Many witnesses emphasised that building self-advocacy skills and increasing access to robust independent advocacy is also crucial to safe, quality service provision and the exercise of choice and control.³⁸ We have heard that advocates can be the difference between a person with disability being able to make or participate in decisions, and having their decision-making taken away.³⁹ In Volume 4, we recommend that the proposed DRA include a right for people with disability to access and use supports, including advocacy services, when making and participating in decisions that affect them, communicating their will and preferences, and developing their decision-making ability. We discuss the role of advocacy further in Volume 6, *Enabling autonomy and access*.

Support coordinators

In Chapter 1, we outlined the status and functions of support coordinators, who are service providers funded through individual NDIS participants' plans. At Public hearing 32, Mr Jess Harper, CEO of Disability Intermediaries Australia (DIA), the peak body for plan management and support coordination providers, said:

Support Coordinators play a vital role in the NDIS because they support Participants to navigate the NDIS system, access the services and support they require, and develop a support plan that meets their specific needs and goals.

...

Support Coordinators also assist Participants to build and maintain capacity, relationships with service providers, and ensure that the services and support they receive are of high quality and align with their NDIS plan.⁴⁰

Mr Harper described the role of support coordinators to support participants to be ‘informed consumers’; to understand their plans and identify the opportunities their NDIS funding is able to procure for them; to engage and connect with service providers; and ultimately support them, as far as possible, to self-direct their service.⁴¹

The provision of effective support coordination services should therefore contribute to ensuring choice and control for people with disability. However, we heard about barriers to achieving this outcome.

Not all NDIS participants have funding for support coordination in their NDIS plans. Mr Harper explained that the National Disability Insurance Agency (NDIA) Service Delivery Model introduced in mid-2017 aimed to achieve 40 per cent of participants being supported by a support coordinator, with 60 per cent supported by a local area coordinator.⁴² However, demand grew and by the first quarter of 2022–23, 55 per cent of approved NDIS plans included support coordination.⁴³

The extent to which a support coordinator can assist an NDIS participant to exercise informed choice and control also depends on the amount of support coordination funding included in the participant’s NDIS plan. Mr Harper said there are too many examples of people receiving 10 or 12 hours of support coordination funding, which limits the assistance their support coordinators can provide.⁴⁴ He referred to a DIA report indicating that 94 per cent of support coordinators provided supports to NDIS participants beyond or outside the funding in their NDIS plans.⁴⁵

The lack of funding in plans also inhibits the ability of support coordinators to act as additional safeguards for participants who may otherwise be isolated or invisible, for example due to living alone⁴⁶ or having high levels of dependency. For example, the *Own Motion Inquiry* report noted that people living in supported accommodation generally have high support needs, depend on others for most of their daily living needs and may have few protective mechanisms available to help them identify and act on risks.⁴⁷ We consider it particularly important that people with disability who live in separate settings, including supported accommodation, have sufficient funding for independent support coordination in their NDIS plans.

We have also heard that:

- Many participants do not understand the scope of their support coordinator’s role, which makes it difficult for them to identify poor performance, change coordinators or make complaints to the NDIS Commission.⁴⁸
- There are risks arising from conflicts of interest when a participant’s support coordinator (or the organisation they work for) also provides other types of supports to the participant. These include support coordinators only presenting information to participants about the services offered by their own organisation.⁴⁹ Such practice limits choice and control and places the interests of the organisation above the interests of the participant.
- The quality of support coordination services is highly variable.⁵⁰
- There are inadequate systems to monitor the performance of support coordinators.⁵¹

In response to Counsel Assisting's submissions following Public hearing 25, 'The operation of the NDIS for First Nations people with disability in remote and very remote communities', the Australian Government said it is:

committed to addressing the issues arising in relation to support coordination, including in remote communities where a support coordinator's role to connect participants with mainstream services is performed in circumstances where these services may not be available, or may not be available in the same way as they are in metropolitan and regional centres.⁵²

We understand that at the time of writing, the NDIA and NDIS Commission were undertaking work to strengthen support coordination, and the NDIS Commission was considering conducting an own motion inquiry on support coordination.⁵³ We support these initiatives.

Lack of understanding of the role of support coordinators

In August 2020, the NDIA released a discussion paper on support coordination and, in November 2021, published *Improving Support Coordination for NDIS Participants* (Support Coordination paper).⁵⁴

The Support Coordination paper described the four roles of a support coordinator as:

- helping participants connect to the NDIS and other supports
- building a participant's capacity and capability to understand their plan, navigate the NDIS and make their own decisions
- brokering supports and services in line with a participant's wishes and their plan budget
- monitoring plan budgets and support effectiveness.⁵⁵

In its Participant Service Improvement Plan 2022–23, the NDIA committed to 'be clearer on what support coordination services [they] fund, and how it should be separate from other service providers'.⁵⁶

The final report on the NDIA's 2021–22 Annual Pricing Review also considered the pricing arrangements for support coordinators, finding 'it would be more appropriate to first clarify the role of Support Coordinators in the NDIS before finalising the pricing arrangements for this support'.⁵⁷ It recommended:

the NDIA should continue an in-depth review of plan management and support coordination, in consultation with participants, providers and other stakeholders, to more clearly establish the roles, functions, responsibilities and accountabilities of Plan Managers and Support Coordinators; and develop recommendations for the NDIA Board on the appropriate pricing arrangements for plan management and support coordination.⁵⁸

From March 2022, the NDIA conducted six virtual information sessions for support coordinators, focusing on evidence, reports and outcomes. In Public hearing 32, the NDIA's General Manager, Provider and Market Development, Ms Gerrie Mitra, said the NDIA would continue to develop and facilitate information sessions for support coordinators every six to eight weeks.⁵⁹

Ms Mitra also told us the NDIS Review will consider support coordination.⁶⁰ It will also examine 'ways to better ensure the delivery of value and outcomes for participants and government, including capacity building' and 'the role of intermediaries to make it easier for participants and carers to find value for money supports that meet their needs and deliver outcomes'.⁶¹

We accept that the NDIA has taken and is continuing to take steps to clarify the scope of the role of support coordinators, as submitted by the Australian Government in its response to Counsel Assisting's submissions on Public hearing 32.⁶² We also note the inclusion of improvements to support coordination in the NDIS Review.

Potential conflicts of interest

I also have concerns about the provision of support coordination services and the extent to which support coordinators are providing sufficiently independent advice and are rigorously seeking and arranging the best possible support for their clients.⁶³

Under the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) (*Code of Conduct*), all NDIS providers, including support coordinators, are required to act with integrity, honesty and transparency.⁶⁴ The *Code of Conduct* does not refer to conflicts of interest.

Guidance for providers about the *Code of Conduct* published by the NDIS Commission in March 2019 says '[f]or clients to be informed consumers they need accurate information about their service providers, the services they receive, and any real or perceived conflicts of interest of the people working with them'.⁶⁵ In addition, the NDIA publishes information about conflicts of interest, specifically directed at support coordinators, on its website. This information states that in order to comply with the obligation under the *Code of Conduct* to act with integrity, honesty and transparency, support coordinators must:⁶⁶

- recommend and provide supports and services appropriate to the needs of the participant
- maintain integrity by declaring and avoiding any real or perceived conflicts of interest
- avoid engaging in, participating in or promoting sharp practices.

The potential for conflicts of interest through the provision of both support coordination and other services was considered by Mr David Tune AO PSM in his 2019 *Review of the National*

*Disability Insurance Scheme Act 2013: Removing red tape and implementing the NDIS participant service guarantee (Tune Review).*⁶⁷

The Tune Review noted the work being undertaken by the NDIA at that time to ‘signal the importance of support coordinators being independent of other service provision’, adding ‘[t]his work is encouraged to the extent it builds market capacity so inappropriate practices can be minimised’.⁶⁸ The Tune Review also identified a need for ‘stronger mitigation strategies’ in relation to SIL providers also providing support coordination ‘lest the risks undermine the intention of the NDIS’.⁶⁹ It recommended that an ‘NDIS Rule’ be amended to make clear that it is not appropriate for the provider of support coordination to be the provider of any other funded supports in a participant’s plan.⁷⁰

Subsequently, at Public hearing 14, then NDIS Quality and Safeguards Commissioner Mr Graeme Head AO told us the NDIS Commission had not formed a view that there was an inherent conflict of interest when a participant receives support coordination from a provider that also provides core NDIS supports to the participant.⁷¹ In relation to whether limitations should be imposed on providers of support coordination providing other types of supports to a participant, Mr Head said imposing any such limitations would need to consider the maturity of the NDIS market and the availability of providers, particularly in rural and remote settings. It would also be necessary to consider whether limitations could allow a participant to choose to use the same provider of support coordination and other supports.⁷²

At Public hearing 20, Mr Scott McNaughton, NDIA General Manager, National Delivery, agreed that there can be a significant conflict of interest when an NDIS participant’s SIL provider also provides their support coordination.⁷³ When asked whether it should be mandatory for support coordination to be independent of SIL and SDA providers, he said it is the NDIA’s preference to have a separation between them but a ‘hard and fast blanket rule’ would be difficult, particularly in regional and remote areas where the market for supports is not well developed.⁷⁴

This position is reflected in the NDIA’s 2021 Support Coordination Paper, which refers to proposed changes to the *National Disability Insurance Scheme (Plan Management Rules) 2013* to implement Recommendation 16(b) of the Tune Review. The Support Coordination Paper notes the Department of Social Services had invited submissions on draft amendments to the legislation. It expressed strong support for the Tune Review’s recommendation but provided no explanation why the proposed legislative amendment had not progressed.⁷⁵

At Public hearing 32, Mr Harper said DIA takes the view, subject to extenuating circumstances, that a provider who delivers support coordination services to an NDIS participant should not be able to provide other supports and services to the same participant.⁷⁶ This view is reflected in the Professional Standards of Practice for support coordination developed by DIA in consultation with people with disability, service providers, the NDIA and the NDIS Commission.⁷⁷ Mr Harper said:

what we have found prior to implementing our professional standards of practice was the number of organisations who are multifaceted, provide lots of different types of supports and services, using support coordination as a client-capture mechanism. It

is extremely difficult for a support coordinator to be able to question and challenge a provider's response to a particular type of service ... when you are an employee of the same organisation.⁷⁸

...

there is inherent bias and challenges with that conflict that will exist if you as the support coordinator are recommending or supporting a participant to engage with your own organisation.⁷⁹

Following Public hearing 32, Counsel Assisting submitted there are good reasons to introduce a legislative requirement for support coordinators to be independent, subject to exceptions, for example in areas where there are limited providers or where a participant makes an informed choice to use the same provider.⁸⁰

In response, the Australian Government said it acknowledges the potential for a conflict of interest to arise and that the NDIA encourages separation of services to avoid such a conflict or perception of conflict. It submitted that any legislative amendments mandating the independence of support coordinators would need to be developed in consultation with NDIS participants to ensure they can retain the supports funded in their NDIS plans.⁸¹

We consider that the current provisions do not address the risks to NDIS participants created by conflicts of interest. An explicit requirement (with defined exceptions) that support coordinators provide independent support to people with disability to ensure they have informed choice about available services would address this gap.

Recommendation 10.2 Independent support coordination

To address potential conflicts of interest, the Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, create or amend an NDIS Rule to make clear that it is not appropriate for a provider of support coordination to be the provider of any other funded supports in an NDIS participant's plan.

Exceptions to the Rule should be developed in consultation with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

Exceptions may include situations where there are limited alternative service options for NDIS participants due to thin disability service markets, or where there are limited culturally appropriate or specialised services available.

Recommendation 10.3 Adequate support coordination

The National Disability Insurance Agency should ensure that participants in the National Disability Insurance Scheme (NDIS) identified as being at heightened risk of violence, abuse, neglect or exploitation, particularly those living in supported accommodation, have funding for support coordination included in their NDIS plans.

Funding for support coordination should reflect the NDIS participant's support and communication needs. Funding for hours of support coordination should also be sufficient to facilitate face-to-face contact at least monthly.

NDIS participant plans should be updated by 30 September 2025.

Quality of support coordinators

At Public hearing 32, Ms Mitra said the NDIA receives 'anecdotal feedback' from participants about the variable quality of support coordination.⁸² Similarly, the Support Coordination Paper refers to submissions made by NDIS participants who described a 'general lack of accountability' among support coordinators who made no or very little contact with them and lacked knowledge about the participants' disability type and/or services available.⁸³ The Support Coordination Paper indicates the NDIA would enhance the quality of support coordinators by publishing information on its website, encouraging better engagement with the *Code of Conduct* and *Practice Standards* (where relevant).⁸⁴

As set out in Chapter 1, at Public hearing 32 Mr Harper explained the three levels of support coordination that may be funded in an NDIS participant's plan. All support coordinators can apply to become registered providers but only level 3 support coordinators providing specialist support coordination must be registered.⁸⁵ Registered NDIS providers of level 1 and level 2 support coordination are subject to the Core Module of the *Practice Standards*. Specialised support coordinators are subject to the Core Module and Module 4: Specialised support coordination, in the *Practice Standards*.⁸⁶

All support coordinators, registered and unregistered, are required to comply with the *Code of Conduct*. In 2022, DIA estimated there were 1,624 support coordinator providers operating in the NDIS, with around 60 per cent being registered and 40 per cent unregistered.⁸⁷

While the NDIA monitors the support coordination environment as part of its role as 'market steward', the regulation of support coordinators is the responsibility of the NDIS Commission.⁸⁸ The NDIS Commission primarily monitors registered support coordinators' compliance with the *Practice Standards* through registration and audit requirements.⁸⁹ In addition, the NDIS Commission would be alerted to an underperforming support coordinator if it received a complaint about that support coordinator. The NDIS Commission's oversight is discussed in Part B.

In 2021 the NDIS Commission developed the NDIS Workforce Capability Framework to translate the *Practice Standards* and the *Code of Conduct* into ‘observable behaviours’ that service providers and workers should demonstrate when delivering services.⁹⁰ We heard that the Framework is expressed as the Australian Government’s expectation of what good disability support work should look like.⁹¹

The NDIS Workforce Capability Framework does not contain specific standards relevant to support coordinators or, indeed, to any category of support. However, the capabilities set out in the Framework are generally applicable to support coordinators. In written submissions following Public hearing 32, the Australian Government told us the NDIS Commission will consider the standards that apply to support coordinators in its proposed own motion inquiry on support coordination.⁹²

In addition, DIA has developed Professional Standards of Practice for support coordination (DIA Professional Standards) to establish the minimum standards DIA members are expected to meet.⁹³ The DIA Professional Standards have been downloaded from DIA’s website more than 500,000 times since publication.⁹⁴

Despite these initiatives, we heard evidence of considerable variations in quality between individual support coordinators and about potential gaps in monitoring the effectiveness of support coordination services.

At Public hearing 11, ‘The experiences of people with cognitive disability in the criminal justice system’, Mr Michael Baker, an employee of the Intellectual Disability Rights Service and former manager with the Cognitive Impairment Diversion Program (CIDP), raised concerns about the capacity of support coordinators to provide the support necessary for people with complex needs. He said support coordinators:

did not always have the expertise, confidence or indeed the time or capacity to engage with the multiple service systems on which many CIDP clients relied. I observed large caseloads, high levels of turnover among Support Coordinators and what appeared to be a degree of burn out. Often, Support Coordinators would resign and/or the client would be reallocated to another Support Coordinator within the organisation, so, in some cases, our clients had to cope with multiple changes of Support Coordinator.⁹⁵

Volume 8, *Criminal justice and people with disability*, discusses the need for better training of support coordinators to meet the needs of people with cognitive disability in the justice system and to understand the interaction between the NDIS and other service systems.

At Public hearing 20, Mr McNaughton said the NDIA does not provide specific training to support coordinators but does provide materials and resources for them to use.⁹⁶ He said the NDIA relies on support coordinators to ‘self-educate’ using these resources.⁹⁷ Mr McNaughton acknowledged that there are varying degrees of skill and knowledge among support coordinators.⁹⁸

The availability and quality of support coordination services was also raised in evidence presented during Public hearing 25, 'The operation of the NDIS for First Nations people with disability in remote and very remote communities'. Witnesses described not being able to access support coordinators who were local to them as well as the variability in the service they received.⁹⁹ For example, the NDIA interaction records from August 2019 for 'Daisy' noted her previous NDIS plan was 'underutilised', as her support coordinator 'did not engage [Daisy] to any service provider'.¹⁰⁰ We also heard about steps taken by the NDIA to improve support coordination in remote and very remote areas through Coordinated Funding Proposals and 'market intervention projects'.¹⁰¹

The NDIA may be alerted to potential underperforming support coordinators in the course of monitoring plan implementation and utilisation.¹⁰² For example, Ms Kitsa Papadopoulos, NDIA Branch Manager, Market Intervention and Commissioning, told us that in circumstances where there has been significant underutilisation of a participant's plan and the only funding being used was for support coordination, the NDIA would look to the support coordinator as the key person accountable for what was happening in that plan.¹⁰³

Active information sharing between the NDIA and the NDIS Commission could assist in identifying deficiencies in support coordination. The NDIA should identify when a participant's plan is not being effectively implemented and make inquiries to ascertain whether the participant is receiving appropriate levels of support from their support coordinator. Where underperformance is identified, it should be referred to the NDIS Commission.

Recommendation 10.4 Quality of support coordination

The NDIS Quality and Safeguards Commission should examine the quality and consistency of support coordination, with a particular focus on National Disability Insurance Scheme participants who:

- live in remote and very remote locations
- are First Nations people with disability
- are culturally and linguistically diverse
- are navigating state or territory housing, health or criminal justice systems
- are experiencing housing insecurity or homelessness
- are living in supported accommodation
- are attending day programs or working in Australian Disability Enterprises.

The examination may be part of the proposed own motion inquiry on support coordination.

Independent advocacy

I think advocacy workers do some of the most important work in our sector ... Someone who is vulnerable or isolated is unlikely to make a complaint directly ... to us without some support from someone who is either an informal support or formal advocate.¹⁰⁴

In Volume 6, *Enabling autonomy and access*, we discuss the importance of advocacy and informal supports in the lives of people with disability, as well as the circumstances in which independent advocacy may be needed. This includes supporting people with disability in their engagement with disability service providers and in exercising choice and control over the services they receive. We observe that in closed settings, such as group homes, advocacy support can be crucial, but that in such settings there may be barriers to accessing independent advocates. This is due to a lack of awareness about disability advocacy and unique structural and organisational barriers that exist within group homes.

The *NDIS Act* defines the term ‘independent advocate’ to exclude any NDIS providers providing supports or services to a particular person.¹⁰⁵ This reflects the recommendation by the Productivity Commission in its 2011 report *Disability Care and Support* that the NDIS should not fund advocates.¹⁰⁶ In Public hearing 32, Ms Mitra said the NDIA is very clear that a support coordinator is an NDIS provider and is not able to be an advocate for a participant.¹⁰⁷ However, the NDIA’s Support Coordination Paper recognises there is ‘no hard and fast line between supported engagement and formal advocacy’.¹⁰⁸ Also at Public hearing 32, Mr Harper acknowledged that the role of support coordinator involves elements of advocacy, but when a participant requires ‘more robust’ advocacy support, the support coordinator may need to assist them with engaging an independent advocate.¹⁰⁹

However, as set out in Volume 6, we heard evidence about the inability of independent advocacy providers across Australia to meet demand for their services. Not all people with disability who require independent advocacy are able to access it.¹¹⁰

Considering this evidence and following Public hearing 32, Counsel Assisting submitted that there is need for an urgent review by the Australian Government – in consultation with state and territory governments, people with disability and advocacy organisations – of the funding arrangements for independent advocacy services, and for the implementation of measures to ensure greater, more stable funding for such services.¹¹¹

Volume 6 outlines the Australian Government’s submissions in response to Counsel Assisting’s submissions on this topic following Public hearing 32. In Volume 6 we recommend the Australian Government commit to additional funding for national advocacy programs from 1 July 2024.

Additional funding should go some way towards ensuring that people with disability living in supported accommodation who require advocacy support have greater access to advocates. However, in light of the barriers people with disability face accessing disability advocates in supported accommodation, we consider that additional steps are needed to connect these people with independent advocacy services.

We consider that the NDIA should play a more active role in this regard by ensuring its planning processes adequately consider the independent advocacy support needs of participants, particularly those identified as being at heightened risk of violence, abuse, neglect and exploitation, and/or who live in shared supported accommodation. These participants' plans should clearly reflect the need for independent advocacy support and indicate who will assist the participant to access an advocacy service.

Recommendation 10.5 Advocacy

- a. The National Disability Insurance Agency (NDIA) should develop a program to connect National Disability Insurance Scheme (NDIS) participants living in supported accommodation with an appropriate disability advocacy organisation. The program should be co-designed with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies.

The program should:

- promote advocacy in the course of NDIS planning processes
- increase awareness of the role of advocacy in disability services among NDIS participants and their families and supporters
- strengthen advocacy referral processes when participants and their families and supporters raise concerns, make complaints or report incidents
- foster relationships between NDIS participants, their families and supporters, and disability advocacy organisations
- strengthen collaboration between disability service providers and disability advocacy organisations to enable advocates to maintain periodic contact with people with disability so they can identify potential or emerging issues.

The program should commence by January 2025.

Following an evaluation of the program's impact and outcomes, the NDIA should consider expanding the program to reach other groups of people with disability who are identified as being at heightened risk of violence, abuse, neglect or exploitation.

- b. The NDIS Quality and Safeguards Commission, when reviewing complaints and reportable incidents, should also actively promote the value of independent advocacy for NDIS participants identified as being at heightened risk of violence, abuse, neglect or exploitation, and/or those who live in supported accommodation.

Choice and control over how services are delivered

The risks of violence against, and abuse and neglect of, people with disability in shared living environments such as group homes, were examined in several public hearings.¹¹² We heard these risks are considerable when people have little or no choice and control over where and with whom they live. The NDIS Commission's *Own Motion Inquiry* report identified the need for specific regulation of group home settings, including a new Practice Standard for these settings.¹¹³ This is explored further in Part B.

A participant's choices may also be constrained by the reality that if they live in a group home, the same provider delivers core supports to all residents. The NDIS Commission's *Own Motion Inquiry* report found that while it is 'technically possible' for NDIS participants living together in supported accommodation to choose different providers, this is not what occurs in practice, with no examples of such a choice observed during the inquiry.¹¹⁴ We consider that further critical thinking is required by providers, in collaboration with people with disability, DPOs and DROs, to develop ideas and test new ways of working that address this issue.

In Volume 7, we discuss alternatives to group homes and more inclusive accommodation pathways for people with disability.

In a written submission, self-advocates from Have a Say Bendigo told us service providers continue to make 'all the choices and decisions', and people with disability are not included in daily decisions, such as what to have for dinner and what activities they participate in.¹¹⁵ In Public hearing 3, 'The experience of living in a group home for people with disability', Dr Claire Spivakovsky, Senior Lecturer in Criminology in the School of Social and Political Sciences at the University of Melbourne, told us the strict regulation of group homes, and the lack of choice and control that characterises these settings, is driven by organisational concerns about reputational risk and a 'complicated deferral to workers' occupational health and safety concerns'.¹¹⁶

At Public hearing 32, witnesses from disability service providers gave evidence about how they deliver shared supports in existing shared accommodation settings to maximise choice and control for service recipients. According to Scope, it supports residents to hold house meetings and develop household agreements under which they make decisions about what happens in their house and how they are going to live together.¹¹⁷ These household agreements can specify how vacancies are to be managed and services are to be provided in the house.¹¹⁸

Scope CEO Ms Kate MacRae said the majority of Scope's clients with NDIS funding for SIL came to Scope through government transfers.¹¹⁹ The living arrangements had already been established and some residents had been in their current homes for 20 or 30 years.¹²⁰ Prior to the NDIS, people were allocated places in accommodation that might be far away from their families.¹²¹ Since the introduction of the NDIS, when a person with disability and their family approach Scope looking for a place to live, the first consideration is geography (where does the person want to live?), followed by housing type (does the person require a specialised house or robust build?) and housemate preference (does the person want to live in an all-female house

or in a house with young men?).¹²² Once a theoretical match is identified, she said ‘it’s all about the house visits’. The person with disability visits the house so they can meet existing residents and test if it is going to be a good match.¹²³ Ms MacRae said:

... 70 percent of our clients do not use their voices to communicate. So understanding somebody’s wishes in terms of is this person going to be a good match takes time. And so the process is elongated because of that. It’s not really a voting system. I wouldn’t say we have ever voted somebody to come in or come out. The factors would be that somebody would come for a barbecue, come for an evening meal. Families would meet if there are (sic) family involvement. They might come for a weekend. And then there would be a discussion about how did it go.¹²⁴

Supporting Independent Living Co-operative (SILC), a registered NDIS provider, was established as a cooperative to support families of people with complex disability to form and operate small, family-governed homes as an alternative to the group home model. SILC CEO Ms Angela Yee told us at Public hearing 32 that in most cases, people with disability whose families approach SILC to establish a house have a connection with their proposed housemates through school or a day program.¹²⁵

Responsibility for operating SILC homes is devolved or delegated to house operators, who are the families of the people with disability who live there.¹²⁶ SILC produces policies and procedures, and employs and pays staff.¹²⁷ SILC has delegated responsibility to house operators for interviewing, screening and selecting staff, and preparing the rosters pursuant to which supports and services are delivered.¹²⁸ SILC maintains oversight of, and provides guidance to, house operators by attending regular meetings of the house operator Board and designated operations leads.¹²⁹ According to SILC, ‘provided House Operators and support workers adhere to SILC’s policies and procedures to comply with NDIS and other regulatory requirements, it allows families to determine how they operate the service’.¹³⁰

An aspect of family-led operations involves choice and control over a participant’s selection of housemates. SILC takes the view that ‘families know their children best’ and is guided by the families’ views about ‘what would work really well’.¹³¹ SILC also considers the views of clinicians, day program providers, practitioners and support workers ‘to find out whether or not [the proposed housemate arrangement] could be a good match’.¹³² Ms Yee said SILC ‘would gauge and work with the families to see whether or not it is going to be okay for [the residents] to be involved in some or all of the interview process, or none at all’.¹³³

We acknowledge that facilitating choice and control is not a simple process and may require providers to develop different approaches to give an adequate voice to people with disability. However, we consider that all service providers should take steps to ensure the views and wishes of the people with disability using their services are at the forefront of decision-making about service delivery.

At Public hearing 13, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)’, and Public hearings 20 and 23, we heard about failures by disability service providers to afford their clients choice in and control over important aspects

of the services they received. These aspects included their personal care, the contents of their service agreements and their daily activities.¹³⁴

Similarly, in Public hearing 3, AAI described the many ways that her daughter was denied choices in her life when she lived in a group home, including when to go to bed and whether she would prefer tea or coffee.¹³⁵ In the same hearing, the Victorian Public Advocate, Dr Colleen Pearce, said a 'one size fits all' model – where people have no choice about the food they eat, when they can use the bathroom and when they go to bed – becomes a source of disempowerment and frustration and is a contributing factor to violence and abuse in group homes.¹³⁶ Then Victorian Disability Services Commissioner, Mr Arthur Rogers, said his office often saw complaints about the routine of the home being prioritised over a person's individual needs.¹³⁷

In Public hearing 32, a witness with disability, Sam Petersen, recalled complaining to a service provider about a support worker Sam found to be dangerous. After the complaint, the support worker was not put on Sam's one-to-one shifts anymore but remained on shared support 'a lot'. As a result, Sam did not feel safe using the shared support service.¹³⁸

NDS told us that supporting people with disability to exercise choice and control and to be involved in decision-making about their services requires time and expertise. In particular, service provider staff need to have the skills to communicate effectively with the people to whom they are providing services in order to provide support for decision-making.¹³⁹ We discuss support for decision-making below.

During Public hearing 32, witnesses from three disability service providers – Scope, UnitingCare Queensland and SILC – emphasised the importance of communication between service providers and their clients about how services are to be delivered.¹⁴⁰ The CEO of SILC, Ms Yee, said a necessary precursor to the delivery of services is service planning and design, looking at what the person with disability wants their day to look like and how their funding can be used to best achieve that.¹⁴¹

Ms MacRae said Scope acknowledges the 'enormous' amount of work to be done in investigating how it can best communicate with its residents.¹⁴² It provides augmented and alternative communication as a key part of disability support worker induction. The focus of the training is on strengthening the ability of Scope's staff to support its clients in exercising choice and control.¹⁴³

She also said supporting people in their homes is 'highly individualised' – some days are predictable and others are not. Support workers need to understand the people they are supporting 'at a very deep level'.¹⁴⁴

Ms Donna Shkalla, the Family and Disability Services Group Executive at UnitingCare Queensland, said there needs to be a lot of negotiation between support workers and people with disability living in shared accommodation about how supports are provided each day. She said a 'lead practitioner' is employed in each UnitingCare Community house to guide support workers in day-to-day arrangements.¹⁴⁵ These arrangements depend on many factors and are driven by what individual residents would like to see in their daily routines.¹⁴⁶

Another challenge in exercising choice and control in a shared living environment relates to the individual support workers engaged and rostered to support a person with disability. In its written response to questions put to providers in advance of Public hearing 32, UnitingCare Community said it is committed to having the recruitment and selection of support teams managed by people with disability.¹⁴⁷ Ms Shkalla described the actions required of UnitingCare Community to give effect to this commitment, including:¹⁴⁸

- working with people with disability to articulate their support needs and to identify the staffing required to meet those needs
- preparing for the interview process by supporting people with disability to think about the sorts of questions they want to ask and how they might ask them
- ensuring the person being interviewed can hear and understand the questions asked, and the person with disability is able to understand the responses received.

Ms Yee also referred to the need for service providers to be flexible and to embed within their service agreements with each client how their goals will be achieved using the funding the NDIA has determined to be reasonable and necessary. She acknowledged there may need to be shared supports at times in which case SILC facilitates a process whereby the families of each resident living in a shared house work together to establish what that shared support will look like.¹⁴⁹

It is also clear that there is no one-size-fits-all approach to enabling people with disability to exercise choice and control over the services they receive. Rather, a person-centred approach to the provision of disability services requires the development and implementation of individualised strategies, established in collaboration with service recipients, their families and supporters.

Service agreements

Although the NDIA does not require written service agreements between NDIS participants and the service providers they use (except for Specialist Disability Accommodation supports), it does recommend written agreements ‘so participants and providers are clear about what each party has agreed to’.¹⁵⁰ This is also reflected in the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018 (Cth) (Quality Indicators)*, which contain provisions about service agreements to be met by registered NDIS providers.¹⁵¹

In Public hearing 32, Ms Leigh of NDS also said it is ‘good practice to have service agreements because it does really clearly set out the contract that a provider has with ... participants’.¹⁵² NDS makes available to its members a ‘high-level template’ service agreement, covering about 20 different aspects of the provider–participant relationship.¹⁵³ Ms Leigh also said there are a range of circumstances that contribute to the level of detail that may be included in service agreements.¹⁵⁴

The NDIS Commission’s *Own Motion Inquiry* report also found:

Many complaints would be avoided if there was clearer communication with a person with disability and/or their supports, and if service agreements were clearer – and presented in a form that was accessible to the person with disability and their supporters.¹⁵⁵

At Public hearings 13, 20 and 23, we heard about cases where service agreements were imprecise about the services to be delivered, difficult to understand or inflexible, and/or there was limited time for them to be reviewed.¹⁵⁶ In the Commissioners' *Report of Public hearing 23*, we observed that people with disability cannot exercise choice in relation to the services they receive unless they have a realistic opportunity to review, understand and discuss service agreements, to ensure:¹⁵⁷

- these agreements properly reflect their needs and preferences
- their NDIS funding will be expended accordingly.

Scope, SILC and UnitingCare Community provided examples of the service agreements they use. UnitingCare Community's agreement includes only an overview of the supports or services to be provided and the fees that will be charged (making reference to the relevant NDIS Pricing Arrangements and Price Limits item code).¹⁵⁸ The details of the supports or services are provided in separate documents, which are prepared after the service agreement has been entered into.¹⁵⁹ UnitingCare Community's template agreement includes an express reference to enabling the person with disability to exercise choice and control in the pursuit of their goals and in the planning and delivery of their supports.¹⁶⁰

While the service agreements provided by Scope and SILC also contain limited details, both include a section containing information about supports or services to be provided to the person with disability. The providers said that this portion of the agreement is discussed with and agreed to by prospective clients prior to entering into a service agreement.¹⁶¹

In its template agreement, Scope informs its clients that it will (among other things) 'consult with you on decisions about how Supports and, or [sic] Products are provided', 'let you know if we intend to use another organisation as our sub-contractor to provide any Supports and, or [sic] Products to you' and 'treat you with courtesy and respect and have your choices and aspirations supported as far as is reasonably possible'.¹⁶²

In accordance with NDIS Pricing Arrangements and Price Limits, the template service agreements provide for fees to be charged if participants do not give notice of cancellation within the required period. However, the templates do not specify consequences for a service provider if it cancels or is unable to deliver an agreed service. Little guidance is provided to participants about the arrangements in such a situation.

SILC's House Roster (Part 3 of its four-part service agreement) includes a notation on the final page, stating that '[i]f regular staff are unavailable, we will aim to replace them with suitably trained workers'.¹⁶³

In its Participant Booklet, UnitingCare Queensland states:

if your support worker cannot come to work with you on the days we agreed to, we will let you know as soon as possible. You can decide if you want a different worker, or have your support on a different day with your regular worker.¹⁶⁴

Sam Petersen's experience was that if a support worker was unable to attend a shift and the provider was unable to cover that shift, Sam could be left with no option but to cancel plans.¹⁶⁵

Promising practice – service agreements

People with disability have written agreements with service providers for services and supports related to activities of daily living, community participation and accommodation.

Service agreements:

- specify service user goals and clearly describe the services and supports they are purchasing, including how, when and by whom services will be provided
- are written in plain English and can be made available in accessible formats and translations
- include guarantees to replace workers who are unable to complete a shift
- are regularly reviewed in collaboration with service users, families, advocates and cultural consultants to ensure they remain fit for purpose and accessible.

Service providers:

- enable participants to obtain legal advice, advocacy, cultural consultation or other external support at all stages of the agreement process, and allow for time to consider and negotiate terms before agreements are finalised
- periodically review agreements with participants to assess performance and outcomes, affording opportunity to give feedback on service delivery
- periodically audit agreements and participant experiences to ensure policies and procedures are consistently applied across the organisation.

Supported decision-making in disability services

At Public hearing 30, 'Guardianship, substituted and supported decision-making', we heard from the NDIA that 62 per cent of NDIS participants will, at some point, need support for decision-making when participating in the NDIS.¹⁶⁶ Advocates and academics alike stressed the importance of supported decision-making for NDIS participants and drew attention to its omission from the scheme.¹⁶⁷

In May 2023, the NDIA released the NDIS Supported Decision Making Policy and the NDIS Supported Decision Making Implementation Plan.¹⁶⁸ The Australian Government's submissions following Public hearing 30 state that the policy is intended to improve the way people with disability are supported to make decisions in the NDIS. The expectation is that the need for substituted decision-making, whether through nominees or public guardians, will be reduced.¹⁶⁹ The policy also states that it is not the role of disability service providers to make decisions on

behalf of people with disability.¹⁷⁰ The implementation plan calls for the NDIA to develop and promote resources to increase the opportunity for participants to make decisions and exercise choice and control. This involves developing training and resources about supported decision-making in the NDIS for ‘participants, providers, the sector and community’.¹⁷¹

We discuss supported decision-making in Volume 6.

Although independent advocates can and do support people with disability to make decisions about services and supports, once a service provider is engaged, disability support workers also have an important role in supporting individual decision-making about day-to-day matters and arrangements for the delivery of disability services. In this way, service providers fulfil their obligation to enable the NDIS participants they support to exercise informed choice and control. However, service providers and support workers need to be aware of the risks of exercising undue influence on the people with disability they support. As discussed in Volume 6, we use the term ‘supported decision-making’ broadly to include daily decision-making support.

In research conducted as part of the NDIS Commission’s *Own Motion Inquiry* report, Professor Christine Bigby describes self-determination as an important component of ‘Active Supports’, a best-practice framework for the delivery of services to people with intellectual disability living in group homes. In this framework, disability support workers have an important role in supporting people with disability to exercise choice and make decisions about everyday matters.¹⁷²

The *Practice Standards* and *Quality Indicators* concerning the provision of person-centred supports to NDIS participants – which support them to make informed choices, exercise control and maximise independence – do not explicitly refer to supported decision-making.¹⁷³

At Public hearing 32, Ms Shkalla described the role of service providers as ensuring support for decision-making ‘becomes the norm’ and Ms MacRae referred to it as needing to be ‘in the fabric of the day’.¹⁷⁴ They also observed that having workers who know the people they are supporting well, and who are able to communicate with them, is crucial to supporting decision-making.¹⁷⁵

Ms Yee explained that most SILC staff only work at one house, meaning they have time to develop a deep knowledge and understanding of the person they are supporting. When staff know how the person communicates, interactions are quicker than if staff needed to refer to a person-centred profile or a file in the office.¹⁷⁶ Ms Yee said there are ‘always constraints’ on the time available to staff because there are ‘a lot of compliance requirements’.¹⁷⁷ However, face-to-face time with residents is prioritised, administrative tasks are handed over to the house manager, and incident reports are completed after the shift or when the resident has gone to bed.¹⁷⁸

Ms MacRae said Scope has one team leader per house and a ‘quality business partner’ or ‘practice guide’ across a number of houses. She expressed the view that there had been a shift from ‘passive’ houses being managed, to ‘homes where the participants and the clients really dictate what is happening in the house’.¹⁷⁹ She suggested that the amount of training provided to support workers before commencing work has assisted with this.¹⁸⁰ She referred to a Scope project called the ‘Culture of Communication’, which was co-designed by people with disability

through the Scope Centre of Excellence and had been implemented in more than 200 homes. Around 60 per cent of staff said they were better able to understand people who did not use speech as their main form of communication after completing the training.¹⁸¹

Ms Shkalla identified competing demands on support workers' time and the structure of the funding model for disability services as constraints on support workers having sufficient time to enable supported decision-making.¹⁸² These issues are discussed below.

NDS also emphasised the time needed for supported decision-making, noting that it requires expertise and skilled professional staff who have been trained sufficiently.¹⁸³ Ms Leigh agreed there was a short supply of workers who have this kind of training and supported the proposal for a national framework to establish a shared understanding of the concepts and principles underpinning supported decision-making. She said NDS also provides resources to service providers on supported decision-making, including e-learning modules and in-house workshops.¹⁸⁴

The NDIS Supported Decision Making Policy and Implementation Plan do not provide a great level of detail about steps to improve the practice of service providers in respect of daily supported decision-making. We consider the policy and implementation plan would be strengthened by:

- amending the *Quality Indicators* to include a greater focus on supported decision-making and more specific quality indicators
- the NDIS Commission developing specific guidance for service providers about supported decision-making, based on the supported decision-making principles we recommend in Volume 6.

Recommendation 10.6 Supported decision-making in disability services

The NDIS Quality and Safeguards Commissioner should amend the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) to reflect that each participant:

- is entitled to support to make everyday life decisions including what services they receive, in what way and from whom
- has opportunities to make decisions about their goals and aspirations
- is supported to develop their decision-making skills
- is supported to communicate their will and preferences
- has the right to choose their own supporter.

Amendments should be completed by 30 June 2025.

Recommendation 10.7 Practical guidance on supported decision-making

The NDIS Quality and Safeguards Commission should co-design – with people with disability, disabled people’s organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, and peak bodies – a practice guide on supported decision-making for service providers. This should be consistent with the NDIS Supported Decision Making Policy and the supported decision-making principles outlined in Recommendation 6.6.

3.3. Disability service provider governance

Large organisations by necessity develop large bureaucracies, which can become quite remote from their clients.¹⁸⁵

... we won’t be able to satisfy our obligation of duty of care towards our clients by being ignorant, arrogant and ill prepared.¹⁸⁶

The term ‘governance’ has a wide range of meanings. Broadly, it refers to the structures, systems and processes in place for managing an organisation. Governance will often be centred around the leadership and decision-making elements of an organisation, and the frameworks and rules that underpin the way in which they are expected to operate.

Governance in disability service providers affects how a provider functions, its culture, the quality and safety of the services provided, and the individual experiences of the people with disability accessing its services.¹⁸⁷

In written submissions following Public hearing 32, Counsel Assisting observed that there is no single ideal model of governance for disability service providers as they differ significantly in important respects.¹⁸⁸

We heard how some providers’ governance arrangements were ineffective in preventing violence against and abuse and neglect of people with disability. For example, in the Commissioners’ *Report of Public hearing 13*, we found that members of the Sunnyfield Board had not regularly visited its accommodation services, nor held regular meetings with its residents. Furthermore, senior managers did not ensure they received reliable reports and accurate information about what was happening at the house in Western Sydney because Sunnyfield did not have appropriate systems in place for doing so.¹⁸⁹

In the Commissioners' *Report of Public hearing 20*, we concluded that LWB had a 'culture of reacting to cases of violence, abuse, neglect and exploitation of residents, rather than actively seeking to prevent conduct of that kind'. We recognised the need for an organisation the size of LWB to be able to 'audit itself, to reflect upon deficiencies and failings and to identify how and why failures have occurred'. This would have enabled LWB to 'determine what action can be taken to prevent such failings from occurring in the future' and ensure such action is taken.¹⁹⁰

Service providers' governance and leadership arrangements are critical to identifying and managing risks, including the risk of violence against, and abuse, neglect and exploitation of, the people receiving their services.

During Public hearing 23, we heard about events at Afford following the 2019 death of Ms Merna Aprem, a young woman with disability who died while living in supported accommodation provided by Afford. In an internal email, an Afford board member recommended the preparation of a 'Care Support Governance Framework', as well as the creation of a new executive role and committee, noting that the board was not sufficiently analysing its internal data in order to devise policies and procedures to mitigate risks.¹⁹¹ The Afford Board did not pursue the matter.¹⁹² We found Afford's Board had failed to effectively discharge its governance obligations to ensure the safety and quality of services provided by Afford.¹⁹³

Regulatory regimes

The way in which disability service providers organise and govern themselves often reflects the regulatory regimes that apply to them. These regimes are affected by various factors, including the size of the providers, the location(s) in which they operate, their legal structures and their registration with the NDIS Commission.

As discussed in Chapter 1, the service provider market that has developed in Australia since the introduction of the NDIS is extremely diverse. It includes organisations with thousands of staff operating across different states and territories and providing a range of services, as well as sole practitioners who may be specialists in particular fields of allied health or other forms of support. Most of the disability service providers that have been the subject of detailed evidence during our public hearings have been medium to large, not-for-profit and NDIS-registered. Much of the discussion in this section is concerned with these kinds of service providers, although all providers should be aware of, and have systems to address, the risk of violence, abuse, neglect and exploitation.

Legal structures and obligations

The way a disability service provider is governed and subject to rules, regulations and liability starts with its form as a legal entity. The legal entity may be a corporation, incorporated association, unincorporated association, co-operative or sole trader. Some disability service providers may be part of a broader corporate group structure or be the 'parent' entity of subsidiaries.

Corporations are subject to the *Corporations Act 2001* (Cth) (*Corporations Act*) whether they are private or public companies, limited by shares or guarantee, or unlimited. Aboriginal and Torres Strait Islander corporations are registered under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth). Incorporated associations are registered under state or territory associations incorporation legislation.¹⁹⁴

The majority of service providers represented in Public hearing 32 are corporations and operate as charitable organisations registered with the Australian Charities and Not-for-profits Commission (ACNC) in accordance with the *Australian Charities and Not-for-profits Commission Act 2012* (Cth). Entities registered with the ACNC are classified as small, medium or large registered entities, depending on their revenue for a financial year. Large registered entities are those with more than \$1 million in revenue during a financial year.¹⁹⁵

Disability service providers are also subject to legal obligations by virtue of their involvement in trading, the provision of goods and/or services, and their engagement of staff. These include:

- duties under state or territory work health and safety laws¹⁹⁶
- duties as employers with respect to employees under the *Fair Work Act 2009* (Cth)¹⁹⁷
- obligations under Commonwealth and state and territory anti-discrimination legislation¹⁹⁸
- obligations under consumer protection legislation.¹⁹⁹

Obligations under the *NDIS Act*

A further layer of regulation applies to disability service providers that deliver services and supports to NDIS participants.

The *Code of Conduct* applies to all NDIS providers, whether registered or unregistered, and their workers. Among other things, the *Code of Conduct* requires that services and supports be provided in a safe and competent manner, with care and skill, and that providers take all reasonable steps to prevent and respond to all forms of violence against, and abuse, neglect and exploitation of, people with disability.²⁰⁰

Not all service providers delivering services and supports to NDIS participants are required to be registered, although registration is required in certain circumstances. Two of the NDIS Commission's functions are registration of disability service providers under the *NDIS Act*, and monitoring registered service providers' compliance with their conditions of registration.²⁰¹ We discuss this further in Chapter 10, 'Provider registration'.

To obtain and maintain registration, a provider must be audited against the *Practice Standards* that apply to the NDIS supports and services to be provided.²⁰² Part 3 of the *Practice Standards* relates to provider governance and operational management.

The *Practice Standards* require that each NDIS participant's support is overseen by 'robust governance and operational management systems relevant and proportionate to the size,

and scale of the provider and the scope and complexity of the supports being delivered'.²⁰³

The *Quality Indicators* state that to achieve this outcome, service providers should demonstrate that:²⁰⁴

- opportunities are provided by the governing body for people with disability to contribute to the governance of the organisation and have input into the development of organisational policy and processes relevant to the provision of supports and the protection of participant rights
- a defined structure is implemented by the governing body to meet a governing body's financial, legislative, regulatory and contractual responsibilities, and to monitor and respond to quality and safeguarding matters associated with delivering supports to participants
- the skills and knowledge required for the governing body to govern effectively are identified, and relevant training is undertaken by members of the governing body to address any gaps
- the governing body ensures that strategic and business planning considers legislative requirements, organisational risks, other requirements related to operating under the NDIS (for example agency requirements and guidance), participants' and workers' needs and the wider organisational environment
- the performance of management, including responses to individual issues, is monitored by the governing body to drive continuous improvement in management practices
- the provider is managed by a suitably qualified and/or experienced person with clearly defined responsibility, authority and accountability for the provision of supports
- there is a documented system of delegated responsibility and authority to another suitable person, in the absence of a usual position holder, in place
- perceived and actual conflicts of interest are proactively managed and documented, including through development and maintenance of organisational policies.

While the 'Governance and operational management' *Practice Standards* appropriately place emphasis on the performance of leadership, staff and risk management, they do not provide details concerning the expectations of disability service providers' governing bodies in ensuring that serious matters involving people with disability are properly dealt with, and in tracking trends identified in complaints and incidents. We discuss this further in Chapter 10, 'Provider registration'.

Organisational frameworks and accountability

[T]here's a level of sophistication that's now required in relation to corporate governance ... and it needs to continue to evolve and grow as the sector continues to evolve and grow.²⁰⁵

In general, a service provider's organisational structure will include:

- the board, made up of directors who set the strategic direction; oversee performance, risk and finances; and hold overall governance responsibility. Directors have personal duties under the *Corporations Act* and relevant work health and safety legislation
- board committees, that support the board in performing its functions on particular matters and in certain areas and are comprised of members of the board and sometimes other non-board members
- senior managers such as CEOs and officers who have day-to-day control of the provider; report to and carry out the directions of the board; and manage the service provider's operations, finances, employees and administration, among other things.

Boards, board committees and senior managers must act in accordance with rules and requirements set out in governing documents such as the service provider's constitution or rules of association, board and/or committee charters, and various policies and procedures. These documents generally have a hierarchy, with the constitution or rules of association at the top, and procedure documents providing more detail at the bottom. However, their overall effect for disability service providers should, among other things, be to ensure appropriate levels of scrutiny of how services are being delivered, as well as setting out responsibilities and accountabilities.

Board committees have different names and responsibilities. In some cases, an audit and risk committee will deal with matters of safety and quality in service delivery. In others, a quality and care committee perform this function.²⁰⁶ These committees are generally made up of board members who are thought to have the skills, knowledge and experience to ensure the committee discharges its functions.²⁰⁷

In Public hearing 32, Ms Jennifer Cullen, Ms Hayley Dean and Ms Kate MacRae were asked about how they – as CEOs of Synapse, Melba and Scope, respectively – are accountable to their boards and to the people with disability to whom they deliver services. Ms Dean told us she is answerable to a group of participants at Melba called ARROW, through their participation in board meetings.²⁰⁸ Ms MacRae said she had never considered the question of her accountability to those who receive services from Scope and acknowledged this was 'probably something that we should be considering'.²⁰⁹

Counsel Assisting's submissions following Public hearing 32 identified periodic review of governance arrangements as a vital tool to ensure good governance practice and maintenance of service quality.²¹⁰ We agree with Counsel Assisting's submissions.

In its response to the Counsel Assisting submissions, NDS agreed there is a need for service providers to have planned quality and governance improvement initiatives but observed that many providers have more 'immediate and pressing work pressures'. Workforce-related issues and funding are discussed further below and in Chapter 5.

Counsel Assisting also proposed that periodic reviews should look at a number of other matters such as the extent to which people with disability are involved in governance and decision-making; the necessity for evaluation of board members' experience and skills; how approaches to risk are conceived and managed; and how positive cultures are developed. We agree with this approach and deal with each of these below.

Promising practice – periodic governance reviews

Service providers conduct periodic reviews of their governing documents, governance structures, board and committee charters and so on, to ensure they:

- remain fit for purpose
- reflect human rights-based service delivery.

Inclusion of people with disability in governance and management

Board and leadership representation

Disabled people have simply not been considered as leaders. We seem to have been left by the wayside when it comes to being considered as people who are able to do leadership.²¹¹

In the Commissioners' *Report of Public hearing 13*, we found that the absence of people with lived experience of disability on Sunnyfield's Board significantly impeded the board's ability to discharge its responsibilities effectively.²¹²

In the Commissioners' *Report of Public hearing 23*, we found that at the relevant time, no members of the Afford Board had direct or indirect lived experience of disability, and few had experience or expertise in the provision of disability services.²¹³

Following Public hearing 23, Afford reviewed its constitution.²¹⁴ The revised constitution requires Afford have at least six and no more than 10 board directors, at least one of whom must be a person with disability.²¹⁵ In line with this constitutional requirement, at the time of Public hearing 32, Afford had recruited two new board directors who are people with disability. In addition, a limit of no more than a total of nine consecutive years for each director had been added to Afford's constitution.²¹⁶

Many of the disability service providers who participated in Public hearing 32 recognised the importance of including people with disability in their governance and leadership structures, and some had actively sought to recruit people with disability to these roles.²¹⁷ For example, at the time of the hearing, Melba and Yooralla each had a board member who identified as a person with disability.²¹⁸

The CEO of The Disability Trust, Ms Carol Berry, suggested quotas on boards of disability service providers might be useful, describing them as 'an excellent opportunity to compel organisations like ours to ensure that we have the voice of people with disability, including the voice of people with intellectual disability, on our boards'.²¹⁹

Some service providers were aware of, or had been involved in, an initiative of the Australian Institute of Company Directors (AICD), which set up a scholarship program to promote and support people with disability to acquire leadership skills.²²⁰ Yooralla CEO, Mr Terry Symonds, also described a board 'observership program' developed by Yooralla for people with disability 'to contribute to a pipeline of future candidates' for board roles. He said it was Yooralla's aim to have people with disability representing 50 per cent of its board members.²²¹

Similarly, in January 2021, Hireup launched a board observership program for people with disability. By the time of Public hearing 32, three people had completed the program, and two more were due to participate in 2023.²²² Ms Jaci Armstrong, a member of the Hireup Board, gave evidence that participants in the program receive formal, external training and are remunerated for their time on the board.²²³

Ms Dee-Anne Kapene, CEO of Coastal Residential Services (CRS), a small Tasmania-based service provider, said it can be difficult for people to commit to a board for an extended period of time, noting, in particular, CRS's circumstances as a smaller service provider operating in a regional setting. She said CRS struggled to attract talent, competing with other not-for-profits, including organisations that do not have a disability focus.²²⁴ These challenges were echoed by NDS, which submitted that many providers are struggling to recruit when it comes to skills and availability of board directors, particularly in regional and remote areas.²²⁵

Counsel Assisting submitted that disability service providers should periodically review the extent to which their governance structures and arrangements include people with disability.²²⁶ We accept that this should form part of a periodic review.

However, while it may be helpful for some providers to have quotas for the number of people with disability on their boards, such quotas may not be appropriate in all circumstances, particularly for smaller providers operating in regional and remote areas. Separately, a

provider's constitution may allow for the remuneration of its board members. Whether this is appropriate for a given provider will generally be specific to its circumstances, noting that this can have consequences for certain funding arrangements, legal and regulatory matters, and governance documents.²²⁷

Promising practice – disability leadership

Service providers:

- consider whether their boards and leadership structures have a meaningful level of representation of people with disability
- take measures to recruit people with disability as board directors, leaders, managers and advisors.

Participation in organisational decision-making

I think a critical lesson for service provision is around strengthening the voice of people with disability in a range of ways throughout the services we provide.²²⁸

We heard considerable evidence about the negative consequences that can result from failure to consult people with disability on decisions affecting their lives. This includes decisions about how services are provided to them.²²⁹

In the Commissioners' *Report of Public hearing 13*, we found the composition of Sunnyfield's senior leadership team at the time relevant to the hearing failed to appropriately involve people with disability in the organisation's decision-making processes.²³⁰

In its *Own Motion Inquiry* report, the NDIS Commission concluded that improving the accountability of boards and senior management can be facilitated by 'an embedded and authentic presence of the people with disability at every level of governance, and for that representation to reflect the diversity of the people they support'. It noted that a number of providers involved in the inquiry were well advanced in their plans to expand the role of people with disability at every level of their governance.²³¹

During Public hearing 32, Yooralla CEO, Mr Symonds, told us about a new internal CEO internship program for people with disability. He said that the first intern selected for this program would shortly commence working with him at Yooralla.²³² Similarly, we heard about a number of initiatives to involve the recipients of services in consultative and decision-making processes. In a written submission, NDS told us some providers have implemented 'service

user advisory committees' to provide input in the leadership and governance of the organisation.²³³

An example of this is the Yooralla Community Partnership Advisory Committee (YCPAC) that now advises Yooralla's Board, CEO and senior management on aspects of service delivery. YCPAC's members include people supported by Yooralla. The Chair and Management Sponsor of the committee are people with lived experience of disability.²³⁴

We also heard from Melba about its three regional ARROW committees. The purpose of these committees is to represent people with disability supported by Melba. They advise and report directly to the CEO and the Practice Quality and Safeguards Committee. The role of the ARROW committees includes: ²³⁵

- reviewing and contributing to the development of organisational policies and procedures that impact on services provided to people supported
- participating in co-design and stakeholder engagement workshops to ensure that people supported have a central voice in organisational decisions
- encouraging and supporting people to provide feedback to the organisation about the quality of the services provided.

UnitingCare Queensland also has a Disability Services Customer Advisory Group (CAG), involving disability service users and their representatives. The CAG meets monthly, and a member of the board and an external committee member of UnitingCare Queensland's Quality and Care Governance Committee (QCG Committee) are invited to its meetings. The CAG provides advice to the QCG Committee, and its meeting minutes and agenda are provided to the QCG Committee.²³⁶

Following Public hearing 32, Counsel Assisting submitted that service providers' periodic review of their governance arrangements should consider the extent of involvement of people with disability and whether appropriate arrangements exist to incorporate consultation with people with disability as consumers of their services.²³⁷ In response, NDS agreed that authentic involvement of people with disability at every level of disability service provider governance is one mechanism for ensuring boards are accountable for service quality improvement.²³⁸ NDS suggested such representation should reflect the diversity of those who are supported.²³⁹

Promising practice – inclusive governance

Service providers:

- have a formal committee that includes service users and their support networks (including family, friends, carers, and other people who have a supportive relationship with participants)
- provide opportunities for service users to participate in decision-making about the design and delivery of services

- consider whether their boards and leadership structures have a meaningful level of representation of people with disability
- take measures to recruit people with disability as board directors, leaders, managers and advisors.

Service user committees:

- are proportionate to the size of the provider and its client base
- provide formal reports to the board or a board committee
- meet with board members periodically to provide feedback, raise issues, and contribute to organisational policies and processes.

Board director skills and training

At Public hearing 32, Afford CEO, Ms Joanne Toohey, observed that some disability service providers have grown rapidly and evolved from localised community-based organisations to handling hundreds of millions of dollars. She expressed the view that ‘a level of sophistication’ needs to exist in corporate governance across the disability sector.²⁴⁰ This ‘sophistication’ requires not only reviewing and updating governance frameworks and structures – and including people with disability in those structures – but also ensuring board directors have the appropriate experience, skills and training to oversee the safety and quality of services.

A submission from the Institute for Healthy Communities Australia Ltd pointed to the need for better training of those in leadership positions within disability service providers, particularly in relation to risk, harm, abuse, neglect and exploitation.²⁴¹

In Public hearing 23, we heard evidence about the professional backgrounds of members of the Afford Board in the period relevant to the hearing. In the Commissioners’ report on the hearing, we found that the majority of the directors had corporate or local government experience²⁴² and were not adequately trained or informed about the human rights of people with disability or about disability service provision.²⁴³ Some directors had served on the board for long periods of time, during which the disability service environment in Australia had changed fundamentally and Afford itself had expanded rapidly.²⁴⁴

Governance documents such as board charters and corporate governance frameworks can articulate the skills required of board directors. For example, the ‘Governance Charter’ of The Disability Trust requires board directors to complete a ‘skills matrix’ that is reviewed every year and when new directors are elected.²⁴⁵ Ms Toohey told us that following a review by the AICD, Afford has also begun developing a comprehensive board skills matrix.²⁴⁶

Witnesses representing disability service providers who appeared at Public hearing 32 agreed with Counsel Assisting that director training and induction is crucial.²⁴⁷ Melba, The Disability

Trust, Afford and Coast Residential Services (CRS) described the types of induction processes and training provided to members of their boards, including requiring them to complete the NDIS Worker Orientation Module, attend site visits, and complete human rights training conducted internally or by external providers.²⁴⁸

Ms Kapene of CRS said it should not be assumed that human rights are understood by board directors, which is why CRS ensures human rights issues are discussed at every board meeting.²⁴⁹ She explained this involves discussion of real-life examples of quality and safeguarding issues faced by people who receive services from CRS. These interactions provide its directors with a practical context of human rights in action to develop their understanding of where CRS is performing well and where its support workers and participants face challenges.²⁵⁰

Following Public hearing 32, NDS agreed with Counsel Assisting's submission that boards of disability service providers should include directors with a range of skills and experience relevant to the disability service environment, including:²⁵¹

- expertise in regulatory compliance and financial matters
- the ability to implement human rights principles
- processes to identify and manage risks of violence against, and abuse, neglect and exploitation of, people with disability.

We accept the submission. Service providers should ensure appropriate training and professional development is provided in situations where board members are not already equipped with such skills and experience when appointed. This should be more than the completion of the two-hour NDIS Worker Orientation Modules.

Promising practice – board director skills and training

Service providers:

- have skills criteria to guide recruitment of directors and senior managers
- periodically review board skills and experience to assess whether there are any gaps, and develop a plan to fill these gaps
- when necessary, provide resources to undertake Australian Institute of Company Directors programs and other training in governance
- provide regular training and development activities across the life of a board member's appointment, including visiting services and meeting with service recipients and staff.

Measures to address risk in disability service provision

Obligations to manage risks

The *Practice Standards* require that registered NDIS providers identify and manage risks to NDIS participants, workers and the organisation.²⁵² Providers with robust systems for risk management:²⁵³

- are able to identify, analyse, prioritise and treat organisational risks
- have a documented risk management system that effectively responds to identified risks
- provide services and supports in a manner consistent with the risk management system.

Under work health and safety legislation, service providers are required to ensure, so far as is reasonably practicable, that the health and safety of employees and other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.²⁵⁴

Directors and officers who fail to take preventative action to ensure work health and safety can be held personally liable for any acts or omissions by the service provider, or its employees and contractors, that affect the health and safety of its workers or other persons.

Directors and officers must exercise due diligence to ensure that a service provider is complying with its work health and safety obligations.²⁵⁵ This includes having up-to-date knowledge of work health and safety matters; understanding the business and associated risks; and ensuring there are appropriate resources and processes to eliminate or minimise those risks.

These obligations require boards, senior managers and relevant committees to play an active role in risk management. We heard that different risk management approaches have both positively and negatively affected the safety of people with disability using disability services.

Organisational risk, individual risk and dignity of risk

Risk management overly focused on mitigating a service provider's exposure to legal liability or reputational damage is often at the expense of upholding the rights of people with disability.

In Public hearing 13, the then CEO of Sunnyfield, Ms Caroline Cuddihy, was asked about Sunnyfield's 2019 Risk Management Policy. The policy stated:

Sunnyfield aims to achieve best practice in the management of risks that potentially threaten to adversely impact on the organisation, its functions, objectives, operations, assets, staff, contractors, volunteers, clients, and members of the public or are associated with new business and services.²⁵⁶

Ms Cuddihy disagreed with the suggestion that risks to the organisation were prioritised over risks to clients.²⁵⁷ When asked whether the policy was really directed at managing corporate risk rather than the risks to the recipients of services, Ms Cuddihy said 'it could present that

way'.²⁵⁸ She also said it was her belief everyone at Sunnyfield would understand implicitly that preventing violence against, and abuse, neglect or exploitation of, clients was part of what they were there to do.²⁵⁹

We also heard about Sunnyfield's decision to terminate the Service and Residency Agreements it had with 'Melissa'.²⁶⁰ Melissa's sister, 'Eliza', had been labelled as 'querulant' (troublesome or a trouble maker) by Ms Cuddihy and others, after she raised numerous issues and concerns about the services Melissa received.²⁶¹ In the Commissioners' *Report of Public hearing 13*, we found Sunnyfield's decision to terminate the agreements with Melissa was heavily influenced by concern for its own reputation and it had prioritised its own interests over Melissa's.²⁶²

In Public hearing 20, we heard that LWB considered 'Sophie's' behaviour after being sexually assaulted as a source of risk in the Lismore house.²⁶³ This is particularly evident in the recorded minutes of a staff meeting where Sophie is described as being 'a risk to herself, the other residents, the staff and the home'.²⁶⁴ We also heard about the Relationship Rules that LWB imposed on Sophie, which focused on keeping staff and other residents safe, at the expense of Sophie's safety.²⁶⁵ Among other things, we found that the rules did not sufficiently respect Sophie's dignity of risk.²⁶⁶

The NDIS Quality and Safeguards Framework describes 'dignity of risk' as 'supporting people to take informed risks to improve the quality of their lives'. It states:

Rather than trying to find ways to eliminate all risk – which can be highly restrictive and out of proportion to the level of risk involved – the dignity of risk for NDIS providers means working with participants to define acceptable risk levels in delivering supports to achieve their goals. This must be done in a way that considers the individual circumstances of each participant. It also means supporting participants in positive risk-taking, including recognising when the risk is something the participant can decide on, and negotiating how best to support the wishes of the participant.²⁶⁷

Throughout our inquiry, people with disability, their families and supporters, as well as disability service providers and oversight bodies, have referred to the importance of dignity of risk for people with disability. In Public hearing 3, Mr Colin Hiscoe described growth through trying something new, and the role of disability services in supporting people to take risks. He said:

I think that if you try and help and support me and give me the chance to try to do something, you may – you may be really surprised of what can happen, and I think all that we really need is that one chance. Now, you might say to me, "Colin, I don't want you to go and make toast because you might burn it and set the place on fire." How do you know that? Yes, I might burn it. You might burn it. But unless I try, I will never know.²⁶⁸

In Public hearing 32, we heard from Ms Dean that when it comes to balancing dignity of risk with taking a zero-tolerance approach towards violence, abuse, neglect and exploitation, there should be a zero-tolerance approach but not necessarily a zero-tolerance approach to risk overall. She recognised it was Melba's responsibility to work with a person with disability to ensure they are informed in terms of risk and supported to participate in an activity that has some level of risk.²⁶⁹

Organisations will often set out their approach to risk, and dignity of risk, in a risk appetite statement. For example, The Disability Trust's Risk Appetite Statement says it has a low risk tolerance on matters of client safety but that this tolerance does not apply in situations where dignity of risk considerations apply, and instead becomes a medium risk.²⁷⁰

Ms Berry said the Risk Appetite Statement was framed in this way to 'enable people to take risks where that's their desire'. She said risk assessments had to be conducted and staff trained so they can enable people with disability to take risks. This requires knowing the person they are supporting, knowing their goals and interests, and constructing supports around enabling risk for that person.²⁷¹

Similarly, Afford's new Risk Appetite Statement indicates a very low risk appetite in relation to the safety and wellbeing of participants, but acknowledges this has to be:

considered in conjunction with the participants [sic] own risk appetite, choices and ability to make decisions about how they wish to live their lives. This 'dignity of risk' is based on the belief that self-determination and their right to take reasonable risks is essential for dignity and self-esteem'.²⁷²

In Public hearing 32, Ms Toohey said disability service provision has a tendency towards a culture of risk aversion. She explained:

When you are working in a heavy – heavily regulated environment, then often you will put in place more extensive documentation than possibly is required because you put a risk lens over it, and you will be more risk averse in that sort of environment.²⁷³

This is similar to evidence provided by Ms Jodi Rodgers, a relationships and sexuality counsellor, in Public hearing 20. Ms Rodgers told us 'many staff of the large providers are governed by policies and procedures that are overly focused on risk management or risk aversion'.²⁷⁴

Ms Liz Dore, also a relationships and sexuality counsellor who gave evidence in Public hearing 20, said 'most service providers still haven't achieved a fair balance between promoting safety as well as ensuring that clients can take risks in their relationships and sexual lives'.²⁷⁵

We acknowledge that it can be difficult for providers and for support workers to navigate the challenges that come from weighing dignity of risk and safety in the multitude of different situations and scenarios that can arise, often at short notice. This is especially the case in circumstances where the desire to undertake a riskier activity occurs in a more unplanned or ad hoc fashion that may not necessarily allow for extensive planning and assessment, and requires a decision to be made by a support worker.²⁷⁶

A preventative approach to risks of violence, abuse, neglect and exploitation

In the Commissioners' *Report of Public hearing 20*, we found that LWB had a reactive approach to cases of violence, abuse, neglect and exploitation rather than an active approach that sought to prevent harm before it occurred.²⁷⁷

Similarly, in the Commissioners' *Report of Public hearing 23*, we found Afford's risk management framework during the relevant period had been fundamentally deficient in addressing the risks to its clients of violence, abuse, neglect and exploitation. We also found that Afford's Finance, Audit and Risk Committee lacked sufficient oversight of risk management.²⁷⁸ Reports to the board were 'not organised into a systematic assessment of incidents, complaints and other data that would enable the board to identify and assess risks to the health and safety of Afford's clients across the organisation'.²⁷⁹

Effective reporting and data systems

In Public hearing 32, Ms Berry discussed the need for service providers to take a proactive approach to preventing incidents of violence, abuse, neglect and exploitation. She said that data can be used to detect potential emerging cultures of concern, and prevent abusive cultures developing. This in turn requires a range of channels for reporting information to managers.²⁸⁰

The way data is organised inevitably differs between providers. Factors such as context, time, scale, validity, timelines, reliability and grouping of the data are matters that need to be considered. For smaller service providers, reporting information to senior managers and leaders can be relatively simple.²⁸¹ However, larger organisations are likely to have greater volumes of more complex information. This may require more elaborate structures for reporting.

Afford has adopted a Board and Executive Reporting Framework that sets out the nature, type and frequency of reports, and to whom the reports should be distributed.²⁸² At Public hearing 32, Ms Toohey said there was 'far more visibility for the board' about the safety and quality of Afford's service provision since Public hearing 23.²⁸³

Melba also has systems for collecting different streams of data related to the safety and quality of its services, including its Personal Outcome Measures tool.²⁸⁴ Data is reviewed and reported to the board, which also receives reports through Melba's Practice, Quality and Safeguards Committee.²⁸⁵

Melba uses 'VANE templates' to inform its Practice, Quality and Safeguards Committee and its board. Reports break down incident data, including averages, by region, type of incident, persons involved and entity.²⁸⁶

In addition to receiving data, providers need to have the capacity to analyse and use that data. We heard that UnitingCare Community has a dedicated Client Data Integrity, Reporting and Support team to develop, implement and maintain safety and quality data recording and reporting systems.²⁸⁷ This team is part of UnitingCare Community's Practice Improvement and Development team.²⁸⁸ Ms Berry of The Disability Trust also emphasised the need for boards to receive reflections from staff members and managers about potential areas of concern.²⁸⁹

We accept the submission of Counsel Assisting following Public hearing 32 that data made available to members of service providers' boards and leadership teams should be from a range of sources and be both qualitative and quantitative in nature. Service providers may need to enhance their internal data analysis capabilities to achieve this.²⁹⁰

Promising practice – approaches to risk

Service providers:

- ensure that risks affecting service users, the organisation and the organisation's reputation are appropriately ranked
- develop an approach to risk that is preventative and enabling rather than reactive
- develop data collection, analysis and reporting capabilities
- regularly evaluate how data is gathered and disseminated throughout the organisation.

Creating a positive culture

Without the flow of accurate and up-to-date information within an organisation, it can be difficult for boards and senior managers to assess and address risks of violence, abuse, neglect and exploitation. For this to occur, organisations must have a culture that encourages feedback, 'speaking up', and transparent reporting and recording at all levels.

In the Commissioners' *Report of Public hearing 23*, we found that the pursuit of a growth-driven strategy by the board and former executive management of Afford contributed to a culture focused on expansion and financial matters at the expense of the safety and quality of its services. This culture also inhibited staff from raising concerns or providing feedback about how Afford was operating.²⁹¹

The consequences of poor culture being allowed to develop were also illustrated in Public hearing 13. Reports from an external investigator engaged by Sunnyfield, Ms Jennie Piaud, about the house in Western Sydney referred to a culture of fear among staff regarding the house manager, SP1.²⁹² We found Sunnyfield's lack of appropriately robust systems to supervise SP1 and prevent him from intimidating other staff enabled a toxic workplace culture to pervade the house.²⁹³

During Public hearing 32, Sunnyfield CEO Mr Andrew Hyland said:

One of the key lessons from the hearing was that culture was critical. Culture – the type of culture that I'm talking about is we want to have a culture that is open, where people feel safe to speak up, where people feel safe to report an incident, to report a complaint. And that comes from leadership. It comes from the top.²⁹⁴

Similarly, Ms Toohey said 'making sure that staff speak up' and wanting 'staff to be able to call it out with each other as well' was an important part of a 'good safeguarding framework'.²⁹⁵

Also during Public hearing 32, disability support worker Ms Zelda Riddell said that in her experience, ‘if people feel like reporting will go nowhere, [or] have a perverse outcome, where the thing doesn’t get solved and you just get in trouble, people will be really hesitant to report’.²⁹⁶ She also spoke of situations when ‘casual and permanent staff tell me they are uncomfortable with how staff treat residents’ and that they ‘told me about retributive complaints, bullying, harassment and abuse they have received or witnessed when there have been formal reports’.²⁹⁷

When asked what would promote the raising and reporting of issues, including matters of neglect, Ms Riddell said the greatest facilitator is to have a ‘confident reporting culture’. In her opinion, this includes measures to ensure support workers become experienced in writing reports, understand what a quality report looks like, and are able to see the consequences or changes resulting from a report.²⁹⁸

Following the hearing, Counsel Assisting submitted that in addition to fostering an environment where workers are encouraged to raise concerns, disability service providers should encourage users of disability services, and their families or supporters, to give feedback and raise concerns about service delivery. This was based on evidence given in Public hearings 13, 14 and 20.²⁹⁹

In Public hearing 13, we heard how Eliza repeatedly tried to raise concerns and provide feedback to Sunnyfield about issues at the house in Western Sydney and the conduct of SP1.³⁰⁰ Senior managers within Sunnyfield labelled her as ‘querulant’ rather than valuing her feedback for contributing to the improvement of its service delivery.³⁰¹

In Public hearing 14, Mrs Karen Rogers described a deterioration in communication between Department of Human Services (DHS) staff and herself at the house where her son Mr Daniel Rogers lived, as well as in the quality of care and services he received, even though she chose to ‘pick her battles’ when making complaints.³⁰²

Similarly, in Public hearing 20, ‘Paul’ and ‘Catherine’ described difficulties they experienced in communicating with LWB staff at the Melbourne house and LWB managers, and in receiving timely responses to the concerns they raised.³⁰³

We agree with Counsel Assisting’s submission that disability service providers should encourage feedback from service recipients and their supporters. We discuss further breakdowns in communication with service providers, and failures by service providers to respond to complaints and concerns, in Chapters 4 and 9.

Promising practice – creating a positive culture

Service providers:

- have clear values, philosophies and principles that guide decisions and behaviours, and that emphasise the unique needs of every service user
- have systems and strategies to ensure values, philosophies and principles are understood and applied in practice throughout the organisation
- identify and address problematic subcultures
- communicate openly and regularly with service users and staff.

3.4. The disability workforce

We devalue support work, we devalue it with our attitudes, pay, and the perception of the job being temporary.³⁰⁴

Because of the high turnover of managers, the house appeared to me to limp along on the goodwill and initiative of individual support workers.³⁰⁵

We have repeatedly heard that without support from workers who are trusted, skilled, experienced and supported, the safety and quality of the services received by people with disability can be compromised.

In Public hearing 14, the former NDIS Commissioner, Mr Head, told us the NDIS Commission had developed the Workforce Capability Framework to help service providers and workers respond to the risk of violence, abuse, neglect and exploitation in the delivery of supports and services.³⁰⁶ In its *Own Motion Inquiry* report, the NDIS Commission observed that ‘the attitude and aptitude of the workforce drives a high number of the issues evident in group settings’, which was revealed through the inquiry.³⁰⁷ Following Public hearing 32, the Australian Government submitted that among the matters being considered by the NDIS Review are opportunities to strengthen the NDIS through ‘recommendations on building a more responsive, supportive and sustainable workforce’.³⁰⁸

We acknowledge that the vast majority of workers who provide paid supports to people with disability strive to do so to the best of their abilities. Many, like Ms Riddell who gave evidence in Public hearing 32, are undoubtedly committed to delivering high-quality, person-centred support.

Indeed, we have heard about the close, positive relationships that can develop between people with disability and their support workers, and about the tremendous contributions support workers have made to the quality of life of people with disability.³⁰⁹

We have received evidence and information from people who are or have been part of the disability support workforce. We are grateful for their participation in our work and their willingness to share their experiences and observations about the challenges they have faced. For example, in Public hearing 23, ‘Dianne’ and ‘Erynn’ gave evidence about some of their concerns when working at the Mount Druitt day program operated by Afford.³¹⁰ Their evidence, along with evidence provided by families of former participants of the day program, and others, allowed Commissioners to make findings about the safety and quality of services delivered.

Overview of the disability support workforce in Australia

Working as a frontline disability worker can be a difficult job, but there are lots of good workers who absolutely want to provide the best possible services and supports to their clients.³¹¹

The disability support workforce includes workers who provide services to people with disability funded through the NDIS. However, as we noted in Chapter 1, ‘Introduction’, the NDIS is only one source of funding for services received by people with disability in Australia. People with disability receive services through other schemes and arrangements, including aged care, education support and disability employment services.³¹² Workers who provide services under such arrangements also form part of the disability support workforce.

At Public hearing 32, Dr Fiona Macdonald, Policy Director, Industrial and Social, at the Centre for Future Work within the Australia Institute, explained that the classification of occupations used by the Australian Bureau of Statistics does not distinguish between aged care and disability support workers. As a result, it is not possible to identify industry-specific data from demographic characteristics, education level, qualifications and/or training.³¹³ Further, labour force data collection focuses on workers’ main jobs. Dr Macdonald said this is problematic in a field with a high rate of part-time and casual employment, multiple job-holding, platform or ‘gig’ workers, and independent contractors.³¹⁴

Dr Macdonald told us that limitations on the availability and quality of data inhibit the development of an understanding of the workforce, which is essential to carry out ‘workforce monitoring, planning and development, as well as job design, career progression, training investment and remuneration’.³¹⁵

Dr Macdonald was able to say that in 2020 the Australian ‘care and support workforce’ comprised 460,000 people. Of this total, the ‘NDIS care and support workforce’ comprised

approximately 242,000 people.³¹⁶ She explained community and home-based support workers who provide personal support, assistance and care to people with disability comprise the majority of this number.³¹⁷ Data for the broader 'care and support workforce' reported in the National Skills Commission *Care Workforce Labour Market Study Final Report* shows the workforce is highly feminised, with an older age profile than most other occupations and a higher representation of people born overseas.³¹⁸

The evidence we heard about the disability support workforce has predominantly focused on workers supporting NDIS participants and/or employed through registered NDIS providers. In addition, when referring to 'workers' in this section, our focus is on those individuals who undertake direct support activities, including assisting people with disability with activities of daily living, and social, community and economic participation.

Employment of people with disability

In advance of Public hearing 32, we sought information from several service providers about the proportion of their workforces who identify as people with disability. Four providers – LiveBetter, Sunnyfield, Minda and Afford – told us that 1, 10, 14 and 20 per cent of their respective workforces are people with disability. However, these figures include employees of Australian Disability Enterprises.³¹⁹

Hireup told us that 13 per cent of its 'support office' employees identify as having disability.³²⁰ Disability service provider BET Group said only 0.5 per cent of its total workforce identify as having a disability and service provider Araluen said it does not collate any data about the proportion of its total workforce who identify as having a disability.³²¹

We also looked specifically at the workforce employed by providers who provide direct support to people with disability. Sunnyfield, Afford, LiveBetter and Hireup either did not provide or do not collate data on the proportion of support workers who identify as having a disability.³²²

When asked at Public hearing 32 about the employment of people with disability in their respective providers, the witnesses from Afford, Araluen and Sunnyfield said they did not have any policies in place to specifically address active recruitment of people with disability. Each witness agreed it would be sensible to develop one.³²³

Worker qualifications

There are no mandatory minimum qualifications for the provision of paid supports to people with disability, including supports funded through the NDIS.³²⁴ In several of our public hearings, witnesses expressed a view about whether a minimum qualification for disability support workers should be mandated. For example, at Public hearing 3, Dr George Taleporos argued strongly against the introduction of mandatory qualifications for all support workers, stating '[a]s a person with disability, I should have the right to decide who supports me, whether that's someone with a Certificate IV or a PhD, that choice should be up to me'.³²⁵ In Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', two general

practitioners who specialise in health care for people with intellectual disability expressed the opposing view that all disability support workers should complete a minimum of a Certificate III in 'Disability Studies' or similar prior to their employment.³²⁶

Despite the absence of a qualification mandate for the sector, some disability service providers require or prefer workers to have relevant qualifications such as a Certificate III or Certificate IV in areas like Individual Support or Disability.³²⁷

For example, Minda told us its support workers must hold a Certificate III as a minimum qualification.³²⁸ Since September 2022, Afford has started to enforce a requirement that candidates for employment in direct support roles have at least a Certificate III.³²⁹ At Public hearing 32, the CEO of Minda, Dr David Panter, said candidates are not automatically ruled out if they do not possess this qualification; instead, Minda will support such candidates to obtain one if they have the 'right aptitude for the job and are beginning to make progress on the qualification side'.³³⁰ BET Group, while noting that a Certificate III is only 'generally' required, said 98 per cent of its support workers have at least this qualification.³³¹

During Public hearing 32, Ms Riddell described her experience becoming a disability support worker in Victoria, saying she did not need any qualifications to begin her first role in the workforce as a casual employee.³³² She was, however, required to undertake or have already completed a Certificate IV in order to secure a permanent position.³³³

We asked providers about the effect a potential qualification mandate might have on their ability to recruit disability support workers. Both the CEO of BET Group, Ms Emily Korir, and Dr Panter supported the proposal for the introduction of mandatory minimum qualifications for support workers. As discussed above, Minda requires its workers to hold Certificate III qualifications.³³⁴

The CEO of Livebetter, Ms Natalie Forsyth-Stock, expressed concerns that a mandatory minimum qualification would impose a further barrier to recruitment. While she said she was 'all in favour of qualifications', she noted her organisation struggles to recruit adequate numbers of support workers now. Ms Forsyth-Stock said she would not want to lose some of her casual workers who are studying nursing.³³⁵ Sunnyfield also said it would prefer if disability support workers held such a qualification, but if this were a requirement it would increase pressure on an already limited potential workforce.³³⁶ Sunnyfield added that such a mandate may make the disability support role less attractive, given the time, effort and cost involved in gaining a qualification.³³⁷

These views were shared by Hireup, that said mandating a minimum qualification for support workers would be inconsistent with ensuring choice and control for people with disability and their families. It said a mandate would also result in 59 per cent of its current workforce no longer being able to work, causing disruptions to service delivery and continuity of support.³³⁸

According to Dr Macdonald, minimum qualification requirements could be introduced in a staged approach that does not disadvantage existing workers.³³⁹ Ms Toohey explained that when Afford introduced a requirement that its workers have a Certificate III qualification, it also incorporated training modules into its learning and development strategy that form part of the Certificate III, to allow for the recognition of prior learning.³⁴⁰

There is an insufficient basis for us to recommend the introduction of a mandatory formal qualification for all disability support workers as a measure to reduce the risk of violence, abuse, neglect and exploitation. We are also conscious of the need for people with disability to be able to choose who provides their services and supports. In Chapter 5, we discuss a system of registration that could increase the professionalisation of the disability workforce and recognise not only formal qualifications but also skills and experience.

Recruitment

In Public hearing 13, we heard about the need for robust worker screening and recruitment processes to prevent violence, abuse, neglect and exploitation. We found that at the time of the hearing, Sunnyfield did not have sufficiently thorough processes to check the accuracy of information provided by applicants for disability support roles, or to identify and investigate gaps in resumé.³⁴¹

At Public hearing 32, Mr Hyland outlined new practices Sunnyfield had implemented since Public hearing 13 with respect to recruiting disability support workers. He said Sunnyfield now verifies applicants' employment history and qualifications, as well as requiring them to provide a complete resumé with no unexplained gaps.³⁴²

Also at Public hearing 32, Afford said it requires potential recruits to have a qualification in addition to past experience of disability support.³⁴³ BET Group has a similar requirement and told us that successful applicants are chosen based on a number of criteria, including previous work experience in disability support or the completion of a placement.³⁴⁴

The witnesses from LiveBetter, BET Group and Minda discussed their recruitment processes and the different strategies they use to find candidates for employment.³⁴⁵ Ms Forsyth-Stock said LiveBetter recruits against position descriptions that include the skills and competencies it is looking for, based in part on the NDIS Workforce Capability Framework. In addition, it seeks candidates who are able to work in a team and have communication and comprehension skills. Generally speaking, it looks for candidates who 'care about people', but this is not easy to assess.³⁴⁶

Ms Korir also emphasised the importance of communication skills when selecting candidates for disability support work. She said BET Group first telephones candidates in order to assess these skills before inviting them to a face-to-face interview.³⁴⁷

Dr Panter agreed that aptitude is as important as qualifications and said Minda seeks workers who have an ability to engage. It evaluates potential workers' ability to do this by running assessment centres, where candidates have to meet and interact with some of Minda's clients who have volunteered to be involved.³⁴⁸ Following that stage in the recruitment process, and before they are allocated to a particular house or centre, candidates meet with the people with disability with whom they will be working, as well as their families or supporters.³⁴⁹ In response to a question from Commissioner McEwin, Dr Panter acknowledged the people with disability involved in Minda's recruitment process are not paid for their time and said this is something it is looking into.³⁵⁰ We consider that service providers should take steps to ensure that people with

disability who contribute to business activities, such as recruitment, are fairly remunerated. This is particularly important where others are being paid, because their involvement in the activity is part of their paid work. An exception may be participation on boards and committees, if all members except specific officers are classed as volunteers.

The involvement of people with disability in the process of recruiting support workers can be an important element of exercising choice and control. In Public hearing 32, Sam Petersen referred to the failure of a service provider to properly consult with or involve Sam in the process of interviewing and hiring support workers, despite promising that this would happen.³⁵¹

It is also a requirement for some disability support workers to hold a clear NDIS Worker Screening Check, as discussed in greater detail in Part B. In addition, some service providers require their disability support workers to hold a valid Working with Children Check.³⁵² Hireup, Mable, LiveBetter and Sunnyfield said they also require candidates for support worker roles to undergo a National Criminal History Check.³⁵³

As well as these screening requirements, and checking their references before recruitment, LiveBetter, BET Group and Minda each employ new support workers for six-month probationary periods, during which time they do induction training.³⁵⁴

The emergence of digital platforms in the disability sector adds complexity to existing systems for recruiting and screening workers. Once a support worker is either employed (as is the case with Hireup) or verified (as is the case with Mable), the choice to engage a worker to provide support ultimately lies with the person with disability, who makes this decision with reference to information included on the platforms' 'job boards'.³⁵⁵ Mable CEO Mr Peter Scutt told us the platform provider model adopted by Mable allows 'lots of people with various life experience to come into the sector', which is opening up diversity and allowing more people with greater capabilities to provide support.³⁵⁶

While we agree that attracting workers to the disability sector is positive and necessary, this must not be at the expense of the safety and quality of services delivered.

Training

Most often I see incidents occur as a result of staff who are undertrained, under-resourced and under-supported, or staff who lack understanding about disability rights and inclusion, or are under pressure to do tasks they aren't confident with. Issues can also arise where policies are not known to staff, staff do not receive adequate training in these policies, or where policies are applied inconsistently.³⁵⁷

In several hearings we received evidence about how deficiencies or gaps in training for support workers can lead to serious risks of violence against, and abuse and neglect of, people with disability. This includes interpersonal violence and conflict between people with disability, and the overuse of psychotropic medication for people with disability exhibiting behaviours of concern.³⁵⁸ Deficiencies in skills and training can also lead to inadequate responses when incidents of violence and abuse occur.³⁵⁹

We heard that support workers need training in the specific skills or requirements of a particular role and the individual support needs of each person they provide services to. They also need training specific to promoting the human rights of people with disability and preventing violence, abuse, neglect and exploitation.

Educating and training staff working in group homes is integral to developing a culture dedicated to preventing abuse.³⁶⁰ Witnesses at Public hearing 3 stressed that better supervision, management, training and monitoring of support staff by providers is required in order to minimise the risk of abuse.³⁶¹

In the Commissioners' *Report of Public hearing 6*, we found it is critical to the safety and wellbeing of people with cognitive disability who display behaviours of concern to have support from workers who are aware of best practice alternatives to psychotropic medication, such as positive behaviour support.³⁶²

In the Commissioners' *Report of Public hearing 20*, we found LWB did not adequately train or support its staff to reduce or eliminate interpersonal violence and conflict between residents.³⁶³ In the Commissioners' *Report of Public hearing 23*, we observed how frontline staff were inadequately trained and supported in safeguarding their clients against violence, abuse, neglect and exploitation.³⁶⁴

We also heard that training provided to new workers by service providers is variable in terms of the kind of training required, its frequency (such as the need for refresher training), how such

training is delivered and how the costs of training are met.³⁶⁵ Counsel Assisting summarised this evidence in written submissions on Public hearing 32, so we will not repeat it in detail here.³⁶⁶

In Public hearing 32, Ms Toohey, Ms Cattach and Mr Hyland said Afford, Araluen and Sunnyfield respectively each had a dedicated learning and development team or manager.³⁶⁷ Although some training resources were developed by or with people with disability, they were unaware of any training delivered by people with disability.³⁶⁸ They accepted that unless training is co-designed and co-delivered by people with disability, there will be a shortfall in quality.³⁶⁹

The NDIS Worker Orientation Module is a tool provided by the NDIS Commission for disability service providers to use to ensure their workers meet their obligations under the *Code of Conduct*. In written statements prepared for Public hearing 4, former NDIS Commissioner Mr Head told us registered NDIS providers are required to embed the module within their worker induction and learning programs.³⁷⁰

The four-part NDIS Worker Orientation Module is delivered as an interactive online course that takes approximately 90 minutes to complete.³⁷¹ According to Mr Head, it was developed by the NDIS Commission in consultation with the disability sector and is delivered from the perspective of NDIS participants, with a strong focus on the human rights of people with disability.³⁷² Mr Head explained how the NDIS Worker Orientation Module outlines worker obligations under the *Code of Conduct*. For example, it covers such topics as:³⁷³

- providing supports and services in a safe and competent manner
- promptly taking steps to raise and act on concerns about matters that impact the quality and safety of supports and services
- taking all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability
- preventing and responding to sexual misconduct.

We make recommendations in Part B about amendments to the *Practice Standards* and *Quality Indicators*, including to ensure disability service providers require their staff to complete the NDIS Worker Orientation Module.

Training in individual client support needs

...in terms of how to interact with the clients and carry out my duties on a day to day basis, I felt that I was put in a sink or swim situation and I needed to teach myself how to undertake my duties.³⁷⁴

Training also needs to reflect the client's specific needs and not be outsourced to organisations that don't know the resident. Not all training needs to be formal accreditation. For example, peer-education on how to support a resident to engage in a specific activity that is important to them. The ability to share information between staff has a big impact on a resident's quality of life.³⁷⁵

Support workers should be sufficiently trained to identify when people with disability may require behaviour support, to implement strategies to understand what is being communicated through behaviour, and to respond appropriately. At Public hearing 6, Professor Leanne Dowse said '[d]irect support staff working with clients who experience behaviours of concern require adequate training, supervision and support in order to consistently implement often complex and demanding behaviour support strategies'.³⁷⁶

Failures to do this were illustrated in Public hearings 20 and 23. In Public hearing 20, Sophie said an LWB clinician had developed a behaviour support plan (BSP) that support workers were supposed to follow when Sophie was upset, angry or frustrated.³⁷⁷ Sophie's parents said support workers should have been familiar with her BSP before they commenced working with her and should have been given the appropriate training.³⁷⁸ Sophie gave evidence that there were times when she did not feel heard and that sometimes the workers could have supported her better when she was upset or angry.³⁷⁹ On one occasion, a support worker ignored her, contrary to her BSP, and pushed her in a manner constituting an assault.³⁸⁰ We found LWB had failed to adequately train Sophie's support workers to address her behaviours of concern and to ensure implementation of her BSP.³⁸¹

Similarly, LWB failed to adequately train and support staff in behaviour support and intervention tailored to the needs of each individual resident in the Melbourne house.³⁸² Ms Christine Barbuto, a community visitor who attended the Melbourne house said:

I had ... a conversation with a support worker from another LWB operated house in my area who told me that she did not have any qualifications relevant to the role of disability support worker. She said this was the case for a number of others. She also told me they were not equipped to deal with the level of violence in that house, with neither specific training nor sufficient support from LWB.³⁸³

Prior to Public hearing 32, LWB said it had an increased focus on staff training on client behaviour management since Public hearing 20, to better prevent and respond to potential instances of resident-to-resident violence, as well as training on complaints management.³⁸⁴

At Public hearing 23, we heard about the reasons for and effect of inadequate training for Afford's day program staff about the individual requirements of participants. Former Team Leader Dianne and former Senior Lifestyle Assistant Erynn both gave evidence of the difficulties they and other workers faced in gaining sufficient understanding of individual clients.

Erynn said when she commenced at Afford, she was not given particular training about the individual support needs of each client, or about their behaviours or preferences.³⁸⁵ Erynn also said that because staff were constantly 'under the pump' they had insufficient time during shifts to read and absorb client files.³⁸⁶

In the Commissioners' *Report of Public hearing 23*, we found Afford workers did not receive sufficient or adequate induction or training focused on the specific support needs of each participant, and did not have paid administrative time to sufficiently familiarise themselves with information about participants.³⁸⁷ This compromised workers' ability to prevent and respond to incidents.³⁸⁸ Afford told us that since Public hearing 23, new workers are required to complete modules on individual management plans, client profiles and personal care routines as part of its onboarding program.³⁸⁹

In Public hearing 32, several service providers told us about the different approaches they take or are developing to ensure their workers understand the individual support needs of their services users. This includes buddy shifts, focused training modules, time to read care plans, service user-directed training, and support from specialist teams like in-house behaviour support practitioners.³⁹⁰

Trauma-informed training about violence, abuse, neglect and exploitation

[T]here is definitely a need [for workers] ... to certainly have a degree of understanding, of recognising signs of distress that may indicate that someone is being harmed, to know how to respond, to know how to report.³⁹¹

As we heard in Public hearing 13, following allegations of violence and abuse by two Sunnyfield employees, Sunnyfield commissioned an investigation by Ms Jennie Piaud, which made it clear workers were not sufficiently trained in incident reporting. Ms Piaud recommended, among other

things, that Sunnyfield improve its training to ensure workers understand the requirement to report incidents.³⁹²

In preparation for Public hearing 32, Sunnyfield told us it now requires workers to complete yearly online training on reporting, recognising and responding to abuse, assault and neglect. It also requires workers to complete training on topics such as restrictive practices, incident management, positive support, managing challenging behaviour and human rights.³⁹³

Similarly, in Public hearing 20, the evidence showed some LWB support workers had witnessed incidents involving a worker referred to as 'LWB Worker 3' inappropriately touching a client during personal care. However, they did not report these incidents in a timely manner.³⁹⁴ In the Commissioners' report on the hearing, we found LWB had failed to consider whether deficiencies in worker training contributed to LWB Worker 3's conduct and/or to the failure of LWB workers to report it at an earlier time.³⁹⁵ Since Public hearing 20, LWB said it has made its Understanding Abuse – Zero Tolerance training module mandatory for all frontline workers.³⁹⁶

In Public hearing 32, several providers told us about the training they provide to workers about violence, abuse, neglect and exploitation, reportable incidents, customer safeguarding and human rights.³⁹⁷

Without an understanding of how these training sessions are delivered, and the duration of each session, it is difficult to assess whether they sufficiently prepare workers to adequately recognise and respond to incidents of potential violence against, or abuse, neglect or exploitation of, people with disability.

In Public hearing 32, Ms Leigh described the zero tolerance initiative developed by NDS in partnership with the disability sector to improve practices that safeguard the rights of people with disability. She said this includes free online resources such as videos, workbooks and worksheets to assist workers and providers to understand what violence, abuse, neglect and exploitation are and how to respond to them. These resources give examples of day-to-day practice and situations.³⁹⁸ She said NDS did not collect data on whether support workers use these resources in their own time or whether they are paid by providers to do so.³⁹⁹

It is important to recognise that the existence of policies and training may not be enough to ensure that workers have the skills to recognise and respond to violence, abuse, neglect and exploitation. For example, in the Commissioners' *Report of Public hearing 23*, we found that Afford's workers did not always follow its policies and procedures.⁴⁰⁰ We also found the training and information provided to workers about incident reporting processes and obligations were inadequate.⁴⁰¹

Administrative tasks

In the course of providing direct supports to people with disability, support workers need to complete certain administrative tasks, including writing daily notes and incident reports; reading and updating client plans or files; and familiarising themselves with organisational policies and procedures.

During Public hearing 32, Ms Riddell emphasised the importance of support workers completing good-quality case notes each day. She drew a particular connection between good-quality case notes and preventing neglect of people with disability receiving supports. She explained that without detailed notes, support workers might miss indications of pain or distress.⁴⁰²

The consequences of a failure to record important information were illustrated by ‘Natalie’s’ experience of a serious bowel obstruction when she lived in supported accommodation provided by LWB in northern NSW.⁴⁰³ In the Commissioners’ *Report of Public hearing 20*, we commented that ‘a failure to properly document these matters may jeopardise a client’s health and potentially risk their life. For this reason, a failure to create and maintain proper health records is capable of constituting neglect’.⁴⁰⁴

These issues were further exposed in Public hearing 23, where former Afford support workers Erynn and Dianne both referred to administrative tasks during their period of employment being impossible to complete within rostered hours of work.⁴⁰⁵ This created a situation in which workers were either distracted from supporting the day program participants because they were trying to complete such tasks within their allocated shift time and/or were working unpaid hours to catch up on the outstanding paperwork.⁴⁰⁶ We found that from at least 2016 to 2020, ‘Lifestyle Assistants’ (a term used by Afford to refer to direct support workers in its day programs), including those in senior roles, did not have paid administrative time to sufficiently familiarise themselves with information about participants or to complete necessary paperwork.⁴⁰⁷

In Public hearing 32, Araluen told us it gives support workers a period of ‘administration time’, which they can use to read service users’ support plans, including mealtime management, medical needs, behaviour support and epilepsy management.⁴⁰⁸ However, most service providers involved in the hearing did not explain whether they allocate support workers any non-contact administrative time, funded by them or the NDIS, to review service users’ files or otherwise develop an understanding of individual service user requirements.⁴⁰⁹

During the hearing, Mr Hyland of Sunnyfield and Ms Cattach of Araluen acknowledged that funding for support workers to complete administrative tasks is an issue.⁴¹⁰ The sufficiency of NDIS-funded time to complete such tasks is discussed in Chapter 5.

Supervision and management of workers

I recall having a meeting with someone from Human Resources ... where I expressed concern about the volume of work I was being expected to do and the lack of support I felt I was receiving. By this stage I had had enough, felt very stressed by work and was ready to leave.⁴¹¹

In addition to training, it is evident that disability service providers must ensure active supervision of and support for workers to reduce the risk of violence against, and abuse, neglect and exploitation of, people with disability. We heard about the serious effects of inadequate supervision and management in Public hearings 13, 20 and 23.

In the Commissioners' *Report of Public hearing 13*, we observed that regardless of any failures in the recruitment of SP1 and SP2, once they started working at Sunnyfield it was Sunnyfield's responsibility to ensure they were properly managed and supervised.⁴¹² Sunnyfield did not appropriately manage or supervise SP1 even after receiving Eliza's complaints about his conduct.⁴¹³ We also found that Sunnyfield did not have appropriately robust systems in place to supervise SP1 and prevent him intimidating other staff. Sunnyfield managers were deceived by SP1 and SP2, but did not act on several red flags that should have resulted in greater scrutiny of their conduct at an earlier stage.⁴¹⁴

In Public hearing 32, Mr Hyland reflected on changes made by Sunnyfield to address these failures in supervisory arrangements. He said Sunnyfield had introduced training initiatives to develop the 'skills and capabilities of house managers', and additional reporting requirements.⁴¹⁵

In Public hearing 20, 'Catherine' – mother of 'Rebecca', a former resident at the Melbourne house operated by LWB – said she felt the disability support workers could only do so much, and it appeared they were not being well supported by their team leaders and managers.⁴¹⁶ This was consistent with the reports of community visitors who attended the house.⁴¹⁷ We found there was inadequate support and leadership from LWB's management for disability support workers at the Melbourne house, particularly with respect to managing residents' behaviours of concern, responding to resident-to-resident violence and giving staff enough time to do critical paperwork during their shifts.⁴¹⁸

Following Public hearing 20, LWB introduced a new Disability Support Leader role, responsible for the delivery of services through direct leadership and oversight of disability support workers.⁴¹⁹

As discussed above, at Public hearing 23 there was considerable evidence about senior lifestyle assistants and team leaders working at the Mount Druitt day program having to do significant amounts of administrative work, often in their own time. Dianne said when she was the team leader she was 'stuck behind computer screens' rather than leading her team and being able to monitor what was happening on the floor.⁴²⁰ In our report on the hearing, we observed that team leaders and other managers did not have time or capacity to focus on or adequately supervise the supports being provided by frontline staff to participants in the day program.⁴²¹ At Public hearing 32, Ms Toohey explained that she had taken steps to reduce the administrative burden on team leaders and other frontline staff.⁴²²

Several providers that gave evidence at Public hearing 32 also discussed ongoing supervision arrangements in place for new staff members, most involving some variation of a one-on-one review on a number of occasions within the first six months of employment.⁴²³ They said the cost of any supervision and/or performance appraisal is covered by providers, as there is no specific NDIS funding for the supervision of new employees.⁴²⁴

Drawing on the work of Professor Christine Bigby and Professor Julie Beadle-Brown, the NDIS Commission's *Own Motion Inquiry* report discussed the value of Active Support and Frontline Practice Leadership in training and supervising disability support workers. It also considered various elements of Professor Bigby's proposed best practice framework.⁴²⁵

The model of Active Support 'makes the abstract concept of person-centred practice more specific and concrete for staff to learn' and 'translates complex knowledge into skills that can be taught to frontline workers without tertiary education'.⁴²⁶ Frontline Practice Leadership is a style of frontline management that involves supervising the practice of each staff member individually; coaching and modelling quality support; and facilitating teamwork and the sharing of information across teams to ensure consistency.⁴²⁷

The NDIS Commission observed several elements of the proposed best practice framework were particularly relevant to its inquiry:

- Active Support practice by staff supporting people with intellectual disabilities in group homes (element 1)
- positive staff culture, with emerging evidence that cohesive, respectful, enabling and motivating cultures are associated with good Active Support practice and strong Frontline Practice Leadership (element 5)
- staff trained in Active Support who have confidence in management and are satisfied with their work (element 6)
- Frontline Practice Leadership involving frontline managerial practices that support frontline staff to focus on the quality of life of the people they support, and that positively influence the quality of Active Support practiced by staff (element 7)
- senior organisational staff who value and understand practice, and put in place structures to support and maintain Active Support and Frontline Practice Leadership (element 8).⁴²⁸

The Inquiry report stated:

the evidence is sufficiently strong for the NDIS Commission to commence work to include the elements of the best practice framework relating to Active Support, Frontline Practice Leadership, and senior organisational staff practices in Practice Standards and Quality Indicators that apply specifically to supported accommodation settings.⁴²⁹

We endorse the NDIS Commission's findings and welcome efforts to strengthen the quality of training and supervision provided to frontline support workers, particularly those working with people with intellectual disability living in supported accommodation settings.

Support workers engaged through digital platforms operate in a different environment. In Public hearing 32, Hireup said it is generally the clients themselves who supervise their direct support workers, with clients or their account managers being able to raise concerns regarding the quality of support received. Hireup also has a Community Support Team to whom these concerns can be brought.⁴³⁰

For Mable, Mr Scutt said, ‘I think supervision is a challenge for providers in the sector because the services are delivered inside homes ... so there’s not a person that has direct line of sight’.⁴³¹ While Mable also employs technology to assist in a process of collecting ‘non-invasive continuous feedback on quality experience’, ultimately the onus is on the service recipient to conduct supervision and quality assurance.⁴³² Mr Scutt observed that most of the people with disability coming to Mable have the capacity to do this themselves or with assistance.⁴³³

Effects of workforce instability

Disability support workers interviewed or surveyed as part of Dr Macdonald’s research reported that service providers’ reliance on casual employees and part-time employment contributed to significant gaps in essential support for people with disability. Based on her research, Dr Macdonald said there had been ‘a loss of collective organisational responsibility for the well-being of people being supported’.⁴³⁴ In several hearings, we heard about the negative effects of high turnover of disability support staff, and the use of many different workers on the quality and safety of supports provided to people with disability. This is a particular concern for people with disability who live in supported accommodation, have high support needs, and require workers who can communicate effectively with them and implement behaviour support strategies.

For example, in Public hearing 3, AAG said that between 2014 and 2019, 1,340 shifts were worked by casual staff in her daughter’s group home. Given her daughter’s need for a consistent routine, AAG said the continual procession of casual staff resulted in her daughter having no stability and it was almost impossible for her to cope.⁴³⁵ In the Commissioners’ *Report of Public hearing 3*, we observed that group homes cannot function safely and effectively unless the organisational culture supports staff to understand their role and ensures they are well trained. We said these objectives are difficult to achieve if the workforce is largely casualised.⁴³⁶

Following Public hearing 5, ‘Experiences of people with disability during the ongoing COVID-19 pandemic’, we found the reliance of service providers on casual disability support staff heightened the risk of people with disability being exposed to COVID19.⁴³⁷

In Public hearing 6, ABF emphasised that some of the triggers for her brother ABG’s behaviours were changes to his routine, unfamiliar support workers and support workers changing too frequently.⁴³⁸ She described occasions when ABG’s behaviours were exacerbated by numerous casual workers coming in and out of his accommodation.⁴³⁹

Similarly, in Public hearing 20, witnesses referred to the importance of the Melbourne house residents having familiar support workers who knew them well. A community visitor who visited the house said ‘there were times when the house was completely staffed by casual and agency staff’, and described a ‘revolving door’ of casual staff.⁴⁴⁰ She said:

when you have agency staff coming in, they very often will not even have time to read a behaviour support plan, let alone appropriately support a resident. It is upsetting for the resident and they often will find that their heightened behaviours increase and the number of incidents of resident-on-resident violence increase.⁴⁴¹

In Public hearings 20 and 23, witnesses described the impacts of turnover of direct support workers working in individual houses or day programs, and of supervisory or managerial staff employed at the site level.⁴⁴²

In light of our finding in Public hearing 23 about the detrimental effect of staff turnover at the Mount Druitt day program, at Public hearing 32 we asked Ms Toohey what Afford had done to achieve workforce stability. In response, she referred to efforts to change the culture within the organisation and to create belief in its purpose. She also mentioned efforts to develop stronger relationships within teams and the implementation of a new reward and recognition policy, as well as lifting the team leaders' administrative burden.⁴⁴³

Also in Public hearing 32, Dr Macdonald and Mr Angus McFarland, Branch Secretary, Australian Services Union NSW and ACT (Services) Branch, both described the 'churn' of workers in the disability support sector and some of the consequences of that churn. Worker churn refers to worker attrition (the reduction in worker numbers within an organisation) and turnover (the reduction in workforce due to workers leaving the workplace and new workers joining the workplace). Dr Macdonald cited a study that gathered data over the course of a decade and found that three out of five of all industry entrants left the 'care and support workforce' work within three years.⁴⁴⁴ Only 10 per cent of workers remain for nine years, with the greatest turnover in the first year.⁴⁴⁵ Mr McFarland said one in four workers leave the sector each year.⁴⁴⁶ We discuss this further in Chapter 5.

In June 2021, the Australian Government reported that historically, NDIS workforce turnover has been high relative to other sectors, being between 17 and 25 per cent.⁴⁴⁷ The worker turnover rates for service providers who gave evidence at Public hearing 32 were variable, ranging between 21 and 47 per cent.⁴⁴⁸

Among the factors that service providers listed as contributing to worker turnover are the rise in digital care platforms, and support workers transitioning to becoming sole traders rather than employees.⁴⁴⁹ Primarily, however, we heard evidence about how the design of the NDIS has inadvertently led to the casualisation and fragmentation of the disability support workforce, both of which are factors that negatively impact workforce stability. We address this in Chapter 5.

Conclusions

Our inquiry has revealed that more needs to be done to ensure a stable, appropriately trained and well-supported disability support workforce, capable of meeting the expectations articulated in the NDIS Workforce Capability Framework. The Australian Government recognised this in its decision to examine 'ways to build a more responsive, supportive and sustainable market and workforce' in Part 2 of the NDIS Review.⁴⁵⁰ We discuss proposals to address some of the structural or systemic challenges faced by service providers and their workers in Chapter 5.

At the same time, disability service providers need to take practical steps to enable their workers to deliver safe, high-quality services and supports. This includes implementing policies and procedures to recruit workers with the skills and attributes to do so, and providing sufficient training and support throughout their employment.

Service providers must have robust internal processes for recruiting and screening workers. People with disability receiving the services should be actively involved in the process. Elements of best practice include conducting reference checks, querying gaps in employment history, and involving service users and/or their supporters in interviews and assessments. Providers should also actively seek to employ people with disability at all levels.

Once employment has commenced, the training and supervision service providers give their support workers is fundamental to the delivery of safe, high-quality services.⁴⁵¹ This is particularly the case for workers providing daily living supports and personal care to people with disability whose circumstances heighten their risk of experiencing violence, abuse, neglect and exploitation. In addition, providing a workplace where workers consider themselves sufficiently trained and supported to perform their jobs well could assist in reducing workforce churn.

We are not in a position to assess the effectiveness of any particular training offered by the service providers involved in Public hearing 32. However, as Ms Riddell observed, training is not only the completion of one-off face-to-face or online modules on specific topics. She said it can and should include ongoing refresher and on-the-job training, particularly with respect to the individual support needs and preferences of the people with disability who are receiving services. This could be achieved by implementing a clear model or framework, like Active Support and Frontline Practice Leadership, embedded into service delivery and reinforced through workplace supervision.

Providers should also train their workers how to recognise potential indicators of violence, abuse, neglect and exploitation, and about the channels for reporting any concerns. They should periodically assess workers' capabilities in this regard and provide further training if required.

Service providers should also ensure workers have sufficient paid time built into their rosters for training, as well as for handovers and completing essential administrative tasks like record keeping and making and reviewing daily notes. Providers should also have effective supervisory arrangements in place, not just for new starters but throughout workers' employment.

Elements of promising practice – disability support workforce

In addition to implementing thorough pre-employment screening and recruitment processes, service providers:

- have structured processes to enable people with disability and their families to meaningfully participate in recruiting disability support workers
- actively seek to employ people with disability at all levels of service provision, and develop remuneration strategies for people with disability participating in business activities such as worker recruitment
- regularly review worker training to assess its ongoing fitness for purpose, including:

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- whether there are opportunities for training beyond online modules and formal sessions, such as on-the-job training
 - how workers learn about the individual support needs and preferences of people they will be supporting
 - the need for regular refresher training, particularly in areas related to safety and quality, such as positive behaviour support; supported decision-making; and indicators of violence, abuse, neglect and exploitation
 - the involvement of service users and their families or supporters in training
 - the tools and resources available from the NDIS Commission and NDS
 - how training and education is translated into practice, particularly on topics such as identifying and responding to violence against, and abuse, neglect and exploitation of, people with disability, and the provision of person-centred, human rights-based services and supports
 - pay workers for their time when completing training
 - regularly review the administrative tasks workers must complete, and assess whether they have sufficient time allocated during shifts
 - implement frontline management practices for individual supervision, mentoring and modelling of quality, person-centred support.

Endnotes

- 1 Gerard Quinn, Transformation of services for persons with disabilities: Report of the special rapporteur on the rights of persons with disabilities, A/HRC/52/32, 52nd sess, Agenda Item 3 (31 March 2023), p 18 [92].
- 2 Exhibit 3-19, 'Statement of Sam Petersen', 27 November 2019, at [39].
- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 3(1)(a)(i).
- 4 United Nations Office of the High Commissioner for Human Rights, Guiding principles on business and human rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework.
- 5 *National Disability Insurance Scheme Act 2013* (Cth) ss 3–4; *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) sch 1, cl 3.
- 6 Submissions by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 2.
- 7 Transcript, Public hearing 32, 15 February 2023, P-276 [4]–P-279 [43].
- 8 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-288 [1–5].
- 9 Transcript, Kate MacRae and Hayley Dean, Public hearing 32, 13 February 2023, P-79 [6–26].
- 10 Transcript, Hayley Dean, Public hearing 32, 13 February 2023, P-79 [23–35].
- 11 Exhibit 32-21, SCP.9999.0001.0001, [3.5], [5.5(a)]; Transcript, Kate Macrae, Public hearing 32, 13 February 2023, P-82 [42–44]; Exhibit 32-72, ARA.9999.0003.0001, p 10 [50]; Exhibit 32-74, SUN.9999.0006.0009, p 9; Transcript, Natalie Forsyth-Stock, Public hearing 32, 14 February 2023, P-159 [24–25].
- 12 Name changed to protect identity.
- 13 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Findings 1 and 3.
- 14 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [99–101], Finding 10.
- 15 United Nations Human Rights Office of the High Commissioner, Guiding principles on business and human rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework, pp 15–23.
- 16 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 60 [192].
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- 18 Gerard Quinn, Transformation of services for persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities, A/HRC/52/32, 52nd sess, Agenda Item 3 (31 March 2023), [18–32].
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- 210 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 103 [364]–107 [365].
- 211 Transcript, Christina Ryan, Public hearing 18, 9 November 2021, P-137 [38–40]; Submission of Counsel Assisting the Royal Commission following Public hearing 18, 14 December 2021, pp 115–16 [421].
- 212 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Finding 21.
- 213 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 21.

214 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-235 [6–8].

215 Exhibit 32-90, AFF.0014.0001.0223, [18.1].

216 Exhibit 32-90, AFF.0014.0001.0223, [20.2].

217 Transcript, Dee-Anne Kapene, Carol Berry and Joanne Toohey, Public hearing 32, 15 February 2023, P239 [5]–P-240 [31]; Exhibit 32-55, AFF.0014.0001.0687, [27.3], [29.3]; Exhibit 32-92, TDT.9999.0001.0001, pp 4, 8.

218 Exhibit 32-41, MAS.9999.0001.0003, p 10; Exhibit 32-164, YPL.9999.0002.0004, [90]; Exhibit 32-55, AFF.0014.0001.0687, [29.3].

219 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-250 [26–29].

220 Transcript, Carol Berry, Dee Anne Kapene and Joanne Toohey, Public hearing 32, 15 February 2023, P-240 [6–30].

221 Transcript, Terry Symonds, Public hearing 32, 16 February 2023, P-332 [27–34].

222 Transcript, Jaci Armstrong, Public hearing 32, 17 February 2023, P-410 [40–41].

223 Transcript, Jaci Armstrong, Public hearing 32, 17 February 2023, P-410 [45–47].

224 Transcript, Dee-Anne Kapene, Public hearing 32, 15 February 2023, P-328 [42–47].

225 Submission by the National Disability Services in response to Counsel Assisting’s submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.

226 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 103 [366].

227 ‘Remunerating Responsible People’, Australian Charities and Not-for-profits Commission, web page. <<https://www.acnc.gov.au/tools/guides/remunerating-responsible-people>>

228 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-250 [23–25].

229 For example, see Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 8; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Findings 8 and 10.

230 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Finding 24.

231 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 93.

232 Transcript, Terry Symonds, Public hearing 32, 16 February 2023, P-332 [36–39].

233 National Disability Services, Submission in response to Safeguards and quality issues paper, 2 February 2021, ISS.001.00532, p 3.

234 Exhibit 32-164, YPL.9999.0002.0004, [109–12].

235 Exhibit 32-41, MAS.9999.0001.0003, pp 9–10.

236 Exhibit 32-29, UCQ.9999.0004.0001, [22.1–22.3].

237 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 103 [366].

238 Submissions by National Disability Services in response to Counsel Assisting’s submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.

239 Submissions by National Disability Services in response to Counsel Assisting’s submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.

240 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-250 [31–47].

241 Institute for Healthy Communities Australia, Submission in response to Safeguards and quality issues paper, 5 February 2021, ISS.001.00540, p 3.

242 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [165].

243 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 21, [167].

244 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 21.

- 245 Exhibit 32-92, TDT.9999.0001.0001, p 4; Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-241 [23–25], [43]–P-242 [1].
- 246 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-241 [37–41].
- 247 Transcript, Public hearing 32, 15 February 2023, P-242 [4]–P-243 [2].
- 248 Transcript, Dee-Anne Kapene and Carol Berry, Public hearing 32, 15 February 2023, P-242 [4] – P-243 [15]; Exhibit 32-91, CRS.9999.0001.0001, p 2; Exhibit 32-92, TDT.9999.0001.0001, pp 4–5; Exhibit 32-41, MAS.9999.0001.0003, pp 2–3; Exhibit 32-55, AFF.0014.0001.0687, pp 22–23, 30; Exhibit 32-84, AFF.0014.0001.0108.
- 249 Transcript, Dee-Anne Kapene, Public hearing 32, 15 February 2023, P-242 [4–10].
- 250 Transcript, Dee-Anne Kapene, Public hearing 32, 15 February 2023, P-243 [28–37].
- 251 Submissions by National Disability Services in response to Counsel Assisting’s submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.
- 252 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) sch 1, cl 10.
- 253 *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) s 12.
- 254 *Work Health and Safety Act 2011* (Cth) s 19; *Work Health and Safety Act 2011* (NSW) s 19; *Work Health and Safety Act 2011* (Qld) s 19; *Work Health and Safety Act 2011* (ACT) s 19; *Work Health and Safety Act 2012* (SA) s 19; *Work Health and Safety Act 2012* (Tas) s 19; *Work Health and Safety (National Uniform Legislation) Act 2011* (NT) s 19; *Occupational Safety and Health Act 1984* (WA) s 19.
- 255 *Work Health and Safety Act 2011* (Cth) s 27; *Work Health and Safety Act 2011* (NSW) s 27; *Work Health and Safety Act 2011* (Qld) s 27; *Work Health and Safety Act 2011* (ACT) s 27; *Work Health and Safety Act 2012* (SA) s 27; *Work Health and Safety Act 2012* (Tas) s 27; *Work Health and Safety (National Uniform Legislation) Act 2011* (NT) s 27; *Occupational Safety and Health Act 1984* (WA) s 27.
- 256 Exhibit 13-218, SUN.0001.0008.7936.
- 257 Transcript, Caroline Cuddihy, Public hearing 13, 26 May 2021, P-238 [7–11].
- 258 Transcript, Caroline Cuddihy, Public hearing 13, 26 May 2021, P-238 [43].
- 259 Transcript, Caroline Cuddihy, Public hearing 13, 26 May 2021, P-238 [37–38].
- 260 Name changed to protect identity.
- 261 Name changed to protect identity.
- 262 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Findings 9 and 10.
- 263 Name changed to protect identity; Exhibit 20-3, ‘Statement of Michelle’, 16 November 2021, at [88], [90]; Transcript, Michelle and Greg, Public hearing 20, 7 December 2021, P-92 [14–20]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, [118].
- 264 Exhibit 20-561, LWB.1010.0001.0257.
- 265 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, [112].
- 266 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 3.
- 267 Australian Government Department of Social Services, NDIS Quality and Safeguarding Framework, December 2016.
- 268 Transcript, Colin Hiscoe, Public hearing 3, 5 December 2019, P-360.
- 269 Transcript, Hayley Dean, Public hearing 32, 15 February 2023, P-262 [24–30].
- 270 Exhibit 32-95, TDT.9999.0002.0043, p 1.
- 271 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-265 [16–17], [35–39].
- 272 Exhibit 32-81, AFF.0014.0001.0606_E, p 2.
- 273 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-224 [9–12].
- 274 Exhibit 20-5, ‘Statement of Jodi Rodgers’, 16 November 2021, at [75].
- 275 Exhibit 20-6, ‘Statement of Liz Dore’, 16 November 2021, at [63].
- 276 Transcript, Public hearing 32, 15 February 2023, P-262 [16]–P-264 [36].

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- 277 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 32, [345–48].
- 278 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 24.
- 279 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [229].
- 280 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-257 [31–43].
- 281 Transcript, Dee-Anne Kapene, Public hearing 32, 15 February 2023, P-245 [8–10].
- 282 Exhibit 32-82, AFF.0014.0001.0684.
- 283 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-246 [45].
- 284 Exhibit 32-41, MAS.9999.0001.0003, p 6.
- 285 Exhibit 32-41, MAS.9999.0001.0003, pp 6–7.
- 286 Exhibit 32-41, MAS.9999.0001.0003; p 8; Exhibit 32-98, MAS.9999.0001.0159.
- 287 Exhibit 32-29, UCQ.9999.0004.0001, pp 22–23.
- 288 Exhibit 32-29, UCQ.9999.0004.0001, pp 21–23.
- 289 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-257 [37–43].
- 290 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, [369–70].
- 291 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 22.
- 292 Exhibit 13-139, SUN.0001.0045.0593, p 43.
- 293 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Finding 15.
- 294 Transcript, Andrew Hyland, Public hearing 32, 14 February 2023, P-182 [18–21].
- 295 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-259 [25–30].
- 296 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-109 [4–6].
- 297 Exhibit 32-2, ‘Statement of Zelda Riddell’, 25 January 2023, at [67].
- 298 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-108 [35–40].
- 299 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 101 [356–57].
- 300 Exhibit 13-2, ‘Statement of Eliza’, 29 April 2021, at [38–56].
- 301 Transcript, Caroline Cuddihy, Public hearing 13, 28 May 2021, P-436 [19–21]; Exhibit 13-287, SUN.0001.0008.5676, p 2.
- 302 Exhibit 14-5, ‘Statement of Karen Rogers’, 5 May 2021, at [39].
- 303 Names changed to protect identities. Exhibit 20-64, ‘Statement of Paul’, 17 November 2021, at [65–72]; Exhibit 20-63, ‘Statement of Catherine’, 16 November 2021, at [37].
- 304 Exhibit 32-1, ‘Statement of Sam Petersen’, 24 January 2023, p 7.
- 305 Exhibit 20-64, ‘Statement of Paul’, 17 November 2021, at [49].
- 306 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [55].
- 307 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, 16 January 2023, p 3.
- 308 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 13 [38].
- 309 Exhibit 23-1, ‘Statement of Sally’, 26 April 2022, at [102–04]; Exhibit 23-15, ‘Statement of Lilly’, 28 April 2022, at [95–99]; Exhibit 23-26, ‘Statement of Suzie’, 28 April 2022, at [100–03]; Transcript, Raylene Griffiths, Public hearing 6, 22 September 2020, P-62–63; Exhibit 20-20.4, ‘Statement of Jennifer’, 16 November 2021, at [137–41].
- 310 Names changed to protect identities.
- 311 Exhibit 23-56, ‘Statement of Erynn’, 2 May 2022, at [64].
- 312 Exhibit 32-5.1, VDW.9999.0001.0001, [16].
- 313 Exhibit 32-4, ‘Statement of Dr Fiona Macdonald’, 3 February 2023, at [105].
- 314 Exhibit 32-4, ‘Statement of Dr Fiona Macdonald’, 3 February 2023, at [105].

315 National Skills Commission (2022), Care workforce labour market study: Final report, 30 September 2021, pp 45–48; Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [104].

316 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [13].

317 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [13].

318 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [17]; Exhibit 32-4.3, EXP.0108.0002.0706, pp 12–13, 97, 102, 108–10.

319 Exhibit 32-50, MIN.9999.0001.0001, [2(b)]; Exhibit 32-49, LBS.9999.0001.0001, [2(b)]; Exhibit 32-74, SUN.9999.0006.0001, [2.1(b)]; Exhibit 32-55, AFF.0014.0001.0687, [2.8].

320 Exhibit 32-143, HUP.9999.0001.0001, p 15.

321 Exhibit 32-72, ARA.9999.0003.0001, [15]; Exhibit 32-47.1, BET.9999.0001.0018.

322 Exhibit 32-49, LBS.9999.0001.0001, [2(b)]; Exhibit 32-74, SUN.9999.0006.0001, [2.1(b)]; Transcript, Andrew Hyland, Public hearing 32, 15 February 2023, P-197 [29–45]; Exhibit 32-55, AFF.0014.0001.0687, [2.8]; Exhibit 32-143, HUP.9999.0001.0001, p 15.

323 Transcript, Joanne Toohey, Tamara Cattach and Andrew Hyland, Public hearing 32, 15 February 2023, P-201 [21–39]. In terms of how such recruitment would be facilitated, only Ms Toohey noted that Afford had an existing reasonable adjustments policy (Transcript, Joanne Toohey, Tamara Cattach and Andrew Hyland, Public hearing 32, 15 February 2023, P-202 [32]–P-203 [9]).

324 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [54]; Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [21]; Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-117 [14–18].

325 Transcript, George Taleporos, Public hearing 3, 5 December 2019, P-375 [21–23].

326 Exhibit 6-21, 'Statement of Dr Maya Luks', 7 September 2020, at [56]; Exhibit 6-10, 'Statement of Dr Jane Law', 10 September 2020, at [80.6].

327 Exhibit 32-50, MIN.9999.0001.0001, [6].

328 Exhibit 32-50, MIN.9999.0001.0001, [6].

329 Exhibit 32-55, AFF.0014.0001.0687, [6.2].

330 Transcript, David Panter, Public hearing 32, 14 February 2023, P-158 [20–28].

331 Exhibit 32-47.1, BET.9999.0001.0018; Exhibit 32-47, BET.9999.0001.0002, [6].

332 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-96 [20–36].

333 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-97 [5–6].

334 Exhibit 32-50, MIN.9999.0001.0001, [6].

335 Transcript, Natalie Forsyth-Stock, Public hearing 32, 14 February 2023, P-170 [45]–P-171 [1–9], [35–37].

336 Exhibit 32-74, SUN.9999.0006.0001, [6.1].

337 Exhibit 32-72, SUN.9999.0006.0001, [6.1–6.2].

338 Exhibit 32-143, HUP.9999.0001.0001, pp 19–20.

339 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [110].

340 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-206 [44–48]–P-207 [1–2].

341 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Finding 14.

342 Exhibit 32-74, SUN.9999.0006.0001, [4.5].

343 Exhibit 32-55, AFF.0014.0001.0687, [4.6], [4.10], [6.2].

344 Exhibit 32-47, BET.9999.0001.0002, p 4.

345 Transcript, Emily Korir, Natalie Forsyth-Stock and David Panter, Public hearing 32, 14 February 2023, P-154 [13]–P-156 [45].

346 Transcript, Public hearing 32, 14 February 2023, P-154 [44]–P-155 [30].

347 Transcript, Emily Korir, Public hearing 32, 14 February 2023, P-156 [33–38].

348 Transcript, David Panter, Public hearing 32, 14 February 2023, P-156 [1–22].

349 Transcript, David Panter, Public hearing 32, 14 February 2023, P-156 [16–22].

350 Transcript, David Panter, Public hearing 32, 14 February 2023, P-170 [5–26].

351 Exhibit 32-1, 'Statement of Sam Petersen', 24 January 2023, at p 5.

352 Exhibit 32-72, ARA.9999.0003.0001, [25(a)]; Exhibit 32-74, SUN.9999.0006.0001, [4.5(j)]; Exhibit 32-55, AFF.0014.0001.0687, [4.6]; Exhibit 32-49, LBS.9999.0001.0001, [4(b)]; 'What do I need to register as a Hireup support worker?', Hireup, web page, 2021. <[help.hireup.com.au/hc/en-us/articles/360031344751-What-do-I-need-to-register-as-a-Hireup-support-worker-;](https://help.hireup.com.au/hc/en-us/articles/360031344751-What-do-I-need-to-register-as-a-Hireup-support-worker-)>

353 Exhibit 32-49, LBS.9999.0001.0001, [4(b)]; Exhibit 32-74, SUN.9999.0006.0001, [4.5(h)].
 354 Transcript, Natalie Forsyth-Stock, Emily Korir and David Panter, Public hearing 32,
 14 February 2023, P-157.
 355 Transcript, Laura O'Reilly, Public hearing 32, 17 February 2023, P-412 [37–39]; Exhibit 32-141,
 MBL.9999.0001.0001, pp 1, 5.
 356 Transcript, Peter Scutt, Public hearing 32, 17 February 2023, P-415 [28–33].
 357 Exhibit 32-2, 'Statement of Zelda Riddell', 25 January 2023, at [23].
 358 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies), February 2023, Finding 29; Exhibit 6-3,
 'Statement of Dr Manya Angley', 5 September 2020, [97].
 359 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (a case study), March 2023, Findings 19 and 20.
 360 Exhibit 3-16, 'Statement of Arthur Rogers', 21 November 2019, at [102–06].
 361 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 3: The experience of living in a group home for people with disability,
 September 2020, [353]; Exhibit 3-16, 'Statement of Arthur Rogers', 21 November 2019, at
 [62]; Exhibit 20-3, 'Statement of Michelle', 16 November 2021, at [144–46]; Submissions by
 National Disability Services in response to Counsel Assisting's submissions in Public hearing 32,
 SUBM.0056.0001.0069, p 6.
 362 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 6: Psychotropic medication, behaviour support and behaviours of
concern, June 2021, p 151.
 363 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies), February 2023, Finding 29.
 364 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (a case study), March 2023, [311–12].
 365 Exhibit 32-55, AFF.0014.0001.0687, [13.7]; Exhibit 32-72, ARA.9999.0003.0001, [46]; Exhibit
 32-143, HUP.9999.0001.0001, p 24; Exhibit 32-74, SUN.9999.0006.0001, [9.2]; Exhibit 32-
 47, BET.9999.0001.0002, [9]; Submission by BET Group in response to Counsel Assisting's
 submissions in Public hearing 32, 18 April 2023, SUBM.0056.0001.0001; Exhibit 32-49,
 LBS.9999.0001.0001, [9].
 366 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
 31 March 2023, [467–533].
 367 Transcript, Joanne Toohey, Tamara Cattach and Andrew Hyland, Public hearing 32,
 15 February 2023, P-208 [6–19].
 368 Transcript, Joanne Toohey, Tamara Cattach and Andrew Hyland, Public hearing 32,
 15 February 2023, P-211 [8–27].
 369 Transcript, Joanne Toohey, Tamara Cattach and Andrew Hyland, Public hearing 32,
 15 February 2023, P-212 [13–23].
 370 Exhibit 4-32, 'Statement of Mr Graeme Head AO', 11 February 2020, at [179(b)]; Exhibit 4-455,
 'Supplementary Statement of Mr Graeme Head AO', 13 March 2020, at [53].
 371 Australian Government, 'Worker Orientation Module', NDIS Quality and Safeguards Commission,
 web page, 12 May 2020. <[www.ndiscommission.gov.au/workers/worker-training-modules-and-
 resources/worker-orientation-module](http://www.ndiscommission.gov.au/workers/worker-training-modules-and-resources/worker-orientation-module)>
 372 Exhibit 4-455, 'Supplementary Statement of Mr Graeme Head AO', 13 March 2020, at [89–90].
 373 Exhibit 4-455, 'Supplementary Statement of Mr Graeme Head AO', 13 March 2020, at [91].
 374 Exhibit 23-56, 'Statement of Erynn', 2 May 2022, at [34].
 375 Exhibit 32-2, 'Statement of Zelda Riddell', 25 January 2023, at [54].
 376 Exhibit 6-14, 'Statement of Prof Leanne Dowse', 7 September 2020, at [36].
 377 Transcript, Sophie, Public hearing 20, 7 December 2021, P-42–43.
 378 Transcript, Michelle and Greg, Public hearing 20, 7 December 2021, P-85 [11]–P-86 [16].
 379 Transcript, Sophie, Public hearing 20, 7 December 2021, P-43 [6]–P-44 [7]; Exhibit 20-1,
 'Statement of Sophie', 9 November 2021, at [52–53].

380 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 7.

381 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 30.

382 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, [314].

383 Exhibit 20-66, 'Statement of Christine Barbuto', 17 November 2021, at [50].

384 Exhibit 32-138, LWB.9999.0004.0001, pp 15–16, 24–25.

385 Exhibit 23-56, 'Statement of Erynn', 2 May 2022, at [9]; Transcript, Erynn, Public hearing 23, 17 May 2022, P-204 [21–47].

386 Exhibit 23-56, 'Statement of Erynn', 2 May 2022, at [10], [15], [20].

387 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Findings 11 and 19.

388 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 19.

389 Exhibit 32-55, AFF.0014.0001.0687, p 16 [13.2].

390 Exhibit 32-55, AFF.0014.0001.0687, pp 16–17 [13.8]; Exhibit 32-55, AFF.0014.0001.0687, p 16 [13.2]; Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-207 [6–29]; Exhibit 32-74, SUN.9999.0006.0001, [13.1–13.5]; Exhibit 32-143, HUP.9999.0001.0001, pp 28–29; Exhibit 32-72, ARA.9999.0003.0001, p 11 [59].

391 Transcript, Cathy Want, Public hearing 17.1, 13 October 2021, P-54 [1–6].

392 Transcript, Jennie Piaud, Public hearing 13, 25 May 2021, P-164 [42–46]; Exhibit 13-145, SUN.0001.0050.7176, p 9.

393 Exhibit 32-74, SUN.9999.0006.0001, [11.1].

394 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, [327].

395 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 31.

396 Exhibit 32-138, LWB.9999.0004.0001, p 9.

397 Exhibit 32-55, AFF.0014.0001.0687, [11.1]; Exhibit 32-47, BET.9999.0001.0002, [9]; Exhibit 32-72, ARA.9999.0003.0001, [61(a)]; Exhibit 32-143, HUP.9999.0001.0001, p 26; Exhibit 32-49, LBS.9999.0001.0001, [9]; Exhibit 32-50, MIN.9999.0001.0001, [11].

398 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-278 [5–41].

399 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-279 [19–43].

400 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 19.

401 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 19.

402 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-105 [11–28].

403 Name changed to protect identity.

404 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, [200].

405 Erynn and Dianne are pseudonyms.

406 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [124].

407 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 11.

408 Exhibit 32-72, ARA.9999.0003.0001, p 11.

409 Exhibit 32-47, BET.9999.0001.0002, p 13; Exhibit 32-49, LBS.9999.0001.0001, p 12; Exhibit 32-143, HUP.9999.0001.0001, p 28.

410 Transcript, Tamara Cattach and Andrew Hyland, Public hearing 32, 15 February 2023, P-223 [4–16].

411 Exhibit 23-59, ‘Statement of Dianne’, 2 May 2022, at [35].

412 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, [356].

413 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, [367–74].

414 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Findings 15 and 16.

415 Transcript, Andrew Hyland, Public hearing 32, 14 February 2023, P-181 [18–28].

416 Names changed to protect identities; Exhibit 20-65, ‘Statement of Catherine’, 16 November 2021, at [60].

417 Exhibit 20-66, ‘Statement of Christine Barbuto’, 17 November 2021, at [33]; Transcript, Christine Barbuto, Public hearing 20, 9 December 2021, P-284 [15–19]; Exhibit 20-67, ‘Statement of Suzanne Rewell’, 18 November 2021, at [108].

418 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 26.

419 Exhibit 32-138, LWB.9999.0004.0001, p 19.

420 Transcript, Dianne, Public hearing 23, 17 May 2022, P-173 [10–14].

421 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [209].

422 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-221.

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425 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 68–77; Christine Bigby, Living with Disability Research Centre, Evidence about best practice in supported accommodation services: What needs to be in place?, a literature review for the NDIS Quality and Safeguards Commission, October 2022, pp 4–9.

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- 430 Transcript, Laura O'Reilly, Public hearing 32, 17 February 2023, P-424–26; Exhibit 32-143, HUP.9999.0001.0001, pp 26–27.
- 431 Transcript, Peter Scutt, Public hearing 32, 17 February 2023, P-420 [32–38].
- 432 Transcript, Peter Scutt, Public hearing 32, 17 February 2023, P-420 [39]–P-421 [9].
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- 434 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [29].
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- 438 Exhibit 6-5, 'Statement of ABF', 9 September 2020, at [14].
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- 440 Exhibit 20-66, 'Statement of Christine Barbuto', 17 November 2021, at [51]; Transcript, Christine Barbuto, Public hearing 20, 9 December 2021, P-287 [11–13].
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- 442 Exhibit 20-64, 'Statement of Paul', 17 November 2021, at [49]; Exhibit 23-1, 'Statement of Sally', 26 April 2022, at [34]; Exhibit 23-15, 'Statement of Lilly', 28 April 2022, at [42–45]; Exhibit 23-26, 'Statement of Suzie', 28 April 2022, at [32], [45], [74]; Transcript, Suzie, Public hearing 23, 16 May 2022, P-118 [4–47]; Transcript, Erynn, Public hearing 23, 17 May 2022, P-191 [11–40].
- 443 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-226–27.
- 444 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-122 [31–45].
- 445 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-122 [42–45].
- 446 Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-122 [20–23].
- 447 Exhibit 24-91, CTD.9999.0072.0001, p 10.
- 448 Hireup – 38 per cent of workers who worked shifts in 2021 did not work shifts in 2022 (Exhibit 32-185, SUBM.0053.0001.0011, p 1); Afford – 33 per cent average over past two years (Exhibit 32-55, AFF.0014.0001.0687, [8.2]); BET Group – 35 per cent in the year up to November 2021 and 47 per cent in the year up to November 2022 (Exhibit 32-47, BET.9999.0001.0002, [8]); LiveBetter – 31 per cent in 2022 (Exhibit 32-49, LBS.9999.0001.0001, [2(a)], [8]); Minda – 27 per cent in 2022 (Exhibit 32-50, MIN.9999.0001.0001, [8]); Sunnyfield – 21 per cent in year up to November 2022 (Exhibit 32-74, SUN.9999.0006.0001, [8.1]).
- 449 Exhibit 32-49, LBS.9999.0001.0001, [8]; Exhibit 32-72, ARA.9999.0003.0001, [30]; Exhibit 32-143, HUP.9999.0001.0001, p 23.
- 450 Australian Government, 'Terms of Reference: Building a strong, effective NDIS', NDIS Review, web page. <www.ndisreview.gov.au/about/terms-of-reference>
- 451 Submissions by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 6.

4. Responding to violence, abuse, neglect and exploitation in disability services

Key points

- Robust and transparent policies and procedures are required to support people to report incidents of, or make complaints about, violence, abuse, neglect and exploitation.
- Power imbalances between people with disability and their service providers can be a barrier to raising concerns and making complaints.
- Service providers should be aware of and address the barriers people with disability and their supporters face when raising concerns, making complaints or reporting incidents.
- Leaders and senior managers should develop organisational cultures that encourage and welcome feedback, the raising of concerns, and complaints.
- Providers should be careful to avoid conflating persistent self-advocacy by a person with disability, or advocacy by a family member or supporter, with unreasonableness.
- Support workers and their managers should have access to reliable incident reporting systems and be trained to use them.
- Providers should implement processes to monitor incident reporting and the quality of service delivery.
- Investigations are a key tool for understanding how and why incidents occur and what can be done to mitigate future risk.
- An investigation should have a clear purpose and should be conducted after assessing and managing the risks to the alleged victim(s) and taking into account internal and external reporting obligations.
- In matters involving suspicion or allegations of violence, abuse, neglect or exploitation, poor communication can compound feelings of distrust and anxiety.
- When people with disability, or their family or supporters, raise issues or concerns, providers should actively involve them in investigative processes to find solutions.
- Providers should understand the effects of trauma and provide trauma-informed and culturally safe supports to people who have reported or have been exposed to violence, abuse, neglect or exploitation.

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- Regardless of how an issue is raised, or how an incident comes to a service provider's attention, if the information suggests criminal conduct may be involved the provider should report the matter to the police.
 - Providers should have processes in place to identify and analyse the root causes of incidents, or failures to provide safe, high-quality services and implement preventive measures in response.
 - Where violence, abuse, neglect or exploitation has occurred, providers should actively consider redress and, if warranted, provide appropriate redress to those concerned.
 - Closed-circuit television (CCTV) is not a substitute for effective safeguarding measures, but it may be useful in some circumstances. The wishes of the people with disability receiving services at a particular location or site should be central to decisions relating to the use of CCTV.

As discussed in Chapters 2, 'What we heard about violence, abuse, neglect and exploitation in disability services', and 3 'Preventing violence, abuse, neglect and exploitation in disability services', we heard about cases where service providers' policies, systems and practices to prevent violence, abuse, neglect and exploitation have been ineffective. During public hearings, we also examined service providers' responses when incidents occurred, or allegations or complaints were made. In some cases, we made findings about deficiencies in those responses.

Service providers need robust and transparent policies and procedures to detect and respond to violence, abuse, neglect and exploitation. The policies and procedures should be person-centred. They should support people with disability and their families and advocates, as well as workers or third parties, to raise concerns, make complaints and report incidents.

We accept the view expressed at Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', by Mr Richard Bruggemann, the former CEO of South Australia's Intellectual Disability Services Council. He said service providers need to focus not just on preventing the worst things from happening, but on developing indicators to determine whether people with disability are becoming more independent, achieving their goals and living a 'good life'.¹ This includes seeking continual feedback from service recipients and their supporters and promptly addressing any concerns.

In this chapter, we discuss what we have heard about how disability service providers handle feedback, concerns and complaints. We examine service providers' obligations, their policies and organisational cultures, and the barriers people with disability and their families and supporters experience. We also address incident reporting and the duty of service provider staff to report incidents internally and to external bodies.

We then look at how service providers respond to concerns, complaints and incidents, including through investigations, and the role of families and other advocates in supporting people

with disability through these processes. We discuss the importance of communicating with and supporting people with disability who have experienced violence, abuse, neglect and exploitation, as well as with their families and supporters. We also examine the need for service providers to actively consider appropriate forms of redress.

4.1. Managing concerns and complaints

When people with disability or their support networks provide feedback, raise concerns or make complaints, they are exercising their human rights and choice and control over their lives.

However, people with disability and their family members often find service providers' complaints processes confusing or ineffective in addressing and resolving their concerns and complaints. The evidence suggests that even when some service providers acknowledged shortcomings, their responses relied on the good will of individual staff rather than a whole-of-service response to overcome the core problem.

Throughout our public hearings, people with disability and their supporters have spoken of their feelings of frustration, confusion, disappointment and fear about the way their complaints or feedback have been received by service providers.

For example, Sam Petersen described the experience of providing feedback to a service provider. The feedback was met with resistance and raised voices, with workers calling Sam 'rude, impatient and fussy' and 'the angry one'.²

Complaints policies

Registered NDIS providers are required under the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) (*Complaints Rules*) to have an effective system for managing and resolving complaints about their services. Their complaints management and resolution systems must ensure people can easily make a complaint and that all complaints are dealt with fairly and quickly.³ The NDIS Quality and Safeguards Commission's (NDIS Commission) *Complaints Management and Resolution Guidance* suggests it is good practice for all NDIS providers to have appropriate and effective complaints management and resolution systems in place.⁴ However, unregistered providers are bound only by the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) (*Code of Conduct*), and are not required by the *Complaints Rules* to demonstrate an effective complaints management system.

Registered NDIS providers must also inform clients how to make a complaint to the provider and to the NDIS Commission, and keep records about the complaints they receive.⁵

In addition, the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) (*Practice Standards*) require registered providers to ensure each participant has knowledge of and access to the provider's complaints management and resolution system.⁶ They require complaints to be welcomed, acknowledged, respected and well-managed by providers.⁷

To achieve these objectives, as outlined in the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) (*Quality Indicators*), service providers should ensure:⁸

- a complaints management and resolution system is maintained that is relevant and proportionate to the scope and complexity of supports delivered and the size and scale of the organisation. The system follows principles of procedural fairness and natural justice and complies with the requirements under the *Complaints Rules*.
- each participant is provided with information on how to give feedback or make a complaint, including avenues external to the provider, and their right to access advocates. There is a supportive environment for any person who provides feedback or makes complaints.
- demonstrated continuous improvement in complaints and feedback management by regular review of complaint and feedback policies and procedures, seeking of participant views on the accessibility of the complaints management and resolution system, and incorporation of feedback throughout the provider's organisation.
- all workers are aware of, trained in, and comply with the required procedures in relation to complaints handling.

We discuss complaints management further in Chapter 9, 'Complaints'.

Registered NDIS providers are bound by the requirements of both the *Complaints Rules* and the *Practice Standards*. However, complaints policies, procedures and practices can vary considerably among service providers. Different processes are followed and definitions used. Teams that manage complaints and investigations vary in numbers, experience and expertise.

For example, policies contain various descriptive terms, the meaning of which can differ in important respects. These terms include 'feedback', 'compliment', 'suggestion', 'concern', 'complaint', 'serious complaint', 'informal complaint', 'formal complaint', 'simple complaint' and 'dispute'. Differences in policy language and in the understanding of those invoking the policies can produce different outcomes for complaints.⁹

Some internal policies explain the potential outcomes of a complaint, including an apology or financial redress. However, these outcomes may not be set out in policies provided to service users or their families or supporters.¹⁰ In some cases, complainants can appeal or seek a review of a decision about a complaint,¹¹ but the process may require the complainant to identify faults in the original process for dealing with the complaint.¹²

At Public hearing 32, 'Service providers revisited', representatives of four service providers gave evidence about complaint handling and incident reporting. They agreed that model policies and procedures for handling complaints would be helpful. Ms Sonya Furey, interim CEO of Cara, said she could see that 'a standard approach across the sector would be helpful'.¹³ Ms Liz Forsyth, CEO of Northcott, said:

[T]he ability to streamline or get a consistent nature of some of the structures we talk about, be that terminology, definitions, frameworks for assessing risk, would be useful, because I think that might provide frontline workers the ability to understand it across settings.¹⁴

Ms Forsyth said any model policies or procedures would need to consider that organisations have different online complaint and incident management systems.¹⁵

In response to Counsel Assisting's written submissions following Public hearing 32, the Australian Government referred to the guidance published by the NDIS Commission about complaints handling.¹⁶ We discuss this further in Chapter 9.

Assistance to raise concerns or make complaints

It is often family members or supporters of people with disability who raise concerns or make complaints about the safety and quality of services provided or the treatment of a person with disability. Most service providers giving evidence at Public hearing 32 told us that family members had made about 40–50 per cent of the complaints they had received in the previous 12 months.¹⁷ Hireup and Sunnyfield reported lower figures, with complaints from family members and support networks accounting for 22 per cent and 26 per cent of total complaints respectively.¹⁸ The number of complaints submitted for people with disability by independent advocates varied among providers.¹⁹

Similarly, complaints to the NDIS Commission about NDIS supports and services delivered by the seven providers examined in the Own Motion Inquiry into Aspects of Supported Accommodation were mainly from family members or friends of a person with disability. Others came from advocates, support workers or another provider.²⁰ In the *Own Motion Inquiry into aspects of supported accommodation* Inquiry report (*Own Motion Inquiry* report), the NDIS Commission observed that 'many people living in group homes may more frequently rely on others to raise issues on their behalf'.²¹

Family members or advocates may raise concerns about matters that go unnoticed by support workers or that have become normalised. For example, Mrs Karen Rogers complained to South Australia's Department of Human Services (DHS) about the physical environment of her son's home, as well as issues about his grooming and personal hygiene.²² 'Sophie's' parents, 'Greg' and 'Michelle', raised concerns with Life Without Barriers (LWB) about her personal hygiene at the Lismore house examined in Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)'.²³ 'Robert's' father, 'Paul', expressed concerns about basic repairs and cleaning at the Melbourne house also examined in Public hearing 20, while 'Rebecca's' mother, 'Catherine', repeatedly complained about the level of interpersonal violence and conflict there.²⁴

In the Commissioners' *Report of Public hearing 20*, we found that LWB had failed to adequately respond to requests and complaints made by families of residents at the Melbourne house about the upkeep, cleanliness and maintenance of the house over a three-year period.²⁵

For people with disability who have no or limited family support, independent advocates may be the only way to raise concerns and make complaints. At Public hearing 32 a panel of advocates told us of the challenges in advocating for people with disability, particularly those living in group homes, in raising concerns or making complaints. We also heard from service providers about the steps they take to facilitate residents' access to independent advocates.

For example, Northcott told us it organised an advocate to support a complainant following an alleged sexual assault. The complainant was under a guardianship order and had no other support networks besides staff. However, Northcott said that the limited availability of advocates means they are used infrequently because they are hard to engage.²⁶ Civic and Endeavour told us its service users are also given information and support to access advocates.²⁷

Barriers to raising concerns and making complaints

Counsel Assisting's submissions following Public hearing 32 outlined a range of factors that create barriers to people with disability or their supporters giving feedback to service providers, raising concerns or making complaints. These include:²⁸

- inaccessible policies and processes for making complaints, particularly where policies are framed in legal language designed to protect service providers from liability, rather than to assist complainants or potential complainants who need to use them
- failure to provide information in Easy English or in Easy Read formats
- uncertainty about the types of concerns or complaints that can be raised
- the absence of a range of options and alternatives based on a person-centred and 'no wrong door' approach
- fear of not being believed or concerns not being treated seriously
- delays in responding to feedback or concerns raised previously
- fear of being victimised if a person receiving services or a family member raises a concern or makes a complaint
- not being consulted about or involved in the handling of the concern or complaint
- the absence of a trauma-informed approach and support during the process
- concern about loss of privacy and autonomy, especially if a complainant is unsure whether information will be treated confidentially
- belief that the service provider will not respond or take action, and that nothing will change.

Knowing about complaints processes

We received some evidence about how service providers inform people of their rights to make complaints and provide feedback. But we also heard there can be confusion about where to address complaints and the kinds of matters that can be complained about.

For example, in Public hearing 25, 'The operation of the NDIS for First Nations people with disability in remote and very remote communities', First Nations witnesses spoke of not knowing how or where to make a complaint. They also described facing language barriers and sometimes having to rely on one provider because that is the only service available.²⁹ In Public hearing 20, Catherine said she was often not sure who to raise concerns with at LWB because of the frequent turnover of workers and managers.³⁰

In Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', we focused on the Australian Foundation for Disability (Afford) and its day program in Mount Druitt, New South Wales. In the Commissioners' report following the hearing, we found that while Afford's service agreements for the Mount Druitt day program referred to the possibility of making complaints, Afford did not adequately explain the process to day program participants.³¹

In Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', the evidence showed that Sunnyfield had a *Complaints and feedback guide* available to residents and their families at one of its group homes. 'Eliza', the sister of one resident, 'Melissa', read the guide carefully, but when she made complaints, her experience was very different to what the guide described.³²

Both Eliza and 'Sophia', the mother of 'Carl', told us they felt 'brushed off' or ignored when they raised matters with Sunnyfield about what was happening at the house in Western Sydney, which was the subject of Public hearing 13.³³ This led to a sense of frustration and distrust, as well as fears about the safety of Melissa and Carl.³⁴ Eliza said she felt like 'a nuisance' for raising questions.³⁵ She also said when Sunnyfield managers responded to her, this was done in a defensive way, focusing on attributing blame rather than dealing with the matters she wanted them to address.³⁶

Fear of raising concerns or making complaints

In my opinion, things did not improve in the house in 2019. However, I felt really burned by the eviction process and backed away from making as many complaints.³⁷

In some hearings, witnesses spoke of fear of negative consequences for their family members with disability in supported accommodation if they continued to complain or advocate strongly on their behalf.³⁸ For Eliza, these fears became particularly acute after Sunnyfield informed her it would be terminating its service agreements with Melissa, putting her at risk of becoming homeless.³⁹

Ahead of and during Public hearing 32, we asked service providers how they reduce the risk of adverse treatment of family members who complain. None could identify strategies to

protect family members even though their concerns reportedly constituted up to half of all complaints received.⁴⁰

Disability support workers and other service provider staff may also be reluctant to make reports or complaints, fearing negative consequences for their employment.⁴¹ This can create a culture of under-reporting by staff on serious issues.

In Public hearing 13, we heard few support workers at the house in Western Sydney operated by Sunnyfield made complaints about the conduct of two colleagues, 'SP1' and 'SP2'. An investigator engaged by Sunnyfield, Ms Jennie Piaud, found that the lack of complaints arose from a culture of fear and intimidation.⁴² She said there was a 'disjointed and distrusting' culture at the house, with workers 'segregated based on ethnicity. They also feared reprisals, such as loss of shifts or even loss of their jobs for reporting incidents.'⁴³ Ms Piaud said this type of culture can lead to either non-reporting of incidents, or misrepresented or inaccurate reporting to cover for other staff members.⁴⁴ In the case of Sunnyfield, disability support workers observed serious incidents involving SP1 and SP2 but were intimidated to the extent they felt unable to escalate complaints.⁴⁵

We also heard about the effect of workplace culture on the willingness of workers to raise complaints and concerns in Public hearing 23. Former District Manager Mr Wayne Adamson gave evidence that the culture at Afford discouraged workers from speaking up and sharing ideas.⁴⁶ 'Rachel', a former senior manager at Afford, questioned the safety and quality of Afford's services, calling on whistleblower protection under the *Corporations Act 2001* (Cth).⁴⁷ Afford's Board commissioned an investigation into Rachel's allegations, but she resigned due to stress and resulting illness.⁴⁸ A subsequent report to Afford's Board concluded that workers were generally reluctant to come forward with complaints or concerns. This was partly attributed to a fear of retribution.⁴⁹

In Public hearing 32, witnesses from some service providers described their whistleblower policies to protect complainants from adverse treatment. They highlighted various initiatives to encourage workers and other stakeholders to report concerns.⁵⁰

Effect of power imbalances

Service providers' complaints policies and procedures implicitly require a person with disability or their support network to initiate the complaints process.⁵¹ This may place significant responsibility on the individual or their families or supporters.⁵² For those who do not have family members or access to independent advocates, it can make raising a complaint extremely difficult.

Several witnesses spoke of the power disparity that exists between a person with disability who relies on daily supports, and their service providers. Sam Petersen told us in Public hearing 32, '[t]he responses from management to complaints or negative feedback from myself and others was inconsistent, inadequate, and untimely. Sometimes complaints and feedback were simply ignored'.⁵³

Additionally, during Public hearing 32, the Victorian Disability Worker Commissioner, Mr Daniel Stubbs, said making a complaint against a person who provides daily support and assistance is 'the most difficult thing a person with a disability can ever do'.⁵⁴

People with disability receiving services may have concerns and complaints regarding:

- another person with disability or client of the same provider
- a person's family member or friend
- another client's family member or friend who visits the service
- a support worker or another person employed by the service provider
- an independent support worker from outside the organisation
- an advocate
- a support coordinator
- a guardian or financial administrator
- a third party or visitor
- a neighbour
- a member of the public.

Likewise, any of the above people may wish to raise concerns or complaints and need clearly identified pathways to do so, such as access to complaint and whistleblower information on provider websites.

Some service provider policies classify complaints according to a scale of seriousness that takes account of organisational needs. Endeavour CEO Mr David Swain said all complaints to Endeavour were considered critically important and valuable, 'but we need a way of interpreting or identifying who is best skilled to manage and support the resolution of that complaint'.⁵⁵

Different skills may well be required to resolve different types of complaints. However, classifying complaints in a manner that results in greater management attention and resources being given to complaints involving business risks, as opposed to risks to the safety of people with disability, is problematic. For example, under Endeavour's complaint management procedure, complaints made via a solicitor, complaints made to the media, and complaints about the CEO, board or executive members were rated as 'severe' (the highest level). Accusations of violence, abuse, neglect or exploitation were rated as 'major' (a lower level), and recurring complaints were rated as 'moderate'.⁵⁶

Classifying the seriousness of complaints in this way creates a risk that a matter of serious concern to a person with disability might be deemed relatively unimportant or not requiring a response. It is also not clear on the evidence how complaints policies address the kind of 'slow violence' Sam Petersen described as the 'last straw' in a series of acts of neglect.⁵⁷

We heard examples of service providers failing to respond to potentially significant concerns, especially when matters were raised informally during telephone calls or without going through a designated complaint process.⁵⁸ Paul's evidence in Public hearing 20 emphasised the difficulties

faced when staff or managers leave and people with disability or their families have to raise the same issues again with new personnel.⁵⁹

Service providers should be alert to how their workplace culture contributes to barriers to speaking out. We heard that leaders and senior managers need to develop an organisational culture that encourages feedback and complaints when people have genuine concerns about their safety or wellbeing, or that of family members.

In its written response to questions ahead of Public hearing 32, Cara said it had introduced a new feedback mechanism for clients. It explained:

The Cara Connect Team meets every three months with the customer and their family where complaints or concerns can be raised. Having a specific employee assigned to a customer and family member also allows complaints to be raised outside of these review meetings.⁶⁰

In Chapter 3, we outlined how service providers can foster a positive rights-based culture. Initiatives like that of the Cara Connect Team may also provide structured opportunities for people with disability and their support networks to discuss issues directly with a representative of the service provider.

Establishing clear lines of communication, creating an opportunity for a trusted relationship to develop with someone at arm's length from front-line service delivery, and placing responsibility on providers to check in on clients, appear to be important features of this approach.⁶¹

Attitudes towards complainants

The way service providers respond to feedback, concerns or complaints is affected by attitudes towards the people concerned. In the Commissioners' *Report of Public hearing 13*, we found the labelling of Eliza as 'querulant' (troublesome or a trouble maker) by the former Sunnyfield CEO and other staff to be inappropriate. Labels of this kind negatively influence how service providers perceive and respond to complaints and can compromise the health, safety and wellbeing of service recipients.⁶²

Furthermore, service providers may have policies or procedures for responding to complaints or expressions of concern that they characterise as 'unreasonable'.

For example, Civic's Managing Unreasonable Complainant Conduct Procedure applies to 'all complainants whose conduct is determined as unreasonable under this procedure'.⁶³ It divides unreasonable conduct into five categories: unreasonable persistence, unreasonable demands, unreasonable lack of cooperation, unreasonable arguments and unreasonable behaviour. If a client's behaviour is deemed to fall within these categories, the CEO can 'change or restrict a complainant's access to Civic services'.⁶⁴

Northcott has similar provisions within its Feedback and Complaints Policy and Procedure, under which 'unreasonable complainant conduct' is divided into the same five categories. If the behaviour of the person making the complaint is recorded as unreasonable, Northcott can reject the complaint.⁶⁵

Both policies adopt language and classifications used by the NSW Ombudsman in its *Managing unreasonable conduct by a complainant* manual, published in 2021. The manual aimed to 'help organisations and their staff take a systemic and consistent approach to managing their interactions with people engaging in unreasonable conduct'.⁶⁶ The manual appears not to have been designed to address the circumstances of people with disability receiving services from providers.

The evidence in Public hearing 13 demonstrated the risk that service providers will classify persistent self-advocacy by a person with disability, or determined lobbying by a family member or supporter, as unreasonable.⁶⁷ This process is necessarily subjective, and the decision may be made by managers or workers who are subjected to criticism or not fully informed of the circumstances.

Service providers should view any issue raised about service quality or safety as an opportunity to engage with people with disability and to better understand how that issue can be addressed. While we acknowledge this may require significant resources and that service providers have obligations as employers for the wellbeing of their staff, the starting point when receiving any feedback, concern or complaint should be one of constructive and active engagement.

Promising practice – feedback, concerns and complaint management

Service providers:

- have a dedicated team or individual, separate from those delivering services, to engage with service users and their support networks about the quality of services or supports and ensure feedback and complaints are dealt with appropriately
- prioritise complaints involving or alleging risk to a service user when assessing and classifying the seriousness of complaints
- have established lines of communication that encourage everyone to speak up when something does not seem right
- keep records of all complaints and how they are concluded or resolved.

Leaders and senior managers develop organisational cultures that:

- encourage and welcome feedback, concerns and complaints
- reinforce the value of regular feedback from service users and their support networks.

4.2. Managing incidents

Regulatory framework

The provider incident management systems we have examined reflect the requirements imposed on registered providers under the *Practice Standards* and the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) (*Incident Management Rules*). These require all registered NDIS providers to implement and maintain a system to record and manage incidents that happen while providing supports or services to people with disability.⁶⁸

A broad range of incidents must be covered by a provider's incident management system, including acts, omissions, events or circumstances that:⁶⁹

- occur while providing supports or services to a person with disability
- have or could have caused harm to the person with disability.

Incidents also include acts by a person with disability that either:⁷⁰

- occur while receiving supports
- have caused serious harm or a risk of serious harm to another person.

The *Incident Management Rules* also require incident management systems to include procedures for identifying, assessing, recording, managing, resolving and reporting incidents.⁷¹ All incidents must be assessed to understand whether they could have been prevented and how well they were managed and resolved. The assessment must consider the views of people with disability affected by incidents.⁷²

Service providers must also notify the NDIS Commission of the following 'reportable incidents' within 24 hours:⁷³

- the death of an NDIS participant
- serious injury of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with or assault of an NDIS participant
- sexual misconduct towards or in the presence of an NDIS participant, including grooming of the NDIS participant for sexual activity.⁷⁴

The unauthorised use of a restrictive practice involving an NDIS participant is also a reportable incident, and the NDIS Commission must be notified within five business days.⁷⁵

The NDIS Commission provides guidance to registered NDIS providers about responding to and preventing reportable incidents. If a reportable incident raises a serious compliance

issue, the NDIS Commission has special powers. These include requiring the provider to undertake remedial action, carry out an internal investigation, or engage an independent expert to investigate and report on the incident.⁷⁶ The NDIS Commission's oversight of reportable incidents and restrictive practices is discussed further in Chapter 8, 'Reportable incidents'.

Factors affecting the reporting and management of incidents

Service providers' incident management systems rely on the knowledge, capacity, willingness and honesty of frontline workers to accurately and consistently report incidents. However, we have heard that registered service providers and their workers do not always follow their own incident management policies and procedures or comply with their NDIS reporting obligations.

In the Commissioners' *Report of Public hearing 20*, we found that LWB managers failed to immediately report alleged sexual misconduct by 'Worker 3' against 'Natalie' and to promptly remove the staff member from working at the residence or with other clients in the community.⁷⁷ Nor did LWB keep proper records including bowel charts for Natalie, or seek medical care for her bowel obstruction in a timely manner prior to her hospitalisation.⁷⁸

LWB also failed to record the sexual assault of Sophie in its incident management system and did not conduct an internal investigation. Its staff did not respond appropriately to her changing needs over the following 18 months.⁷⁹

Evidence in Public hearing 23 about incidents at Afford's Mount Druitt day program suggested workers did not always understand or follow policies and procedures on incident management. In some cases, forms and reports were not completed or were only partially completed.⁸⁰ Former Team Leader 'Dianne' told us that while workers had access to policies and procedures for reporting incidents, she did not think everyone had a detailed knowledge of the contents.⁸¹

Former Senior Lifestyle Assistant 'Erynn' said the incident management system used by Afford was often unavailable due to internet connection difficulties.⁸² As discussed in Chapter 3, this meant workers had to complete administrative tasks at home, in their own time.⁸³

In our report on Public hearing 14, we found deficiencies in DHS's responses to injuries sustained by Mrs Rogers' son, Mr Daniel Rogers. The information recorded in the department's Riskman system used for incident reporting was inaccurate, contributing to delays in appreciating the seriousness of his injuries.⁸⁴

It is clear incidents can only be properly reported when support workers and their managers have access to reliable incident reporting systems. They must also be trained to use them and provided with the time to undertake training. Workers need to be able to identify when to report an incident and have the skills required to generate the report. Issues relating to training and allocating administrative time to disability support workers were discussed in Chapter 3.

In Public hearing 32, disability support worker Ms Zelda Riddell emphasised the importance of all service provider staff being enabled and encouraged to report incidents. She said, 'a no-

wrong-door policy means it's everyone's business when there are failures in care, and everyone is accountable'.⁸⁵ However, she explained the way incidents are handled varies widely:

the greatest facilitator of a confident reporting culture at work is that people are experienced at writing reports, that they have been trained to write quality reports, that they have seen the consequences of reporting stuff and believe it to be effective in providing better care and better support.⁸⁶

As with complaints, service providers must understand the barriers and power disparities that exist in order to create a culture that encourages the reporting of incidents and concerns. If workers have experienced situations where they are criticised or penalised for reporting, or their reporting results in no remedial action, the risk of under-reporting violence, abuse or neglect grows.⁸⁷

Some service providers actively promote compliance with incident reporting systems and policies.⁸⁸ For example, Endeavour told us it had introduced quality and practice health checks to more proactively identify issues at sites where supports are delivered. This was 'instrumental in uncovering a significant issue, which led to criminal charges against an employee'.⁸⁹ Northcott has also introduced a site review process, using incident data to identify locations in need of additional attention to address gaps or deficiencies.⁹⁰

We consider measures such as these to be critical in settings like group homes, where people may be at heightened risk of violence, abuse, neglect and exploitation. For larger service providers, oversight teams should be kept at arm's length from daily operations and possess significant experience in best practice and rights-based service delivery. Management should empower oversight teams to undertake their work independently and objectively.

As submitted by Counsel Assisting following Public hearing 32, and accepted by the peak body for non-government service providers, National Disability Services (NDS), incident management systems are also a key safeguarding mechanism. They can provide boards, senior management and workers with important information about circumstances where people with disability may be exposed to violence, abuse, neglect and exploitation. As discussed in Chapter 3, when the data from these systems is analysed and shared, it illustrates what is going on within an organisation and what changes are needed to improve quality and increase safety.⁹¹

4.3. Responding to concerns, complaints and incidents

How a disability service provider responds to a complaint, concern or incident depends on several factors, including the potential seriousness of the matter and risk of further harm. It also depends on who is involved and whether further information is needed. These factors should be clearly documented in policy and procedure.

A service provider's response to violence, abuse, neglect and exploitation affects not only the person concerned but everyone to whom it provides services. This was emphasised at Public hearing 23 by 'Lilly', mother of 'Simon'.⁹² Simon attended the day program run by Afford at Mount Druitt and received supports from Mr Daniel Nuumaalii. Afford did not inform Lilly when

Mr Nuumaalii was charged with criminal offences, Lilly said:

When Daniel's abuse came to light, which I believe was in mid-2020, I did not receive any communication from Afford about it. I only found out about it by speaking to the parents of other Afford clients. I was shocked when I heard the news. I was also disappointed that Afford had not communicated with me about what had happened and about what they were doing, if anything, to prevent it from happening again.

Even after Daniel's conviction and sentencing, I received no acknowledgement from Afford about what had happened nor any apology ... I do not believe anyone will ever know which clients he might have abused and not recorded.⁹³

Afford accepted that it should have supported and communicated with all families involved in the Mount Druitt day program, even those not directly affected by Mr Nuumaalii's abuse.⁹⁴

At Public hearing 32, service providers were asked whether they share information with their service users about service quality and safety issues, including the number and nature of past complaints. Ms Forsyth from Northcott and Ms Doyle representing Civic confirmed neither of their organisations share this information.⁹⁵

Ms Forsyth said Northcott's decision not to share information more broadly about complaints and incidents was not 'an issue of reputation'.⁹⁶ She said:

one of the things we are mindful of in considering how we should appropriately share that type of information is that at times, numbers of complaints or incidents reporting can sometimes serve as a disincentive around a culture of open reporting.⁹⁷

Inadequate responses

We heard of situations in which service providers' responses to incidents, concerns or complaints have been inadequate. In some cases, staff responsible for incident reporting or complaint handling, such as support workers, team leaders or area managers, have not followed policies and procedures. In other instances, the policies and procedures fell short, or oversight by senior managers was lacking.

For example, in the Commissioners' *Report of Public hearing 14*, we found DHS failed to seek an urgent medical opinion about the nature and likely cause of significant bruising sustained by Mr Rogers in February 2019.⁹⁸ In the report on Public hearing 20, we found LWB staff provided inadequate support to Sophie following her sexual assault.⁹⁹

In Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', we heard about Anglicare's Harm Prevention and Response Procedure at the time of the sexual assault on 'Niky'. The guidelines provided that if a suspected crime had been committed but not yet reported to the Queensland Police Service, the service manager or line supervisor should report the matter to police.¹⁰⁰ However, when Niky's father informed Anglicare of the assault, he was advised he should report it to the police.¹⁰¹

The relevant service manager for Anglicare at the time acknowledged the organisation did not follow its Harm Prevention and Response Procedure in a number of respects regarding the sexual assault.¹⁰² In the Commissioners' report on the case study, we found that Anglicare had placed the burden of reporting the assault on Niky and her parents, demonstrating a lack of regard for trauma-informed practice.¹⁰³ We also found that Anglicare had failed to follow procedures by not supporting Niky to attend the nearest sexual assault service for counselling, medical examination and forensic sampling.¹⁰⁴

Regardless of how a concern, complaint or incident comes to a service provider's notice, if a matter raises potential criminal conduct, the provider should report it to police. For example, in New South Wales, it is an offence to not report a 'serious indictable offence' unless there is a 'reasonable excuse'.¹⁰⁵

Several service providers told us they have policies about when workers must contact the police about a complaint or incident. For example, Northcott's Investigation Guide stipulates:

Where a customer is the victim of a criminal offence by a person who is not a Northcott employee, they (or their legal decision maker) may choose to make a police report themselves, with or without Northcott staff support. They may wish for staff to make a report on their behalf. The customer may also elect not to involve police at all. The customer's choice must be respected in this case.

If an employee of Northcott is suspected of having committed a crime against a Northcott customer and/or while carrying out their duties as an employee a POLICE REPORT MUST BE MADE. However, the customer (or their legal decision maker) may choose not to participate in a police investigation.¹⁰⁶

Deciding when to investigate

Complaints and incident management procedures may result in an investigation by a service provider.

The NDIS *Practice Standards*, *Quality Indicators* and *Incident Management Rules* provide limited guidance on when an investigation should take place.¹⁰⁷ For example, section 10(1)(f) of the *Incident Management Rules* simply states the incident management system of a registered NDIS provider must establish procedures to apply:

[w]hen an investigation by the NDIS provider is required to establish the causes of a particular incident, its effect and any operational issues that may have contributed to the incident occurring, and the nature of that investigation.¹⁰⁸

Service provider safeguarding teams, in consultation with senior leadership teams, often determine which complaints or incidents require formal investigation. Some service providers have a policy or procedure to guide when and/or how an investigation should be conducted.¹⁰⁹

For example, Cara's Investigations Procedure states, 'formal investigations are based on the level of harm caused and the severity of the incident or complaint'. Examples of incidents include:¹¹⁰

- the unexpected death of a customer from unnatural causes
- serious injury leading to a hospital admission, including fractures, burns, extensive bruising
- repeated abuse of any kind
- unlawful physical or sexual contact or indecent assault
- multiple incidents of grossly inadequate care
- unauthorised restrictive practices without prescription, consent or a Positive Behaviour Support Plan.

In practice, it appears service providers' decisions about whether to conduct investigations are sometimes arbitrary. It is not clear whether providers regularly consult people with disability or their family members about decisions to investigate, or if they provide reasons for any decision not to proceed with an investigation.

In the Commissioners' *Report of Public hearing 20*, we found that LWB should have conducted internal investigations into the sexual assault of Sophie, and into Natalie's bowel obstruction. It was only through our examination of Sophie's case that LWB's failure to conduct an internal investigation and provide relevant information became known to Sophie and her family.¹¹¹

If the police are investigating potential criminal matters, service providers must ensure that any internal investigation does not jeopardise the criminal investigation and any prosecution. Some providers give guidance to their staff about liaising with police and seeking their approval before commencing an investigation.¹¹² Preferably, providers should be guided by the police before commencing their own investigations. However, they must still conduct their own inquiry to fully understand what happened, why it happened, consider redress options, and mitigate future risks.

In Public hearing 23, we heard how senior staff at Afford relied on the ongoing police investigation into the abuse committed by Mr Nuumaalii as a reason not to conduct internal inquiries. We concluded that Afford failed to follow its own abuse and neglect procedure¹¹³ and did not conduct an investigation wrongly believing that it could not investigate because of the police investigation.¹¹⁴ This meant Afford could not gain an understanding of the extent of the abuse, how it could have occurred and what measures it needed to take to prevent the risk of similar abuse in the future.

Decisions about who investigates

Service provider decisions about who conducts investigations were examined at several of our public hearings. Investigations can place too much emphasis on the wrongdoing of an individual (the 'bad apple' effect) and ignore organisational or systemic factors that contributed to an incident, such as ineffective supervision or training.¹¹⁵ This approach may also ignore the effect of the incident on the person with disability.¹¹⁶

Some providers have dedicated safeguarding or investigation teams. Others rely on their human resources team or a senior manager to oversee internal investigations. For example, Endeavour said its Customer Safeguarding Team is responsible for leading investigations and works with local managers to examine complaints and incidents.¹¹⁷

Northcott does not have a dedicated investigations team and said incidents are investigated 'by operational staff selected by the business rules built into the Noggin system'.¹¹⁸ Noggin is Northcott's electronic incident and risk management system.¹¹⁹ Where an incident is rated as 'critical' and involves abuse and neglect, the lead investigator role is assigned to a senior operations manager. Northcott also has a full-time manager of investigations who oversees and advises on critical investigations.¹²⁰ Operational staff who conduct investigations are required to have training in the use of the Noggin system, but relevant Northcott training modules do not include training about obtaining information or documents from relevant sources, interviewing complainants or witnesses, or critically analysing information.¹²¹

In Public hearing 13, we heard about the weaknesses of Sunnyfield's Response Team, which was responsible for investigating, monitoring, reporting and responding to allegations of abuse, assault and neglect.¹²² Sunnyfield has subsequently conducted a review of the team's membership, roles and responsibilities, and since April 2021, investigations are only conducted by trained investigators.¹²³ Sunnyfield now requires investigators to complete training in trauma-informed care and behavioural support.¹²⁴

Yooralla also has an investigations team, comprised of an investigator and an investigations manager. The individuals holding these positions at the time of Public hearing 32 had legal backgrounds.¹²⁵

In some cases, service providers engage external investigators to investigate particular matters.¹²⁶ In response to questions ahead of Public hearing 32 about the circumstances in which external investigators are engaged, service providers said they will consider using external investigators when:

- cases involve an actual or perceived conflict of interest¹²⁷
- cases are of particular complexity¹²⁸
- the complaint is serious or the complainant's demands will continue to have an impact on the time and resources of staff¹²⁹
- a systemic or whole-of-service issue is identified¹³⁰
- cases involve significant fraud¹³¹
- cases are highly sensitive or confidential¹³²
- the resources and expertise are not held internally¹³³
- cases relate to a senior manager¹³⁴

-
- cases are of a potentially serious criminal nature and could lead to a conviction or incarceration (such as a sexual assault or serious physical assault of a disability service user by a worker)¹³⁵
 - the matter is subject to a protected disclosure¹³⁶
 - the matter is part of a merits review process (which involves a person other than the original decision-maker reviewing a decision afresh) or when findings of an investigation are disputed¹³⁷
 - industrial matters are involved.¹³⁸

Information we received suggests external investigators are used infrequently. Northcott, Yooralla and Sunnyfield engaged external investigators on seven, five and two occasions, respectively, over the three years preceding Public hearing 32.¹³⁹ Hireup did not engage any external investigators during this period.¹⁴⁰

Service providers also told us the external investigators they used had various qualifications and experience, including in workplace relations, law and police investigations. None appeared to have specific training or experience in disability, human rights or safeguarding.

Quality of investigations

We found service provider investigations into incidents of potential violence, abuse and neglect were sometimes sub-standard in the manner they were carried out and their scope, analysis, findings, outcomes and recommendations.¹⁴¹ Consequently, they did not sufficiently enlighten providers about the circumstances surrounding particular incidents, or respond to the needs of people with disability affected by the incidents, or members of their support networks. Nor did they offer an adequate analysis of the underlying issues, or provide suggestions for corrective and preventative action.

For example, in the Commissioners' *Report of Public hearing 14*, we found:

DHS's failure to undertake thorough and competently conducted inquiries into the identity of the author of the 3 March letter and the seriousness of the threat to 'Mitchell's' safety and wellbeing caused 'Victoria' and 'James' significant distress and led to them losing trust and confidence in DHS.¹⁴²

In the Commissioners' *Report of Public hearing 23*, we found that the investigation conducted by an external investigator engaged by Afford into the abuse by support worker Mr Nuumaalii was grossly inadequate. Among other things, it failed to identify the causes of, and/or contributing factors to, the abuse.¹⁴³ Similarly, in the Commissioners' report on the Niky case study, we found deficiencies in Anglicare's investigation, and that it made no assessment of how its organisational practices and procedures could have prevented the risk of the assault occurring.¹⁴⁴

While ways of handling investigations may vary according to the circumstances, they should generally seek to go beyond simply establishing whether disciplinary action against a worker

is warranted. Investigations should contribute to the provider's understanding of what has happened and why it happened so that strategies can be put in place to prevent similar issues happening again. They should also centre on the people with disability concerned to determine what supports they need and whether additional supports or remedies are required.

Communication with and support for people with disability

After Jason was abused, I lost what trust I still had in Afford. I was not satisfied that they were doing anything substantial to help Jason recover from his abuse, or to prevent something similarly horrible from happening again.¹⁴⁵

Communication

Poor communication between service providers and people with disability or their families or supporters following complaints or incidents has been a common theme across our service provider hearings.

For example, in Public hearing 23, 'Sally', mother of 'Jason', said she emailed Afford's CEO in 2018 expressing concern about the level of support being provided to her son and requesting more communication.¹⁴⁶ In her email, she wrote:

Additionally, more communication is key. His communication book can go days and weeks without any communication. Having a son that has severe autism, non-verbal communication and an intellectual disability ... it is difficult to know what is happening on a day-to-day basis.¹⁴⁷

Sally said she does not believe she ever received a response to her complaint.¹⁴⁸ Both she and Lilly spoke of the difficulties they had obtaining incident reports from Afford about incidents involving their sons.¹⁴⁹ We found that Afford did not have adequate systems in place 'for families to receive regular information or reports about participants' activities, to be notified of any issues or concerns or to make suggestions or provide feedback for service improvements at the day program'.¹⁵⁰

We also found that after the abuse by Mr Nuumaalii was uncovered, and while it was being investigated, Afford's communication with participants in the Mount Druitt day program was deficient.¹⁵¹

Eliza and Sophia's difficulties in communicating their concerns to Sunnyfield about the running of the house in Western Sydney have been discussed earlier. In the Commissioners' *Report of Public hearing 13*, we found Sunnyfield's responses to their feedback and complaints was 'defensive and hostile'.¹⁵²

In Public hearing 20, Paul described how he and the families of the other residents of the Melbourne house experienced years of feeling frustrated about LWB's apparent inability or unwillingness to respond to the concerns they raised.¹⁵³ He eventually sent a proposed procedure document for communication and consultation with families to LWB.¹⁵⁴

In the Commissioners' *Report of Public hearing 14*, we found that:

The breakdown of communication between DHS and Victoria and James over a lengthy period demonstrates the importance of open and effective communication in maintaining trust and confidence between the service provider and the family or supporters of the person with disability in the care of a service provider.¹⁵⁵

In matters involving suspicion or allegations of violence, abuse, neglect or exploitation, poor communication can compound feelings of distrust and anxiety. Communication needs to go beyond providing information about what service providers are doing in response to complaints or incidents.

Actively involving people with disability in the complaint process

Several hearings identified the need for providers to actively involve people with disability, and their families or supporters, in the process of investigating or finding solutions to issues or concerns raised. Without active engagement, important information may be lost, the effects of the underlying issue or event may be exacerbated, and trust between providers and service recipients may be damaged. In the Commissioners' *Report of Public hearing 6*, 'Psychotropic medication, behaviour support and behaviours of concern', we also observed that:

when there is an incident involving a person's behaviour escalating, incident reports are generally written by the service provider staff. Incident reports and other important documents and information may not always be shared with the person themselves, or their families. Consequently, the person with disability may not get the opportunity to tell their side of the story and written reports go unchallenged.¹⁵⁶

This demonstrates the need for those investigating incidents or complaints to be trained and skilled in engaging with people with disability and their supporters, including those who do not communicate verbally.

Of the service provider policies relating to complaints or incidents made available to us, most note the importance of processes being 'accessible' and the need for people with disability to be updated, informed or involved.

For example, Endeavour's Feedback (Compliments and Complaints) Policy refers to a 'person-centred approach' under which any person with disability involved or affected should be included throughout the process 'to the extent possible'.¹⁵⁷ The accompanying procedure says a person-centred approach includes 'ensuring that people are listened to and are kept informed throughout the process including actions taken as a result of feedback'.¹⁵⁸ Civic's Feedback, Disputes and Complaints Policy commits to providing '[i]nformation in ways that enable our

clients and other stakeholders to know how to make a complaint', and 'is flexible enough to respond to individual needs'.¹⁵⁹

We accept Counsel Assisting's submission following Public hearing 32 that few providers involved in the hearing explained in practical terms how frontline workers can support people with disability to express a complaint, provide feedback or participate in an internal process. There was a general lack of guidance about the steps service providers should take when engaging with an individual to both invite and respond to feedback or complaints.¹⁶⁰

There may be limits to an individual's capacity or willingness to be involved in an ongoing process, particularly where an investigation is required. However, providers need to be mindful not to inadvertently exclude or limit the involvement of people with disability because the process is inaccessible. Consideration should also be given to whether the affected person should be referred to an advocate.

Northcott's Investigations Guide provides some guidance to its staff on matters to consider when engaging with people with disability as part of a formal investigation, including:¹⁶¹

- what communication needs does the customer have and how will you accommodate them for the interview?
- does the customer wish to have a witness, support person or advocate available for the interview?
- if the customer is unable to participate in an interview or chooses not to, is there someone they may elect to attend on their behalf such as a family member or guardian?
- if the customer is unable to be consulted, what are other ways you can consider the customer's views and preferences?

It also instructs staff to ask 'customers' about:¹⁶²

- their preferences regarding the incident (What they would like to see happen now?)
- their preferences regarding the investigation (How and when they would like to be kept informed and involved? Would they like to view and confirm meeting minutes?).

During any investigation of, or response to, an incident or complaint, service providers need to take steps to safeguard the health, safety and wellbeing of people with disability.

In Public hearing 17, Niky's mother told us that Anglicare did not offer support to Niky or the family after the sexual assault. She said:

The only thing that happened was that two long-term workers who'd known her since she first went there, let us know that they were absolutely mortified, but that's about all. We couldn't really have a conversation about it, that was at the centre, so that was all that was said. There was nothing from anyone who was in charge of the centre, or nothing from the overriding organisation until an audit happened last year and that's when I voiced, or we voiced our concerns.¹⁶³

All of the service providers who presented evidence for Public hearing 32 said they arrange supports to ensure the health, safety and wellbeing of people with disability following an incident and during the investigative process. For example, Civic said it determines what actions are required to protect a client including their physical, emotional and medical needs. It assists them to access counselling, medical, legal or other services. It also supports clients to inform family members or support networks of the incident as soon as possible.¹⁶⁴

While support may be required immediately following an incident or as investigations begin, there may also be a need for ongoing or changing support depending on the seriousness of the incident. For example, a person with disability who is physically or sexually abused by a worker at a group home may require continuing support. Factors that influence this include the location of the violence in the person's home, the breach of trust, the ongoing reliance on support workers for personal care and the conduct of criminal and internal investigations.

At Public hearing 23, Sally described how after the abuse by Mr Nuumaalii came to light, she made a list of improvements she wanted Afford to make to ensure Jason's safety at the Mount Druitt day program. She called Afford, and requested meetings with the Team Leader and District Manager to discuss her proposed improvements and also attended the centre to book appointments with them. While a meeting did eventually take place between Sally and the District Manager, Mr Adamson, Sally was not satisfied with its outcome.¹⁶⁵ In its submissions following the hearing, Afford acknowledged that it should have put initial and ongoing supports in place for those affected by Mr Nuumaalii's abuse, and that families and clients were not supported as they should have been.¹⁶⁶

Northcott's Adult Abuse and Neglect Policy provides some guidance on how to support service users after incidents, noting that abuse and neglect 'can have lasting impacts on a person and additional supports may be beneficial both immediately and long term'.¹⁶⁷

The policy instructs staff to regularly review the person's wellbeing and health in the months following an incident to check for any trauma impact. It suggests considering opportunities for person-centred healing strategies, including wellbeing programs, exercise, mindfulness activities and social opportunities.¹⁶⁸ The policy also encourages staff to help service users, with their consent, expand their network of formal and informal supports to better address their needs after an incident. This may include family and friends, clinicians, advocates, sexual assault services, therapy or mental health counselling, and domestic violence, legal or financial services.¹⁶⁹

Cultural safety and trauma-informed practice

In written submissions following Public hearing 17, Counsel Assisting explained the importance of adopting culturally safe and trauma-informed approaches:¹⁷⁰

Culturally safe or culturally responsive practice means different things in different contexts. The concept of *kawa whakaruruhau*, or 'cultural safety' originally arose out of Māori nurse educators in Aotearoa (New Zealand).¹⁷¹

Cultural safety refers to an environment that is spiritually, socially and emotionally safe; where there is no challenge or denial of identity, who a person is, or what they need.

It is about shared respect, shared meaning, shared knowledge, learning together with dignity, and truly listening.¹⁷²

Culturally safe practices include actions which recognise and respect the cultural identities of others, and safely meet their needs, expectations and rights. Culturally *unsafe* practices are those that diminish, demean or disempower the cultural identity and wellbeing of an individual.¹⁷³

Cultural safety focuses on professional empathy, reflective practice, an understanding of identity and culture and addressing the impact of systemic discrimination on health and wellbeing.¹⁷⁴

Strategies that enhance cultural safety include:¹⁷⁵

- using inclusive language
- maintaining confidentiality
- acknowledging the differences in others, such as disability, age/generation, sexual orientation, gender diversity, occupation/socioeconomic status, cultural and linguistic diversity, and religious and spiritual beliefs
- clear, non-judgemental, open and respectful communication
- developing trust
- recognising and avoiding stereotypes
- being prepared to engage with others in a two-way dialogue where knowledge is shared.

We also explored the effects of trauma in Public hearing 29, 'The experience of violence against, abuse, neglect and exploitation of people with disability from culturally and linguistically diverse communities'. Ms Kylie Scoullar, General Manager of Foundation House, explained the importance of service systems that adopt a trauma-informed approach to engage with and provide support to people. She told us this requires:

systems and services understanding the nature, severity and psychosocial consequences generated by the trauma history of asylum seekers and refugees and using this knowledge to determine how they can best support the individuals, families and communities who are impacted.¹⁷⁶

Because of discriminatory practices they or others in their community have encountered, First Nations people may be reluctant to engage with complaint or investigative processes. Service providers should be open to exploring alternatives that are safe for First Nations service users. First Nations people with disability experience cultural safety when their identity as First Nations people is understood, respected and celebrated along with their experiences and needs as a person with disability. We discuss this further in Volume 9, *First Nations People with disability*.

At Public hearing 32, the CEO of Scope, Ms Kate MacRae, said it recognises 'all of [its] clients

will be exposed to trauma at some point in their life'. Rather than it being an exception, trauma-informed support has to be the 'backbone' of the model of support.¹⁷⁷ The CEO of Melba, Ms Hayley Dean, said Melba does not have a policy setting out its trauma-informed approach, but incorporates trauma-informed practice in procedures, guidelines and competency-based training.¹⁷⁸ Ms Jennifer Cullen of Synapse explained that for First Nations people, trauma-informed support 'is not an optional extra. It is part of it'.¹⁷⁹

Identifying root causes and preventing incidents

Our hearings emphasised the need for disability service providers to establish processes and strategies to identify the root causes of incidents and reasons for failing to provide safe, high-quality services. They also underlined the need to put in place preventive measures.

For example, in the Commissioners' *Report of Public hearing 23*, we found that Afford had no processes or personnel to effectively monitor incident trends and implement strategies to reduce incidents.¹⁸⁰ Afford's Human Resources Department was the only team conducting investigations of incidents during the period examined. Its focus was on potential disciplinary action against any workers involved, rather than identifying and reducing risks to clients and workers.¹⁸¹ As a result, we heard Afford's Board was unable to analyse care and support data and to devise policies and procedures to mitigate risks.¹⁸² Afford has since made a number of changes to address these shortcomings, including the establishment of a Consumer Experience and Safeguarding team.¹⁸³

Among the other providers involved in Public hearing 32, most said they had managers or teams dedicated to overseeing the records or reports generated by workers about complaints or incidents.¹⁸⁴ These managers or teams are responsible for checking that records are accurately completed, for example, ensuring workers include key information and use impartial language.¹⁸⁵ Senior managers or safeguarding teams may also be responsible for determining if an incident is reportable and notifying the NDIS Commission. Some service providers have developed their complaint and incident management systems to automatically identify and alert the relevant team or manager when a reportable incident is recorded.¹⁸⁶

Endeavour said it had repositioned its Customer Safeguarding team within a newly formed legal and governance division, allowing for stronger oversight and accountability. It said this ensures separation between the investigators and the services being investigated.¹⁸⁷ The team had increased its oversight of incidents with lower severity ratings to bolster the monitoring of matters managed at the local level.¹⁸⁸ Endeavour said it was planning to improve its analytical capacity to enable incident data to be used for prevention and proactive interventions.¹⁸⁹

Several providers also described their processes for analysing incident and complaint data to identify concerning trends and patterns warranting further investigation or preventive measures.

For example, Northcott told us it now reports 'individual incidents of significance', 'critical investigations' and incident data more thoroughly through both its Quality and Risk Committee and Board Risk Committee.¹⁹⁰

In explaining how Cara responds to incident data, Ms Furey said:

The form in which it is done is to meet monthly as a management team and to review all incidents that have arisen during that period, to identify the trends and where they are [of] particular severity is – to identify the cause. But there is much discussion, there is much consultation, to really understand the nature of incidents that are occurring in our organisation and to take responsive action.¹⁹¹

According to Civic, its leaders and managers participate in monthly reporting and also conduct quarterly analyses of feedback, complaints and incidents.¹⁹² This enables managers to review trends and identify where improvements in service quality and safety can be made.¹⁹³

Northcott told us that in 2021, it implemented a site review process targeting particular locations where it delivers services. Such reviews are conducted following the identification of patterns of incidents, and action plans are then developed to address any gaps or deficiencies.¹⁹⁴

The process involves the Investigations Manager attending the site to review a range of records and speak with service users and workers. A site review examines:¹⁹⁵

- gaps in service delivery
- patterns of incidents that individually may not trigger in-depth investigations
- gaps in team training or understanding that may contribute to incident frequency, duration, intensity or impact
- site management
- team culture
- incident investigations where standard processes gathered insufficient evidence to reach a positive resolution or reduce risk.

Northcott also told us it had expanded its site monitoring process to include a post incident review (PIR) to identify root causes of incidents requiring serious investigation. It said a 'PIR is a method for examining and analysing incidents to identify and rectify serious systemic issues to prevent such incidents from re-occurring'.¹⁹⁶ The PIR focuses on Northcott's systems, rather than people, and the review process considers 'the conditions under which individuals work' and 'the complexity and interdependencies of systems'.¹⁹⁷

In the second half of 2022, Northcott introduced a Clinical Practice Review component into the PIR to examine the quality of 'high-intensity' supports provided at group homes. High-intensity supports include things like complex bowel care, feeding tubes and severe dysphagia management, tracheostomy care, urinary catheters and ventilation. Sites are identified as needing this additional support using several indicators such as worker turnover, use of agency staff, reportable incidents, safeguarding investigations, and work, health and safety audits.¹⁹⁸

In Public hearing 32, the NDIS Commissioner, Ms Tracy Mackey, also told us about efforts by the NDIS Commission to encourage practice reviews by service providers. It has published a range of guidance materials for providers on this. Providers can use these to check whether

desired outcomes are being achieved and, if not, what can be done to improve the supports provided. Staff and senior management might reflect on a particular practice area, a cluster of services, or a particular team of support workers to identify grey areas. The resources are published on the NDIS Commission's website and include fact sheets on topics such as 'how to do a practice review' and 'who should lead a practice review'.¹⁹⁹

Strengthening responses to incidents and complaints

Following Public hearing 32, Counsel Assisting submitted that best practice includes service providers taking an integrated and holistic approach to supporting the health, safety and wellbeing of their service users following an incident and in the long term. This requires an assessment of individual needs and preferences, the nature and impact of the incident, and the effect of any investigation or court process.²⁰⁰

Counsel Assisting also submitted that providers should use investigations as a tool for understanding how and why an incident has occurred, and identifying ways to mitigate future risks. Investigations provide an opportunity for people who have been harmed to be heard and to acknowledge their experiences. Through investigations, providers should identify what action they need to take to ensure accountability and to offer remedies to people affected.²⁰¹

These submissions were not contested by any of the 22 service providers and digital platforms participating in Public hearing 32.

The peak body for non-government disability service providers, NDS, agreed with Counsel Assisting's identification of the elements of best practice for responding to complaints or incidents of violence, abuse, neglect or exploitation.²⁰²

Counsel Assisting also submitted that best practice may involve service providers:²⁰³

- ensuring their processes recognise that people respond to and deal with experiences of trauma in their lives in different ways
- speaking openly with First Nations service users and their families about how they would like to provide feedback and exploring ways to ensure they feel empowered and safe to speak up; for example, conducting meetings at a First Nations Community Controlled Organisation
- speaking openly with service users and their families from First Nations and culturally and linguistically diverse backgrounds to identify any cultural or religious preferences, sensitivities, beliefs and practices that need to be considered
- training their workers to recognise and respond to the different needs of people they work with during complaint or incident processes and investigations.

We accept these submissions and encourage service providers, individually and collectively through NDS, to align their policies and practices with these elements of best practice. In addition, providers should implement measures to promote transparency and ensure accountability to

service users and other stakeholders, such as publishing annual data about complaints, incidents and investigations. Service providers should publicly acknowledge incidents such as the death, abuse or serious injury of a person with disability and inform people of the status of investigations (taking into account confidentiality issues and the impact on criminal investigations). Providers might also consider including a 'lessons learned' section in their annual reports in which they reflect on identified shortfalls and outline plans for improvement.

Promising practice – responding to incidents and complaints

Service providers:

- recognise that people respond to and deal with experiences of trauma in their lives in different ways
- consult with people with disability, their families and advocates about how an investigation of a complaint or incident should occur and what support they would like to participate in the process
- speak openly with First Nations service users and their families about how they would like to provide feedback, and explore options to ensure they feel empowered and safe to speak up
- speak openly with service users from First Nations and culturally and linguistically diverse backgrounds and their families to identify any cultural or religious preferences, sensitivities, beliefs or practices that need to be considered
- train workers to recognise and respond to the different needs of people they work with during complaint or incident processes and investigations
- refer people with disability to disability advocacy or legal services as appropriate
- review the adequacy of analysis and recommendations before accepting investigation reports
- analyse incident and complaints data regularly to identify patterns and trends
- conduct reviews or analyses to identify the root causes of incidents, the reasons for failures to provide safe, high-quality services, and the strategies needed to mitigate or prevent similar incidents happening again.

Leaders and senior managers:

- adjust processes to facilitate participation in investigations
- encourage and welcome feedback, concerns and complaints
- reinforce the value of regular feedback from service users and their support networks across the organisation
- inform people with disability and their families or advocates why an investigation will not be conducted and allow them the opportunity to respond or object to the decision, including by providing an internal review process.

Redress

The issue of redress has been examined in several of our public hearings examining cases where there have been clear findings that violence, abuse, neglect or exploitation has occurred. For example, evidence presented at Public hearing 3 demonstrated the disparities in support, compensation or other forms of redress provided by Yooralla to various victims and survivors of sexual abuse.²⁰⁴

In the Commissioners' *Report of Public hearing 13*, we recommended Sunnyfield's CEO and board members meet with the residents of the house in Western Sydney and their families to apologise for its failures to prevent the violence and abuse they endured. We said they should also discuss what redress or additional supports and assistance residents and their families required.²⁰⁵

In Public hearing 17, we heard that Anglicare's Incident Management Procedure provided for 'open disclosure' following an incident resulting in harm to a client while receiving a service.²⁰⁶ This means an incident should be 'acknowledged to the client or their representative and discussed in a timely and open manner in order to demonstrate dignity and respect'.²⁰⁷ Anglicare did not discuss or provide feedback on the incident or make an apology to Niky or her parents until 20 July 2020, two years after the sexual assault occurred at the respite centre.²⁰⁸ At that point, Niky and her mother attended a meeting with Ms Carolyn Cumming, the Anglicare Service Manager, Community Aged and Disability, Brisbane North Region, and another Anglicare staff member. A file note of that meeting recorded that an 'apology for the incident' was provided.²⁰⁹ Ms Cumming provided a more comprehensive apology to Niky and her family during her evidence at Public hearing 17.²¹⁰ Ms Cumming also said that Niky's family had not approached Anglicare regarding any redress, but agreed it was Anglicare's responsibility to approach them, and not the other way around.²¹¹

In the Commissioners' report on the case study, we found that Anglicare failed to comply with its policy of open disclosure and recommended it consult with Niky and her parents about any future redress, as well as making an apology.²¹²

Similarly, in the Commissioners' *Report of Public hearing 20*, we found there had been failures on the part of LWB with respect to redress for Natalie, such as the lack of an apology.²¹³ We also found in our report on Public hearing 23 that Afford's CEO and Board failed to provide a written apology to the people with disability who Mr Nuumaalii abused, and did not meaningfully engage with them to discuss any form of redress.²¹⁴

Among the issues discussed with the witnesses representing service providers at Public hearing 32 was whether they have a policy framework for redress, and what redress options are available, such as:

- apologies
- financial compensation for harm caused
- other financial support, such as contributing towards the cost of counselling or psychological care

- reimbursement of fees
- credits for services
- changes in practice, for example reviewing care plans or rosters to reflect the needs of people with disability following an incident.

Melba CEO Ms Dean said an apology ‘can’t just be words’ and ‘has to come with actions’ that work best for that person. She explained that following an incident or complaint about its services, a meeting would occur with the person to consider the situation and discuss whether any changes in the delivery of supports were needed.²¹⁵ She said Melba does not currently have a policy on compensation for breach of an individual’s rights, but it is something it should consider.²¹⁶

Synapse CEO Ms Cullen said if there was a breach of the rights of a person receiving its services, the most senior person would have to explain how and why that occurred and listen to how it affected the person.²¹⁷ As CEO, she would need to consider what redress would mean to the person whose rights have been breached.²¹⁸

Northcott said it does not have a formal or informal system for providing redress to its service users who have experienced violence, abuse, neglect or exploitation.²¹⁹ Similarly, Cara’s policies and procedures do not provide a framework for compensation, and it described its approach as ‘more ad hoc than a structured redress scheme’.²²⁰

Endeavour also described its past responses as ‘ad hoc or legalistic’ but said it had undertaken significant work over the 12 months prior to Public hearing 32 to change its approach. Part of that was the drafting of a Trauma-Informed Response to Clients Who Have Experienced Harm Policy. This commits Endeavour to engaging in a trauma-informed manner with people who have been abused, and responding to their individual needs and wishes in a way that is meaningful to them.²²¹

At the time of Public hearing 32, the draft policy was under consideration by the board’s Client Services Committee. The possible forms of redress it offers people include:²²²

- an opportunity to meet with the CEO or a senior executive of Endeavour to share their experience and discuss practice
- a formal written and/or verbal apology from the CEO or a senior executive
- financial redress, including a contribution towards ongoing counselling or psychological care
- other supports as agreed between the individual who experienced harm and the CEO.

Yooralla and its CEO, Mr Terry Symonds, gave evidence at Public hearing 32 about the organisation’s approach to redress since Public hearing 3. Yooralla set up a Redress Working Party comprised of the CEO, two board directors (one of whom lives with disability and another of whom is a parent of a person with disability) and three management members.²²³ It also engaged with internal and external stakeholders.²²⁴

Yooralla drafted an interim redress approach, including Guiding Principles for consultation with victim-survivors of abuse.²²⁵ In October 2022, the Yooralla Board approved in principle the organisation's approach to redress, including the Guiding Principles, and authorised further internal and external consultation.²²⁶

Yooralla engaged the Victorian Advocacy League for Individuals with Disability (VALiD), to obtain feedback from people with lived experience of disability outside the organisation and translated the current version of the Guiding Principles into Easy English.²²⁷ Yooralla's CEO also met with the families of two survivors and amended the document in response to their feedback, placing greater emphasis on the importance of stopping abuse.²²⁸

As noted in Chapter 3, Yooralla has also implemented initiatives to strengthen consultative processes across the organisation more generally. The Chief Experience Officer (CXO) role, which is reserved for a leader with lived experience of disability, was established in October 2021. Yooralla said the CXO will use various levers including policy and system design, research and evidence-based practice and service model concepts to improve customer experiences. They will use their specialist understanding of disability, disability sector issues and human rights issues to establish trusted customer and stakeholder engagement.²²⁹ Mr Symonds also referred to a new 'lived experience advisory panel' to be involved in policy and service development across the organisation.²³⁰

These developments reflect an innovative approach to creating a direct communication channel between service users and organisational leaders. They may also contribute to a culture that emphasises consultation and collaboration when responding to instances of violence, abuse, neglect and exploitation through redress mechanisms, both in terms of the process and outcome.

We accept Counsel Assisting's submission following Public hearing 32 that service providers should have provisions for redress in relevant policies and procedures. This includes a flexible and constructive approach to engagement, and processes to ensure the person who has experienced violence, abuse, neglect or exploitation is supported to access the support of an independent advocate.²³¹ Embedding redress within complaint and incident responses is considered further in Chapter 8.

Promising practice – redress

Service providers:

- develop policies and procedures in consultation with service users and their families and supporters, setting out the circumstances in which redress will be offered to people with disability who have experienced violence, abuse, neglect or exploitation.
- when appropriate, offer a range of options for redress, including verbal and written apologies, financial compensation for harm caused, other financial support, reimbursement of fees, credits for services, and changes in practice to reflect the needs of people with disability following an incident.
- offer practical remedies or supports that respond to the needs of a person with disability who has experienced harm.

Closed-circuit television (CCTV)

We accept Counsel Assisting's submission following Public hearing 32 that when a person with disability has experienced violence or abuse while receiving disability services, particularly in their own home or during intimate personal care, the relationship with the service provider may be fundamentally damaged.²³² As observed by Sally in Public hearing 23, the loss of trust in the people and organisations who are relied upon to provide daily care and support to people with disability can have serious consequences on their health and wellbeing.²³³

Calls for the installation of CCTV in places where disability services are delivered may arise following incidents of violence, abuse, neglect or exploitation. This can indicate an absence or loss of trust between people with disability or their families and disability service providers. Calls for increased surveillance may be connected to shortcomings in service providers' responses to incidents, or failures to address concerns and complaints raised about service safety and quality.

For example in Public hearing 23, we heard that Jason's family requested the installation of cameras in Afford vehicles following the abuse by Mr Nuumaalii.²³⁴ In Public hearing 13, we heard that the installation and use of CCTV in the house in Western Sydney was a significant issue of contention between Sunnyfield and the families of the residents. Sophia told us she thought CCTV evidence could have assisted in the criminal proceedings against SP1 and SP2. In her view, the installation of CCTV in the house was essential 'because Carl and the other residents are extremely vulnerable to abuse and cannot speak up for themselves'.²³⁵ Sophia said:

what I would like to see is if a CCTV camera is kept in Sunnyfield, or a third party, that if an incident does happen, we can go to that day and time of the incident that can tell us exactly what happened and there we have it, you know, that's the truth.²³⁶

During his evidence in Public hearing 13, former NDIS Commissioner Mr Graeme Head AO observed that the issue of CCTV in a shared independent living environment raises a range of

issues. These include the importance of the right to privacy for people with disability and the sensitivity of potential surveillance inside people's homes. Mr Head emphasised:

I think there are circumstances probably where there is agreement between people who are entitled to make decisions on behalf of their family members where they would all have the same view, and I think if that's the case, then there are a set of issues for the provider in that circumstance about how they respond to that request without failing to uphold people's rights to privacy.²³⁷

Mr Head also referred to potential issues for disability support workers who may not wish to be filmed while they are at work. He said the matter probably needed to be looked at on a case-by-case basis.²³⁸

In the Commissioners' *Report of Public hearing 13*, we recommended that Sunnyfield should discuss with Melissa, Carl and Chen, or their families, what redress or additional supports they may require.²³⁹ During Public hearing 32, Sunnyfield CEO Mr Andrew Hyland said those discussions had taken place, but the matter of CCTV remained 'somewhat vexed'. He said Sunnyfield was waiting for regulatory advice on how to proceed.²⁴⁰

In written submissions following Public hearing 32, Sunnyfield accepted the need for an individualised approach to the use of CCTV after consultation with all persons affected. Sunnyfield said it would continue to discuss the installation of CCTV in the house in Western Sydney with 'the clients, families and involved staff'.²⁴¹ We welcome this ongoing dialogue.

Since Public hearing 13, the NDIS Commission has released a practice guide for the use of surveillance technology. It suggests any use of surveillance technology should be embedded within a Positive Behaviour Support Framework and underpinned by a human rights approach.²⁴² It also says that surveillance technology should not replace adequate staff resources or human contact, or be a substitute for addressing negative cultures or unethical practices.²⁴³

The installation and use of CCTV cannot by itself restore lost trust. Service providers need to take a range of measures to achieve that goal and ensure people with disability who have experienced violence, abuse, neglect or exploitation have the supports they require. As mentioned earlier, these may include providing or paying for counselling, arranging regular check-ins with senior managers, reviewing supports and ensuring access to independent advocates. Increasing the involvement of people with disability in decision-making and providing particular workers with specific training or expertise are other measures to consider.

CCTV cannot be used as a substitute for these types of safeguarding measures. However, neither should it be ruled out across the board. Providers need to consult widely with people with disability and their families or supporters on this issue. Where services are being delivered in a shared setting, such as group homes or day programs, some service users may be in favour of the installation of CCTV, while others may oppose it. Compromises may be required and measures other than CCTV decided upon. Either way, the wishes and human rights of the people with disability receiving services in a particular location or site should be paramount to the decision-making process.

Endnotes

- 1 Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [97].
- 2 Exhibit 3-19, 'Statement of Sam Petersen', 27 November 2019, at [11], [14].
- 3 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 5.
- 4 NDIS Quality and Safeguards Commission, *Complaints management and resolution guidance*, Version 2.1, September 2019, p 8.
- 5 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 5.
- 6 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) sch 1, cl 13.
- 7 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) sch 1, cl 13.
- 8 *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) s 15.
- 9 For example, Northcott uses 'feedback', 'complaint', 'compliment', 'informal feedback' (Exhibit 32-133, NTH.005.002.0036); Civic uses 'complaint', 'feedback', 'serious complaint', 'dispute', 'complex feedback' and 'concern' (Exhibit 32-120, CIV.9999.0002.0013); Cara uses 'formal complaint' and 'informal complaint' (Exhibit 32-103, CAR.9999.0007.0004).
- 10 Exhibit 32-120, CIV.9999.0002.0013, p 10; Exhibit 32-127, END.9999.0002.0028, p 9.
- 11 Exhibit 32-103, CAR.9999.0007.0004, p 4 [4.3]; Exhibit 32-120, CIV.9999.0002.0013, p 12.
- 12 Exhibit 32-120, CIV.9999.0002.0013, p 12.
- 13 Transcript, Sonya Furey, Public hearing 32, 16 February 2023, P-399 [26–28].
- 14 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-399 [36–41].
- 15 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-399 [41–46].
- 16 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, pp 24–25.
- 17 Exhibit 32-100, CAR.9999.0006.0001, p 3; Exhibit 32-117, CIV.9999.0001.0001, p 7; Exhibit 32-131, NTH.9999.0002.0001, p 7; Exhibit 32-163, YPL.9999.0003.0281, p 6; Transcript, David Swain, Public hearing 32, 16 February 2023, P-312 [4–5].
- 18 Exhibit 32-143, HUP.9999.0001.0001, p 34; Exhibit 32-74, SUN.9999.0006.0001, p 17.
- 19 Exhibit 32-100, CAR.9999.0006.0001, p 3; Exhibit 32-117, CIV.9999.0001.0001, p 7; Exhibit 32-131, NTH.9999.0002.0001, p 7; Exhibit 32-125, END.9999.0002.0001, p 5; Exhibit 32-163, YPL.9999.0003.0281, p 6; Exhibit 32-143, HUP.9999.0001.0001, p 34; Exhibit 32-74, SUN.9999.0006.0001, p 17.
- 20 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 49.
- 21 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 50.
- 22 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [40].
- 23 Names changed to protect identities; Exhibit 20-2.20, 'Statement of Greg', 16 November 2021, at [76]; Exhibit 20-20.03, 'Statement of Michelle', 16 November 2021, at [61].
- 24 Names changed to protect identities. Exhibit 20-64, 'Statement of Paul', 17 November 2021, at [56], [110]; Exhibit 20-65, 'Statement of Catherine', 16 November 2021, at [38–62].
- 25 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, Finding 19.
- 26 Exhibit 32-131, NTH.9999.0002.0001, at [6.5].
- 27 Exhibit 32-120, CIV.9999.0002.0013, p 2; Exhibit 32-117, CIV.9999.0001.0001, at [28]; Exhibit 32-117, CIV.9999.0001.0001, at [28]; Exhibit 32-127, END.9999.0002.0028, p 3.
- 28 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 160–61 [582].

- 29 Transcript, Stella (Topsy) Jackamarra, Public hearing 25, 13 July 2022, P-218–222; Exhibit 25-8, ‘Statement of Joan’, 22 June 2022, at [79–80]; Exhibit 25-33, ‘Statement of Bakoi Namok’, 9 July 2022, at [35], [42]; Exhibit 25-34, ‘Statement of Joanne Houghton’, 21 June 2022, at [70], [113]; Exhibit 25-1, ‘Statement of Daisy’, 21 June 2022, at [15–18]; Exhibit 25-14, ‘Statement of Paulette’, 11 May 2022, at [13–26].
- 30 Exhibit 20-0065, ‘Statement of Catherine’, 16 November 2021, at [62].
- 31 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 18.
- 32 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, [375–79]; Names changed to protect identities.
- 33 Names changed to protect identities; Transcript, Sophia, Public hearing 13, 25 May 2021, P-122 [25]–P123 [12]; Exhibit 13-3, ‘Statement of Sophia’, 29 April 2021, at [19–20]; Transcript, Eliza, Public hearing 13, 24 May 2021, P-60 [1–8].
- 34 Transcript, Sophia, Public hearing 13, 25 May 2021, P-123 [6–12].
- 35 Transcript, Eliza, Public hearing 13, 24 May 2021, P-60 [1].
- 36 Transcript, Eliza, Public hearing 13, 24 May 2021, P-64 [1–4].
- 37 Exhibit 13-2, ‘Statement of Eliza’, 29 April 2021, at [79].
- 38 Exhibit 13-2, ‘Statement of Eliza’, 29 April 2021, at [58–62]; Transcript, Eliza, Public hearing 13, 24 May 2021, P-73; Exhibit 14-5, ‘Statement of Karen Rogers’, 5 May 2021, at [39]; Exhibit 14-27, ‘Statement of Victoria’, 25 May 2021, at [32–48]; Transcript, AAI, Public hearing 3, 2 December 2019, P-30 [29–31].
- 39 Exhibit 13-2, ‘Statement of Eliza’, 29 April 2021, at [60–61].
- 40 Exhibit 32-100, CAR.9999.0006.0001, p 3; Exhibit 32-117, CIV.9999.0001.0001, pp 7–8; Exhibit 32-131, NTH.9999.0002.0001, pp 7–8; Exhibit 32-163, YPL.9999.0003.0281, p 6; Transcript, David Swain, Public hearing 32, 16 February 2023, P-312 [4–5].
- 41 Exhibit 32-2, ‘Statement of Zelda Riddell’, 25 January 2023, at [59–68].
- 42 Exhibit 13-138, SUN.0001.0032.0829, p 27.
- 43 Exhibit 13-138, SUN.0001.0032.0829, p 27.
- 44 Exhibit 13-139, SUN.0001.0045.0593, p 43.
- 45 Exhibit 13-138, SUN.0001.0032.0829, pp 28–29.
- 46 Exhibit 23-84, ‘Statement of Wayne Adamson’, 28 April 2022, at [4.32(b)].
- 47 Exhibit 23-61, ‘Statement of Rachel’, 21 April 2022, at [16]; Exhibit 23-66, IND.0071.0003.0003.
- 48 Exhibit 23-61, ‘Statement of Rachel’, 21 April 2022, at [17]; Transcript, Mike Allen, Public hearing 23, 20 May 2022, P-484–85.
- 49 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023.
- 50 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-390 [11–14]; Transcript, Annie Doyle, Public hearing 32, 16 February 2023, P-390 [18–20]; Exhibit 32-117, CIV.9999.0001.0001, p 9; Exhibit 32-125, END.9999.0002.0001, p 8.
- 51 Exhibit 32-102, CAR.9999.0007.0001; Exhibit 32-119, CIV.9999.0002.0065; Exhibit 32-126, END.9999.0002.0024; Exhibit 32-133, NTH.005.002.0036.
- 52 Transcript, Daniel Stubbs, Public hearing 32, 14 February 2023, P-136 [37–42].
- 53 Exhibit 32-1, ‘Statement of Sam Petersen’, 24 January 2023, at pp 4–5.
- 54 Transcript, Daniel Stubbs, Public hearing 32, 14 February 2023, P-136 [12–22].
- 55 Transcript, David Swain, Public hearing 32, 16 February 2023, P-320 [27–30].
- 56 Exhibit 32-127, END.9999.0002.0028, p 4.
- 57 Exhibit 32-1, ‘Statement of Sam Petersen’, 24 January 2023, p 3.
- 58 Exhibit 23-1, ‘Statement of Sally’, 26 April 2022, at [46–49].
- 59 Name changed to protect identity; Exhibit 20-64, ‘Statement of Paul’, 17 November 2021, at [51].
- 60 Exhibit 32-100, CAR.9999.0006.0001, p 3.
- 61 Exhibit 32-101, CAR.9999.0005.0107, p 13.
- 62 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and*

63 *exploitation in disability services (a case study)*, April 2022, Finding 19.
 64 Exhibit 32-121, CIV.9999.0002.0040, p 1.
 65 Exhibit 32-121, CIV.9999.0002.0040, pp 2–4.
 66 Exhibit 32-133, NTH.005.002.0036, p 13.
 67 Ombudsman New South Wales, Managing unreasonable conduct by complainants –
 Model policy, July 2022; ‘Managing unreasonable conduct by a complainant’, *Ombudsman*
 68 *New South Wales*, web page. <[http://www.ombo.nsw.gov.au/guidance-for-agencies/managing-](http://www.ombo.nsw.gov.au/guidance-for-agencies/managing-unreasonable-conduct-by-a-complainant)
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 69 Transcript, Caroline Cuddihy, Public hearing 13, 28 May 2021, P-435 [8]–P-436 [38].
 70 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 5.
 71 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 9(1).
 72 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 9(2).
 73 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 5.
 74 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 10(3).
 75 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 20.
 76 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) ss 16–17, 20.
 77 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 21.
 78 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) ss 20, 26.
 79 Name changed to protect identity; Royal Commission into Violence, Abuse, Neglect and
 Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to*
violence, abuse, neglect and exploitation in disability services (two case studies), February 2023,
 Findings 11 and 12.
 80 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies), February 2023, Findings 14 and 15.
 81 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies), February 2023, Findings 4 and 5.
 82 Exhibit 23-142, AFF.0005.0001.1347; Transcript, Wayne Adamson, Public hearing 23,
 19 May 2022, P376 [42]–P-377 [41]; Royal Commission into Violence, Abuse, Neglect and
 Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to*
violence, abuse, neglect and exploitation in disability service (a case study), March 2023.
 83 Name changed to protect identity; Transcript, Dianne, Public hearing 23, 17 May 2022,
 P-163 [10–14].
 84 Name changed to protect identity.
 85 Exhibit 23-56, ‘Statement of Erynn’, 2 May 2022, at [13–15].
 86 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (South Australia), June 2022, Finding 6.
 87 Exhibit 32-2, ‘Statement of Zelda Riddell’, 25 January 2023, at [73].
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 89 Exhibit 32-2, ‘Statement of Zelda Riddell’, 25 April 2023, at [66–67]; Exhibit 13-2,
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184 Often referred to as service managers, service coordinators, practice leaders, safeguarding teams or incident response teams.

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5. Areas for systemic change

Key points

- Disability services can be designed and delivered to prevent and appropriately respond to violence, abuse, neglect and exploitation.
- Systemic factors, beyond the control of service providers, contribute to increased risk within disability services.
- The expected NDIS Workforce Strategy must address recruitment, retention, training, skills development, career pathways and pay equity in ways that reflect the diversity and growth required to meet the needs of all NDIS participants, and people with disability more broadly.
- A national disability support worker registration scheme could provide a framework to professionalise and stabilise the disability sector workforce.
- The market approach to disability services has not worked for everyone.
- Urgent work is required in all jurisdictions to address gaps in service delivery.

Throughout our inquiry, we identified systemic issues that contribute to, or increase the risk of, violence, abuse, neglect or exploitation occurring in disability services. Some systemic issues may not be wholly within the control of service providers, and effecting change may require further action by government.

For example, we heard how settings can affect the safety and quality of disability services, particularly in group homes, other forms of supported accommodation, and closed settings such as day programs.

In a written submission to us, Queensland Advocacy Incorporated said:

People who are isolated and separated from the wider community are subject to less safeguards and protective oversight “from the gaze of citizens” and are therefore more vulnerable to acts of abuse and violence.¹

Similarly, inquiries held following the 2020 death of Ms Ann-Marie Smith in South Australia found that when disability supports are delivered in isolation with limited external or independent scrutiny, the ways violence, abuse, neglect or exploitation can be detected are reduced.²

In Volume 7, *Inclusive education, employment and housing*, we set out the concerns we heard about group homes. We discuss the future of the group home model and access to alternative housing options, to give people with disability genuine choice and control over where and

with whom they live. Notwithstanding the need for new accommodation pathways, providers can do more to design and deliver services to reduce the risks that isolation, segregation and dependency create, as discussed in Chapter 3, 'Preventing violence, abuse, neglect and exploitation in disability services'.

Another systemic problem is the current shortage of disability support workers across Australia. As we observed in Chapter 3, disability support workers who are skilled and capable of meeting the individual support needs of people with disability are crucial to the provision of safe, high-quality services. We are aware the NDIS Review is considering this issue and, in this chapter, we recommend several measures the Australian Government can take following completion of the review.

We also discuss what we heard about the challenges some people with disability face in navigating the NDIS and accessing the services and supports they need. As noted in Chapter 1, 'Introduction' we acknowledge that the NDIS has provided tremendous benefits to many people with disability. However for others, access and navigation remain significant barriers that may heighten their risk of exposure to violence, abuse, neglect and exploitation. Additional work remains to be done to ensure all people with disability can navigate the NDIS and access safe, high-quality services and supports equitably.

5.1. Strengthening the disability workforce

State of the disability support workforce

In Public hearing 32, 'Service providers revisited', we heard evidence from several witnesses about the state of the disability support workforce, including Mr Angus McFarland of the Australian Services Union (ASU) and researcher Dr Fiona Macdonald of the Centre for Future Work.³ Dr Macdonald said that in 2020, the 'NDIS care and support workforce' comprised approximately 242,000 workers.⁴ However, in June 2021, the Australian Government estimated 213,000 workers providing services to NDIS participants would be lost to 'churn' by 2024.⁵ Ms Laurie Leigh, CEO of the peak organisation for non-government disability service providers, National Disability Services (NDS), told us that, considering the continuing growth of the NDIS and high turnover in the sector, the number of additional workers required in the next few years is likely to be around 300,000.⁶

In submissions following the hearing, Counsel Assisting provided a detailed analysis of the evidence concerning the disability workforce, discussing a range of factors contributing to current shortages.⁷ In its response, NDS said Counsel Assisting's submissions 'accurately assessed the current state of the disability workforce' as at the time of the hearing. NDS agreed with Counsel Assisting that 'a stable, well-trained, capable and supportive disability workforce is essential to delivering safe and quality services to people with disability'.⁸ It observed that workforce shortages in the disability sector 'have reached crisis levels as tight labour market conditions coincide with growing demand for services'.⁹

As a result of the shortage of available workers, recruiting and retaining a suitably skilled workforce continues to be a significant challenge for service provider organisations.¹⁰ In Public hearing 32, disability support worker Ms Zelda Riddell told us organisations are under pressure to recruit, with high demand for staff and few disability workers available for recruitment.¹¹ NDS told us its 2022 survey data indicated 83 per cent of service providers were finding it difficult to recruit disability support workers, up from 59 per cent in 2020.¹² NDS also observed that providers are facing extreme difficulties recruiting the right people into the right roles, building workforce capability and managing workforce retention.¹³

In the *NDIS National Workforce Plan: 2021–2025* published in June 2021, the Australian Government observed that high workforce retention is crucial for service continuity and reducing the costs of recruiting, onboarding and training replacement workers.¹⁴ In response to Counsel Assisting’s submissions following Public hearing 32, the Australian Government submitted that the ‘diversity of employment models’ used to engage NDIS workers (including direct¹⁵ and indirect¹⁶ employment, and engagement of sole traders and independent contractors) has the potential to address workforce shortages and gaps in thin markets. It submitted that this also offers workers flexibility and NDIS participants greater choice and control.¹⁷

The Australian Government also told us that issues related to the NDIS workforce are being considered as part of the NDIS Review.¹⁸ It said it is developing a comprehensive NDIS Workforce Strategy to address workforce issues across the NDIS. The strategy will address attraction and retention, training, skills development and career pathways, and ensure workers are paid fairly.¹⁹

We accept the critical shortage of available workers poses a real challenge for disability service providers and recognise the Australian Government is making efforts to address this issue. We encourage the Australian Government to work closely with disability service providers, workers, relevant trade unions, NDS and people with disability to finalise and implement the NDIS Workforce Strategy. In doing so, it should consider the matters that have been revealed through our inquiries.

Casualisation and fragmentation of the workforce

At Public hearing 32, witnesses told us that the introduction of the NDIS had contributed to the fragmentation and casualisation of the disability support workforce. Mr McFarland said:

The move to an individualised model of support, which enables participant choice and control, requires a level of flexibility in the workforce to meet the various and changing needs of participants as promised by the scheme.²⁰

Dr Macdonald agreed, observing that the introduction of the NDIS had led to service providers’ reliance on casual employees and short-hours, part-time employment and an increased expectation that all time spent supporting a person must be ‘billable’ time.²¹ Dr Macdonald said this had resulted in ‘a clear degradation of both work and support’.²²

Casualisation

According to figures published by the Australian Government in 2021, 34 per cent of workers employed in the disability sector at that time were employed casually.²³ This was below the peak of 42 per cent reached in late 2018, but remained higher than that of the aged care workforce.²⁴ Mr McFarland told us:

Many disability support workers work multiple jobs, and combine casual and part-time work to make up the hours to provide for themselves and their families. This means that many do not have sick leave if they are unwell or need to care for family members, and they do not have annual leave for rest and recreation.²⁵

The proportion of support workers engaged on a casual basis varies between providers. For example, we heard approximately 14 per cent of support workers at the disability service provider Minda are employed on a casual basis, while 98 per cent of support workers employed by digital platform Hireup are casual.²⁶ Minda told us its preference is to employ staff permanently on a full or part-time basis, but the NDIS system currently impedes this and has encouraged a shift to casualisation.²⁷

Mr McFarland said 80 per cent of disability support workers who are permanently employed are engaged on part-time contracts.²⁸ He said the ASU ‘considers that employment in the disability support sector can be characterised as predominantly insecure’, and that a growing number of disability support workers are working across multiple service providers in order to work sufficient hours to maintain a living income.²⁹ Mr McFarland described the disability support workforce as a ‘low paid industry’.³⁰ He observed that the minimum hourly rate is just seven cents more per hour than the minimum wage of a retail worker, despite the complexity of the work and the skills required.³¹

At Public hearing 32, Ms Tamara Cattach, CEO of the Araluen Centre (Araluen) told us, ‘[m]any casuals already have a second and third job on commencing work at Araluen and are often not available for shifts when required’.³² Likewise, Ms Emily Korir, CEO of BET Group, said most of BET Group’s casual staff also work for other organisations.³³ Digital platform Hireup told us around 55 per cent of active support workers on the platform use Hireup as a secondary source of income.³⁴

Fragmentation

Dr Macdonald said that ‘fragmented working time’ was a significant issue reported by workers.³⁵ She described fragmented working time as:

being engaged for multiple short shifts, having limited certainty of working hours (and therefore income), multiple job-holdings and juggling the requirements of multiple jobs, and underemployment due to unpredictable variability in working time.³⁶

Dr Macdonald said that the fragmentation of working patterns has adverse consequences for disability support workers, including insecure income and work/life arrangements that can lead

to psychological stress and material hardship.³⁷ She said workers' willingness to tolerate such arrangements is underpinned by the insecurity of their earnings and employment.³⁸

Mr McFarland likened working in the disability support sector, since the introduction of the NDIS, to a game of 'snakes and ladders'. He said:

You get a job in the disability sector, you are really passionate about that, that's a ladder. Then suddenly you find it's only a short-hour casual contract. That's a snake. You seek a second job to support your income and your family, that's a ladder. But then you find for that participant, there is no training at all for their very particular disability and you are worried about doing the job safely and well.

[T]hese things compound upon themselves. You are working for multiple employers. You don't have entitlements or recognition of your service in the scheme. You don't have training. You care a lot about the people you support, but you don't want to put yourself or them at risk. And often people leave. They are burnt out. They don't feel supported. They are working isolated.³⁹

At Public hearing 32, service providers said pay expectations combined with insecurity of employment, perceived low job status, the challenging nature of support work and burnout all affect their ability to recruit and retain staff.⁴⁰

Dr Macdonald also said that pay levels, unsustainable working time arrangements, feeling poorly valued, a lack of support, concerns about the quality of support provided, and safety and health risks to self and people being supported all contribute to workers leaving their current employment, or leaving the occupation altogether.⁴¹

The Australian Government acknowledged that NDIS workers are engaged through a variety of employment models.⁴² It confirmed its commitment to increased job security for Australians, including people employed in the disability sector. The NDIS Review will consider how the NDIS market and workforce is responsive and capable of supporting the delivery of quality and safe disability services.⁴³

Payment for training and completion of administrative tasks

In Chapter 3 we outlined the benefits of disability support workers being adequately trained, not only in the provision of support generally but also in the individual needs of the clients they are supporting. We also discussed the importance of the administrative aspects of disability support work. Each of these tasks are necessary for the provision of safe, high-quality supports.

NDIS Disability Support Worker Cost Model

During Public hearing 32, we heard differing evidence about whether the funding arrangements administered by the National Disability Insurance Agency (NDIA) are sufficient to allow support workers to complete training and administrative tasks in paid time. This

evidence was set out in Counsel Assisting's submissions following Public hearing 32 and is not reproduced in its entirety here.⁴⁴

The NDIA uses the NDIS Disability Support Worker Cost Model (DSW Cost Model) to determine the price limits for the majority of supports delivered by disability support workers.⁴⁵ Ms Gerrie Mitra, General Manager, Provider and Market Development at the NDIA, told us the DSW Cost Model estimates the fully loaded cost of a billable hour of support, taking into account: base pay, shift loadings, leave entitlements, salary on costs, employee allowances, operational overheads and corporate overheads and margin.⁴⁶ Ms Mitra said the NDIS Pricing Arrangements account for 'overhead costs' in the DSW Cost Model, including for general training, supervision costs (including quality and safeguarding costs), workforce rostering and administrative costs.⁴⁷

The DSW Cost Model has cost assumptions for four levels of disability support workers (DSW Levels 1 to 4).⁴⁸ The utilisation level is set at 92 per cent for the lowest level, decreasing to 80 per cent for the highest level.⁴⁹ These utilisation levels are modelled on the 'efficient (25th percentile) providers'.⁵⁰

The NDIA does not set the prices service providers charge NDIS participants. Providers must agree with participants on the price for each support, subject to the price limits and pricing arrangements imposed by the NDIA.⁵¹ According to Ms Mitra, the funding model allows 'enough' for service providers to 'maintain their skills'.⁵² The Australian Government also submitted that the DSW Cost Model provides 'enough funding to allow for providers who are operating effectively to manage their provision of training to workers to competently deliver the supports each participant needs'.⁵³ Ms Mitra said the NDIA expects and encourages providers 'to engage a workforce which is sufficient to deliver regular non-face-to-face components of service delivery'.⁵⁴

However, some witnesses raised concerns about workers not being paid for non-client facing tasks, including administrative work.⁵⁵ Ms Riddell, who worked in the sector before and after the introduction of the NDIS, said she was no longer paid for 'non-direct care' work following the introduction of the NDIS.⁵⁶ Ms Riddell described 'non-direct care' work as including paperwork, case notes, communicating information to families, and managing and booking medical appointments.⁵⁷ She along with Dr Macdonald, emphasised the importance of this work in the provision of quality and safe disability services.⁵⁸

Additionally, Dr Macdonald said workers can experience high levels of work intensity and unpaid overtime.⁵⁹ This was consistent with evidence in Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)'. Former Afford support workers 'Erynn' and 'Dianne' both referred to administrative tasks during their period of employment being impossible to complete within rostered hours of work.⁶⁰

Mr Andrew Hyland, CEO of Sunnyfield, said while sufficient funding is built into the DSW Cost Model to cover the orientation and mandatory training of new workers, there is not adequate funding to properly invest in the continuous improvement of ongoing workers.⁶¹ Ms Cattach said the funding model makes it very difficult for service providers to have any flexibility in how they train their workers. She said Araluen had sought advice from its managers and frontline practice leaders about what training should be mandatory for all workers, and created a budget around

that. This training ‘sat outside of the recommendations in the funding model’ but was something Araluen had decided was necessary.⁶² Dr Macdonald told us that service providers have limited incentives to provide training if the DWS Cost Model does not adequately provide for it, and where competition in the market is based on price.⁶³

NDS observed:

The capacity to deliver sufficient, consistent quality training and support is pressured within the context of the current Disability Support Worker Cost Model. The limited budgets, staff turnover and breadth of skills needed all contribute to these challenges.⁶⁴

Dr Macdonald also told us when support workers are unable to complete training and administrative tasks within their rostered time, they report feeling inadequately skilled and unable to ensure participants’ wellbeing and safety.⁶⁵ She said this is a contributing factor to support workers leaving the industry.⁶⁶ In Dr Macdonald’s view, a systemic response is required to lift the skills and capability of the workforce as a whole.⁶⁷

An examination of the sufficiency of the DSW Cost Model was beyond the scope of this inquiry. However, the evidence we heard suggests that there is a disconnect between the Australian Government’s position and the experience of those working in the disability sector. We do not speculate about the precise reason for that disconnect. Nevertheless, an inadequate capacity to complete essential ‘non-direct’ duties may place people with disability at heightened risk of violence, abuse, neglect and exploitation.

The Australian Government noted that the NDIS Review would consider the DSW Cost Model in the context of service providers covering the costs of non-client facing work.⁶⁸ We welcome this and encourage the Australian Government to consult with disability service providers, peak bodies, workers and relevant trade unions following completion of the Review in relation to the sufficiency of the DSW Cost Model.

Encouraging workers to enter and remain in the disability support sector

We accept the submission of NDS following Public hearing 32 that the workforce shortage in disability services has reached ‘crisis levels’. This crisis has been driven both by the growth of the sector and the large number of workers leaving employment in the industry altogether.⁶⁹

Worker stress due to the casualised and fragmented nature of the industry, concerns about having the skills and time to complete all aspects of their jobs within paid working hours, and the undervaluing of disability support work contribute to these workforce shortages. At Public hearing 32, Sam Petersen, a person with disability who requires support from paid workers, said ‘[w]e devalue support work, we devalue it with our attitudes, pay, and the perception of the job being temporary’.⁷⁰ In Sam’s opinion, support workers are leaving the industry because of ‘lack of time, not enough training and support, lack of perceived job importance, not being paid enough money and so they have to work more hours, frequent shortages of staff so they

have to work more hours than is sustainable'.⁷¹ Dr Macdonald also said there are 'longstanding problems of undervaluation of the work of disability support workers'.⁷²

Additionally, workers who enter the industry may leave if there is no clear career pathway for them as they build their skills and experience. Dr Macdonald observed:

Disability support workers coming in don't have career paths, and that goes to the – it goes to the structure of work. The ... service providers' responses to the funding model and the funding models' impact, I think, on the workforce more generally has been establishing a flexible workforce with on-demand workers who are able to meet individual clients of the providers, requirements and variable requirements. So that's led to increasing large workforces of less experienced casual workers with shorter hours who also, because of the funding model ... [are only provided] limited training and supervision, limited peer support, limited contact with peers. And that takes – I think takes away the opportunity for workers to – workers don't get established so quickly. There's very high turnover rates of newer workers.⁷³

The creation of more established and recognised career pathways for people entering the disability support sector might assist with workforce retention.⁷⁴ This includes levels of remuneration commensurate with the development of skills, experience and expertise. We consider that a national disability support worker registration scheme could help achieve these outcomes.

National disability support worker registration scheme

We would welcome a national registration arrangement. Because I think what we currently have is a mish-mash of different regimes, some of those split between federal and state, and it's all too easy for individuals to fall between the gaps.⁷⁵

During Public hearing 32, we heard a variety of views about a potential national registration scheme for disability support workers. While not expressing a view in favour of or against the registration of disability support workers, NDIS Commissioner Ms Tracy Mackey said if the Australian Government chose to implement a registration scheme, the NDIS Quality and Safeguards Commission (NDIS Commission) would support a national approach.⁷⁶ She also said the NDIS Commission would be well placed to operate such a scheme given its responsibilities in relation to worker screening and its development of the Workforce Capability Framework, but the NDIS Commission would need sufficient resources to do so.⁷⁷ Ms Mackey noted that the NDIS Commission often hears from workers that they would like to see some kind of centralised system to record and view the training and development they have done, which could be built on over time.⁷⁸

In addition, we heard detailed evidence from the Victorian Disability Worker Commissioner, Mr Daniel Stubbs, who described the purpose, jurisdiction and function of the Victorian Disability Worker Regulation Scheme (DWRS). The DWRS was established by the *Disability Service Safeguards Act 2018* (Vic) and has been in operation since 2020.⁷⁹ A summary of Mr Stubbs's evidence is set out in Counsel Assisting's submissions following Public hearing 32 and is not reproduced here.⁸⁰

Mr Stubbs told us the DWRS allows for the voluntary registration of people who directly provide a disability service to a person with disability. In order to register, workers must hold an approved qualification or provide evidence of relevant professional experience over at least a two-year period.⁸¹ Once registered, disability workers are listed on a public Register of Disability Workers.⁸² Registration enables workers to use the legally protected titles of 'registered disability support worker' or 'registered disability practitioner'.⁸³ Mr Stubbs told us only workers with a current valid registration are entitled to use these titles, and making a false claim about the type of registration held is an offence.⁸⁴

At the time of Public hearing 32, Mr Stubbs said only a small proportion of disability workers in Victoria had chosen to register through the DWRS.⁸⁵ He told us that the Victorian Department of Family, Fairness and Housing is committed to an independent three-year review of the scheme, which he anticipated would take place in late 2024.⁸⁶ He noted, however, that it would not be necessary to wait until 2024 to make assumptions about the potential to replicate the DWRS at a national level, because the scheme is 'collecting data constantly and seeking to understand new ways of approaching the registration scheme'.⁸⁷

Potential benefits of a national scheme

Mr Stubbs also said one of the main benefits of a worker registration scheme is registration 'promotes professionalisation of the disability workforce and is key to driving increased quality of services'.⁸⁸ He said, '[r]egistration is a significant mechanism for both attracting workers to the sector and promoting respect and recognition for the important work they do'.⁸⁹ If a national worker registration scheme is designed, registration and accreditation standards should be set to 'lift knowledge and capability of the workforce and professionalise the sector'.⁹⁰

The CEO of Minda, Dr David Panter, observed:

having a registration body is a sign that you are a professional group. Nurses have it. Allied health have it. Doctors have it ... Do we so undervalue the job that our direct care staff do that we don't see them warranting some sort of professional registration body?⁹¹

Currently, only workers employed or engaged by registered NDIS providers are required to obtain a worker screening check.⁹² Ms Leigh said anyone providing support to a person with disability should be subject to screening.⁹³ She agreed a national disability support worker registration scheme, which works well and is not a burden, would be a good way of doing that.⁹⁴

The CEO and co-founder of Hireup, Ms Laura O'Reilly, described the absence of any worker screening requirement for workers employed by unregistered providers as a 'loophole' and suggested a national worker registration scheme could 'close down' this 'flaw in the system'.⁹⁵

Portable training and leave entitlements

Mr McFarland told us the ASU recognises the benefits of a national disability support worker registration scheme, if it were appropriately co-designed by stakeholders, including participants and unions.⁹⁶ He said such a scheme could provide risk-based screening functions and ‘act as a vehicle through which workers training and qualifications would be credentialed’ for the purposes of a portable training scheme.⁹⁷ The ASU provided a detailed proposal for a portable training entitlement scheme in a written submission to the Royal Commission.⁹⁸ The proposal sets out three stages of training, one of which includes the completion of a Certificate III or IV qualification in disability. This proposal could be implemented as part of the operation of a national disability support worker registration scheme.

Dr Macdonald suggested that if individual employers are not able to provide security of employment and a career pathway for disability support workers, then this needs to be a ‘system-wide responsibility’.⁹⁹ She said a systemic response would begin with ‘mandatory registration and some form [of] ... collective arrangements ... that allowed for portable entitlements, both leave and training’.¹⁰⁰ Dr Macdonald also stressed the need for organisational support for workers to address the issue of isolation.¹⁰¹ She suggested the scheme could accommodate an ‘umbrella-type body like a group training organisation or regional bodies built on the LACs [local area coordinators]’.¹⁰²

During Public hearing 32, Mr Hyland of Sunnyfield and Ms Cattach of Araluen said they would support a portable training arrangement for disability support workers, while the CEO of Afford, Ms Joanne Toohey, expressed a preference for training that incorporates how each particular organisation does things.¹⁰³ Mr Hyland said while there may be some aspects of training that are bespoke to each provider, some training should be portable to prevent wasted resources.¹⁰⁴ Ms Cattach spoke about the potential benefits to a smaller organisation like Araluen of portable training on fundamental topics such as the human rights of people with disability.¹⁰⁵

Dr Panter said the establishment of a portable training scheme could also facilitate the development of career pathways for disability support workers.¹⁰⁶ Ms Leigh of the NDS suggested some workers may not be looking for progression to management within an individual organisation, but rather to develop additional skills. For example, a person interested in working with people with different types of behaviours might wish to gain the skills to become a behaviour support practitioner.¹⁰⁷ As suggested by Ms Mackey, the scheme could allow for the recording of specific areas of skill and experience.¹⁰⁸

According to Mr McFarland, another potential benefit of a national disability support worker registration scheme would be that it could provide a way to administer portable leave entitlements for disability support workers.¹⁰⁹ He said because many disability support workers work multiple jobs and combine casual and part-time work, many do not have access to sick leave if they are unwell or need to care for family members.¹¹⁰ The ASU’s submission to the Royal Commission further observed ‘the lack of capacity to accrue entitlements acts as a powerful disincentive for recruitment and retention to the sector’.¹¹¹

The ASU suggested that a portable leave scheme could enable workers to accrue annual leave, personal leave, long service leave, paid parental leave, paid family leave and domestic violence leave, and retain those entitlements if they move into a different job in the sector.¹¹² It observed that portable leave entitlement schemes operate in other sectors, including the security, manufacturing, construction and cleaning industries.¹¹³

We consider that there is merit in the proposals for portable training and portable leave arrangements, which should be considered in the design of a national disability support worker registration scheme.

Potential scope of a national scheme

Several witnesses commented on the need to carefully consider the scope of the scheme.

For example, Ms Mackey noted ‘quite a lot of work’ would need to be done ‘on defining who is a disability support worker’.¹¹⁴ Mr Stubbs observed that the number of workers to be covered by the scheme could be very high, and any worker registration scheme would require adequate funding and resources to be effective.¹¹⁵ He also expressed the view that any regulation of disability support work should be based on the nature of the work done, rather than the source of funding for payment for that work, as is the case under the Victorian DWRS.¹¹⁶

Similarly, as noted above, Ms Leigh said the NDS favours working screening requirements for all workers providing supports to a person with disability, and suggested a national disability support worker registration scheme with such requirements is desirable.¹¹⁷

Another issue for consideration is the potential overlap between the proposed scheme and other regulatory systems or requirements, which could cause administrative burden, duplication and confusion. Ms Leigh said the NDS’ absolute preference would be for a national scheme, rather than a piecemeal state-by-state approach.¹¹⁸

Mr Stubbs referred to the importance of aligning any new scheme with the functions of other relevant regulators, such as the Australian Health Practitioner Regulation Agency, Victorian Institute of Teaching, the Aged Care Quality and Safety Commission, and the Victorian Social Services Regulator, and of minimising regulatory duplication where possible.¹¹⁹

Ms Mackey also referred to the benefits of reducing complexity, noting multiple regulators with overlapping responsibilities create confusion. She said, ‘that’s where we get the most feedback about how difficult it is for [people] to understand who they go to for what’.¹²⁰

A further issue relates to ensuring the proposed scheme does not create barriers to workers entering the disability workforce. Requiring strict formal qualifications, or imposing a cost on potential or existing workers, could create such barriers. A related issue is whether worker registration under the scheme should be mandatory or voluntary.

Dr Macdonald argued a registration scheme needs to be mandatory to be effective.¹²¹ However, Mr Peter Scutt, Co-Founder and Executive Director of Mable, expressed the view that any worker registration scheme should be voluntary to facilitate choice and control for people with disability.¹²²

Ms Mackey also referred to the ‘tension’ between regulation and choice and control, noting people with disability must be able to make choices as informed consumers. She also pointed out consumer choices are often based on assumptions about the underlying consumer protections that exist.¹²³

We accept there is sufficient evidence to show an effective national disability support worker registration scheme could contribute to encouraging capable workers to enter and remain in the sector. It could also enhance the overall safety and quality of disability services provided.

Worker registration should be mandatory if it is to achieve these goals. We do not accept a mandatory scheme would unduly restrict choice and control for people with disability. It would simply provide the kind of safeguarding baseline consumers of a variety of services should be able to expect. However, we recognise the value of a provisional registration status to ensure people with disability can engage workers without undue delay. Scheme operators should have key performance indicators to complete applicant screening effectively and quickly so workers can easily achieve provisional status.

The Australian Government could also consider a registration fee amnesty for a fixed period to incentivise registration under the new scheme. Additionally, consideration should be given to making registration and registration-related activities fully tax deductible for eligible workers.

In Chapter 3, we indicated that we do not recommend the prescription of formal qualifications for disability support workers. The requirements for registration under the proposed scheme, including options to recognise formal qualifications, previous experience, or demonstrated skills and capabilities, also needs to be discussed with people who use disability services, their families and supporters, workers, trade unions, service providers and other relevant organisations.

The details of the proposed disability support worker registration scheme require careful consideration, including which workers are covered by the scheme, who administers it and how, and the need to minimise regulatory duplication and burdens on individual disability support workers. Insofar as the scheme promotes the development of skills and capabilities through training, it should also create opportunities for corresponding increases in remuneration.

In the interim, to improve safeguarding immediately, the current arrangements for worker screening through the NDIS Worker Screening Check require attention. We discuss this further in Chapter 15, ‘Worker screening’.

Recommendation 10.8 A national disability support worker registration scheme

The Australian Government should establish a national disability support worker registration scheme by 1 July 2028.

Consultation about the scope and elements of the national disability support worker registration scheme should begin as soon as possible. The consultations should include people with disability, disabled people's organisations, disability representative organisations including member-led First Nations Community Controlled Organisations, support workers and their representative bodies, disability service providers, state and territory governments, and peak and regulatory bodies.

The design of the scheme should consider:

- the definition of 'disability support worker'
- a code of conduct and minimum standards for registered disability support workers, including support coordinators
- mandating the NDIS Worker Screening Check for all disability support workers
- recognition and accreditation of workers' qualifications, experience, capabilities and skills
- continuing professional development requirements for disability support workers
- automatic registration for disability support workers who are registered with other relevant professional bodies
- a First Nations workforce pathway to address barriers to First Nations workers entering the sector
- an accessible portal to enable people with disability and their supporters to view the profiles and registration status of disability support workers
- portable training and leave entitlements.

Remuneration and working conditions

As Dr Macdonald observed, there is evidence connecting the wellbeing of disability support workers and the quality of their jobs with the provision of better supports and services to people with disability.¹²⁴ In addition, the consistency and capability of disability support workers are undermined when the industry is characterised by low pay, insecure employment, limited support and limited pathways for career development.¹²⁵

In order to increase the viability of disability support work as a career path and to retain workers in the industry for longer, remuneration requires reconsideration. Improvements to the safety

and quality of services and supports, and the value ascribed to the work could also serve to retain workers.

This was confirmed by NDS in its response to Counsel Assisting's submissions following Public hearing 32, which stated:

given the projected growth of Australia's disability sector, policy, funding and price settings must consider a long term, sustainable approach to addressing supply, pay and conditions for workers, removing barriers to employment and strengthening retention of existing workers.¹²⁶

Mr McFarland told us that the principal instrument regulating the employment conditions of disability support workers is the Social, Community, Home Care and Disability Services Industry Award (SCHADS Award), made under the *Fair Work Act 2009* (Cth).¹²⁷ He said the majority of the disability support workforce are employed under the SCHADS Award, including workers who provide services funded through an NDIS package.¹²⁸

In addition, some disability support workers are engaged through enterprise bargaining agreements (EBAs) negotiated with their employers. Mr McFarland explained that these EBAs must, at minimum, meet the working conditions set out in the SCHADS Award.¹²⁹ However, according to Mr McFarland, given the NDIS Price Guide caps the cost of disability support workers based on the award minimum pay and conditions, EBAs are somewhat uncommon in the disability sector.¹³⁰

Representatives of Araluen, Minda, Sunnyfield and Yooralla told us their employees are covered by EBAs.¹³¹ Conditions within the respective EBAs above the SCHADS Award include, for example, the right for casual employees to request permanent employment when employed for nine months, and a contract review every 26 weeks.¹³² Minda's EBA provides employees with higher penalty rates, higher leave loading and greater leave entitlements for shift workers than those provided under the SCHADS Award.¹³³ Dr Panter noted this EBA passed its nominal expiry date in 2016 and is now inconsistent with the 'NDIS worker cost model'.¹³⁴ The entitlements place a financial burden on Minda.¹³⁵ Dr Panter said Minda faced significant sustainability issues, following a \$10.5 million loss in the 2022 financial year.¹³⁶

The SCHADS Award regulates employers in the 'social and community services' and the 'home care' sectors. Employees working in the 'social and community services sector' are referred to as 'Schedule B' or 'SACS' employees. Those working in the 'home care sector' (referred to as Schedule E) are generally paid less than Schedule B/SACS employees.¹³⁷

There are also different levels of employees under the SCHADS Award, corresponding with skills and qualifications (for example, SCHADS Schedule B Award Classification level 2.1, level 2.2, and so on.). A worker's remuneration will therefore depend on which schedule their employment falls within, and the level (and pay point) at which they are working.¹³⁸

Mr McFarland told us that it is not appropriate to classify disability support work under the home care stream of Schedule E of the SCHADS Award. He observed that like level 1 of the SACS/

Schedule B stream, the Schedule E classification description only refers to domestic duties and personal care. It does not refer to implementing participants' skills and activities programs, and supporting participants to live independently.¹³⁹ Mr McFarland suggested that the SACS/ Schedule B stream classifications should be updated to ensure they reflect the contemporary expectations of disability support work, as set out in the NDIS Quality and Safeguarding Framework and *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth).¹⁴⁰

Mr McFarland said he is aware of some employers misclassifying disability support workers as home care workers, or under-classifying disability support work as level 1 work within Schedule B.¹⁴¹ In his opinion, support workers cannot be effectively recruited and retained in a workforce when they are underpaid, and wages cannot be lifted across the disability sector if compliance with the minimum award rates of pay is poor.¹⁴²

The Australian Government, in its response to Counsel Assisting's submissions following Public hearing 32, acknowledged workers paid in accordance with Schedule B of the SCHADS Award receive higher wages than workers engaged under Schedule E of the SCHADS. It submitted the DSW Cost Model, which determines the price limits for supports delivered by providers, is based on the more generous SCHADS Schedule B wage rates.¹⁴³

Following recent decisions by the Fair Work Commission (FWC), known together as the Work Value Case,¹⁴⁴ the minimum rates applicable to home care employees (Schedule E of the SCHADS Award) engaged in aged care increased by 15 per cent from 30 June 2023.¹⁴⁵ The Full Bench of the FWC found the SCHADS Award did not properly compensate workers engaged in the provision of aged care for the value of the work performed.¹⁴⁶ It said the case raised complex issues for determination, including the impact on disability support workers covered by the SCHADS Award. It said those issues require close examination and would benefit from further submissions and potentially further evidence.¹⁴⁷ The related determination in the Work Value Case distinguishes between aged care workers and disability care workers within Schedule E, with aged care workers earning 15 per cent more.¹⁴⁸

The Australian Government noted that the responsibility for setting award wages and conditions lies with the FWC, which is independent of the Australian Government.¹⁴⁹ It further observed the decision in the Work Value Case would create a difference in wages between employees from the two sectors.¹⁵⁰ It said the Department of Social Services would continue to work closely with the Department of Health and Aged Care and the Department of Employment and Workplace Relations on any further input the Government makes to the FWC on this issue as the Work Value Case proceeds.¹⁵¹

While neither the Work Value Case nor the differences in disability support work and aged care were examined in detail at Public hearing 32, we note that a consequence of the decision is aged care workers paid under Schedule E of the SCHADS Award are paid 15 per cent more than disability support workers paid under the same schedule.¹⁵² In our view, there does not appear to be a rational basis for this distinction. We consider there would be benefit in a review of the SCHADS Award to ensure it reflects contemporary expectations of disability support work. This includes the expectation that workers are sufficiently skilled, capable and supported to prevent and respond to violence, abuse, neglect and exploitation.

Recommendation 10.9 The Social, Community, Home Care and Disability Services Award

Organisations entitled to represent the industrial interests of members of the disability support workforce covered by the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2010, along with the Australian Government and employers, should consider a joint application to vary the modern award in accordance with section 158 of the Fair Work Act 2009 (Cth).

This would seek to ensure equal remuneration of workers for work of equal or comparable value in accordance with section 302 of the Fair Work Act 2009 (Cth), paying particular attention to employers' continued use of Schedule E and the 'work value' of contemporary disability support work.

5.2. Participants who may be at increased risk

As discussed in Chapter 1, the introduction of the NDIS fundamentally changed the way disability services are funded and provided across Australia. However, we also heard about the difficulties some people with disability, their families and supporters experience navigating the NDIS and accessing the services and supports they need.

The NDIS is a market-based model for the delivery of services, intended to enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports.¹⁵³ However, the NDIS Quality and Safeguarding Framework indicates it was clear from the outset of the NDIS that many participants would need assistance choosing between providers, to ensure their supports are delivered in a way that meets their needs, and to change providers or make a complaint.¹⁵⁴

During Public hearing 25, 'The operation of the NDIS for First Nations people with disability in remote and very remote communities', Ms Kitsa Papadopoulos, then Branch Manager, Market Intervention and Commissioning at the NDIA, provided the following explanation of how the NDIS should work:

the planner is there to take the person up to that point of where they have a plan ... that includes enough supports and funds to meet their reasonable and necessary needs. And then the design of the scheme then fundamentally is about that person then going out into the market and connecting with all the supports that they need ...

the idea of intermediaries was included because it was recognised that not every participant will be able to do that on their own and they might need some support in order to connect to NDIS and other supports, in order to monitor and manage their plan and for someone to help broker supports for them. So, we have a number of intermediaries. We have local area coordinators which are funded by the NDIA. We have early childhood, early intervention service, also funded by the NDIA.

And then we have plan managers, support coordinators and psychosocial recovery coaches, who can all be purchased by the person through their plan, and they make a choice about who they engage. So, they can find someone who suits them and who they can have a good relationship with.¹⁵⁵

At Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', the South Australian Public Advocate Ms Anne Gale noted that before the NDIS, people in South Australia had a 'case manager' through Disability SA. She said the case manager would assist people to connect to paid disability supports, as well as mainstream community supports, and also help with a range of matters, including applications to the South Australian Civil and Administrative Tribunal and other legal processes. She said under the NDIS the closest equivalent role is that of support coordinator, but observed that there are many roles within the NDIS which participants may need to interact with. Ms Gale described this as a 'significant paradigm shift'.¹⁵⁶

While some NDIS participants benefit from exercising increased choice and control over the services they need, we understand the transition to the NDIS has been very challenging for many participants and their supporters.¹⁵⁷ This includes those who have good levels of education, high English language proficiency and the capacity to navigate other systems.¹⁵⁸

Some people have expressed confusion, frustration and desperation about the way in which NDIS decisions and processes impact the development of NDIS plans and funding allocations.¹⁵⁹ We heard evidence that for some people with disability, the changes brought by the NDIS have reduced the level of support they enjoyed under previous arrangements, including during periods of crisis.¹⁶⁰

We accept that some of the difficulties we heard about may have been caused by the transition to new systems and resulting gaps and weaknesses, which have been identified and addressed as the NDIS has matured. Indeed, during the life of this Royal Commission we heard about changes, new initiatives and processes developed by the NDIA and NDIS Commission in particular to address some of the issues raised by people with disability and their supporters. We welcome these changes and encourage continuous review and ongoing improvement in light of feedback from people with disability.

Particular cohorts face additional barriers

The NDIS might work for people with physical disabilities, but I think that it has made people with cognitive disabilities, like my sister, more vulnerable in some ways, and more at risk of violence, abuse, neglect and exploitation.

Privatisation for Melissa, who may be viewed as a liability for a business due to challenging behaviours, means she has no real choice. The market does not exist for her.¹⁶¹

Several of our public hearings examined the experiences of people living in supported accommodation settings, such as group homes, most of whom have high support needs and live with cognitive disability. The experiences of this cohort are particularly instructive because the ability to exercise choice and control over the design and implementation of an NDIS plan depends on the type of support a person receives from support coordinators, support workers, advocates and informal supporters. We heard people receiving disability services in these environments can be excluded from decision-making about the design and delivery of services. They can also have limited choice over where and with whom they live, their daily routines and whether they can have a partner. These issues are explored in detail in Volume 7.

We also heard from particular groups of people with disability who told us they face additional difficulties navigating the NDIS due to their identity and circumstances. We examined the types of barriers First Nations people, people experiencing homelessness and people from culturally and linguistically diverse backgrounds with disability encounter when attempting to engage with the NDIS. We also looked at the measures needed to remove these barriers.

For example, a June 2021 report prepared by the NDIA on the operation of the NDIS in the remote community of Ngukurr in the Northern Territory found that only three of the 24 participants interviewed knew ‘something’ about the NDIS, and the remaining 21 had little to no knowledge of the aims of it.¹⁶² One participant, who had been in the scheme since 2019, said she ‘didn’t know anything about the NDIS’.¹⁶³

During Public hearing 25, ‘The operation of the NDIS for First Nations people with disability in remote and very remote communities’, witnesses gave examples of how the complexities of the NDIS present barriers at all stages of the scheme, including access to the scheme, and planning and using funds.¹⁶⁴ These issues are discussed in greater detail in Volume 9, *First Nations people with disability*.

Ms Emily Carter, a Gooniyandi and Kija woman and CEO of Marninwarntikura Women’s Resource Centre (MWRC), and Dr Lauren Rice from the University of Sydney, said they considered the NDIS to be worse than the previous WA Disability Services Commission for First Nations people with disability in the Fitzroy Valley.¹⁶⁵ They described the challenges associated with accessing and using the NDIS, including its complexity, the lack of local services and the compounding issue of the housing crisis in the region.¹⁶⁶ They also described the significant and unfunded burden placed on Aboriginal Community Controlled Organisations to fill the gap left when the NDIS does not deliver adequate services for people with disability.¹⁶⁷ They explained the need for a place-based NDIS model, including local NDIA staff, local First Nations community navigators to work alongside NDIA staff, and local services.¹⁶⁸

These barriers were anticipated. The Productivity Commission's 2011 Inquiry report, which preceded the introduction of the NDIS, identified key issues with the existing state and territory systems' provision of disability support services.¹⁶⁹ The report found:

- The challenges obstructing effective service provision to First Nations people with disability were greatly magnified in remote communities.¹⁷⁰
- Disability support services in remote communities were either non-existent or limited to basic care and allied health programs,¹⁷¹ and these services could not provide adequate support for people with complex needs on an ongoing basis.¹⁷²
- It was highly unlikely any disability services would exist in remote communities in the absence of block funding,¹⁷³ due to:¹⁷⁴
 - the absence of a competitive market for disability services
 - social pressures that may be applied to people with disability who manage their own funds.

We accept Counsel Assisting's submission following Public hearing 25 that the design and implementation of the NDIS, as it relates to First Nations people with disability in remote communities, has not adequately addressed the problems identified over a decade ago in the Productivity Commission's report.¹⁷⁵ The NDIS has not been adequately adapted to meet their needs and entitlements, nor does it account for the effects of socioeconomic disadvantage and remoteness.¹⁷⁶

At Public hearing 26, 'Homelessness, including experience in boarding houses, hostels and other arrangements', we heard people with disability experiencing homelessness or living in insecure housing also face particular challenges associated with navigating confusing and complex interacting service systems. These systems include the NDIS, Centrelink, medical services, mental health supports, public and emergency housing systems and homelessness services.

'Colin', a wheelchair user who lives with muscular dystrophy, was made homeless by the devastating Lismore floods in February 2022.¹⁷⁷ In late August 2022, Colin had moved multiple times, staying for short periods of time in temporary accommodation, some of which was not accessible.¹⁷⁸ He expressed his frustration trying to navigate the NDIS, including asking his support coordinator for help:

I thought that accommodation, a roof over your head, is something they are to help with. I don't understand what the criteria is for getting that sort of help from the NDIS, but I don't seem to have met it.¹⁷⁹

Following Public hearing 26, Counsel Assisting submitted:

Colin's experiences following the Lismore flood suggest a discrepancy between the support the NDIA says it can provide to participants who become homeless, and the experiences of some participants.¹⁸⁰

Ms Lisa Short, NDIA State and Territory Manager, New South Wales and Australian Capital Territory, told us the NDIA sets up internal teams in response to natural disasters to target the urgent needs of participants. She said that in response to the early 2022 floods in New South Wales, the NDIA had a dedicated telephone line and a team of NDIS planners directly supporting affected participants by ‘making outbound calls to all participants within the affected local government areas’ and remediating plans for any participants that required additional supports.¹⁸¹ Ms Short told us prior to the hearing that ‘during this natural disaster, no participants required an emergency accommodation response from the NDIS’.¹⁸² At the hearing, she acknowledged the support provided to Colin should have been more proactive.¹⁸³ We agree.

At Public hearing 29, ‘The experience of violence against, abuse, neglect and exploitation of people with disability from culturally and linguistically diverse communities’, we heard that people with disability from culturally and linguistically diverse backgrounds often require additional practical support to complete the processes associated with accessing and navigating services like the NDIS system, such as filling in forms, obtaining medical evidence, understanding information in their preferred language and attending appointments.¹⁸⁴ For example ZA, an Iraqi mother of a child with disability, told us no one had ever explained to her the difference between the NDIA and the NDIS Commission. She said that when she made a complaint about a service provider, she did not know which organisation she had complained to.¹⁸⁵

We also heard that refugees and asylum seekers face particular barriers when accessing and navigating service systems, including the NDIS, due to feelings of stigma or experiences of trauma,¹⁸⁶ difficulties accessing advocacy support¹⁸⁷ and less capacity to self-advocate in a new and confusing system.¹⁸⁸

Identifying participants at heightened risk

In Public hearing 14, we examined the South Australian and Australian governments’ responses to reports of two independent inquiries following the death of Ms Ann-Marie Smith in Adelaide on 6 April 2020. Both reports focused on the need for the NDIA to identify whether NDIS participants are at risk of violence, abuse, neglect and exploitation, and to ensure appropriate safeguards are in place.¹⁸⁹

One of those reports was commissioned by the NDIS Commission and undertaken by the Honourable Alan Robertson SC. His report was titled *Independent review of the adequacy of the regulation of supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020* (Robertson report). Mr Robertson provided his report to the then NDIS Commissioner on 31 August 2020.¹⁹⁰ It was released to the public on 4 September 2020.¹⁹¹

The *Robertson* report described a number of steps in Ms Smith’s interactions with the NDIS as ‘transactional’ and ‘form driven’. He suggested a more person-centred approach to the preparation and approval of her NDIS plan would have provided a ‘fundamental quality and safeguarding measure’.¹⁹²

The first recommendation of the *Robertson* report was:

The [NDIS] Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect ... The Commission and the NDIA should have a freer and two-way flow of information for this purpose.¹⁹³

Mr Graeme Head AO, the then NDIS Quality and Safeguards Commissioner, told us that following receipt of the *Robertson* report, the NDIS Commission and the NDIA agreed to formalise a joint program of work, with a particular focus on the relevant recommendations in the report.¹⁹⁴ This resulted in the development of a 'vulnerable participants framework'.¹⁹⁵

At the hearing, the then CEO of the NDIA, Mr Martin Hoffman, gave evidence about the NDIA's risk-streaming processes and its Participant Risk Assessment Tool (PRAT), which is used by NDIS planners to identify risks and any safeguards, strategies and support mechanisms that may be required in the participant planning phase.¹⁹⁶ Streaming refers to the predicted level of assistance or support a participant may need to navigate the NDIS pathway. Participants may be streamed into general, supported, intensive or super intensive streams.¹⁹⁷ Mr Hoffman also told us about the participant check-in model, which had been rolled out by the NDIA in August 2020.¹⁹⁸ He said that the features of the check-in model included using data to make recommendations about NDIS plan status, engaging in conversations with participants to understand their circumstances, identifying risk and recording risk flags, tailor-made plan updates, and steps to ensure participants have a copy of their plans and understand how they have been updated.¹⁹⁹ At Public hearing 32, Ms Mitra said this program of outreach telephone calls continues, using the same risk indicators and criteria as the PRAT.²⁰⁰

Ms Mitra also said the NDIA and the NDIS Commission had finalised an 'Operational Protocol for NDIS participants at risk' (Operational Protocol) in July 2022.²⁰¹ The purpose of the Operational Protocol is to jointly identify participants who are vulnerable and at risk.²⁰² In addition, the NDIA has finalised work to give the NDIS Commission real-time access to its data on participants and providers so they do not need to go through the process of making a request.²⁰³ We discuss data intelligence and data sharing in Chapter 13, 'Data and intelligence'.

Ms Mitra said the NDIA was also trialling a new business system to enable a 'more joined up' approach for monitoring, escalating and managing participant risk.²⁰⁴ According to the Australian Government, through the progressive implementation of a new Participant Safeguarding Policy, discussed below, the NDIA will consider whether any adjustments to the business system are required. Through the business system, risk indicators will be collected, maintained and updated 'throughout the participant journey' across 'key domains' including:²⁰⁵

- living alone and living circumstances (including housing instability and homelessness)
- provider usage (including having a single provider as an indicator of risk)
- critical incidents and complaints
- plan utilisation, including low plan utilisation.

We acknowledge the work underway by the NDIA and the NDIS Commission to establish systems to enable better information sharing about NDIS participants whose circumstances place them at heightened risk of violence, abuse, neglect and exploitation. This is explored further in Part B.

Safeguarding for participants at risk

Guidance to NDIA staff on safeguards is provided in the *Practice guide – Safeguarding the participant's interests*.²⁰⁶ In addition, for NDIS participants with complex support needs, the NDIA has a complex support needs pathway, which entails higher levels of support from a specialised NDIA planner.²⁰⁷

Mr Hoffman told us that during the planning process, the PRAT prompts NDIA planners to record details of safeguards to be considered for participants when risks are identified.²⁰⁸ Safeguards include:²⁰⁹

- referral to community or mainstream supports
- providing additional information about self-management or choosing providers
- including capacity building supports in the participant's plan.

NDIS participants are supported to implement their plans by either a partner in the community, including a local area coordinator (LAC), or a support coordinator, based on their streaming.²¹⁰ NDIA planners are prompted to communicate information regarding specific participant risks to the relevant person responsible for monitoring a plan through an 'interaction' in the system, a discussion, or (for support coordinators) in the 'Request for Service' form.²¹¹

We agree with the *Robertson* report that once an NDIS participant has been identified as being at heightened risk of violence, abuse, neglect or exploitation, additional safeguards should be put in place to address that risk. The *Robertson* report suggested this could include designating a particular person as responsible for that participant. Recommendation 3 of the *Robertson* report said:

[f]or each vulnerable NDIS participant, there should be a specific person with overall responsibility for that participant's safety and wellbeing. That individual should be clearly identified by name and, ideally, introduced in person, to the vulnerable NDIS participant. (Although not within my terms of reference, that individual should be identified in a participant's plan).²¹²

We consider that the person with overall responsibility could be a case manager 'working holistically' with the person with disability, as case managers did before the introduction of the NDIS.²¹³ Case management is not a concept used in the NDIS.²¹⁴ We heard some NDIS participants with complex needs and their support networks prefer case management because of the extra support or sense of security provided under the model. They would like to see an option for case management under the NDIS.

For example, in Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', 'Eliza' referred to the benefits of an individual case manager for her sister, 'Melissa', given Melissa's ongoing high-support needs.²¹⁵

Similarly, in Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', we heard about ABG, an autistic man with intellectual disability and language delays, who had been diagnosed with several mental health disorders. ABG's mother and sister also live with intellectual disability, and his father uses English as a second language. They and his other sister, ABF, struggled to support him in the family home after he left school and began displaying increasing behaviours of concern.²¹⁶ ABF told us that since the introduction of the NDIS, she has had significant difficulties ensuring ABG receives the supports and services he needs without the assistance of a case manager. This has taken a considerable toll on her life and that of her young family. She described her situation at the time of the hearing as 'a black hole'.²¹⁷ She said, 'I'm an educated person and yet I have had a lot of trouble navigating the system'.²¹⁸

The NDIA's view is that different entities, including the NDIS Commission, the NDIA, disability service providers, NDIS participants themselves and their families, share responsibility for promoting the safety and wellbeing of each participant.²¹⁹ While this may be true in a broad sense, it is unclear how this approach is intended to work for a person with disability who has reduced capacity to take responsibility for their own safety and wellbeing and who does not have family or other informal supporters who can play an active safeguarding role. In addition, service providers generally operate as businesses and our public hearings have revealed situations in which business interests conflicted with the interests of people with disability they support.²²⁰

We acknowledge that the NDIA, in collaboration with the NDIS Commission, has developed a new Participant Safeguarding Policy, which was endorsed by the NDIA's Board in early March 2023 and published in April 2023.²²¹ The NDIA also released an implementation plan with the new policy.²²²

Ms Mitra said the new policy 'will articulate roles and responsibilities of the NDIA within the broader ecosystem responsible for promoting and upholding the safety of people with disability'.²²³ She said it outlines a shift in the NDIA to a 'stronger focus on proactive identification, assessment and management of risk to minimise the likelihood of harm occurring'.²²⁴

The Participant Safeguarding Policy reiterates that safeguarding is a shared responsibility across the NDIS service and support system and mainstream services.²²⁵ Among its focus areas is working with people with disability to proactively develop safeguards, by strengthening their informal support networks.²²⁶ It does not refer to or engage with Recommendation 3 of the *Robertson* report.

Addressing market failures and providers of last resort

I wish there was a provider of last resort because at times life seems like hell without being able to call [the NSW Department of Ageing, Disability and Home Care] and have quick access to experienced professionals who can guide me through tricky situations.²²⁷

The NDIS has led to an unprecedented growth in funding and demand for disability services and supports. We heard some parts of the NDIS market have flourished, responding to the demand for new services by supplying a range of new and innovative support options. The emergence of digital platforms is one example of the market developing accessible technology to link NDIS participants with workers in a way that bypasses traditional employment arrangements, arguably providing greater flexibility, choice and control.

However, significant gaps in the market remain. Some services are unavailable in parts of the country, while in other areas the notion of choice remains illusory due to limited providers delivering services.²²⁸ In Public hearing 25, we heard a lack of culturally appropriate and available services is a key factor contributing to the underutilisation of NDIS plan funds in remote communities, with witnesses experiencing difficulties accessing:

- support workers²²⁹
- medical and allied health services²³⁰
- support coordinators²³¹
- respite services²³²
- Supported Independent Living (SIL) and Specialist Disability Accommodation (SDA)²³³
- assistive technology and accessible transport.²³⁴

The NDIA acknowledged that in remote and very remote communities, there may be a gap between the needs of participants and the services available in the market.²³⁵

To counter the lack of NDIS services for First Nations people in remote communities, we heard block funding of various programs and trials has been used to improve participation and access to the NDIS. As discussed in Volume 9, *First Nations people with disability*, block funding refers to funding that provides specific supports to NDIS participants through a contract between government and a service provider.²³⁶ Block funded programs are said to complement and support the operation of the NDIS by wrapping around individualised funding.²³⁷ The use of block funding may in some circumstances be the difference between First Nations participants living in remote communities receiving a service or not.²³⁸ For this reason, we suggest block funding could be considered an example of 'provider of last resort' arrangements for remote communities.

The Australian Government has accepted that ‘a purely market based approach is insufficient to overcome the structural barriers which impact First Nations people’s access to, and utilisation of, the NDIS in remote communities’.²³⁹ It also accepted that, where market-based interventions are insufficient to address market challenges, ‘more direct interventions may be required, such as through direct commissioning or integration with other government services’.²⁴⁰

It is also apparent that the risk of market failure extends beyond remote communities.

Ms Kitsa Papadopoulos of the NDIA told us that, as market steward, the NDIA has initiated a range of projects across the country, including urban and regional areas, to ensure appropriate market settings.²⁴¹ For example, ‘[i]n April 2020, the [NDIA] commenced a direct commissioning and market facilitation approach to deliver positive behaviour support services across the Australian Capital Territory (ACT). The project was completed in late 2022’.²⁴²

People with disability whose needs are complex can also be affected by failed markets.

For example, when Melissa was issued with a notice from Sunnyfield terminating her accommodation and support services in June 2018, her sister Eliza was unable to find an alternative service provider offering suitable accommodation and supports to meet Melissa’s particular needs.²⁴³ Eliza told us she ‘put Melissa on every waitlist for a new service provider that we could’.²⁴⁴ In Public hearing 3, Ms Janine Toomey, Executive Director, Disability and the NDIS in the Victorian Department of Health and Human Services, told us in many cases, service gaps emerge for complex clients with challenging behaviours due to many providers’ unwillingness to support this cohort at the prices set by the NDIA.²⁴⁵

In Public hearing 14, Ms Lois Boswell, CEO at the Department of Human Services (South Australia), accepted there is still a role for states and territories in providing services to people with disability in certain circumstances.²⁴⁶ She said:

I cannot speak for the future policy of Government about whether they intend to deliver services as a provider of last resort forever. However, in the moment I know that that is the position, is that we have fallen back into the position of provider of last resort.²⁴⁷

In the Commissioners’ *Report of Public hearing 14*, we accepted this view and concluded there is a need for a ‘provider of last resort’ in each Australian jurisdiction.²⁴⁸

We also accept Counsel Assisting’s submissions following Public hearing 26 that:

The introduction of the NDIS has created a situation in which there is no clearly identified, or identifiable provider of last resort for a person with disability who is homeless or at risk of homelessness. There is no government entity with ultimate responsibility for supporting people with disability to move off the pathway to homelessness or to exit from homelessness.²⁴⁹

Counsel Assisting’s written submissions following Public hearing 32 identify various frameworks and initiatives developed by the NDIA to support NDIS participants who are in crisis situations.²⁵⁰ We accept Counsel Assisting’s proposal that the Australian Government, in consultation with the states and territories, establish robust provider of last resort arrangements.²⁵¹

Following Public hearing 32, the Australian Government agreed ‘in principle that the market mechanism for responding to situations of crisis require further discussion and development’.²⁵² However, it suggested this requires a ‘range of mechanisms’ rather than a specific provider of last resort approach. It said work needs to be done to enhance the capacity of NDIS providers to fulfil their responsibilities ‘to manage participants experiencing a crisis’, as well as to consult with states and territories responsible for mainstream services and systems to develop their roles in supporting people with disability in crisis.²⁵³

While we agree that enhancing the capacity of both existing NDIS providers and mainstream services to assist people with disability experiencing crises would be beneficial, we do not accept that it obviates the need for a provider of last resort in some cases. This includes in areas where there are no suitable NDIS providers or mainstream services available.

After the NDIS Review

We recognise that since the introduction of the NDIS, and during the course of our inquiry, the NDIA has taken steps to improve its ability to deliver the supports and services needed by people with disability. This includes people living in remote First Nations communities, as well as people with particularly complex support needs. It is premature for us to assess the efficacy of many of these measures.

Following the completion of the NDIS Review, it will be incumbent on the Australian Government to make further changes to the scheme, considering not only the Review report, but also what we learned from people with disability, their families and supporters about the challenges they experienced navigating the NDIS and accessing safe, high-quality services.

In particular, there should be further consideration of the efficacy of existing systems to identify participants at risk of violence, abuse, neglect and exploitation, through information sharing between the NDIA and NDIS Commission. When someone is assessed to be at risk, we consider additional supports should be put in place, including referrals to advocacy services as discussed in Chapter 4, Responding to violence, abuse, neglect and exploitation in disability services’.

In addition, it is essential the Participant Safeguarding Policy is regularly evaluated. This will ensure risks are properly identified during the planning process and beyond, and adequate funding and mainstream referral arrangements are included in plans for additional safeguarding supports. This is critical for those who have few natural safeguards. As part of an evaluation, the NDIA should revisit Recommendation 3 of the *Robertson* report to assess whether those who have been identified as vulnerable or at heightened risk of violence, abuse, neglect and exploitation would benefit from the model outlined in his recommendation.

Finally, we recommend the Australian Government engage in urgent discussions with state and territory governments about funding and arrangements for a provider of last resort scheme, and consult broadly about how such a scheme could operate, including access to case management.

Recommendation 10.10 Provider of last resort

The Australian Government should urgently engage with state and territory governments about funding and arrangements for a provider of last resort scheme. It should also consult with people with disability, disabled people's organisations, disability representative organisations including member-led First Nations community-controlled organisations, and peak bodies about how such a scheme could operate.

The scheme should be designed to address:

- failed or thin markets, particularly for First Nations people with disability in remote or very remote areas, and consider the use of block funding to guarantee service provision in those communities
- access to services for:
 - people in crisis situations
 - people at risk of losing their accommodation and disability services
 - people whose needs cannot be adequately met by existing services
- access to case management for people with disability at heightened risk of violence, abuse, neglect or exploitation
- clarity about which agency has the lead coordinating role.

The Australian Government should put forward a proposal for discussion to the Disability Reform Ministers Council in 2024.

Endnotes

- 1 Queensland Advocacy Incorporated, Submission in response to *Promoting inclusion issues paper*, June 2021, ISS.001.00665, p 12.
- 2 Alan Robertson, *Independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020*, Report to the Commissioner of the NDIS Quality and Safeguards Commission, 31 August 2020, p 41; Exhibit 14-216, DRC.2000.0008.0673, p 41; Government of South Australia, *Safeguarding Taskforce report*, July 2020, p 21.
- 3 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023; Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-114–28; Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-113–28.
- 4 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [13], referring to Exhibit 32-4.3, EXP.0108.0002.0706, pp 38–39.
- 5 Exhibit 24-91, CTD.9999.0072.0001, p 10.
- 6 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-284 [29–33].
- 7 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 104–49 [371–533].
- 8 Submission by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 5; Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 29 [80].
- 9 Submission by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.
- 10 Exhibit 32-159, DRC.9999.0203.0001, pp 30–35.
- 11 Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-106 [12–19].
- 12 Submission by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 6; See also Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-284 [38–47].
- 13 Submission by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.
- 14 Exhibit 24-91, CTD.9999.0072.0001, p 10.
- 15 Such as permanent or casual employees.
- 16 For example, through a labour hire company.
- 17 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 19 [66].
- 18 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 5 [13].
- 19 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 19 [66].
- 20 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [49].
- 21 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [29].
- 22 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [30].
- 23 Exhibit 24-91, CTD.9999.0072.0001, p 15.
- 24 Exhibit 24-91, CTD.9999.0072.0001, p 15.
- 25 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [62].
- 26 Exhibit 32-50, MIN.9999.0001.0001, [2(a)(i)]; Transcript, Laura O'Reilly, Public hearing 32, 17 February 2023, P-416 [13–21].
- 27 Exhibit 32-50, MIN.9999.0001.0001, p 6.
- 28 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [18–19].
- 29 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [18–19]. See also Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [20].
- 30 Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-119 [16].
- 31 Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-119 [5–12].
- 32 Exhibit 32-72, ARA.9999.0003.0008, [42].
- 33 Transcript, Emily Korir, Public hearing 32, 14 February 2023, P-151 [32–34].
- 34 Exhibit 32-143, HUP.9999.0001.0001, p 23.

35 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [37].
 36 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [37].
 37 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [37].
 38 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [38].
 39 Transcript, Angus McFarland, Public hearing 32, 14 February 2023, P-124 [14–26].
 40 Exhibit 32-143, HUP.9999.0001.0001, p 23; Exhibit 32-47, BET.9999.0001.0002, [5];
 Exhibit 32-143, HUP.9999.0001.0001, p 23; Exhibit 32-47, BET.9999.0001.0002, [5];
 Exhibit 32-49, LBS.9999.0001.0001, [5].
 41 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [36].
 42 Submission by the Australian Government in response to Counsel Assisting's submissions in
 Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 19 [65].
 43 Submission by the Australian Government in response to Counsel Assisting's submissions in
 Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 19 [67].
 44 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
 31 March 2023, pp 128 [455] – 131 [466], 229 [852] – 232 [863].
 45 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [11]; Exhibit 32-162,
 CTD.8000.0046.0001.
 46 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [13]; Transcript, Gerrie Mitra,
 Public hearing 32, 17 February 2023, P-472 [18–47].
 47 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [14]; Transcript, Gerrie Mitra,
 Public hearing 32, 17 February 2023, P-465 [37–40].
 48 Exhibit 32-162, CTD.8000.0046.0001, p 5.
 49 Exhibit 25-169, CTD.9999.0080.0001, p 64.
 50 Exhibit 25-169, CTD.9999.0080.0001, p 81 (footnote 17).
 51 Exhibit 32-209, CTD.9999.0107.0001, p 10.
 52 Transcript, Gerrie Mitra, Public hearing 32, 17 February 2023, P-465 [29–40].
 53 Submission by the Australian Government in response to Counsel Assisting's submissions
 in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 17 [56].
 54 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [11].
 55 See, for example, Exhibit 32-2, 'Statement of Zelda Riddell', 25 January 2023, at [25–29];
 Exhibit 23-59, 'Statement of Dianne', 2 May 2022, at [40]; Transcript, Andrew Hyland, Public
 hearing 32, 15 February 2023, P-214 [4–8]; Transcript, Tamara Cattach, Public hearing 32,
 15 February 2023, P-214 [10–20].
 56 Exhibit 32-2, 'Statement of Zelda Riddell', 25 January 2023, at [25–29].
 57 Exhibit 32-2, 'Statement of Zelda Riddell', 25 January 2023, at [25–29].
 58 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [29]; Exhibit 32-2,
 'Statement of Zelda Riddell', 25 January 2023, at [25–29].
 59 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [33].
 60 Names changed to protect identities; Exhibit 23-56, 'Statement of Erynn', 2 May 2022, at [20];
 Exhibit 2359, 'Statement of Dianne', 6 July 2022, at [40].
 61 Transcript, Andrew Hyland, Public hearing 32, 15 February 2023, P-214 [5–8].
 62 Transcript, Tamara Cattach, Public hearing 32, 15 February 2023, P-214 [12–18].
 63 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [98].
 64 Submission by National Disability Services in response to Counsel Assisting's submissions
 in Public hearing 32, SUBM.0056.0001.0069, p 3.
 65 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [27], [33].
 66 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [33].
 67 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [102].
 68 Submission by the Australian Government in response to Counsel Assisting's submissions
 in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, [37].
 69 Submission by National Disability Services in response to Counsel Assisting's submissions
 in Public hearing 32, SUBM.0056.0001.0069, p 5.
 70 Exhibit 32-1, 'Statement of Sam Petersen', 24 January 2023, at p 7.
 71 Exhibit 32-1, 'Statement of Sam Petersen', 24 January 2023, at pp 10–11.
 72 Exhibit 32-4, 'Statement of Dr Fiona Macdonald', 3 February 2023, at [24].
 73 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-121 [36–47].
 74 Exhibit 32-49, LBS.9999.0001.0001, [5].

75 Transcript, David Panter, Public hearing 32, 14 February 2023, P-167 [46]–P-168 [2].
76 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [44–45].
77 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [10–35], [37–39].
78 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [38–42].
79 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [5], [45–46].
80 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, [865–80].
81 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [108].
82 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [113].
83 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [114].
84 See *Disability Services Safeguards Act 2018* (Vic) ss 258–260 as cited in Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [114].
85 Transcript, Daniel Stubbs, Public hearing 32, 14 February 2023, P-134 [16–19].
86 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [196].
87 Transcript, Daniel Stubbs, Public hearing 32, 14 February 2023, P-142 [40]–P-143 [6].
88 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [6(b)].
89 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [6(b)].
90 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [222].
91 Transcript, David Panter, Public hearing 32, 14 February 2023, P-168 [8–14].
92 *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) ss 4(1), 9(1).
93 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-286 [26–31], P-287 [8–9].
94 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-286 [45]–P-287 [10].
95 Transcript, Laura O’Reilly, Public hearing 32, 17 February 2023, P-428 [1–9].
96 Exhibit 32-3, ‘Statement of Angus McFarland’, 25 January 2023, at [64].
97 Exhibit 32-3, ‘Statement of Angus McFarland’, 25 January 2023, at [56], [66].
98 Exhibit 32-3.1, SUB.999.06557, pp 30–31.
99 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-125 [18–20].
100 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-125 [23–24].
101 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-125 [18–29].
102 Transcript, Fiona Macdonald, Public hearing 32, 14 February 2023, P-125 [26–33].
103 Transcript, Andrew Hyland, Public hearing 32, 15 February 2023, P-216 [5]; Transcript, Tamara Cattach, Public hearing 32, 15 February 2023, P-217 [27–29]; Transcript, Joanne Toohey, Public hearing 32, 14 February 2023, P-216 [15–20].
104 Transcript, Andrew Hyland, Public hearing 32, 15 February 2023, P-216 [1–5].
105 Transcript, Tamara Cattach, Public hearing 32, 15 February 2023, P-217 [27–29].
106 Transcript, David Panter, Public hearing 32, 14 February 2023, P-158 [35–45].
107 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-285 [7–35].
108 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [35–45].
109 Exhibit 32-3, ‘Statement of Angus McFarland’, 25 January 2023, at [66]; Exhibit 32-3.1, SUB.999.06557, p 45.
110 Exhibit 32-3, ‘Statement of Angus McFarland’, 25 January 2023, at [62].
111 Exhibit 32-3.1, SUB.999.06557, p 23.
112 Exhibit 32-3.1, SUB.999.06557, p 45.
113 Exhibit 32-3.1, SUB.999.06557, p 24.
114 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [44]–P-452 [3].
115 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [212–13].
116 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [216].
117 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-287 [8–10].
118 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-286 [41–43].
119 Exhibit 32-5, ‘Statement of Daniel Stubbs’, 16 January 2023, at [217–19].
120 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-453 [9–13].
121 Exhibit 32-4, ‘Statement of Dr Fiona Macdonald’, 3 February 2023, at [102–03].
122 Transcript, Peter Scutt, Public hearing 32, 17 February 2023, P-427 [37–43].
123 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-452 [35–45].
124 Exhibit 32-4, ‘Statement of Dr Fiona Macdonald’, 3 February 2023, at [27].
125 Exhibit 32-4, ‘Statement of Dr Fiona Macdonald’, 3 February 2023, at [26–28].

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- 126 Submission by National Disability Services in response to Counsel Assisting's submissions in Public hearing 32, SUBM.0056.0001.0069, p 5.
- 127 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [15].
- 128 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [23].
- 129 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [16].
- 130 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [17].
- 131 Exhibit 32-66, ARA.9999.0002.0022, at [19(a)]; Exhibit 32-50, MIN.9999.0001.0001, at [3]; Exhibit 3274, SUN.9999.0006.0001, at [3.1]; Exhibit 32-164, YPL.9999.0002.0004, at [117]. See also Exhibit 32-71, DRC.9999.0199.0001; Exhibit 32-75, DRC.9999.0198.0603; Exhibit 32-52, DRC.9999.0198.0184.
- 132 Exhibit 32-72, ARA.9999.0003.0001, p 4 [19(b)(iii)]; Exhibit 32-71, DRC.9999.0199.0001, at [12.6]; Exhibit 32-74, SUN.9999.0006.0001, p 4 [3.2 (a)]; Exhibit 32-75, DRC.9999.0198.0603, p 5 [10].
- 133 Transcript, David Panter, Public hearing 32, 14 February 2023, P-160 [15–30].
- 134 Exhibit 32-50, MIN.9999.0001.0001, p 4 [3].
- 135 Exhibit 32-50, MIN.9999.0001.0001, p 4 [3]; Transcript, David Panter, Public hearing 32, 14 February 2023, P-160 [25–30].
- 136 Transcript, David Panter, Public hearing 32, 14 February 2023, P-160 [40–45].
- 137 Exhibit 32-155, DRC.9999.0198.0498, pp 17–24; Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [21–42].
- 138 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [35–36].
- 139 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [37].
- 140 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [42].
- 141 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [43].
- 142 Exhibit 32-3, 'Statement of Angus McFarland', 25 January 2023, at [47].
- 143 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 14 [43].
- 144 *Aged Care Work Value Decision* [2022] FWCFB 44; *Aged Care Work Value Decision* [2022] FWCFB 118; *Aged Care Work Value Decision* [2022] FWCFB 154; *Aged Care Work Value Decision* [2022] FWCFB 200; *Aged Care Work Value Decision* [2023] FWCFB 40; *Aged Care Work Value Decision* [2023] FWCFB 45.
- 145 *Aged Care Work Value Decision* [2022] FWCFB 200, [55].
- 146 *Aged Care Work Value Decision (Stage 2)* [2023] FWCFB 40, [15].
- 147 *Aged Care Work Value Decision* [2022] FWCFB 200, at [902–03].
- 148 *Aged Care Work Value Determination* [2023] MA000100 PR751296.
- 149 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 13 [40].
- 150 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 14 [41].
- 151 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, p 14 [42].
- 152 *Aged Care Work Value Determination* [2023] MA000100 PR751296.
- 153 *National Disability Insurance Scheme Act 2013* (Cth) s 3(1)(e).
- 154 Department of Social Services, NDIS Quality and Safeguarding Framework, December 2016, p 6.
- 155 Transcript, Kitsa Papadopoulos, Public hearing 25, 15 July 2022, P-393 [4–20].
- 156 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [78–79].
- 157 Exhibit 6-5, 'Statement of ABF', 9 September 2020, at [19], [117–20]; Exhibit 26-10, 'Statement of Colin', 5 August 2022, at [40–41]; Exhibit 29-20, 'Statement of ZA', 21 October 2022, at [27–29]; Exhibit 2546, 'Statement of Stella (Topsy) Jackamarra', 22 June 2022, at [41–44]; Exhibit 25-19, 'Joint Statement of Kunmanara (Margaret) Smith and Kim McRae', 21 June 2022, at [73], [96–98], [100–01]; Exhibit 25-64, 'Joint Statement of Emily Carter and Lauren Rice', 20 June 2022, at [30–32].
- 158 See, for example, Exhibit 25-41, 'Statement of Geoff Davis', 15 June 2022, at [43]; Exhibit 25-8, 'Statement of Joan', 22 June 2022, at [79–80].
- 159 See, for example, Exhibit 25-12, 'Statement of Jody Ann Barney', 11 June 2022, at [29]; Exhibit 26-10, 'Statement of Colin', 5 August 2022, at [30–41], [98–100].

160 See for example Exhibit 25-46, 'Statement of Stella (Topsy) Jackamarra', 22 June 2022, at [28–29]; Exhibit 25-64 'Joint Statement of Emily Carter and Lauren Rice', 20 June 2022, at [84–85]; Exhibit 25-19, 'Joint Statement of Kunmanara (Margaret) Smith and Kim McRae', 21 June 2022, at [41]; Exhibit 26-10, 'Statement of Colin', 5 August 2022, at [40–41].

161 Exhibit 13-2, 'Statement of Eliza', 29 April 2021, at [122–23].

162 Exhibit 25-130, CTD.8000.0032.0348, p 11.

163 Exhibit 25-130, CTD.8000.0032.0348, p 11.

164 Exhibit 25-19, 'Joint Statement of Kunmanara (Margaret) Smith and Kim McRae', 21 June 2022, at [100]; Exhibit 25-8, 'Statement of Joan', 22 June 2022, at [79]; Exhibit 25-15, 'Statement of Emily Sherwood', 24 June 2022, at [27].

165 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [84].

166 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [35], [34(e)], [48–70].

167 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [46]; Transcript, Emily Carter, Public hearing 25, 13 July 2022, P-251 [26–32].

168 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [34], [40–41], [43], [86].

169 Exhibit 15-11.21, DRC.1000.0007.1894.

170 Exhibit 15-11.21, DRC.1000.0007.1894, pp 554–55.

171 Exhibit 15-11.21, DRC.1000.0007.1894, pp 531, 544, 555.

172 Exhibit 15-11.21, DRC.1000.0007.1894, p 544.

173 Prior to the National Disability Insurance Scheme, governments contracted disability service providers directly with lump sum payments known as 'block funding'.

174 Exhibit 15-11.21, DRC.1000.0007.1894, p 557.

175 Submissions of Counsel Assisting the Royal Commission following Public hearing 25, 11 November 2022, p 42 [126].

176 Submissions of Counsel Assisting the Royal Commission following Public hearing 25, 11 November 2023, p 140 [509].

177 Name changed to protect identity.

178 Transcript, Colin, Public hearing 26, 29 August 2022, P-68–71.

179 Exhibit 26-10, 'Statement of Colin', 5 August 2022, at [101]. See also: Transcript, Colin, Public hearing 26, 29 August 2022, P-79 [26–43].

180 Submissions of Counsel Assisting the Royal Commission following Public hearing 26, 18 November 2022, [349].

181 Exhibit 26-29, 'Statement of Lisa Short', 3 August 2022, at [137].

182 Exhibit 26-29, 'Statement of Lisa Short', 3 August 2022, at [137].

183 Transcript, Lisa Short, Public hearing 26, 31 August 2022, P-231 [43–48].

184 Exhibit 29-21, 'Statement of Esther Simbi', 28 October 2022, at [60].

185 Transcript, ZA, Public hearing 29, 27 October 2022, P-304 [18–46]. Name changed to protect identity.

186 Transcript, Eman, Public hearing 29, 27 October 2022, P-312 [42–43], P-317 [16–26]; Transcript, Muzhgan, Public hearing 29, 27 October 2022, P-315 [19–20], P-317 [36–41]; Transcript, Zara, Public hearing 29, 27 October 2022, P-316 [46–57]–P-317 [1–10]; Transcript, Anaab Rooble, Public hearing 29, 26 October 2022, P-240 [31–35]; Exhibit 29-16, 'Statement of Kylie Scoullar', 24 October 2022, at [18], [41].

187 Transcript, Giancarlo de Vera, Public hearing 29, 26 October 2022, P-189 [21–39].

188 Transcript, Kylie Scoullar, Public hearing 29, 27 October 2022, P-285 [27–38].

189 Exhibit 14-217, SAG.0002.0023.0114, p 9; Exhibit 14-216, DRC.2000.0008.0673, p 7 [Recommendation 1].

190 Exhibit 14-216, DRC.2000.0008.0673, p 2.

191 NDIS Quality and Safeguards Commission, *Media release*, 4 September 2020. <www.ndiscommission.gov.au/media-centre/robertson-report-released-independent-review-ndis-commission-oversight-and-death-ann>

192 Exhibit 14-216, DRC.2000.0008.0673, pp 46–47.

193 Exhibit 14-216, DRC.2000.0008.0673, p 7.

194 Exhibit 14-183, 'Statement of Graeme Head AO', 14 May 2021, at [39].

195 Exhibit 14-183, 'Statement of Graeme Head AO', 14 May 2021, at [40].

196 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [37–40]; Exhibit 14-205, CTD.8000.0013.0334.

197 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [31–32].

198 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [72].

199 Exhibit 14-202, 'Statement of Martin Hoffman', 6 July 2021, at [72].

200 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [132–36].

201 Exhibit 32-195, CTD.7200.0040.1250; Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, p 37 [194(f)].

202 Transcript, Gerrie Mitra, Public hearing 32, 17 February 2023, P-471 [25–27].

203 Transcript, Gerrie Mitra, Public hearing 32, 17 February 2023, P-471 [31–33].

204 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [140]; Transcript, Gerrie Mitra, Public hearing 32, 17 February 2023, P-471 [37–42].

205 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 17, 9 March 2023, SUBM.0045.0001.0252, p 18 [61].

206 Exhibit 14-209, CTD.8000.0009.9329.

207 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [51].

208 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [40].

209 Exhibit 14-205, CTD.8000.0013.0334, p 19.

210 Exhibit 14-209, CTD.8000.0009.9329, p 21.

211 Exhibit 14-209, CTD.8000.0009.9329, p 21.

212 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 70.

213 See, for example, the description of the pre-NDIS case manager role in Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [78] and Exhibit 6-5, 'Statement of ABF', 9 September 2020, at [145]. See also the proposal for a case manager role in Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [73].

214 Transcript, Kitsa Papadopoulos, Public hearing 25, 15 July 2022, P-392 [20].

215 Names changed to protect identity.

216 Exhibit 6-5, Statement of ABF, 9 September 2020, at [6], [9]. Names changed to protect identity.

217 Exhibit 6-5, Statement of ABF, 9 September 2020, at [137].

218 Exhibit 6-5, Statement of ABF, 9 September 2020, at [19].

219 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [75]; Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [111].

220 See, for example, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, p 87, Finding 9; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 8, Finding 22.

221 Transcript, Gerrie Mitra, Public hearing 32, 17 February 2023, P-471 [29–31]; Submissions by the Australian Government in response to Counsel Assisting's submissions following Public hearing 17, 9 March 2023, at [55].

222 National Disability Insurance Scheme, Participant Safeguarding Policy, April 2023; National Disability Insurance Scheme, Participant Safeguarding Policy, Implementation Plan 2023–2027, April 2023.

223 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [144].

224 Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [158].

225 National Disability Insurance Scheme, Participant Safeguarding Policy, April 2023, p 10.

226 National Disability Insurance Scheme, Participant Safeguarding Policy, April 2023, p 18.

227 Exhibit 6-5, 'Statement of ABF', 9 September 2020, at [145].

228 Exhibit 25-23, 'Statement of Beth Walker', 1 June 2022, at [25].

229 Exhibit 25-14, 'Statement of Paulette', 11 May 2022, at [29]; Exhibit 25-34, 'Statement of Joanne Houghton', 21 June 2022, at [37]; Exhibit 25-19, 'Joint Statement of Kunmanara (Margaret) Smith and Kim McRae', 21 June 2022, at [60]; Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [63].

230 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [64]; Exhibit 2519, 'Joint Statement of Kunmanara (Margaret) Smith and Kim McRae', 21 June 2022, at [57]; Exhibit 258, 'Statement of Joan', 22 June 2022, at [36(d)]; Exhibit 25-1, 'Statement of Daisy', 21 June 2022, at [39], [53].

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- 231 Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [56]; Exhibit 25-15, 'Statement of Emily Sherwood', 24 June 2022, at [29]; Exhibit 25-62, 'Pre-recorded video statement of Mudge', 3 June 2022; Exhibit 25-42, 'Pre-recorded video statement of Jazsikah', 8 June 2022.
- 232 Exhibit 25-63, 'Transcript of pre-recorded video statement of Mudge (Eric) Bedford', 3 June 2022, p 12 [15–25]; Exhibit 25-43, 'Transcript of pre-recorded evidence of Jazsikah', 8 June 2022, p 9 [12–17]; Exhibit 25-34, 'Statement of Joanne Houghton', 21 June 2022, at [48]; Exhibit 25-64, 'Joint Statement of Emily Carter and Dr Lauren Rice', 20 June 2022, at [66–67].
- 233 Transcript, Bakoi Namok, Public hearing 25, 12 July 2022, P-169 [9–14]; Exhibit 25-23, 'Statement of Beth Walker', 1 June 2022, at [16].
- 234 Exhibit 25-1, 'Statement of Daisy', 21 June 2022, at [32], [34], [41]; Exhibit 25-5, 'Statement of Emily Sherwood', 24 June 2022, at [47], [62]; Exhibit 25-34, 'Statement of Joanne Houghton', 21 June 2022, at [37]; Exhibit 25-46, 'Statement of Stella (Topsy) Jackamarra', 22 June 2022, at [88–89].
- 235 Exhibit 25-107, 'Statement of Kitsa Papadopoulos', 14 June 2022, at [13]. See also Exhibit 25-130, CTD.8000.0032.0596, p iii; Exhibit 15-130, CTD.8000.0032.0596, p 1.
- 236 Exhibit 25-159, 'Supplementary Statement of Scott McNaughton and Kitsa Papadopoulos', 29 July 2022, p 3, footnote 4.
- 237 Transcript, Kitsa Papadopoulos, Public hearing 25, 14 July 2022, P-339 [16–21].
- 238 Exhibit 15-11.21, DRC.1000.0007.1894, p 557.
- 239 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 25, 14 December 2023, SUBM.0042.0001.0001, p 4 [9].
- 240 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 25, 14 December 2023, SUBM.0042.0001.0001, p 5 [14].
- 241 Exhibit 25-107, 'Statement of Kitsa Papadopoulos', 14 June 2022, at [99].
- 242 Exhibit 25-107, 'Statement of Kitsa Papadopoulos', 14 June 2022, at [94(a)].
- 243 Transcript, Eliza, Public hearing 13, 14 May 2021, P-75 [22–30].
- 244 Exhibit 13-2, 'Statement of Eliza', 29 April 2021, at [67].
- 245 Exhibit 3-27, 'Statement of Janine Toomey', 26 November 2019, at [149].
- 246 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [1–16].
- 247 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [10–16].
- 248 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 14: Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)*, June 2022, [327].
- 249 Submissions of Counsel Assisting the Royal Commission following Public hearing 26, 18 November 2022, [140–49].
- 250 Exhibit 14-209, CTD.8000.0009.9329, p 8; Exhibit 17-32.01, CTD.9999.0043.0001, at [21]; Exhibit 14-209, CTD.8000.0009.9329, p 9; Exhibit 32-9, 'Statement of Gerrie Mitra', 19 December 2022, at [106].
- 251 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, [847].
- 252 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, [35].
- 253 Submission by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 31 March 2023, SUBM.0056.0003.0005, [35].

Part B: NDIS Quality and Safeguards Commission

Key points

- The NDIS Quality and Safeguards Commission (NDIS Commission) is the key oversight and regulatory agency for ensuring a quality standard of supports and services is provided to people with disability under the National Disability Insurance Scheme.
- The number of complaints and reportable incidents reported to the NDIS Commission is continually rising. Additional measures are needed to enable greater focus on people with disability at heightened risk of abuse.
- We have identified areas where the NDIS Commission could enhance the performance of its functions, in particular by incorporating active engagement with NDIS participants and the disability sector, and increasing its compliance and enforcement measures.
- Model safeguarding policies and procedures should be developed to help providers more effectively respond to incidents and complaints by distilling best practice approaches. This will help prevent duplicated effort.
- The NDIS Commission should collect and publish more disaggregated data about people with disability involved in complaints and reportable incidents, as well as operational performance data.
- Inadequate information sharing arrangements and legislative provisions are restricting the NDIS Commission and other bodies from readily exchanging information critical to safeguarding people with disability.
- The NDIS Commission's efforts to enhance its data systems need to keep pace with its rapidly expanding remit to enable it to make intelligence-driven decisions about operational priorities.

6. Introduction

The primary responsibility for preventing and responding to violence against, and abuse, neglect and exploitation of, people with disability lies with the relevant service providers. However, much responsibility also lies with the NDIS Quality and Safeguards Commission (NDIS Commission) as the principal body regulating National Disability Insurance Scheme (NDIS) supports and services. We heard at public hearings that the oversight of NDIS services does not always operate as intended. The evidence points to gaps in the regulatory settings and the resourcing of the NDIS Commission.

In this part we examine key issues arising from the evidence about preventing, identifying and responding to violence, abuse, neglect and exploitation in NDIS services. We also examine the NDIS Commission's functions, performance and resourcing and where these need to be strengthened or developed. In doing so, we have also sought to identify the NDIS Commission's efforts and achievements.

The key operational areas and regulatory functions of the NDIS Commission explored in this part concern:

- reportable incidents
- complaints
- provider registration
- behaviour support
- compliance and investigations
- data and intelligence
- engagement and capacity building
- worker screening.

We outline how these operational areas and functions intersect. Our recommendations are aimed at enhancing the overall oversight capability and responsiveness of the NDIS Commission.

6.1. About the NDIS Commission

The NDIS Commission was established by section 181A of the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*).¹ It was established for the purpose of furthering the objects and principles of the *NDIS Act*, the NDIS Quality and Safeguarding Framework² and the *Convention on the Rights of Persons with Disabilities*.³

Established in July 2018, the NDIS Commission's fundamental purpose is to improve the quality and safety of NDIS supports and services. Its core functions include upholding the rights of people with disability; promoting the health, safety and wellbeing of people with disability; developing nationally consistent approaches to quality and safeguarding; and securing compliance with the *NDIS Act*.⁴

The NDIS Commission regulates all NDIS providers of supports and services for people with disability. A staged approach to its regulatory oversight was rolled out across the states and territories between 1 July 2018 and 1 December 2020.⁵

The NDIS Commission receives complaints about NDIS providers and workers, and notifications from 'registered NDIS providers' about reportable incidents. A registered NDIS provider is a person or organisation registered with the NDIS Commission in accordance the *NDIS Act*.⁶ The NDIS Commission also oversees NDIS behaviour support practitioners and providers who use behaviour support strategies and regulated restrictive practices.

As the national registration body for NDIS providers, the NDIS Commission sets the standard of quality and safety among the large number of registered providers. It does this through industry education and monitoring providers' compliance with their conditions of registration.⁷ These conditions include compliance with incident and complaint management system requirements and the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) (*Code of Conduct*), which require taking steps to prevent and respond to violence against, and abuse, neglect and exploitation of, people with disability.⁸ Unregistered providers must also adhere to the *Code of Conduct*. The NDIS Commission has powers and enforcement tools to bring about compliance by NDIS providers.⁹

In its five years of operation, the NDIS Commission has made a positive contribution to improving the safety and quality of NDIS supports and services. For example, it has:

- developed the NDIS Workforce Capability Framework and the Positive Behaviour Support Capability Framework¹⁰ and distributed Practice Alerts about a wide range of topics to NDIS providers
- instigated legislative change to enhance information sharing with worker screening units,¹¹ improve banning order provisions,¹² and impose necessary conditions on registered providers within the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth)¹³
- completed the Own Motion Inquiry into Aspects of Supported Accommodation¹⁴
- commenced three civil penalty proceedings in the Federal Court of Australia against NDIS providers for failing to meet their obligations.¹⁵

The NDIS Commission also faces substantial challenges:

- Its workload is increasing. This is, in part, due to the staggered rollout of its jurisdiction, providers becoming more aware of and more likely to comply with their obligation to report incidents, and NDIS participants becoming more aware of their rights. The NDIS market

is also expanding. Over 570,000 Australians are accessing the NDIS,¹⁶ and this figure is projected to exceed one million by 2032.¹⁷ The provider market also continues to expand, with the number of providers registered with the NDIS Commission increasing from around 8,300 as at 30 June 2019 to over 19,300 as at 31 December 2022.¹⁸

- It has staffing and resourcing constraints. The NDIS Commission has had to invest its scarce resources into managing a large number of complaints and reportable incident notifications.¹⁹ In addition, resourcing constraints²⁰ have restricted its ability to enhance the performance of its functions and build its data collection and analytics capability.²¹
- Its systems and processes are not capable of dealing with the volume of complaints it receives and the level of analysis required to identify systemic issues.²² This impacts its performance and its ability to meet demands and progress incoming matters in a timely way.²³

6.2. Issues identified

The Royal Commission has identified the following issues concerning the NDIS Commission:

- There is scope for the NDIS Commission to more actively engage with people with disability, monitor and regulate NDIS providers, and address non-compliance.
- Gaps remain in the complaints and reportable incidents models, which rely on NDIS participants and their support networks knowing their rights and understanding NDIS provider obligations. Complaint and reportable incident processes are lengthy and communication with people with disability is often poor.
- The NDIS Commission needs to do more to improve its 'visibility', enhance NDIS participants' knowledge of their right to complain and build the capacity of providers to comply with their complaint handling and reportable incident obligations.
- To increase confidence in the NDIS Commission, it should be more transparent about its performance and activities. It should collect and publish more disaggregated data about people with disability involved in complaints and reportable incidents and the outcomes of matters it oversees.
- Inadequate information sharing arrangements and legislative provisions are restricting the NDIS Commission and other bodies from readily exchanging information critical to safeguarding people with disability.
- Registered NDIS providers experience considerable regulatory and cost burdens associated with registration, quality audit processes and compliance with their reporting obligations. These issues arise, in part, from overly complicated processes and inefficient reporting systems. Some stakeholders have emphasised the need for more effective regulation to hold providers to account.
- NDIS providers' policies and procedures for managing complaints and reportable incidents are inconsistent. The evidence also suggests some NDIS providers and disability support workers are not complying with their obligations to notify the NDIS Commission of reportable incidents or are unaware of their obligations.

6.3. Our recommendations

The recommendations in this volume are intended to:

- address the NDIS Commission's resourcing challenges and better support its staff to effectively manage complaints and reportable incidents
- enable the NDIS Commission to better focus on high-risk reportable incidents and complaints
- enhance the NDIS Commission's complaints and reportable incidents processes to improve how they are experienced by people with disability, their supporters and NDIS providers
- build the knowledge of NDIS participants, especially First Nations and culturally and linguistically diverse people, about their right to complain and the role of the NDIS Commission
- enhance NDIS providers' capability to effectively resolve complaints
- strengthen NDIS providers' obligations in relation to complaints and incidents management and governance, and enhance related guidelines and training
- reduce unnecessary regulatory burden on registered NDIS providers without compromising the safety of people with disability
- complement existing initiatives to improve access by NDIS participants to behaviour support practitioners, especially in rural and remote locations
- help the NDIS Commission to more actively engage with NDIS participants, improve its monitoring of service providers and strengthen its compliance and enforcement approach
- enable more seamless two-way exchange of information about safeguarding risks with other government oversight bodies, worker screening units and approved quality auditors
- increase the NDIS Commission's communication with NDIS providers and participants about identified trends and systemic issues
- ensure the NDIS Commission's data systems support it to make intelligence-driven decisions about operational priorities
- improve the collection, analysis and publication of operational data about the exercise of the NDIS Commission's functions.

Endnotes

- 1 *National Disability Insurance Scheme Act 2013* (Cth) s 181A. The NDIS Commissioner's functions and powers are set out in s 181D, and the Commissioner's core functions are set out in s 181E.
- 2 Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [10], [18–21]; Department of Social Services, *NDIS Quality and Safeguarding Framework*, December 2016, p 15.
- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 3; *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).
- 4 *National Disability Insurance Scheme Act 2013* (Cth) s 181E.
- 5 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 8; Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [46]; Exhibit 5-48, 'Statement of Samantha Taylor', 13 August 2020, at [51–52].
- 6 *National Disability Insurance Scheme Act 2013* (Cth) s 73E.
- 7 *National Disability Insurance Scheme Act 2013* (Cth) s 181F(c)–(d); Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [50], [53].
- 8 *National Disability Insurance Scheme Act 2013* (Cth) ss 73F(2), 73J; *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) s 6(f).
- 9 *National Disability Insurance Scheme Act 2013* (Cth) ss 55A–57 and ch 4, pt 3A, div 8; *Regulatory Powers (Standard Provisions) Act 2014* (Cth) pts 2–7.
- 10 'NDIS Workforce Capability Framework', *NDIS Quality and Safeguards Commission*, web page, 7 November 2022. <<https://www.ndiscommission.gov.au/workers/worker-training-modules-and-resources/ndis-workforce-capability-framework>>; NDIS Quality and Safeguards Commission, *Positive Behaviour Support Capability Framework*, July 2019.
- 11 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [161]; *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) s 11(8).
- 12 *National Disability Insurance Scheme Act 2013* (Cth) ss 73ZN(1), 73ZN(2); *National Disability Insurance Scheme Amendment (Strengthening Banning Orders) Act 2020* (Cth).
- 13 For example, *National Disability Insurance Scheme Act 2013* (Cth) ss 4A, 13, 13A–13C, 24, 16A, 26A; *National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2019 Measures No. 1) Rules 2019* (Cth); *National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2021 Measures No. 1) Rules 2021* (Cth); 'New NDIS Practice Standards and Quality Indicators', *NDIS Quality and Safeguards Commission*, web page, 9 January 2023. <www.ndiscommission.gov.au/providers/registered-ndis-providers/provider-obligations-and-requirements/ndis-practice-standards>
- 14 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023.
- 15 NDIS Quality and Safeguards Commission, *NDIS Commission commences legal action over the death of an NDIS participant*, media release, 6 December 2021; NDIS Quality and Safeguards Commission, *NDIS Commission commences legal action against Integrity Care*, media release, 29 March 2022; NDIS Quality and Safeguards Commission, *NDIS Commission commences legal action over the death of an NDIS participant*, media release, 3 April 2023.
- 16 'The NDIS in each state', *National Disability Insurance Agency*, web page, 20 February 2023. <www.ndis.gov.au/understanding/ndis-each-state>
- 17 National Disability Insurance Agency, *Projected participant by state and territory data*, Dataset, 30 June 2022.
- 18 NDIS Quality and Safeguards Commission, *Annual report 2018–19*, October 2019, p 18; NDIS Quality and Safeguards Commission, *Activity report: 1 October to 31 December 2022*, January 2023, p 5.
- 19 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 258–59 [981].
- 20 Exhibit 32-007, 'Statement of Tracy Mackey', 25 November 2022, at [204–05].
- 21 Exhibit 32-007, 'Statement of Tracy Mackey', 25 November 2022, at [97], [102], [156], [159], [208].
- 22 Exhibit 32-007, 'Statement of Tracy Mackey', 25 November 2022, at [97], [156], [164], [171].
- 23 Exhibit 32-007, 'Statement of Tracy Mackey', 25 November 2022, at [97], [102]; Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, at P-453 [39–45], P-454 [1–5].

7. Current context

Key points

- The NDIS Quality and Safeguards Commission (NDIS Commission) is the key oversight and regulatory agency for ensuring a quality standard of supports and services is provided to people with disability under the National Disability Insurance Scheme.
- The NDIS Commission has a number of core functions including upholding the rights of people with disability; promoting the health, safety and wellbeing of people with disability; developing nationally consistent approaches to quality and safeguarding and securing compliance with the *National Disability Insurance Scheme Act 2013* (Cth).
- The NDIS Commission is subject to oversight and external scrutiny in the performance of its functions and powers. This oversight is provided by parliamentary committees, the Commonwealth Ombudsman and the Auditor-General through performance audits of the NDIS Commission's operations, as well as through decisions by administrative tribunals.
- A number of past reports and inquiries have made findings and recommendations about the NDIS Commission and its role. They suggest some of its processes could be more accessible and that the NDIS Commission should be more active in ensuring the quality and safety of services.

The NDIS Quality and Safeguards Commission (NDIS Commission) is the key oversight and regulatory agency for the supports and services provided to people with disability under the National Disability Insurance Scheme (NDIS).

After a staggered rollout, the NDIS Commission had national coverage from 1 December 2020.¹ All the NDIS Commission's functions were fully operational from 1 February 2021 when national worker screening arrangements commenced in all jurisdictions except the Northern Territory, where they began on 1 July 2021.²

In this chapter, we describe the legislative and policy framework establishing the NDIS Commission. We also explain how its functions are overseen by other bodies and provide an overview of relevant past and ongoing reports and inquiries concerning the NDIS Commission.

7.1. The NDIS Commission

The NDIS Commissioner

The NDIS Commission consists of the NDIS Quality and Safeguards Commissioner (the NDIS Commissioner) and the NDIS Commissioner's staff.³ Mr Graeme Head AO, was the inaugural NDIS Commissioner. He was appointed on 16 December 2017 and took up the statutory office on 1 July 2018.⁴ The current NDIS Commissioner, Ms Tracy Mackey, was appointed for a three-year term commencing 10 January 2022.⁵

Functions and powers of the NDIS Commission

The NDIS Commission's function is to assist the NDIS Commissioner in carrying out the Commissioner's functions.⁶

The NDIS Commissioner's core functions are to:⁷

- uphold the rights, and promote the health, safety and wellbeing of people with disability receiving supports or services, including those received under the NDIS
- develop a nationally consistent approach to managing quality and safeguards for people with disability receiving supports or services, including those received under the NDIS
- promote the provision of advice, information, education and training to NDIS providers and people with disability
- secure compliance with the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) through effective compliance and enforcement arrangements, including through the monitoring and investigation functions conferred on the NDIS Commissioner
- promote continuous improvement among NDIS providers and the delivery of progressively higher standards of supports and services to people with disability
- develop and oversee the broad policy design for a nationally consistent framework relating to the screening of workers involved in the provision of supports and services to people with disability
- provide advice or recommendations to the National Disability Insurance Agency (NDIA) or the Board of the NDIA in relation to the performance of the NDIA's functions
- engage in, promote and coordinate the sharing of information to achieve the objects of the *NDIS Act*
- provide NDIS market oversight, including by monitoring changes in the NDIS market that may indicate emerging risk, and by monitoring and mitigating the risks of unplanned service withdrawal.

The NDIS Commissioner also has functions set out in the *NDIS Act* relating to:

- registration and reportable incidents⁸
- complaints⁹
- behaviour support.¹⁰

The NDIS Commissioner is supported by key management personnel responsible for specific functions, including the:¹¹

- Registrar, to oversee registration of providers
- Complaints Commissioner, to oversee the complaints function
- Senior Practitioner, to oversee activities for the behavioural support function.

The *NDIS Act* provides the NDIS Commissioner with additional powers to carry out these functions.¹² For example, compliance and enforcement powers assist the NDIS Commissioner to promote best practice among NDIS providers and their compliance with obligations under the *NDIS Act*, and to respond to risk to NDIS participants.

In addition to powers set out in the *NDIS Act*, a number of the NDIS Commission's activities are prescribed through a series of rules, commonly referred to as 'the NDIS Rules'.¹³

7.2. Oversight of the NDIS Commission's activities

As a non-corporate Australian Government entity within the Social Services portfolio, the NDIS Commission is accountable under the *Public Governance, Performance and Accountability Act 2013* (Cth) and the *Public Service Act 1999* (Cth).

The NDIS Commission is also subject to oversight and external scrutiny in the performance of its functions and powers. This oversight is provided by parliamentary committees, the Commonwealth Ombudsman and the Auditor-General through performance audits of the NDIS Commission's operations, as well as by administrative tribunals when cases are brought before them.

The NDIS Commission has been the subject of a number of external independent inquiries and past reports. Reoccurring themes in these reports include the lack of public awareness of the NDIS Commission and its role, inaccessible NDIS Commission processes and the need for the NDIS Commission to be more active in its approach to ensuring the quality and safety of services.¹⁴

Joint Standing Committee on the NDIS

The Joint Standing Committee on the NDIS (Joint Standing Committee) was appointed by resolution of the House of Representatives on 4 July 2019 and the Senate on 22 July 2019.

The Joint Standing Committee is required to inquire into the following:¹⁵

- the implementation, performance and governance of the NDIS
- the administration and expenditure of the NDIS
- such other matters in relation to the NDIS as may be referred to it by either House of the Parliament.

On 23 June 2020, the Joint Standing Committee decided to conduct an inquiry, on its own initiative, into the NDIS Commission after issues with the oversight and regulation of disability service providers emerged.¹⁶ The *NDIS Quality and Safeguards Commission* report was tabled in Parliament in November 2021.¹⁷ The report identified areas where the NDIS Commission could improve how it worked, including in relation to registration audits, the complaints process, behaviour support arrangements and NDIS Commission systems. The Joint Standing Committee also recommended the NDIS Commission engage more actively with participants and the disability sector, and enhance its compliance and enforcement measures.¹⁸

In February 2022, the Joint Standing Committee's *NDIS workforce final report* contained eight recommendations with the NDIS Commission having a role to input on data, training and upskilling initiatives for disability support workers.¹⁹

Commonwealth Ombudsman

The Commonwealth Ombudsman has power to consider and handle complaints, undertake investigations and make recommendations about the administration of the NDIS.²⁰ This includes investigating complaints about the NDIS Commission's actions and decisions,²¹ the provider registration process and the NDIS Commission's handling of a complaint.²²

The Commonwealth Ombudsman cannot direct the NDIS Commission to take action or change a decision. However, where the Ombudsman considers an agency's actions are deficient, it can suggest or recommend the agency revisit the matter or provide a remedy.²³

The Commonwealth Ombudsman told us in a submission that, following the NDIS Commission's commencement of operations in July 2018, the Ombudsman received 30 complaints in 2018–19 and 74 complaints in 2019–20.²⁴ By comparison, the Ombudsman received 1,711 complaints in 2018–19 and 1,331 complaints in 2019–20 about the NDIA.²⁵ The complaints concerning the NDIS Commission have predominantly related to its handling of complaints. At the time of its submission in February 2021, the Ombudsman told us it was satisfied the NDIS Commission generally responds appropriately to complaints it receives.²⁶

The NDIS Review

An independent review of the NDIS is currently underway (NDIS Review). The final report, with findings and recommendations, is due to be presented to the Disability Reform Ministerial Council by October 2023. The terms of reference for the NDIS Review include examination

of the design, operations and sustainability of the NDIS and ways to build a more responsive and supportive market and workforce. The roles of and interactions between the NDIA, NDIS Commission and Australian Government Department of Social Services, and the NDIS Commission's operational models and costs will also be explored.²⁷

7.3. NDIS Commission reviews, reports and own motion inquiries

To improve its operation and practices, the NDIS Commission can commission reviews and reports. Early in 2019, it commissioned a scoping review to understand the prevalence of, and factors contributing to, the deaths of people with disability (Scoping Review). The Scoping Review included findings and recommendations on practice improvement.²⁸

The NDIS Commissioner also commissioned an independent review into the adequacy of the NDIS Commission's regulation of the provision of NDIS supports and services to Ms Ann-Marie Smith. Ms Smith was a NDIS participant who lived alone in her own home and received services from a registered provider. She died on 6 April 2020 after being neglected for a substantial period.²⁹ The review was undertaken by the Honourable Alan Robertson SC and a report was completed in 2020 (*Robertson report*).³⁰ The then NDIS Commissioner, Mr Graeme Head AO, gave evidence about the NDIS Commission's response to the *Robertson* report, including that the NDIS Commission and the NDIA agreed to formalise a joint program to consider the report recommendations.³¹ This resulted in the development of a 'vulnerable participants framework'.³²

In addition to commissioning reports, the NDIS Commission may initiate its own inquiries and produce reports that include findings and observations about how it will improve its own practices. The NDIS Commission has powers to initiate and conduct own motion inquiries about supports or services delivered by NDIS providers that are the subject of a complaint or a reportable incident, or a series of complaints or reportable incidents.³³

The NDIS Commission commenced its first Own Motion Inquiry into aspects of supported accommodation in August 2021. The NDIS Commission commenced its first Own Motion Inquiry into Aspects of Supported Accommodation in August 2021. This followed a series of reportable incidents and complaints about supported living arrangements. The NDIS Commission published a report in January 2023.³⁴ The inquiry examined the nature of complaints and reportable incidents received by the NDIS Commission between 1 July 2018 and 30 September 2022 in connection with supported accommodation services (specifically, group homes) operated by seven of Australia's largest disability service providers. The NDIS Commission published an Action Plan documenting how it would implement changes arising from the inquiry.³⁵

On 13 February 2023, the NDIS Commission announced a second Own Motion Inquiry into Platform Providers Operating in the NDIS Market. NDIS platform providers are online platforms and online subscription services that connect workers with NDIS participants. This inquiry aims to better understand how services accessed through platform providers support people with disability to exercise choice and control and facilitate the delivery of quality NDIS funded services.³⁶

Endnotes

- 1 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 8; Exhibit 5-48, 'Statement of Samantha Taylor', 13 August 2020, at [51–52].
- 2 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 22.
- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 181A.
- 4 Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [7].
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- 12 *National Disability Insurance Scheme Act 2013* (Cth) s 181D.
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- 15 'Committee Resolution', *Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia*, web page. <www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/Committee_Resolution>
- 16 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp xix, 1.
- 17 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021.
- 18 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p xix.
- 19 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS workforce final report*, February 2022, Appendix 3 'NDIS workforce interim report recommendations and Australian Government response', recommendations 4, 5, 12, 13; See also NDIS Quality and Safeguards Commission, *Annual report 2021–22*, p 65.
- 20 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 3.
- 21 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 2.
- 22 'National Disability Insurance Scheme', *Commonwealth Ombudsman*, web page. <www.ombudsman.gov.au/complaints/australian-government-agency-complaints/national-disability-insurance-scheme>
- 23 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 3.
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- 25 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 4.
- 26 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 4.
- 27 Exhibit 32-160, CTD.7200.0040.1180, pp 2–3.
- 28 Carmela Salomon & Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia: Findings*, August 2019; Carmela Salomon & Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia: Summary of key findings*, August 2019; Carmela Salomon and Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia: Summary of recommendations*, August 2019.
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- 30 Alan Robertson, *Independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020: Report to the Commissioner of the NDIS Quality and Safeguards Commission*, August 2020.
- 31 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [39].
- 32 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [40]; Exhibit 5-48, ‘Statement of Samantha Taylor’, 13 August 2020, at [64(b)], [89].
- 33 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 27; *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 29.
- 34 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023.
- 35 NDIS Quality and Safeguards Commission, ‘Own Motion Inquiry into aspects of supported accommodation – Action Plan’, *NDIS Quality and Safeguards Commission*, web page. <www.ndiscommission.gov.au/own-motion-inquiry-aspects-supported-accommodation-action-plan>
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8. Reportable incidents

Key points

- There is a strong connection between effective responses to violence, abuse, neglect and exploitation and the prevention of such issues in the future.
- The reportable incidents function of the NDIS Quality and Safeguards Commission (NDIS Commission) is critical to improving responses to violence against, and abuse, neglect and exploitation of, people with disability.
- The insights gained from the reportable incidents function provide valuable intelligence for the NDIS Commission's registration, compliance and investigation functions.
- The number of reportable incidents reported to the NDIS Commission is continually rising. This is not necessarily due to an increase in incidents, but may be in part attributable to a better understanding of reporting obligations. Additional measures are needed to reduce the volume of reportable incidents and enable the NDIS Commission to give greater attention to people with disability at heightened risk of abuse.
- Despite the NDIS Commission having operated for five years, some large National Disability Insurance Scheme (NDIS) providers are not fully complying with their incident management and reporting obligations.
- There are deficiencies in NDIS providers' management of reportable incidents, including the quality of provider-led investigations.
- The NDIS Commissioner should issue a guideline detailing the core components of accessible and responsive complaint handling and investigative practice.
- Model safeguarding policies and procedures should be developed to help providers more effectively respond to incidents and complaints by distilling best practice approaches, and to reduce duplicated effort.
- The NDIS Commission should improve its handling of reportable incidents, including by reducing timeframes, improving communication with parties and enhancing the online reporting system for providers.
- The NDIS Commission should establish a panel of suitably credentialed 'safeguarding' investigators and make greater use of its ability to require providers to engage independent expert investigators when appropriate.

Management of ‘reportable incidents’ is a key responsibility of the NDIS Quality and Safeguards Commission (NDIS Commission) under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act).¹ A ‘reportable incident’ is defined to mean:²

- the death of a person with disability
- serious injury to a person with disability
- abuse or neglect of a person with disability
- unlawful sexual or physical contact with, or assault of, a person with disability (excluding incidents of unlawful physical contact where the impact on the person with disability is ‘negligible’)³
- sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity
- the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a state or territory in relation to the person.

When a reportable incident occurs, registered National Disability Insurance Scheme (NDIS) providers are obliged to report this to the NDIS Commission within a prescribed period of time. The first contact an NDIS provider or support worker will often have with the NDIS Commission will be in connection with the reportable incidents function.

A registered NDIS provider’s obligation to report certain incidents serves to provide the NDIS Commission with considerable information about serious incidents affecting people with disability. Although reporting incidents is mandatory for registered NDIS providers, people with disability and their families are more likely to report abuse and neglect to their NDIS provider if they have confidence in the regulatory framework and the independent body responsible for implementing it.

We heard that the NDIS Commission’s reportable incidents processes can be lengthy and involve poor communication with providers, people with disability and their families. Some people perceive the NDIS Commission to be inactive and inattentive once a reportable incident is reported. We also heard concerns the NDIS Commission relies too heavily on information from providers when overseeing their management of a reportable incident, and does not sufficiently test the accuracy of the information.

We identified the need to examine the efficacy of current reporting practices given the immense volume of notifications the NDIS Commission receives, and likelihood that its staff struggle to ‘see the wood for the trees’. For example, in the 2021–22 financial year the NDIS Commission received 1,438,931 notifications of reportable incidents, including the unauthorised use of restrictive practices.⁴ The NDIS Commission has had to invest resources into managing a large volume of complaints and reportable incident notifications.⁵ With its current resources, it is not able to assess and respond to matters or exercise regulatory intervention in a timely way.⁶

We make recommendations aimed at streamlining reportable incident oversight processes so they are proportionate and less of a regulatory burden on NDIS providers who have demonstrated a history of managing incidents well. These processes should be geared towards investing greater effort on matters concerning individuals identified as being at greater risk of experiencing violence, abuse, neglect and exploitation.

In Public hearing 32, 'Service providers revisited', NDIS providers gave evidence about the need for the NDIS Commission to provide them with additional guidance on the more challenging areas of safeguarding practice.⁷ In public hearings and in submissions we heard about several troubling issues around registered NDIS providers' responses to incidents.⁸ The experiences were often made worse by ineffective prevention strategies and poor organisational responses.

These issues include:

- provider non-compliance with reporting obligations
- lack of knowledge of incident management requirements within the disability workforce
- inadequate safeguarding policies, procedures and models for responding to incidents (as well as inconsistent practices across the sector)
- poor quality investigations undertaken by individuals lacking safeguarding expertise
- limited involvement of people with disability in investigation processes
- insufficient attention given to linking people with disability with communication supports and advocacy services
- inadequate capture and analysis of incident data by NDIS providers to identify and mitigate risks to individuals and within the service environment
- failure to apologise or offer other suitable forms of redress to people with disability and their families impacted by violence, abuse, neglect and exploitation
- mismanagement of incidents by providers' governing bodies and senior leadership.

The NDIS Commission has a critical role to play in identifying and informing the disability sector about systemic issues and practice trends detected through its oversight function. This role extends to working with people with disability, advocates and NDIS providers to ensure that adequate guidance and resources are developed. These aim to improve safeguarding practices by frontline staff all the way up to a provider's governing body. To this end, we recommend the NDIS Quality and Safeguards Commissioner (NDIS Commissioner) co-designs and develops with the disability sector a guideline for accessible and responsive complaint handling and investigative practice that upholds the rights of people with disability. In Recommendation 10.15, we recommend the NDIS Commissioner issues this guideline by notifiable instrument under section 181D(2) of the *NDIS Act*. We also recommend the NDIS Commission develops model complaint and incident management policies in conjunction with people with disability and the disability sector to promote sector-wide consistency and quality.

Providers also told us they would like to see more reporting by the NDIS Commission about reportable incidents to help monitor performance, systemic issues and trends and to drive sector-wide improvements.⁹

The NDIS Commission is uniquely placed to identify and share the many good practices that have been implemented by NDIS providers, including new and innovative models used to manage complaints and incidents. The NDIS Commission must regularly interact with stakeholders to remain in touch with the challenges being faced ‘on the ground’ by NDIS participants and providers alike. Without this knowledge, it is difficult for the NDIS Commission to play a role as an agent of change.

There are many similarities between the complaints and reportable incidents functions. It is no surprise that many issues identified concerning the reportable incidents function parallel those relating to the complaints handled by the NDIS Commission described in the following chapter. For this reason, we have made several recommendations at the end of this chapter that are intended to enhance both complaint handling and incident management practices.

8.1. Overview of the reportable incidents function

The NDIS reportable incident scheme provides independent oversight of serious incidents.¹⁰ The scheme imposes enforceable obligations on registered providers and allows the NDIS Commission to conduct impartial assessments of incidents and providers’ responses to incidents.

As a condition of registration, NDIS providers must notify the NDIS Commission of particular serious incidents or alleged serious incidents that have occurred in connection with the provision of supports and services that have (or could have) caused harm to an NDIS participant. Providers must appropriately manage and act upon those incidents.¹¹

The timeframes for reporting incidents, and the types of information that must be provided, to the NDIS Commission are set out in the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) (*Incident Management Rules*). All reportable incidents must be notified to the NDIS Commission within 24 hours of the NDIS provider becoming aware of them, with the exception of the use of unauthorised restrictive practices, which must be reported within five days.¹²

The then NDIS Commissioner, Mr Graeme Head AO, explained the NDIS Commission:¹³

- receives and assesses reportable incidents and manages notifications of reportable incidents from providers
- responds to and oversees the provider’s investigation and management of reportable incidents
- investigates reportable incidents in certain circumstances
- refers matters to other relevant authorities when required.

The reportable incidents process

Registered NDIS providers use the NDIS Commission's online portal to notify it of reportable incidents and provide relevant information. These providers must also keep the NDIS Commission updated with any new information it becomes aware of, and provide the NDIS Commission with a final report if requested to do so.¹⁴

The *Incident Management Rules* set out the information a provider must supply when notifying the NDIS Commission of an incident, including:¹⁵

- a description of the reportable incident
- a description of the impact on, or harm caused to, the person with disability
- the immediate actions taken in response to the reportable incident.

Upon receiving notification of a reportable incident, the NDIS Commission may do one or more of the following:¹⁶

- gather additional information to assess and respond to the incident
- require the provider to conduct an investigation
- conduct its own inquiry in relation to the incident.¹⁷

For both reportable incidents and complaints, the NDIS Commission may decide to investigate any allegations of possible non-compliance with the *NDIS Act* or other matters that arise.¹⁸

Provider obligations in relation to incident management

A provider registered with the NDIS Commission must comply with a range of rules and obligations as a condition of registration. An unregistered provider is not registered with the NDIS Commission and is only required to comply with the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth).¹⁹

As a condition of registration, registered providers must maintain incident management systems and act to prevent recurrent incidents, including but not limited to reportable incidents.²⁰

A registered provider must establish procedures for identifying, managing and resolving incidents. This includes how incidents are identified, recorded and reported; who is responsible for reporting incidents to the NDIS Commission; how affected people with disability will be supported and involved in the management and resolution of the incident; and when corrective action is required.²¹

A provider's incident management system must require an assessment of all incidents to be performed, considering the views of people with disability affected by the incident. In doing so, the provider must assess (among other matters) whether the incident could have been prevented and what, if any, remedial action it should take to prevent further similar incidents or to minimise their impact.²²

The *Incident Management Rules* also require providers to afford procedural fairness when dealing with an incident and keep documents or records of specific details in relation to each incident that occurs.²³

8.2. What the data is telling us

Table 10.8.1 shows the number of reportable incident notifications made to the NDIS Commission each financial year and the proportion of these notifications that relate to the use of unauthorised restrictive practices (URPs). The use of a restrictive practice is ‘unauthorised’ if its use has not been approved in accordance with any applicable state or territory authorisation requirements and/or it is not used in accordance with a behaviour support plan for the participant.²⁴

Table 10.8.1: Reportable incidents received between 2018–19 and 2021–22

Reportable incident type	2018–19	2019–20	2020–21	2021–22
Alleged sexual misconduct	173	350	418	439
Any death	353	838	1,179	1,921
Alleged unlawful physical or sexual contact	539	1,671	2,030	2,443
Serious injury including accidents	641	1,854	3,189	4,178
Alleged abuse and neglect	1,213	3,637	5,971	7,655
Use of unauthorised restrictive practices (URP)	1,358	289,417	903,018	1,422,295
Total (including URP)	4,277	297,767	915,805	1,438,931
Total (excluding URP)	2,919	8,350	12,787	16,636

Note: The NDIS Commission commenced operating in New South Wales and South Australia from 1 July 2018, with Victoria, Queensland, Northern Territory, Australian Capital Territory and Tasmania commencing on 1 July 2019 and Western Australia on 1 December 2020.

Source: NDIS Commission annual activity reports, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme Report* (2022).²⁵

The data in Table 10.8.1 indicates that around 99 per cent of all reportable incident notifications made to the NDIS Commission after 1 July 2019 related to the use of unauthorised restrictive practices. The incident notifications involving alleged abuse and neglect are consistently the highest category of incidents, excluding notifications concerning unauthorised restrictive practices. These made up 46 per cent of incident notifications in

2021–22, with the second highest category being those involving serious injuries including accidents, at around 25 per cent.

The data in Table 10.8.1 demonstrates the vast increase in the workload of the reportable incidents function as the NDIS Commission commenced operating in each state and territory. As of December 2022, over 570,000 Australians were accessing the NDIS,²⁶ and the National Disability Insurance Agency (NDIA) projects the number of participants will exceed one million by 2032.²⁷ As the numbers grow, the volume of reportable incidents notified to the NDIS Commission will continue to rise. We explore resourcing issues and demand across the NDIS Commission's functions in Chapter 16, 'Resourcing'.

8.3. Process and procedural issues

In this section we examine issues raised with us about the NDIS Commission's processes and procedures underpinning its reportable incident function.

Overreliance on information from providers

A challenge for the NDIS Commission and operators of similar oversight schemes is striking the right balance between overseeing providers' responses to reportable incident notifications and directly intervening. This is particularly so given the substantial volume of matters under its watch. A theme raised in public hearings and submissions is the NDIS Commission's dependence on the information NDIS providers report to it when it is overseeing the provider's management of an incident.

What we heard

Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', considered a reportable incident involving 'Sophie', an NDIS participant who resided at a home operated by Life Without Barriers (LWB).²⁸

Case study: The reportable incident concerning ‘Sophie’ and Life Without Barriers

We heard evidence about the alleged assault of Sophie by her support worker on 26 March 2019.²⁹ LWB notified the NDIS Commission of this incident on 13 May 2019.³⁰ LWB emailed a copy of its investigation report about the incident to the NDIS Commission on 11 September 2019.³¹

The report noted that a support worker admitted she had pushed Sophie, resulting in Sophie falling over. But the report showed that LWB did not sustain the allegation that the worker had assaulted Sophie.³² The then Acting NDIS Commissioner, Ms Samantha Taylor, said she was concerned the reportable incidents officer did not identify ‘this potential issue’ on receipt of the report.³³

In responding to the incident, LWB documented a range of issues concerning its management of the incident, staff training and rostering at the house.³⁴ In one document, LWB noted that the support worker involved responded to Sophie ‘in an inappropriate manner’ and ‘went to extreme lengths to ignore [Sophie]’.³⁵

This particular document was not provided to the NDIS Commission in LWB’s response to the reportable incident.³⁶

In its submissions following the hearing, LWB said the failure to provide this document was unintentional and inadvertent.³⁷ Ms Taylor expressed the view that the document would have assisted the NDIS Commission.³⁸ Ms Taylor said the NDIS Commission does not check if a provider has produced all relevant documents and information about an incident, but emphasised that it is a condition of registration for providers to assure the NDIS Commission they are managing an incident appropriately.³⁹

In Public hearing 13, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)’, ‘Eliza’ gave evidence about an incident of co-resident violence at a home operated by NDIS provider, Sunnyfield.⁴⁰ She told us that another resident grabbed her sister, ‘Melissa’, by the hair.⁴¹ Sunnyfield reported the incident to the NDIS Commission and said the support workers managed the incident by locking Melissa alone in the bathroom. Eliza told us Melissa’s behaviour support plan recorded she was a drowning risk and should not be left alone in a bathroom. Eliza was concerned that the NDIS Commission accepted the report from Sunnyfield without talking to Melissa’s family or reading the plan.⁴²

As far as possible, the reportable incidents function should pay careful attention to investigation reports and other information or documents provided as part of the reportable incident notification, and require providers to address any evidentiary gaps and concerns. NDIS Commission staff should also contact the people with disability involved and their families where there are concerns about a provider’s handling of an incident to gain a full understanding of its issues and causes. Reportable incidents procedures should be reviewed and amended where required to reflect this.

Improving oversight processes

A number of NDIS providers raised concerns about the NDIS Commission's processes for overseeing incidents, including the efficiency of its online reporting system and timeframes for responding to matters.⁴³

In its evidence to Public hearing 32, Endeavour Foundation, a registered NDIS provider, described the process of reporting incidents to the NDIS Commission as 'primarily a one-way process'. Endeavour said it regularly gets questions back from the NDIS Commission, but 'nothing substantive' to inform it about the quality of its response or the issues that led to the incident. Endeavour said the NDIS Commission has sector-wide oversight and the opportunity to provide 'significant value-add' to providers.⁴⁴

A report by the Victorian Office of the Public Advocate suggested the NDIS Commission should encourage increased and better-quality reporting by making it simpler for support workers to report instances of abuse.⁴⁵ The report states that guidance material should cover how to report instances of abuse and include the steps and follow-up that should take place to respond.⁴⁶

National Disability Services (NDS), the peak body for non-government disability service providers, told us the NDIS Commission should foster a more collaborative relationship with providers as it matures. It suggested this would allow greater opportunity for the regulator to hear from providers about the barriers they face in providing safe and high-quality services.⁴⁷ NDS noted (based on results from its 2020 survey) only 29 per cent of providers surveyed believed the NDIS Commission was working well with providers, with 33 per cent saying that was not the case.⁴⁸

The Joint Standing Committee on the NDIS (Joint Standing Committee) heard similar issues about the NDIS Commission's approach to its reportable incidents and complaints functions, including poor communication with people with disability and providers.⁴⁹ In its 2021 report on the NDIS Commission, the Joint Standing Committee said aspects of the reportable incidents framework should be addressed to 'strike the right balance' between ensuring providers understand their obligations to notify the NDIS Commission of serious incidents and ensuring providers are not subjected to unnecessary burdens.⁵⁰

In Public hearing 20, Ms Taylor told us that improvements to reportable incidents and complaints processes will enable staff to undertake a more thorough review of investigation reports of reportable incidents conducted by or on behalf of providers.⁵¹

What else is required?

The NDIS Commission should evaluate the effectiveness of its internal reportable incidents procedures. It should pay particular attention to its engagement with providers, communicating feedback about the quality of providers' incident handling and the accessibility and useability of the online portal used by providers to report incidents.

To encourage ongoing compliance by registered providers and adequate capturing of reportable incidents data, the NDIS Commission should look at simplifying and streamlining reporting processes while ensuring that required information is still included and relevant data captured.

In Chapter 13, 'Data and intelligence' we propose the Australian Government assess whether the NDIS Commission is adequately resourced to remediate or replace its information and communication technology systems to ensure they are fit for purpose. This includes addressing issues concerning duplication of effort by providers when they are required to enter information on two systems.

The NDIS Commission should publish information about any refinements made to its complaints and reportable incident procedures on its website. It should remain open to receiving ongoing feedback about how to further refine its processes from participants and providers through surveys, consultative committees and stakeholder forums.

Recommendation 10.11 Internal procedures for monitoring reportable incidents

The NDIS Quality and Safeguards Commission should improve its internal procedures for monitoring reportable incidents, paying particular attention to:

- a. communicating feedback about the quality of providers' handling of incidents
- b. seeking clarification from providers, National Disability Insurance Scheme participants and their families when deficiencies or evidentiary gaps are identified, particularly where participants have been harmed or are at immediate risk of harm
- c. the efficiency of the online portal used by providers to report incidents.

Controlling volume to focus on risk

Like many oversight bodies, the NDIS Commission's workload is high and its resources are finite. At Public hearing 32, we heard from a number of registered NDIS providers about their experiences of reporting incidents to the NDIS Commission. Ms Annie Doyle, CEO of NDIS provider, Civic Disability Services, said if they were uncertain about whether an incident should be reported, they would report it anyway.⁵² It was put to current NDIS Commissioner, Ms Tracy Mackey, that the evidence suggested an approach was being taken by many providers of 'when in doubt, just make the notification'.⁵³ Ms Mackey said the NDIS Commission has seen an increase in complaints and is receiving more reportable incident notifications as more providers begin to understand their reporting obligations.⁵⁴

Any incident notification that does not meet the reportable incident threshold should be quickly treated, finalised or referred appropriately. Ms Mackey said the NDIS Commission is undertaking a major review of reportable incidents to understand if a particular provider may be under-reporting or over-reporting, given their size and scope of activities.⁵⁵

The NDIS Commission's *Own Motion Inquiry into aspects of supported accommodation* Inquiry report (*Own Motion Inquiry* report) said the NDIS Commission is considering whether the information required in notifications and notification timeframes under the *Incident Management Rules* should be amended to reduce the regulatory burden associated with reporting incidents. The review includes requirements for reporting incidents where multiple notifications are made in relation to the same issue over a short period of time, or when multiple participants were affected by the same incident.⁵⁶ The NDIS Commission's *Own Motion Inquiry* report observed:

The issue here is not whether the NDIS Commission should adjust what is required to be reported, but rather whether some adjustments to the Incident Management Rules are needed so that the requirements are proportionate to the regulatory response that might be required as a result of the incident.⁵⁷

We agree with these views. We consider it is also necessary to enhance service providers' understanding of what constitutes a reportable incident. We discuss this issue further below.

We heard evidence that there are people who are identified as at risk of experiencing violence, abuse, neglect or exploitation but do not have advocacy or support to make complaints and ensure incidents are reported to the NDIS Commission.⁵⁸ In Chapter 13, we explain how the NDIA and the NDIS Commission share information to identify and manage participants at greater risk. However, Ms Mackey told us, in November 2022, that with its current resourcing and workload, the NDIS Commission is not able to conduct 'continuous risk-sensing activities across its data holdings or transform information into intelligence in a consistent and timely way'. In some cases, Ms Mackey said, this caused delays to regulatory interventions against workers and providers.⁵⁹

Against this background, we consider it both appropriate and necessary for the NDIS Commission to have access to 'class or kind' determinations to more effectively manage the volume of reportable incidents it receives. Class or kind determinations allow oversight bodies to exempt certain providers from notifying less serious types of incidents where they have demonstrated a satisfactory level of competence in managing and investigating incidents. This approach has been used in police complaint oversight⁶⁰ and child-related reportable conduct schemes in New South Wales for over two decades.⁶¹ Reportable conduct schemes established more recently in Victoria and the Australian Capital Territory also embed class or kind determinations.⁶² Importantly, class or kind determinations were endorsed by the Royal Commission into Institutional Responses to Child Sexual Abuse and included as a key component of the reportable conduct scheme model it recommended for national rollout, based on the New South Wales experience.⁶³

The use of the NDIS Commission's resources must be proportionate to the risk or impact on people with disability that incidents represent. How the NDIS Commission responds, investigates and addresses non-compliance identified via reportable incidents impacts how failures are addressed and whether future harm is prevented. With such a substantial volume of incidents, the NDIS Commission must have access to levers so it can direct resourcing towards the oversight of more serious or higher-risk incidents. Drawing on its intelligence holdings, the NDIS Commission should develop measures to determine which providers

should be exempt from making notifications. It should also regularly consult with providers, people with disability and disability advocates about the effectiveness of these exemptions. As with other conduct oversight schemes, the NDIS Commission should regularly conduct audits to assess whether NDIS providers have appropriately responded to reportable incidents excluded from its oversight.

Consistent with other conduct oversight schemes, relevant NDIS Rules should be amended to reflect the introduction of class or kind determinations.

Recommendation 10.12 Introduction of class or kind determinations

The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) to:

- a. introduce 'class or kind' determinations exempting certain registered providers from notifying less serious types or categories of reportable incidents where they have demonstrated a satisfactory level of competence in managing and investigating incidents
- b. enable the NDIS Quality and Safeguards Commission to conduct audits to assess compliance with class or kind determinations.

8.4. Own motion inquiries

One of the most effective levers the NDIS Commission and other oversight bodies have is the 'own motion' inquiry (or investigation) power. This power can be used to examine individual matters and wider systemic issues. The NDIS Commission has powers under the *Incident Management Rules* and the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) (*Complaints Rules*) to initiate an inquiry about supports or services delivered by NDIS providers that were the subject of a reportable incident or complaint, or a series of reportable incidents or complaints.⁶⁴ These are known as 'own motion' inquiries.

The NDIS Commission has commenced two inquiries using its own motion inquiry powers. The first commenced in August 2021, referred to as the Own Motion Inquiry into Aspects of Supported Accommodation (Own Motion Inquiry).⁶⁵ This inquiry considered the experiences of NDIS participants living in supported accommodation to better understand the challenges faced in those environments.⁶⁶ It examined 6,269 reportable incidents and 851 complaints about supports in group homes notified or made to the NDIS Commission between 1 July 2018 and 30 September 2022.⁶⁷ It examined reportable incidents where it was determined that the incident impacted an NDIS participant receiving supported accommodation in a group home setting from the particular provider.⁶⁸ All notifications were from seven of the largest Supported Independent Living (SIL) providers.⁶⁹ The *Own Motion Inquiry* report was published in January 2023. The following case study explains the outcomes of the inquiry in relation to reportable incidents.

Case study: Own Motion Inquiry into Aspects of Supported Accommodation

The *Own Motion Inquiry* report made the following observations about the reportable incidents examined during the inquiry:

- 85 per cent of all reportable incidents notified by the seven providers (including those not related to the inquiry) occurred in group home settings.⁷⁰ Of those, the most common reportable incident type was serious injury (28 per cent), followed by abuse (27 per cent) and the neglect of a person with disability (21 per cent).⁷¹
- A significant number of incidents were associated with participant-on-participant altercations.⁷²
- Most of the incidents concerning deaths were about a person with disability who died as a result of a chronic or diagnosed medical condition.⁷³
- Reportable incidents drive a high volume of matters to the NDIS Commission but the way in which notifications are received is inefficient. There are multiple notifications about the same incident.⁷⁴
- Some providers used the reportable incidents function to raise concerns about the quality of supports—matters that should instead be raised through the complaints function.⁷⁵

The NDIS Commission committed to remedial action including the following:⁷⁶

- improve ('when resourcing allows') its systems and ability to analyse reportable incident data and information collected through its other functions
- conduct a comprehensive inquiry into deaths notified to the NDIS Commission
- conduct a review of the reportable incidents function and the guidance for registered NDIS providers about the incidents that should be notified
- consider whether the notification timeframes and reporting requirements should be adjusted under the *Incident Management Rules*.

Endeavour was one of the providers who participated in the Own Motion Inquiry. In evidence provided for Public hearing 32, Endeavour saw the inquiry as an opportunity to learn from, question its own assumptions and processes, and identify areas for further development such as analysing trends.⁷⁷

In our view, the Own Motion Inquiry demonstrates the NDIS Commission's commitment to improving oversight of NDIS providers and the quality and safety of NDIS supports and services. Ms Mackey said the NDIS Commission is committed to using the own motion inquiry power and now has more than four years of data to draw on to help inform and direct these inquiries.⁷⁸

On 13 February 2023, the NDIS Commission announced it would commence its second Own Motion Inquiry into Platform Providers Operating in the NDIS Market. ‘Platform providers’ are businesses that provide online platforms and subscription services to connect workers with NDIS participants, and can include registered and unregistered providers. Platform providers represent a significant and growing proportion of NDIS providers.⁷⁹ Through its own motion inquiry, the NDIS Commission is seeking to support people with disability to enhance their understanding of platform providers.⁸⁰

8.5. Provider-led investigations

It is appropriate for the NDIS Commission to play a ‘light oversight role’ where it has received a comprehensive notification from a provider clearly outlining the steps already taken or planned to be taken to respond to an incident, including steps to review its causes and take rectification action. The known competence or otherwise of the provider regarding their incident management and investigative practices will also be a relevant consideration. As we discussed earlier in this chapter, it is also important that the NDIS Commission tests the veracity of material providers give to it and follow up on any outstanding information.

An important lever available to the NDIS Commission is its ability to require a provider to carry out an internal investigation or to engage an ‘appropriately qualified and independent expert’ to undertake an independent investigation.⁸¹ The NDIS Commission must still consider whether an investigation of this type is of suitable quality. It is also important for providers to have either the skills to carry out safeguarding investigations internally or to know what to look for when engaging independent investigators to conduct investigations on their behalf.

Frequency of provider-led investigations

Table 10.8.2 shows the number of times between July 2018 and June 2021 the NDIS Commission has exercised powers under the *Incident Management Rules* to require an NDIS provider to conduct an internal or independent expert investigation.

Table 10.8.2: Internal and independent investigations required by the NDIS Commission under the *Incident Management Rules*

Financial year	Number of internal investigations	Number of independent expert investigations
2018–19	0	1
2019–20	11	6
2020–21	30	7
Total	41	14

Source: Exhibit 32-008, ‘Statement of Tracy Mackey, Commissioner, NDIS Quality and Safeguards Commission’, 3 February 2023, at [92], [95], [98].

In addition to the investigations shown in Table 10.8.2, Ms Mackey told us registered NDIS providers have carried out investigations on their own initiative in relation to incidents without the NDIS Commission exercising its powers under the *Incident Management Rules*.⁸² For example, in 2018–19 registered NDIS providers undertook an internal investigation on 23 occasions without being formally required to do so by the NDIS Commission.⁸³

While the data indicates that the NDIS Commission is increasingly requiring provider-led investigations to be conducted, the number of times it has exercised its powers is low compared with the high and continuously increasing volume of reportable incidents it has received.

Provider-led investigations give service providers an opportunity to engage with affected people with disability and their families about what may have led to an incident and how services can be improved. They are also an opportunity to engage with frontline workers about issues such as the adequacy of supervision, training and guidance. Importantly, they allow providers to examine and address any misconduct or poor performance by staff, while ensuring parties are afforded procedural fairness.

There would appear to be value in the NDIS Commission making use of the provider-led investigation powers more often when notifications are sufficiently serious to warrant a more forensic examination. More frequent use of these powers would enable the NDIS Commission to direct its own investigation and compliance resources at matters that cannot be easily resolved, such as those which present immediate safeguarding concerns.

Engaging suitability skilled investigators

Despite the benefits of provider-led investigations, we heard concerns about the quality of investigations conducted by providers themselves and those undertaken by independent investigators. In Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)' we heard about incidents reported to the NDIS Commission by registered provider, the Australian Foundation for Disability (Afford).

Case study: Abuse by Daniel Nuumaalii

Mr Daniel Nuumaalii was employed by the Australian Foundation for Disability (Afford) in June 2019 at its day program in Mount Druitt, New South Wales.⁸⁴ He was arrested in May 2020 by NSW Police and charged with multiple criminal offences, including offences that involved the abuse of people with disability at the day program.⁸⁵

The NDIS Commission received a total of eight reportable incidents from Afford involving Mr Nuumaalii.⁸⁶ On 27 May 2020, the NDIS Commission notified Afford of its decision to require Afford to engage an appropriately qualified and independent expert, to carry out an investigation in relation to the incidents.⁸⁷ The NDIS Commission instructed Afford that the investigation should report on the causes and factors contributing to the alleged offending and identify actions taken to prevent reoccurrence.⁸⁸

On 25 September 2020, Afford provided a copy of the final investigation report prepared by the external investigator to the NDIS Commission.⁸⁹ The investigator documented a number of issues with Mr Nuumaalii's training and induction.⁹⁰ It noted reports that clients had exhibited discomfort around Mr Nuumaalii.⁹¹ No findings were made about the risks presented by these issues. The eight reportable incidents were closed on 10 October 2020.⁹²

The Commissioners' *Report of Public hearing 23* identified a number of issues with the investigation conducted by the independent investigator and the investigation report. Those included:

- The investigator did not perform a risk analysis or identify any root cause of the abuse.⁹³
- Mr Nuumaalii's former team leader, who was no longer employed by Afford at the time of the investigation, was not interviewed, nor were the impacted people with disability or their family members.⁹⁴
- No recommendations were made to improve Afford's procedures nor did the investigation identify what could be done to avoid the risk of abuse in future.⁹⁵

In its submissions following the Public hearing, Afford accepted it should have engaged an investigator who had appropriate experience in dealing with allegations of abuse. It also accepted it should have incorporated a review of other clients who may have been affected by Mr Nuumaalii's conduct.⁹⁶

The Commissioners' *Report of Public hearing 23* found the independent investigation into the abuse perpetrated by Mr Nuumaalii was grossly inadequate.⁹⁷ It also found the NDIS Commission's oversight of the incident concerning Mr Nuumaalii's abuse relied almost entirely on uncritical acceptance of information provided by Afford, including information contained in the independent investigator's report.⁹⁸

Ms Taylor told us the NDIS Commission did not further scrutinise the independent investigator's qualifications.⁹⁹ Mr Head was asked in Public hearing 13 if there would be merit in having a panel of independent investigators, certified by the NDIS Commission, that NDIS providers can select from to ensure investigations are genuinely independent. Mr Head said he had not considered this closely, but it was something that could be examined. He noted the Approved Quality Auditor scheme and accreditation is 'an existing feature of the system that is not miles apart from that idea'.¹⁰⁰

Selecting the right investigator

The issues raised in relation to the use of independent external investigators are complex. It is unlikely the NDIS Commission's reportable incidents, compliance or investigations functions are sufficiently resourced to carry out in-depth investigations into many of the serious reported incidents. Given the increasing volume of reportable incident notifications, the use of independent investigators by providers is a sound approach to exploring such incidents and is line with practices in other contexts, such as child safety and aged care.

The critical issue here relates to investigator suitability and ensuring providers engage investigators who are well-versed in issues relevant to safeguarding in the disability service context as well as being experienced in conducting fact finding investigations. Investigators need to be genuinely independent with no previous involvement in the matter under investigation. Investigators should also be experienced in interviewing people with complex communication needs or cognitive impairment. Investigation reports should include a root cause analysis of the incident and make systemic recommendations for change when appropriate.

Ms Mackey told us the NDIS Commission can use its compliance notice powers to give more specific instructions to an NDIS provider about the required skills or qualifications of the independent expert to be engaged, the nature of the investigation and the reporting requirements. She referred to compliance notices issued to NDIS providers in South Australia, which required the providers to engage independent health expertise or behaviour support and restrictive practices expertise to conduct independent reviews and report to the provider and the NDIS Commission.¹⁰¹ The innovative use of compliance tools is an effective way of requiring these types of investigations to be done well and by an appropriate investigator.

In Public hearing 32, Counsel Assisting's submissions noted the Royal Commission had examined a number of different investigations undertaken by people with varying levels of experience. Counsel Assisting observed that we have not seen investigators with skills and expertise in using a rights-based approach to investigations. Nor have we seen investigators with an understanding of human rights, trauma-informed communication methods and who have cultural awareness.¹⁰²

Counsel Assisting asked NDIS providers if further guidance on engaging external investigators would be of assistance. Ms Liz Forsyth, Managing Director and CEO of the Northcott Society, said Northcott had undertaken work to determine a panel of suitable external investigators. However, she said not all organisations would necessarily have the capacity to implement such

a process.¹⁰³ She said assisting provider organisations to make appropriate decisions about investigators would be good for the sector.¹⁰⁴

The NDIS Commission should establish a panel of independent investigators with strong credentials in relation to safeguarding, human rights and investigative practice. It should ensure it seeks regular feedback from providers about the quality of independent investigators' work.

Recommendation 10.13 Creating an independent investigators panel

The NDIS Quality and Safeguards Commission (NDIS Commission) should establish a panel of independent investigators with strong credentials in relation to safeguarding, human rights and investigative practice. The NDIS Commission should seek regular feedback from providers about the quality of independent investigators' work.

8.6. Improving provider safeguarding practices

In addition to the need to strengthen investigative practices, we identified further systemic issues in relation to how NDIS providers respond to incidents:

- Some providers are still unsure about what incidents should be reported and when.
- Disability support workers are still unaware of their obligations to notify their employers of certain incidents.
- Some NDIS providers fail to offer appropriate support, redress or other remedies when appropriate.
- NDIS Commission guidance is required to achieve consistent and good quality complaint handling and investigative practices.
- Provider governing bodies need to have safeguarding expertise and stronger accountability.

Nexus between complaints and incidents

While the complaints and reportable incidents functions are distinct and exercised according to separate rules under the *NDIS Act*, complaints and reportable incidents are closely connected. Serious complaints, certainly those involving allegations of violence, abuse, neglect and exploitation, are often also reportable incidents. For this reason, several recommendations in this section about improving provider compliance with complaint handling and incident obligations are dealt with together.

An effective response to complaints and incidents can require the use of similar strategies. For example, resolution and investigation processes should be accessible and incorporate supports, where appropriate, to facilitate the effective participation of the person with disability at the centre of the matter. More serious complaints, and incidents not suited to informal

resolution or systemic review only should be independently investigated by the provider using a trauma-informed approach.

Improving provider understanding of reporting obligations

Incident management systems rely on the knowledge, understanding, capacity, willingness and honesty of front-line workers to accurately and consistently report incidents. Registered NDIS providers and their workers do not necessarily follow their own incident management policies and procedures or comply with their NDIS reporting obligations.

The reportable incidents function enables the NDIS Commission to identify which providers are preventing and responding to incidents well, and which providers need more education or should be the subject of compliance or enforcement action. The function is critical to safeguarding NDIS participants. Yet it can only operate well when providers and disability support workers are aware of, and comply with, their obligations to manage and report incidents to the NDIS Commission.

Some registered NDIS providers are still failing to notify incidents to the NDIS Commission within required timeframes, and uncertainty exists around what must be reported and when. In Public hearing 23, the evidence indicated that Afford's policies and procedures on incident management were not understood or followed by staff at the time of the incidents examined at the hearing.¹⁰⁵

For example, Ms Taylor told us about the NDIS Commission's concerns regarding Afford's compliance with reporting obligations.¹⁰⁶ The NDIS Commission wrote to Afford in September 2021 recording its concerns and required Afford to review incidents that had not been reported to the NDIS Commission.¹⁰⁷ Afford reported it had not notified the NDIS Commission about a considerable number of incidents of missed medication,¹⁰⁸ because it did not believe it was required to do so.¹⁰⁹ Ms Taylor confirmed that missed medication was a reportable incident and could constitute neglect.¹¹⁰

The NDIS Commission's compliance work regarding Afford was continuing at the time of Public hearing 23. Ms Taylor was not satisfied at the time that Afford was correctly identifying and notifying it of all reportable incidents.¹¹¹

The Commissioners' *Report of Public hearing 20* found LWB failed to notify the NDIS Commission of the 26 March 2019 incident involving Sophie (described in the case study earlier in the chapter) within 24 hours as required. It did not make a notification until 13 May 2019, 48 days after the incident.¹¹² Ms Taylor told us the NDIS Commission issued a compliance notice to LWB in September 2020 in relation to non-compliance with its conditions of registration and its late notification of reportable incidents.¹¹³

There remains uncertainty among providers about what incidents should be notified and how they fit within the categories of reportable incidents defined in the *NDIS Act*.¹¹⁴ The Joint Standing Committee on the NDIS also considered there is insufficient clarity and consistency about what is deemed an 'incident' within the reportable incidents framework. This can cause confusion for

providers and limits the NDIS Commission's ability to effectively address issues associated with the quality and safety of supports and services.¹¹⁵ The Australian Government's response to the Joint Standing Committee said amendments to the *NDIS Act* in October 2021 would enable the NDIS Rules to clarify the circumstances in which reportable incidents must be notified.¹¹⁶

It is concerning that several large and established NDIS providers did not comply with, or were unaware of, their obligation to report incidents. Ms Taylor expressed similar concerns in Public hearings 20 and 23.¹¹⁷

In its *Own Motion Inquiry* report, the NDIS Commission observed:

There is a widely held view among stakeholders that all incidents reported to the NDIS Commission concern events that should be reported to Police, or where the NDIS Commission should take enforcement action, such as banning a provider or imposing a civil penalty. The vast majority of incidents examined through this Inquiry did not relate to events of that nature.¹¹⁸

The NDIS Commission also said it is reviewing the reportable incident function, including the guidance to registered NDIS providers about what incidents should be notified.¹¹⁹

Model policies and procedures

Public hearing 32 examined whether the policies and practices of NDIS providers prevent violence against, and abuse, neglect and exploitation of, people with disability. In addition to several witnesses with disability, we heard from witness panels comprising representatives from NDIS providers, advocates, experts, unions and industry bodies. The hearing inquired into whether the policies and regulations governing the disability workforce support high-quality disability services. It also examined best practice management of complaints and incidents, including dispute resolution processes and redress.

The evidence shows NDIS providers would like to see improved guidance and a clear benchmark for quality safeguarding practice. Witnesses from NDIS providers were receptive when asked if model policies and procedures on complaint handling processes set out in a template would assist them.¹²⁰

Ms Mackey said she considers there is an opportunity for the NDIS Commission to identify and share best practice with NDIS providers. However, she also stated:

So I think there is an opportunity for the Commission to play a role in identifying and sharing good practice, not to the point where we are templating what needs to happen. Because if we do that, we are not respecting the fact that there are around 580,000 NDIS participants, all of whom have different rights, different choices that they make.¹²¹

We agree that the rights, wants, needs and choices of NDIS participants must be reflected within the policies and procedures of NDIS providers. However, we consider the NDIS Commission should develop and disseminate model templates and policies for registered NDIS providers. Individual NDIS providers should adapt these templates and policies to suit the needs of their particular clients.

The *Own Motion Inquiry* report recommended providers of supported accommodation should:

review their policies and procedures, and the channels they use to obtain, record and respond to feedback, including complaints, to take account of the needs of people with higher support needs living in group home settings. This includes building an awareness of the NDIS Commission and its role with these people and their networks.¹²²

The *Own Motion Inquiry* report said providers of supported accommodation should:

regularly review their practices, incident management policies and procedures, and the incidents that they are notifying to the NDIS Commission, to ensure that these align with the NDIS Commission's guidance.¹²³

In a submission to our inquiry, the New South Wales Office of the Children's Guardian (OCG) told us about the value in oversight bodies taking a collaborate approach with stakeholders to support best practice and compliance. The OCG said model procedures should not come at the expense of individual providers needing to demonstrate their commitment to customising the core policies, procedures and implementation strategies to their own unique service settings.¹²⁴

The NDIS Commission should develop and disseminate, in collaboration with NDIS providers and participants, model templates and policies for use by registered NDIS providers. They should embed a human rights approach. These model templates and policies should be made available in a variety of accessible formats.

Recommendation 10.14 Developing model policies and procedures

The NDIS Quality and Safeguards Commission should develop model procedures for National Disability Insurance Scheme (NDIS) providers, including:

- a. for frontline workers about recognising and reporting incidents, with clear definitions around what incidents must be reported and when
- b. for incident management, incorporating guidance on undertaking causal reviews of incidents and preventive action, as well as implementing wider system improvements
- c. for complaints, articulating person-centred approaches for managing and resolving complaints and providing feedback, and requiring supports for a participant who needs to participate in a complaints process
- d. that address the need to consider the impact or harm caused to a participant and provide guidance on forms of redress that should be offered to people with disability involved in incidents and complaints.

These procedures should be developed in consultation with people with disability, family members, advocates and NDIS providers.

Investigation guidance

The NDIS Commission publishes resources for providers about incident management and reportable incidents that give guidance on provider-led investigations.¹²⁵ These resources address issues such as the purpose of an investigation, the circumstances in which an investigation may be appropriate and general principles for conducting investigations. They also explain the role of the investigator, including the need for any investigator appointed at the direction of the NDIS Commission to be impartial, independent and have appropriate training and experience.¹²⁶

While the NDIS Commission's guidance and resources about reportable incidents currently on its website are helpful, they do not provide detailed guidance about conducting provider-led investigations.

In March 2020, the NDIS Commission awarded a grant of \$825,000 to industry peak body NDS to develop risk management, complaints handling and reportable incidents systems, tools and resources for small to medium NDIS providers.¹²⁷ The grant was to help reduce compliance costs by having NDS develop these resources, rather than requiring providers to develop their own.¹²⁸ NDS published a series of resources for sole traders and small and medium-sized organisations that can also be useful for larger providers.¹²⁹ The resources are contained within an interactive PDF document, *Risk, incidents and complaints management resource guide – iPDF*, published on the NDS website.¹³⁰ NDS also offers training workshops for providers on incident reporting and investigations.¹³¹

In December 2021, Ms Taylor, said the NDIS Commission was developing its own training material for providers and NDIS Commission staff to help both parties with reviews of formal investigation reports.¹³² However, in February 2023, Ms Mackey told us this work had not been completed. Ms Mackey said, when resources permit, the work undertaken will be reviewed in light of the resources developed by NDS. Ms Mackey said if providers would be assisted by further guidance from the NDIS Commission, it will then be finalised.¹³³

Upholding the rights of people with disability in complaint and incident investigation processes

As noted earlier in this chapter, it is a condition of registration that registered providers comply with the *Incident Management Rules* and the *Complaints Rules*.¹³⁴ These rules must also be considered by approved quality auditors when they audit providers that are applying for or renewing their registration.¹³⁵ While the rules place enforceable obligations on registered NDIS providers, they do not specify in detail how a provider manages and investigates complaints and incidents.

For example, the *Incident Management Rules* state that a registered provider's incident management system must establish procedures that specify how the provider will 'provide support and assistance to persons with disability affected by an incident (including information about access to advocates such as independent advocates), to ensure their health, safety and wellbeing'. They must also set out 'how persons with disability affected by an incident will be involved in the management and resolution of the incident'.¹³⁶ They do not, however, elaborate on or explain what constitutes an appropriate 'support' beyond advocacy services, or provide guidance about appropriate ways to involve the affected participant in the management and resolution of the incident.

Under the *NDIS Act*, the NDIS Commission must:

- provide education, guidance and best practice information to NDIS providers in relation to compliance matters¹³⁷
- support registered NDIS providers to develop and implement effective incident management systems and to build provider capability to prevent and manage incidents¹³⁸
- build NDIS provider capability to develop a culture of learning and innovation to deliver high quality supports and services, prevent incidents and respond to complaints.¹³⁹

The NDIS Commissioner may also, by notifiable instrument, make guidelines relating to the performance of any of their functions.¹⁴⁰

We consider the NDIS Commissioner should, by notifiable instrument, issue a guideline setting out the core components of accessible and responsive complaints handling and investigation practices when dealing with complaints and incidents. This guideline would apply to the NDIS Commissioner's reportable incident and complaints functions.

The guideline should be considered when assessing whether a registered provider is complying with the *Incident Management Rules* and the *Complaints Rules*. The guideline should include the core components depicted in our Table 11.2.1 and referred to in Recommendation 11.5 in Volume 11, *Independent oversight and complaint mechanisms*. Both sets of rules should be amended to include recognition of, and a requirement for, compliance with the guideline. The NDIS Commission should abide by the guideline when dealing with complaints it receives directly.

Recommendation 10.15 Complaint handling and investigative practice guideline

- a. The NDIS Quality and Safeguards Commissioner should issue a guideline, by notifiable instrument, addressing accessible and responsive complaint handling and investigative practice. The guideline should:
 - outline the core components of an accessible and responsive complaint handling and investigative practice involving people with disability, consistent with Recommendation 11.5
 - be co-designed by people with disability and their representative organisations and involve consultation with National Disability Insurance Scheme (NDIS) provider representatives.
- b. The Minister for the NDIS should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) and *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to include recognition of, and a requirement for compliance with, the guideline.

Redress, outcomes and other supports

Different meanings may be ascribed to the word ‘redress’ and to all the various forms redress might take. ‘Redress’ often means financial compensation or reparation for harm caused to another. Individuals may have different views on what redress looks like for them. Redress can include:

- an apology
- financial compensation for harm caused
- other financial support such as contributing towards the cost of counselling or psychological care
- reimbursement of fees
- credits for services
- changes in practice, for example reviewing care plans or staff rosters to reflect the needs of people with disability following an incident.

In addition to supporting people with disability during the investigation of a complaint or incident, NDIS providers should have systems that provide for some form of redress in appropriate circumstances.

Redress experiences – what we heard

Commissioners' public hearing reports have found that NDIS providers failed to provide a written apology or discuss any form of redress when people with disability, for whom they were responsible, experienced violence, abuse, neglect or exploitation.¹⁴¹

For example, Public hearing 3, 'The experience of living in a group home for people with disability', examined Yooralla's response to a number of serious sexual assaults perpetrated against people with disability who lived in its group homes between 2011 and 2014.¹⁴² Despite the severity of the harm sustained by the victims and the similarity of the circumstances in which the assaults occurred, there were considerable disparities regarding:¹⁴³

- whether a complaint was made or legal proceedings were commenced by or on behalf of the victim
- how victims were supported in making a complaint and referral of matters to police for criminal investigation
- the outcome or resolution of any complaint or legal proceedings
- any support, compensation or other forms of redress provided to the person with disability.

In at least one instance, a victim received neither independent legal advice nor any form of compensation from Yooralla, despite there being no dispute that they had suffered serious harm as a consequence of the criminal acts committed against them.¹⁴⁴

Public hearing 13 considered redress in relation to Sunnyfield's response to alleged incidents of abuse and neglect of people with disability receiving services from Sunnyfield by two of its former support workers. We heard about breakdowns in communication between Sunnyfield and the residents' families, and Sunnyfield's defensive and hostile responses to feedback and complaints. We recommended that Sunnyfield's Board meet with the residents at the centre of the incidents and their families to apologise for its failure to prevent the violence and abuse they endured and discuss what redress, additional supports and assistance they required.¹⁴⁵

In Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', 'Niky' and her mother gave evidence about their experiences following the sexual assault of Niky by a fellow attendee of a day program run by Anglicare.¹⁴⁶ The Commissioners' *Report of Public hearing 17* found that Anglicare failed to follow its own policies by not offering a face-to-face apology to Niky and her family and an opportunity to discuss their experiences, or providing additional support and follow up.¹⁴⁷ Ms Carolyn Cumming, an Anglicare Service Manager, agreed with the Chair's proposition that redress was something Anglicare should approach Niky and her family about, rather than the other way around.¹⁴⁸ It was only as a result of an NDIS certification audit in July of 2020,

almost two years after the assault occurred, that Anglicare identified that follow-up had not been provided to Niky or her family.¹⁴⁹

The Commissioners' *Report of Public hearing 20* found, in relation to allegations of indecent and sexual assaults of 'Natalie' by her support worker,¹⁵⁰ LWB failed to apologise to Natalie or her family, and failed to inform Natalie of her right to obtain legal advice in respect of her possible entitlement to compensation.¹⁵¹

In Public hearing 23, the parents of two NDIS participants described feeling sick on learning of the abuse of their sons by Mr Nuumaalii, who was employed at a day program run by Afford. They developed a feeling of mistrust towards people providing support.¹⁵² Shortly after the abuse was revealed, one NDIS participant was diagnosed with anxiety, for which he was still receiving treatment at the time of the hearing.¹⁵³

The Commissioners' *Report of Public hearing 23* found that Afford's communications with participants affected by Mr Nuumaalii's abuse did not comply with its own procedures¹⁵⁴ and were deficient in the following respects:¹⁵⁵

- Afford's CEO and Board failed to provide a written apology to the participants in the Mount Druitt day program who were abused by Mr Nuumaalii and did not meaningfully engage with them to discuss any form of redress.
- Afford failed to engage properly with the participants in the Mount Druitt day program who were abused by Mr Nuumaalii, or their families, about the impact of the abuse and any additional support they required.
- Afford failed to properly engage with the other participants in the Mount Druitt day program, or their families, to investigate whether any further abuse occurred and to respond accordingly.
- Afford did not act promptly to address the concerns of participants or their families or to safeguard against further abuse in the future. The only step taken to prevent a repeat of the conduct of Mr Nuumaalii was not taken until two years after the offending was detected.

On 4 August 2022, Afford issued a formal written apology to the participants and family members who were affected by Mr Nuumaalii's abuse and who gave evidence during Public hearing 23.¹⁵⁶

At Public hearing 32, representatives of NDIS providers the subject of earlier Public hearings, namely Yooralla, Sunnyfield, LWB and Afford, were called to provide evidence about steps taken in response to findings and recommendations arising from those hearings. Both LWB and Sunnyfield provided apologies for the failings identified at our public hearings.¹⁵⁷

During Public hearing 32, NDIS providers told the Royal Commission about their current and planned approaches related to redress for victim-survivors:

-
- Yooralla has established a Redress Working Party comprised of the CEO, two board directors (one of whom lives with a disability and another who is a parent of a person with disability) and three management members.¹⁵⁸ Yooralla has also developed a redress approach including Guiding Principles for consulting with victim-survivors. The Guiding Principles include commitments to offer support services such as independent legal advice and advocacy to impacted people with disability and their support networks.¹⁵⁹
 - Northcott said it participates in the National Redress Scheme for survivors of childhood sexual abuse but does not have a formal or informal system for providing redress to their customers who have experienced violence, abuse, neglect or exploitation.¹⁶⁰
 - Endeavour Foundation described its past responses as ‘ad hoc or legalistic’ but said it had undertaken significant work over the previous twelve months to change its approach, including drafting a new policy on redress for victims of abuse.¹⁶¹ The options for redress include a formal apology, financial redress including contributing to costs of counselling, and other forms of support.¹⁶²

Embedding redress within complaint and incident responses

In Public hearing 32, Ms Mackey told us the NDIS Commission is now considering redress as part of its standard complaint resolution process. Complaints officers now explore whether the affected NDIS participant would like an apology, refund, or services reinstated. Ms Mackey said, ‘that’s become sort of part of the way we work in that space’.¹⁶³ She did not indicate whether a similar approach was being used in relation to reportable incidents.

Ms Mackey has asked her new General Counsel to explore the use of enforceable undertakings to require redress or similar actions.¹⁶⁴ An enforceable undertaking is a legally binding written commitment to take specific action (or not take action) to prevent, or respond to, non-compliance.¹⁶⁵ Enforceable undertakings form part of the NDIS Commissioner’s compliance and enforcement powers¹⁶⁶ but Ms Mackey acknowledged enforceable undertakings had not been used by the NDIS Commission.¹⁶⁷

We consider the NDIS Commission should examine whether it has power to incorporate in enforceable undertakings a requirement that service providers provide redress to NDIS participants in appropriate cases. If not, it should seek the necessary powers and be prepared to use them where appropriate.

The way NDIS providers engage with victims and their families about redress can have a significant bearing on how they feel about any particular outcome. The research report *Complaint mechanisms: Reporting pathways for violence, abuse, neglect and exploitation* published by the Royal Commission in November 2022 highlights the importance of ‘just outcomes’ and ‘just processes’:

The overall finding of much of the research relating to procedural justice indicates, perhaps counter-intuitively, that individuals place great value on just processes, so much so that experiencing positive procedural justice can be more important than receiving a favourable outcome.¹⁶⁸

A just process in the context of dealing with complaints and managing incidents means being listened to, having one's feelings validated, knowing one's perspectives and experiences have been considered, being updated and involved in a process and being asked what will help make things better.

In submissions following Public hearing 32, Counsel Assisting proposed NDIS providers should be prepared, on their own initiative, to consider and provide redress in appropriate cases to people with disability to whom they are liable for an act of violence, abuse, neglect or exploitation. It should not be left to people with disability or their family to ask for some form of redress following violence, abuse, neglect or exploitation.¹⁶⁹ Counsel Assisting concluded:

Best practice for disability service providers in responding to violence, abuse, neglect or exploitation includes having provisions relating to redress in relevant policies and procedures. Such provisions should take a flexible approach, to enable constructive engagement between service providers and the person who has experienced violence, abuse, neglect or exploitation, and their supporters, about what redress they would like. They also should incorporate ensuring people with disability have access to independent advocates or other forms of advice, including legal advice.¹⁷⁰

The evidence reveals reluctance by NDIS providers to offer redress to people with disability for whom they are responsible and who have experienced violence, abuse, neglect or exploitation in connection with receiving disability services. To ensure redress is considered in these circumstances and, where appropriate, offered to NDIS participants, we consider there needs to be both a requirement to do this and further guidance from the NDIS Commission. This guidance should set out the redress NDIS providers should adopt as standard practice.

The *Incident Management Rules* and the *Complaints Rules* should be amended to give the NDIS Commission power to require NDIS providers to consider redress and forms of support to an NDIS participant in certain circumstances. These are where the NDIS Commission forms the view that the service provider bears responsibility for the violence, abuse, neglect or exploitation experienced by the NDIS participant. The forms of redress should include an apology, support for counselling and advocacy services and monetary compensation.

Currently, the *Incident Management Rules* and the *Complaints Rules* confer no such power. Although there are provisions relating to resolution processes and remedial actions,¹⁷¹ these are not the same as a requirement to consider providing redress. There is also no guidance on the standard practice providers should adopt with respect to redress and meaningfully engaging with people with disability, their families and supporters when responding to feedback and complaints.

Where the NDIS Commissioner is not satisfied a provider has properly considered providing suitable redress to an NDIS participant involved in a complaint or reportable incident, the NDIS Commissioner should have power, subject to any constitutional constraints, to impose a redress obligation by means of enforceable undertakings.

Recommendation 10.16 Requirement to consider redress

- a. The Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) and *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to include a requirement for NDIS providers to consider redress and forms of support to an NDIS participant where the NDIS Quality and Safeguards Commission (NDIS Commission) forms the view that the service provider bears responsibility for the violence, abuse, neglect or exploitation experienced by the NDIS participant.
- b. The NDIS Commission should:
 - provide practical advice on suitable forms of redress when making the guideline on accessible and responsive complaint handling and investigative practice (see Recommendation 10.15)
 - consider whether it has power to incorporate in enforceable undertakings a requirement that service providers afford redress to NDIS participants in appropriate cases. If not, it should seek the necessary powers and be prepared to use them where appropriate.

Safeguarding indicators and expertise

Incident management systems are a key safeguarding mechanism that can provide boards, senior leadership teams and workers with significant information about how and where people with disability may be harmed by violence, abuse, neglect and exploitation. When the data from these systems is analysed and shared it tells a story about what is going on within an organisation and what changes are needed to improve quality and increase safety.

In Part A of this volume, we examined the role of governing bodies and issues such as the composition of boards, director skills and training, responsibilities for promoting a positive safeguarding culture within organisations and approaches to risk management and ‘dignity of risk’ considerations. In Chapter 10, ‘Provider registration’, we examine what more the NDIS Commission can do to strengthen the safeguarding obligations on registered NDIS providers’ governing bodies through changes to the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) and the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth). In this section, we focus on the specific issue of ‘safeguarding data’ relating to incidents and complaints. We look at the need for key personnel (including boards)¹⁷² to have access to specialist safeguarding advice to interpret, and advise on, what the data is revealing.

Fulfilling duties to prevent violence, abuse, neglect and exploitation

NDIS providers, key personnel and persons employed or otherwise engaged by NDIS providers are required to take all reasonable steps to prevent and respond to violence, abuse, neglect and exploitation of people with disability.¹⁷³ They also have obligations under workplace health and safety laws to ensure, so far as is reasonably practicable, that the health and safety of employees and other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.¹⁷⁴ Key personnel who fail to take preventive action to ensure the health and safety of their workers can be held personally liable for any acts or omissions by the provider, its employees and contractors that have an effect on the health and safety of its workers.¹⁷⁵

NDIS provider governing bodies, such as boards, should focus on and receive regular and accurate information about the issues and risks arising from complaints and incidents. This information should include whether provider obligations are being met, safety risks are being well managed, appropriate inquiries are being made, outcomes for the affected individuals are fair, rectification action is taken and redress is provided in appropriate cases.

It is not the role of the governing body to ‘directly’ manage incidents or complaints. Rather, it is to ensure that the organisation has an effective system in place for dealing with complaints and incidents and responds appropriately to serious individual matters. However, without having regular access to sufficiently detailed data, a board’s ability to properly assess the adequacy of the system and its implementation will be compromised. In addition, an organisation should advise its board of incidents and complaints where serious harm to a person with disability has been, or is alleged to have been, caused as they arise. This is because of the risk such matters pose to the safety and wellbeing of the affected person. The organisation should also confirm with the board that all regulatory and other statutory obligations have been fulfilled.

For serious matters, particularly those involving criminal allegations, boards also need to be confident that appropriate individuals are selected to undertake ‘provider-led’ investigations into the incident (or complaint), and that any concurrent inquiries being undertaken by police are not in any way compromised. Board directors should seek to satisfy themselves that the impacted person with disability has been, or is being, well supported to participate in any criminal process in accordance with their wishes.

What we heard about safeguarding data indicators and related systems

Public hearing 32 revealed inconsistencies across NDIS providers concerning the information regularly reported to and analysed by governing bodies.

For smaller NDIS providers, reporting information to its board can be relatively simple.¹⁷⁶ The boards of larger organisations are likely to require more information and have more elaborate reporting structures.

For example, the Commissioners’ *Report of Public hearing 23* addressed deficiencies in reporting information to Afford’s board:

what was presented was not organised into a systematic assessment of incidents, complaints and other data that would enable the board to identify and assess risks to the health and safety of Afford's clients across the organisation.¹⁷⁷

Afford has now adopted a Board and Executive Reporting Framework that sets out the nature and types of reports, their frequency and who the reports should be distributed to.¹⁷⁸ Since Public hearing 23, Ms Joanne Toohey, the new CEO of Afford, said there is now 'far more visibility for the board' in relation to the safety and quality of Afford's service provision. She also said the full executive team attends all board meetings with her, meaning the board has 'direct line of sight' to the team.¹⁷⁹

Data received by boards and governing bodies need not be exclusively quantitative (such as the number of incidents or complaints) but can also be qualitative. Ms Carol Berry, CEO of The Disability Trust, emphasised the need for boards to receive staff member and manager reflections about potential areas of concern.¹⁸⁰

Registered NDIS provider Melba provided information about its systems to collect different streams of data related to the safety and quality of its services, including the Personal Outcome Measures tool.¹⁸¹ It also seeks feedback from clients and their supporters, as well as from staff, through surveys, focus groups and in-person engagement. Data from these sources is reviewed and reported through to its board, which also receives reports through its Practice Quality and Safety Committee.¹⁸²

The way data is organised and assessed will differ between providers. Some providers have dedicated teams to assist with data collection and analysis.¹⁸³ However, the provider needs to be able to show the information within the specific context and across time periods. For example, Melba reports to its Practice Quality and Safety Committee and to its board in relation to all reportable incidents of violence, abuse, neglect and exploitation. These reports provide data breakdowns including averages, by region, by type of incident, by persons involved in the incident and by entity. Its Practice Quality and Safety Committee also receives a more detailed list and a summary of specific incidents.¹⁸⁴

Sample safeguarding indicators

NDIS providers can improve internal accountability mechanisms for preventing and responding to incidents and complaints in a variety of ways. However, all boards should include 'safety, quality and risk' as a standing agenda item at meetings. Board meetings should dedicate sufficient time to allow for meaningful discussion of safeguarding data and individual high-risk matters.

The sample indicators outlined in Table 10.8.3 could form the basis of a monthly or quarterly 'dashboard' style reporting tool for boards reflecting the regulatory requirements in relation to effective complaints and incident management systems.

Table 10.8.3: Sample indicators for the relevant reporting period

Area	Indicator
Incidents	• number and types of incidents received • number and types of restrictive practices used (broken down by authorised and unauthorised – including reason for unauthorised use) and number of involved NDIS participants • number of notifications of reportable incidents and the proportion notified outside of legislative timeframe • notifications of reportable conduct to state scheme operators (where relevant) and proportion notified outside of legislative timeframe • personnel involved in incidents (role type, such as employee, labour hire worker or volunteer) • number of matters referred to police, offence types, and whether active police investigation is underway • number of matters the subject of statutory child protection reports and whether investigation is underway • number of matters finalised and related outcome including: ◦ sustained/not-sustained – such as employee misconduct or an assessment that incident was preventable ◦ remedial action – including complainant focused actions, such as apology, ex gratia payment, changes to service provision; and subject of allegation focused actions such as criminal charge/conviction, or disciplinary action or dismissal • systemic/clinical review outcomes – changes to systems, practices, training • feedback given or action taken by the regulator • significant matters overview: summary details, identified risks and action taken or proposed to ameliorate current or future risks (such as risks to the impacted person with disability and others affected clients; risks to the service environment).¹⁸⁵
Complaints	• number of complaints received • nature of issues raised in complaints received • number of complaints made directly to the agency or referred by regulator • whether complaint raises issues that require notification as a reportable incident • number of matters handled by resolution or investigation • nature of complaint investigation/resolution outcomes (see outcomes listed above).
Trends and issues	Regular safeguarding reports should also include an analysis of any incident or complaint trends; for example, patterns relating to program areas, geographic location, or types of roles within the organisation. It should also include an analysis of the volume of matters reported and changes over time.

Area	Indicator
Prevention data	There is also value in regular reporting on broader safeguarding information such as: • learning and development data – disaggregated by employee grouping and program area against completion of mandatory safeguarding and disability services training • probity and screening check compliance data – disaggregated by employee grouping, program area, role type (such as employee, volunteer, board member) including expiry dates and renewals.

Specialist safeguarding expertise

In addition to having people with disability and other subject matter experts on providers boards, it is essential they include, or have direct access to, advice from a safeguarding specialist. A safeguarding specialist should not only have expertise in understanding safeguarding policy and related regulatory environments, but expertise in conducting safeguarding investigations into complaints and incidents involving people with disability. It is necessary for boards to have the benefit of this type of expertise when considering safeguarding data, risk and individual matters.

Guidance for providers

In its *Own Motion Inquiry* report, the NDIS Commission committed to ‘develop guidance and education to NDIS providers on best practice governance models that embed a person-centred culture; that act on issues and incidents affecting people with disability; and holds the organisation to account for quality and safety’.¹⁸⁶ The Royal Commission fully supports the NDIS Commission’s intention to develop guidance and education in this area. In doing, so we recommend that the NDIS Commission has regard to the safeguarding indicators and related commentary discussed in this section.

Recommendation 10.17 Access to safeguarding indicators and expertise

In developing and publishing guidance about best practice governance models for National Disability Insurance Scheme (NDIS) providers, the NDIS Quality and Safeguards Commission should:

- include safeguarding indicators for use by NDIS providers based on the sample indicators outlined in Table 10.8.3
- provide guidance encouraging governing bodies of NDIS providers to have regular access to specialist safeguarding advice in considering issues arising from complaints and incidents.

Endnotes

- 1 *National Disability Insurance Scheme Act 2013* (Cth) s 181F.
- 2 *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4).
- 3 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 16(2).
- 4 NDIS Quality and Safeguards Commission, *Activity report: 1 July to 31 December 2021*, January 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 January to 31 March 2022*, April 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 April to 30 June 2022*, July 2022, pp 7–8; NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, February 2023, p 6.
- 5 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, pp 258–59 [981].
- 6 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [97], [208].
- 7 Exhibit 32-100, CAR.9999.0006.0001, p 6; Exhibit 32-125, END.9999.0002.0001, p 23; Exhibit 32-143, HUP.9999.0001.0001, pp 44–45; Exhibit 32-131, NTH.9999.0002.0001, p 17; Exhibit 32-074, SUN.9999.0006.0001, p 24.
- 8 For example, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, [146–62], Findings 15–19; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, 28 February 2023, [143–59], Findings 8–10; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 21 March 2023, [145–55], Findings 19–20.
- 9 For example, Exhibit 32-125, END.9999.0002.0001, p 23; Exhibit 32-143, HUP.9999.0001.0001, pp 46–47; Exhibit 32-131, NTH.9999.0002.0001, p 17; National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 7; Name withheld, Submission in response to *Safeguards and quality issues paper*, 16 February 2020, ISS.001.00559, pp 2, 5, 9.
- 10 *National Disability Insurance Scheme Act 2013* (Cth) s 181F.
- 11 Exhibit 4-32, ‘Statement of Graeme Head’, 11 February 2020, at [65–67] and [77]; *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 8–13, 20–21.
- 12 Exhibit 4-32, ‘Statement of Graeme Head’, 11 February 2020, at [75]; *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 20–21.
- 13 Exhibit 4-32, ‘Statement of Graeme Head’, 11 February 2020, at [50(d)].
- 14 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 23–24.
- 15 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 20–21.
- 16 Exhibit 13-232, ‘Statement of Graeme Head’, 18 December 2020, at [111].
- 17 Under s 26(1)(e) of the *Incident Management Rules*, at any time after receiving a reportable incident notification, the Commission may decide to carry out an inquiry in relation to the incident in accordance with s 27 of the *Incident Management Rules*.
- 18 Exhibit 13-232, ‘Statement of Graeme Head’, 18 December 2020, at [111]; See also *National Disability Insurance Scheme Act 2013* (Cth) ch 4, pt 3A, div 8 – Compliance and enforcement.
- 19 *National Disability Insurance Scheme Act 2013* (Cth) s 73F; *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) s 5.
- 20 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) Pt 2.
- 21 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 10(1).

- 22 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 10(3).
- 23 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 11.
- 24 *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4); *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 16(3).
- 25 NDIS Quality and Safeguards Commission, *Activity report July 2018 – June 2019*, July 2019, p 2; NDIS Quality and Safeguards Commission, *Activity report: 1 July 2019 to 30 June 2020*, July 2020, p 5; NDIS Quality and Safeguards Commission, *Activity report: 1 July 2020 to 30 June 2021*, July 2021, p 5; NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, Report, January 2022, p 3; NDIS Quality and Safeguards Commission, *Activity report: 1 July to 31 December 2021*, January 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 January to 31 March 2022*, April 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 April to 30 June 2022*, July 2022, pp 7–8.
- 26 ‘The NDIS in each state’, *National Disability Insurance Agency*, web page, 20 February 2023. <www.ndis.gov.au/understanding/ndis-each-state>
- 27 National Disability Insurance Agency, *Projected participant by state and territory data*, Dataset, 30 June 2022. <data.ndis.gov.au/data-downloads>
- 28 Names changed to protect identity.
- 29 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [55], [60–61].
- 30 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [53–55].
- 31 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [74].
- 32 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [77], [82].
- 33 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [85]; Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-200 [1–18].
- 34 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-201 [35]–P-204 [3].
- 35 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-203 [6–17].
- 36 Exhibit 23-073, CTD.9999.0040.0001, p 4.
- 37 Submissions of Life Without Barriers, Public hearing 20, 13 April 2022, SUB.0020.0001.0293, p 51 [165].
- 38 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-202 [1–23].
- 39 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-196 [27]–P-197 [25].
- 40 Names changed to protect identities.
- 41 Exhibit 13-002, ‘Statement of [Eliza]’, 29 April 2021, at [109].
- 42 Exhibit 13-002, ‘Statement of [Eliza]’, 29 April 2021, at [109].
- 43 For example, Name withheld, Submission, 2 September 2020, [SUB.001.00548, p 2]; National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 6; Submissions of Counsel Assisting the Royal Commission following Public hearing 20, March 2022, [727]; Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-195 [41]–P-196 [20]; Name withheld, Submission, 2 September 2020 [SUB.001.00548, p 2].
- 44 Exhibit 32-125, END.9999.0002.0001, p 23.
- 45 Office of the Public Advocate, *‘I’m too scared to come out of my room’: preventing and responding to violence and abuse between co-residents in group homes*, November 2019, p 51.
- 46 Office of the Public Advocate, *‘I’m too scared to come out of my room’: preventing and responding to violence and abuse between co-residents in group homes*, November 2019, p 51.
- 47 National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 8.
- 48 National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 8.
- 49 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 137.
- 50 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 142.
- 51 Exhibit 20-1349, ‘Statement of Samantha Taylor’, 17 November 2021, at [92].
- 52 Transcript, Annie Doyle, Public hearing 32, 16 February 2023, P-394 [34–39].

53 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-454 [7–13].

54 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-454 [15–26].

55 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-454 [28].

56 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Inquiry report, January 2023, pp 73–74.

57 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Inquiry report, January 2023, p 73.

58 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-217 [28]–P-218 [25].

59 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [208].

60 The police complaint oversight function was transferred from the NSW Ombudsman to the Law Enforcement Conduct Commission (LECC). Prior to this transfer, s 121 of the *Police Act 1990* (NSW) defined a ‘notifiable complaint’ as ‘any complaint that (in accordance with guidelines agreed between the Police Integrity Commission and the Ombudsman after consultation with the Commissioner) is required to be notified to the Ombudsman’. The guidelines were known as the ‘Class or Kind Agreement’. Part 5, div 1, s 33 of the *Law Enforcement Conduct Commission Act 2016* (NSW) requires the Commissioner of Police (and others) to notify the LECC of possible officer misconduct and serious maladministration. Section 33(5) enables the Commission to issue guidelines as to what matters do or don’t need to be reported.

61 The child-related reportable conduct scheme in New South Wales was established in 1999. The scheme was transferred to the New South Wales Government Office of the Children’s Guardian in 2019. Prior to this transfer, Part 3A, s 25CA(1) of the *Ombudsman Act 1974* (NSW) enabled the NSW Ombudsman to exempt any ‘class or kind’ of conduct by employees of an agency from being reportable conduct. Part 4, div 4, s 30 of the *Children’s Guardian Act 2019* (NSW) enables the Children’s Guardian to exempt a class or kind of conduct by employees of a relevant entity from notification under s 29 of the Act.

62 *Child Wellbeing and Safety Act 2005* (Vic) s 16i; *Ombudsman Act 1989* (ACT) s 17G(3).

63 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, vol 7, December 2017, p 274.

64 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 27; *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 29.

65 ‘Own Motion Inquiry into aspects of supported accommodation in the NDIS’, *NDIS Quality and Safeguards Commission*, web page, 23 January 2023. <ndiscommission.gov.au/resources/reports-policies-and-frameworks/inquiries-and-reviews/own-motion-inquiry-aspects>

66 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Inquiry report, January 2023, p 4.

67 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 44.

68 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 44.

69 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 4.

70 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 46.

71 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 46.

72 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 58.

73 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 60.

74 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 61.

75 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 61–62.

76 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 59–62.

77 Exhibit 32-125, END.9999.0002.0001, p 23.

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- 78 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-448 [37–41].
- 79 NDIS Quality and Safeguards Commission, *Own Motion Inquiry Terms of Reference: Platform providers operating in the NDIS market*, February 2023, p 2.
- 80 NDIS Quality and Safeguards Commission, *Own Motion Inquiry Terms of Reference: Platform providers operating in the NDIS market*, February 2023.
- 81 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 26(1)(c)–(d); Exhibit 13-232, ‘Statement of Graeme Head’, 18 December 2020, at [111].
- 82 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [89].
- 83 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [92].
- 84 Exhibit 23-199, NSW.0065.0001.0001, p 1; Exhibit 23-140, AFF.0008.0001.0281, pp 2–3.
- 85 Exhibit 23-199, NSW.0065.0001.0001, pp 1–5, 8; Exhibit 23-201, NSW.9999.0048.0013.
- 86 Exhibit 23-070, ‘Statement of Samantha Taylor’, 22 April 2022, at [120].
- 87 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-240 [42–43]; Exhibit 23-070, ‘Statement of Samantha Taylor’, 22 April 2022, at [138–39]; Exhibit 23-194, AFF.0004.0001.3816.
- 88 Exhibit 23-194, AFF.0004.0001.3816, p 1.
- 89 Exhibit 23-070, ‘Statement of Samantha Taylor’, 22 April 2022, at [147]; Exhibit 23-140, AFF.0008.0001.0281.
- 90 Exhibit 23-140, AFF.0008.0001.0281, p 7; Transcript, Wayne Adamson, Public hearing 23, 19 May 2022, P345–346.
- 91 Exhibit 23-140, AFF.0008.0001.0281, pp 10–11.
- 92 Exhibit 23-070, ‘Statement of Samantha Taylor’, 22 April 2022, at [150–53]. Exhibit 23-72, CTD.7200.0035.0011.
- 93 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-250 [1–7]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, Finding 28.
- 94 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [64].
- 95 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [68].
- 96 Submissions of Australian Foundation for Disability, Public hearing 23, 16 September 2022, SUBM.0032.0001.0001, [45].
- 97 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 31 [Finding 3].
- 98 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 101 [Finding 28].
- 99 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-242 [19–30].
- 100 Transcript, Graeme Head, Public hearing 13, 28 May 2021, P-492 [30]–P-493 [13].
- 101 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [49].
- 102 Transcript, Kate Eastman, Public hearing 32, 16 February 2023, P-400 [30–38].
- 103 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-400 [21–28].
- 104 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-400 [47]–P-401 [1].
- 105 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability service (a case study)*, March 2023, [148]; Transcript, Dianne, Public hearing 23, 17 May 2022, P-163 [10–14], P-168.
- 106 Exhibit 23-070, ‘Statement of Ms Samantha Taylor PSM’, 22 April 2022, at [18–25].
- 107 Exhibit 23-070, ‘Statement of Ms Samantha Taylor PSM’, 22 April 2022, at [87–88].
- 108 Exhibit 23-070, ‘Statement of Ms Samantha Taylor PSM’, 22 April 2022, at [99].
- 109 Transcript, Samantha Taylor, Public hearing 23, 17 May 2022 P-225 [40–50]; Transcript, Wayne Adamson, Public hearing 23, 18 May 2022, P-293 [4–6].
- 110 Exhibit 23-070, ‘Statement of Ms Samantha Taylor PSM’, 22 April 2022, at [100]; Transcript, Samantha Taylor, Public hearing 23, 17 May 2022 P-226 [44–45].

111 Transcript, Samantha Taylor, Public hearing 23, 17 May 2022 P-219 [31–37]; Exhibit 23-070,
 112 ‘Statement of Ms Samantha Taylor PSM’, 22 April 2022, at [114–15].
 113 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
 114 Report of *Public hearing 20: Preventing and responding to violence, abuse, neglect and
 exploitation in disability services (two case studies)*, February 2023, p 55 [159], Finding 9.
 115 ‘Statement of Samantha Taylor’, 17 November 2021, at [98–99].
 116 For example, NDIS provider Civic Disability Services told us if they were in doubt about whether
 the event or occurrence was a ‘reportable incident’ for the purposes of the *NDIS Act*, they would
 err on the side of caution and report the incident to the NDIS Commission anyway.
 The Endeavour Foundation further said the NDIS Commission should provide more resources
 on what constitutes a reportable incident. This should include greater detail and guidance in
 developing consistent approaches to assessment and decision making; Transcript, Annie Doyle,
 Public hearing 32, 16 February 2023, P-394 [34–39]; Exhibit 32125, END.9999.0002.0001, p 23.
 115 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia,
NDIS Quality and Safeguards Commission, November 2021, p 139.
 116 Australian Government, Response to the Joint Standing Committee on the National Disability
 Insurance Scheme report: NDIS Quality and Safeguards Commission, 20 April 2023, p 10.
 Refers to amendments to s 73Z(1) of the *National Disability Insurance Scheme Act 2013* (Cth)
 made under the *National Disability Insurance Scheme Amendment (Improving Supports for
 At Risk Participants) Act 2021* (Cth).
 117 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-192 [35–47]; Transcript,
 Samantha Taylor, Public Hearing 23, 17 May 2022 P-219 [31–37], P-226 [47–50].
 118 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported
 accommodation*, Final inquiry report, January 2023, p 60.
 119 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported
 accommodation*, Final inquiry report, January 2023, p 74.
 120 Transcript, Sonya Furey, Public hearing 32, 16 February 2023, P-399 [26–32]; Transcript,
 Liz Forsyth, Public hearing 32, 16 February 2023, P-399 [26–32], [38–46].
 121 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-459 [33–37].
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 accommodation*, Inquiry report, January 2023, p 51.
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 124 New South Wales Government Office of the Children’s Guardian, Critical issues paper to the
 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
 31 March 2023, p 8.
 125 NDIS Quality and Safeguards Commission, ‘Reportable incidents: Detailed guidance for
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 ‘Incident Management: Detailed Guidance for Registered NDIS Providers’, June 2019, p 30.
 126 NDIS Quality and Safeguards Commission, ‘Incident Management: Detailed Guidance for
 Registered NDIS Providers’, June 2019, pp 30–31.
 127 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [34–35].
 128 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [34]; ‘Grant award view –
 GA73435-V2’, *Australian Government Grant Connect*, web page. <[www.grants.gov.au/Ga/
 Show/4fd9ee8b-cc03-4ad3-9bf9-ae06c6d8d42b](http://www.grants.gov.au/Ga/Show/4fd9ee8b-cc03-4ad3-9bf9-ae06c6d8d42b)>
 129 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [37].
 130 ‘NDIS Quality and Safeguards resources’, *National Disability Services Limited*, web page.
 <www.nds.org.au/resources/all-resources/ndis-quality-and-safeguards-resources-hub>
 131 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [40].
 132 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-200 [30–32].
 133 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [42].
 134 *National Disability Insurance Scheme Act 2013* (Cth) ss 73F(2)(e)–(h), 73W, 73X, 73Y, 73Z.
 135 *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards)
 Guidelines 2018* (Cth) ss 15(1), 16(1).
 136 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)
 Rules 2018* (Cth) s 10(1).
 137 *National Disability Insurance Scheme Act 2013* (Cth) s 181F(d).

- 138 *National Disability Insurance Scheme Act 2013* (Cth) s 181F(f).
- 139 *National Disability Insurance Scheme Act 2013* (Cth) s 181G(d).
- 140 *National Disability Insurance Scheme Act 2013* (Cth) s 181D(2).
- 141 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, February 2023, p 106 [353], Finding 33; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability service (a case study)*, March 2023, p 31, [84], Finding 1.
- 142 Exhibit 3-034, 'Statement of Dr Sherene Devanesen', 28 November 2019, at [167–69], [177], [181], [189–90].
- 143 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 3: The experience of living in a group home for people with disability*, September 2020, [342].
- 144 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 3: The experience of living in a group home for people with disability*, September 2020, [343].
- 145 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, [463].
- 146 A pseudonym.
- 147 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 17: The experience of women and girls with disability with a particular focus on family, domestic and sexual violence*, 16 May 2032, p 28 [98], Finding 5, p 32 [115], Finding 6.
- 148 Transcript, Carolyn Cumming, Public hearing 17, 31 March 2022, P-258 [15–16].
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- 150 A pseudonym.
- 151 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*, 28 February 2023, p 106 [353], Finding 33.
- 152 Exhibit 23-026, 'Statement of [Suzie]', 28 April 2022, at [37–38]; Exhibit 23-001, 'Statement of [Sally]', 26 April 2022, at [84], [87].
- 153 Exhibit 23-001, 'Statement of [Sally]', 26 April 2022, at [84].
- 154 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 31 [84], Finding 1.
- 155 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 31 [84], Finding 1.
- 156 Submissions by the Australian Foundation for Disability in response to Counsel Assisting's submissions in Public hearing 23, 16 September 2022, SUBM.0032.0001.0001, p 7 [47–49].
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- 158 Exhibit 32-164, YPL.9999.0002.0004, pp 4–5.
- 159 Exhibit 32-163, YPL.9999.0003.0281, p 4, pp 16–17; Exhibit 32-164, YPL.9999.0002.0004, pp 4–7; Transcript, Terry Symonds, Public hearing 32, 16 February 2023, P-336 [30]–P-337 [7].
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- 161 Exhibit 32-125, END.9999.0002.0001, p 20.
- 162 Exhibit 32-125, END.9999.0002.0001, p 20.
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- 165 NDIS Quality and Safeguards Commission, Enforceable Undertakings Policy, V1.0, January 2022, p 4.

166 *National Disability Insurance Scheme Act 2013* (Cth) s 73ZP.
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 169 Counsel Assisting submissions following Public hearing 32, 31 March 2023, p 203 [743].
 170 Counsel Assisting submissions following Public hearing 32, 31 March 2023, p 203 [744].
 171 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 10(3)(c), 26(1)(b); *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 20(1).
 172 'Key personnel' is defined in s 11A of the *National Disability Insurance Scheme Act 2013* (Cth) to include a person, or member of a group of persons, who is responsible for the executive decisions of the person or entity, or any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the person or entity. This includes a director of the body corporate (if the provider is an incorporated entity) and/or a member of the governing body.
 173 *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) s 6.
 174 *Work Health and Safety Act 2011* (Cth) s 19(2).
 175 *Work Health and Safety Act 2011* (Cth) s 27.
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 177 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, [229].
 178 Exhibit 32-082, AFF.0014.0001.0684.
 179 Transcript, Joanne Toohey, Public hearing 32, 15 February 2023, P-247 [1–7].
 180 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-257 [38–42]. Ms Berry also discussed the need for a proactive model of prevention that involves providers using internal data to detect problems and prevent abusive cultures from emerging in the first place: Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-257 [27–29], [41–42].
 181 Exhibit 32-041, MAS.9999.0001.0003, pp 6–7.
 182 Exhibit 32-041, MAS.9999.0001.0003, p 6.
 183 For example, Araluen has a data team to assist with data collection and analysis capabilities. UnitingCare Community also has a dedicated Client Data Integrity, Reporting and Support team, which develops, implements and maintains safety and quality data recording and reporting systems. This team is part of UnitingCare Community's Practice Improvement and Development team: Transcript, Tamara Cattach, Public hearing 32, 15 February 2023, P-222 [14–15]; Exhibit 32-029, UCQ.9999.0004.0001, pp 21–22.
 184 Exhibit 32-041, MAS.9999.0001.0003, p 8; Exhibit 32-98, MAS.9999.0001.0159.
 185 In determining which matters are 'significant', NDIS providers should pay regard to individual 'participant risk indicators', drawing from the joint NDIS Commission and NDIA Operational Protocol for NDIS participants at risk: Exhibit 32-195, CTD.7200.0040.1250, p 8.
 186 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 94.

9. Complaints

Key points

- The NDIS Quality and Safeguards Commission (NDIS Commission) complaints function is critical to its oversight of the quality and safety of National Disability Insurance Scheme (NDIS) supports and services.
- If people who complain to NDIS providers feel heard and believe the process overseen by the NDIS Commission is fair and robust, they are more likely to raise concerns in future. The NDIS Commission has a critical role to play in giving feedback to NDIS providers about how they can improve their responses to complaints.
- Using data collected through its complaints function, the NDIS Commission is well placed to inform providers about safety and quality issues and target its educational and compliance activities.
- We have identified deficiencies in the way NDIS providers manage and investigate complaints, highlighting the need for the NDIS Commission to strengthen provider requirements in this area and enhance guidelines for accessible complaint handling practice.
- The complaints function attracts a high volume of incoming complaints. As the number of NDIS participants increases and the provider market expands, it is likely the number of complaints made will continue to increase.
- Given the increasing volume of complaints, the NDIS Commission should be empowered to require providers to investigate complaints and report back on investigation outcomes, when appropriate.
- The NDIS Commission's own internal complaint processes also need to be enhanced and made more accessible. We were told about lengthy timeframes, and poor communication with NDIS providers, NDIS participants and other people involved in complaints.

It costs a huge amount of energy both emotionally and physically to complain. And for people with disabilities it costs even more, because we have so much more to get over to get anything done...¹

An accessible and well-understood complaint management system is a key mechanism for recording, reporting and investigating instances of alleged violence, abuse, neglect and exploitation of people with disability. It also provides a framework for providers to respond effectively to complainants and to prevent similar occurrences happening again within their service. If people who complain to National Disability Insurance Scheme (NDIS) providers feel heard and believe the process overseen by the NDIS Quality and Safeguards Commission (NDIS Commission) is fair and robust, they are more likely to raise legitimate concerns.

Dissatisfaction is a common experience for people involved in making a complaint, but does not always indicate a failure of process. However, we heard repeatedly of the risk to people with disability when complaints or concerns are not seen to be taken seriously or properly handled by NDIS providers. This risk is compounded if adequate action is not taken by the NDIS Commission to address poor responses from NDIS providers.

We heard the NDIS Commission's own complaint handling processes:

- can be lengthy and involve poor communication
- do not always properly explore issues raised by complaints or sufficiently test the veracity of NDIS providers' responses
- need to be more accessible
- should do more to connect those who complain with supports to assist them to meaningfully participate in complaint processes when required.

In this chapter, we consider the steps the NDIS Commission is taking to improve its complaint processes and what more should be done. We examine how the NDIS Commission might focus on situations that present greater risks, and on people with disability at higher risk of experiencing violence, abuse, neglect and exploitation.

9.1. Overview of the complaints function

Complaints management and resolution is one of the core functions of the NDIS Commission.² The NDIS Commission investigates, manages and resolves complaints about NDIS supports and services provided by registered and unregistered providers. It also:³

- educates people about, and develops resources relating to, best practice complaint handling
- enhances provider capacity to respond to complaints
- builds capacity of people with disability to pursue complaints
- collects, analyses and disseminates information relating to complaints.

Complaints management and resolution is primarily regulated under the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth)

(*Complaints Rules*). It is a condition of an NDIS provider's registration to have a complaints management and resolution system.⁴

The *Complaints Rules* also stipulate how the NDIS Commission must handle the complaints it receives about providers.⁵ For example, the NDIS Commission must:⁶

- consider the views of any person with disability affected by the complaint if it is reasonable and appropriate to do so
- allow the person or provider who is the subject of the complaint a reasonable opportunity to comment on any proposed adverse finding against the person
- seek to resolve the complaint as quickly and with as little formality as possible, while giving proper consideration to the issues raised in the complaint.

The complaints process

The NDIS Commission has also developed a procedure for its staff about managing complaints,⁷ which involves four steps:⁸

1. receiving the complaint and completing intake
2. assessing risk, triaging and allocation to a stream
3. gathering information and taking action
4. closing and reconsidering a complaint.

A complaint is considered 'in-scope' by the NDIS Commission if it is:⁹

- an 'expression of dissatisfaction with an NDIS support or service, including the handling of the complaint by the provider, where a response or resolution is explicitly or implicitly expected or legally required'
- about an issue concerning the provision of supports and services supplied by an NDIS provider.

Complaints officers can support the complainant to contact another more suitable agency to address their concerns (a 'warm referral').¹⁰ For example, the NDIS Commission has an agreed information sharing protocol for referring complaints to the National Disability Insurance Agency (NDIA).¹¹

The former NDIS Commissioner Mr Graeme Head AO explained that each issue raised in a complaint is assessed. A decision is then made about what action to take in response to it,¹² which may involve resolution, conciliation, investigation or finalisation.¹³

The NDIS Commission has also published the *Complaints Management and Resolution Guidance* for people with disability and their support networks. The *Complaints Guidance* does not provide any commitments about likely timeframes to resolve matters, but says some

complaints can be resolved quickly, whilst others can take longer to gather information and reach a resolution.¹⁴ The *Complaints Guidance* also states the person with disability should be involved as much as possible in the process.¹⁵

Own motion inquiries

The recent Own Motion Inquiry into Aspects of Supported Accommodation (Own Motion Inquiry) conducted by the NDIS Commission examined 850 complaints concerning supported accommodation providers.¹⁶ In relation to complaints, the inquiry found:

- the main causes of complaints were the capability and culture of the workforce, the nature of supported accommodation settings and inadequate transparency and communication¹⁷
- of the complaints examined, 68 per cent related to group home settings¹⁸
- complaints most frequently related to provider practice, alleged abuse or neglect by support workers, or provider policies and procedures¹⁹
- most complaints concerning provider practices related to the general quality of the experience in supported accommodation, poor communication with the person's support network, and use of medication or other inappropriate measures to manage a person's behaviours²⁰
- complaints about alleged abuse and neglect were mostly about support workers' conduct, including verbal abuse, disrespectful behaviour or conduct, and exercising undue influence towards people with disability²¹
- complaints about provider policies and procedures related to alleged negligence, failure to provide appropriate supervision, and failing to take a participant's preferences and rights into account when providing support.²²

9.2. What the data is telling us

In Chapter 13, 'Data and intelligence', we recommend the NDIS Commission enhance its data analytics and intelligence capacity using data collected through its complaints function to inform providers about quality issues and focus its educational and compliance activities. However, some observations can be made from the data it publishes. In particular, the number of complaints made to the NDIS Commission has increased steadily since it commenced operating in July 2018.²³

Table 10.9.1 shows the number of complaints received and complaint types (as a percentage of the total) for each financial year between July 2018 and June 2022.

Table 10.9.1: Number of complaints and complaint types between July 2018 and June 2022

Complaint type	2018–19	2019–20	2020–21	2021–22
Total complaints received	1,422	4,469	7,231	7,843
Provider practice	54%	48%	43%	39%
Worker conduct or capability	9%	19%	23%	33%
Alleged abuse and neglect*	9%	13%	19%	19%
Provider policies and practices	16%	20%	15%	6%
Communication quality	13%	na	na	na
Other	na	na	na	2%

* This category was known as 'Alleged assault and abuse' in 2018–19.

Note: 'na' indicates the data is not available because the particular complaint type was not publicly reported on during the period.

Source: NDIS Quality and Safeguards Commission²⁴

The NDIS Commission's jurisdiction extended beyond New South Wales and South Australia on 1 July 2018 to the Australian Capital Territory, the Northern Territory, to Queensland and Victoria and Tasmania on 1 July 2019, and finally to Western Australia on 1 December 2020.²⁵ Table 10.9.1 demonstrates that the number of complaints increased significantly as each state and territory commenced operating, and continues to rise.

Apart from this increase, the main discernible trend over the four years is the more than tripling of the proportion of complaints about worker conduct and capability (rising from 9 per cent to 33 per cent of all complaints). The share of complaints about abuse and neglect has also more than doubled (increasing from 9 per cent to 19 per cent). There has been a notable decrease in the proportion of complaints about provider practice over the period.

Table 10.9.2 shows the number of complaints received and who made them (as a percentage of the total) each financial year.

Table 10.9.2: Primary complainant

Primary complainant	2018–19	2019–20	2020–21	2021–22
Total complaints received	1,422	4,469	7,231	7,843
People with disability	56%	30%	26%	25%
Family member or friend	na	31%	22%	20%
Support workers or service providers	18%	18%	21%	21%
Government bodies	4%	4%	4%	4%
Unknown (data not available)	na	na	na	5%
Others, incl. guardians & advocates	22%	17%	27%	25%

Note: 'na' indicates the data is not available because the particular complainant category was not publicly reported on during the period. In 2018–19, the NDIS Commission publicly reported on the complainant types 'People with disability' and 'Family member or friend' as one combined category.

Source: NDIS Quality and Safeguards Commission²⁶

Since July 2019, only 25 to 30 percent of complaints have come directly from a person with disability. On the one hand, this demonstrates the critical role family members, friends, guardians and advocates have in supporting people with disability to make complaints. But it may also be an indication that people with disability are not being supported to make complaints directly. Support networks of NDIS participants (family members or friends, and others including guardians and advocates) are consistently the primary source of complaints recorded by the NDIS Commission, accounting for a combined 45 percent of all complaints received in the 2021–22 financial year. It is also noteworthy that the proportion of complaints made by people with disability directly has more than halved since July 2018.

9.3. Critical issues identified

We have referred to the concerns expressed in the evidence about the NDIS Commission's approach to assessing and resolving complaints.²⁷ The key concerns relate to poor communication, lengthy timeframes, inaccessible complaints processes, insufficient involvement of people with disability in the process and a lack of attentiveness to issues raised in complaints.

The Joint Standing Committee on the NDIS (Joint Standing Committee) recorded similar concerns about how the NDIS Commission handles complaints, including that the process is:²⁸

- difficult to access due to its complexity and lack of clarity about how it operates, as well as the significant barriers faced by participants
- frustrating for parties due to a lack of information provided by the NDIS Commission regarding timeframes for resolution or progress of a complaint, confusion about the NDIS Commission's referral process, and perceptions from participants that the process favours providers.

In a submission to the Royal Commission, the Commonwealth Ombudsman told us that a complaint handling system needs to be accessible and trusted by people with disability. Complaint pathways should be actively promoted and explained to increase the likelihood of issues being raised and there should be clear guidance about the process, including to manage expectations of potential outcomes and likely timing.²⁹

Improving NDIS provider complaint practices

An important role for the NDIS Commission is to identify systemic issues with the complaint handling practices of individual NDIS providers, as well as common themes detected in complaint handling practice across the NDIS service sector.

Witnesses told us of their frustration, confusion and fear about how their complaints or feedback have been handled by providers. They said:

- Providers are resistant to feedback, with complainants labelled as 'unreasonable', 'the angry one', 'querulant' or 'rude' by NDIS providers.³⁰
- Responses to concerns are inconsistent, inadequate, untimely or even completely ignored. For example, in Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', 'Sally', mother of 'Jason', said she emailed NDIS provider Afford's CEO in 2018 expressing concern about her son's support and requested more communication. To her knowledge, she never received a response to her complaint.³¹
- Some family members who made complaints felt like they were considered a 'nuisance' and were ignored by the provider.³² Some family members felt there were repercussions as a result of making complaints, or feared repercussions if they continued to make complaints.³³
- Disability service provider complaint policies and procedures allow for a person with disability, their support network, advocates and others to initiate the process.³⁴ However, for those who do not have a support network, raising a complaint is extremely difficult.
- Some First Nations people with disability experience language barriers and have difficulty understanding how the NDIS works or where to go for help.³⁵
- Some provider policies rate complaints according to a scale based on organisational needs, or exclude certain issues from the scope of matters that could be considered a complaint. For example, Endeavour's procedure rates a complaint made via a solicitor or a complaint

made to the media as ‘severe’, the highest rate available. Complaints about violence, abuse, neglect and exploitation are rated at the next level down of ‘Major 4’.³⁶ Provider complaint policies can have the effect of characterising complainants as ‘unreasonable’.³⁷ The evidence in Public hearing 13, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)’, demonstrated there is a risk of service providers conflating persistent self-advocacy by a person with disability, or advocacy by a supporter, with unreasonableness.³⁸

- There is considerable variation in provider policies, procedures and practices, including definitions used and the nature of investigations.³⁹
- Disability support workers and other service provider staff might be afraid of making reports, or complaints, out of fear this may have negative consequences for their employment.⁴⁰

Timeframes and communication with parties to a complaint

Two common concerns raised in submissions and by witnesses at public hearings, were inadequate communication by the NDIS Commission with parties to a complaint and delays resolving complaints.⁴¹ The following case study on ‘Robert’ and ‘Paul’ and their experience with the NDIS Commission illustrates these concerns.⁴²

Case study: Robert and Paul's experience

Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', focused on the experiences of people with disability who received accommodation and support services from Life Without Barriers (LWB) – a registered NDIS provider. One case study focused on a group home in Victoria run by LWB, referred to as the Melbourne house.

We heard evidence from Paul, who is a foster parent of Robert. Robert is blind, developmentally delayed and has autism.⁴³ Robert moved into the Melbourne house when he was 27 years old in 2011.⁴⁴

Paul had concerns about how residents' money was being spent after LWB told him it had no record keeping systems relating to spending.⁴⁵ Paul made a complaint to the NDIS Commission on 4 November 2020.⁴⁶

Almost four months later, Paul received an email from the NDIS Commission acknowledging receipt of his complaint.⁴⁷ Paul received no other contact from the NDIS Commission for the next five months. On 20 July 2021 he wrote to the then Acting NDIS Commissioner, Ms Samantha Taylor. His letter set out his view of systemic failures by LWB, including the lack of programs to monitor supported independent living (SIL) providers and non-compliance by SIL providers.⁴⁸ An NDIS Commission officer phoned Paul shortly after this. He then received a letter dated 3 September 2021 that emphasised the role of quality auditors in addressing compliance with the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth).⁴⁹

The first time the NDIS Commission received any information from LWB about the complaint was by email on 2 September 2021, almost 10 months after Paul first complained.⁵⁰ On 20 September 2021, the NDIS Commission called Paul and outlined LWB's response, noting LWB was implementing a client expenditure system project, and it would be monitoring its implementation.⁵¹ The NDIS Commission notified Paul on 1 October 2021 that his complaint had been closed.⁵²

During Public hearing 20, Ms Taylor was asked to comment on why it took four months for the NDIS Commission to acknowledge Paul's complaint. She agreed that it 'seems long' and said, the NDIS Commission at the time was experiencing a 'very significant volume of complaints' and was understaffed.⁵³ Ms Taylor accepted that complaints were not being addressed in a timely fashion, causing frustration to people involved.⁵⁴ She said additional resources had been allocated to address the backlog of complaints.⁵⁵

During Public hearing 25, 'The operation of the NDIS for First Nations people with disability in remote and very remote communities', Ms Beth Walker, the Public Guardian and Trustee of the Northern Territory, told us the NDIS was 'very transactional and bureaucratic' and reported that 'finding the right person to lodge your complaint with or who you should be talking to can be very difficult at times'.⁵⁶ Ms Walker said 'there is a long way to go' for the NDIS Commission in

terms of its responsiveness and communication with people making complaints.⁵⁷ There were often times her office is chasing up matters because people making complaints are not aware of the outcome, and it is frustrating for people involved in these matters when there's not a timely response or good communication.⁵⁸ Ms Walker also noted the NDIS Commission is 'very keen to improve what's happening for people', and when a matter is actively investigated, there is more personalised interaction between the NDIS Commission and the parties involved.⁵⁹

In Public hearing 4, 'Health care and services for people with cognitive disability', Ms Kathryn McKenzie from the New South Wales Ageing and Disability Commission (ADC) gave evidence about complaints made by its official community visitors to the NDIS Commission. She said in a number of those matters, the ADC either did not hear back from the NDIS Commission until it had made further enquiries, or received advice back from the NDIS Commission that it could not provide information to ADC about the action taken or outcome for privacy reasons. Ms McKenzie explained that the type of matters it refers to the NDIS Commission are 'significant' and 'not trivial', with the relevant official community visitor actioning the matter as far as they can within the scope of their role.⁶⁰

In contrast to other submissions, the Queensland Office of the Public Guardian (OPG) submitted that, in its experience, the NDIS Commission has in many cases been able to provide positive outcomes for clients who are dissatisfied with the services provided to them.⁶¹ The OPG also said the NDIS Commission had been effective in supporting the identification and resolution of systemic issues at a higher level.⁶²

However, in November 2022, the current NDIS Commissioner Ms Tracy Mackey told us the NDIS Commission was still experiencing resourcing challenges, which was affecting how quickly it could handle complaints. Ms Mackey stated:

With its current resources, the NDIS Commission is not consistently able to respond to complaints in a timely manner, nor is it able to conduct continuous risk-sensing activities across its data holdings or transform information into intelligence in a consistent and timely way. In some cases, limited resources require regulatory interventions against workers and providers to be delayed.⁶³

The Joint Standing Committee said a key concern raised in its inquiry was the lack of information provided by the NDIS Commission to parties about the timeframes for resolution or progress of a complaint.⁶⁴ The committee heard similar concerns from complainants who had experienced inconsistent responses from the NDIS Commission. The committee suggested that, to build trust in its systems, the NDIS Commission should do more to explain to participants how a complaint will be investigated, and provide regular communication about its progress and the outcomes when finalised.⁶⁵

The importance of managing expectations

We commissioned a research project to examine accessible complaint mechanisms that function as a reporting pathway for violence against, and abuse, neglect and exploitation of people with disability.⁶⁶ As part of this project, the researchers examined past research that

suggests, contrary to common expectations, individuals can place great value on experiencing 'positive procedural justice', so much so that this can be more important than receiving a preferred or favourable outcome. A positive experience of procedures can contribute to a sense that justice was achieved.⁶⁷ The research also suggests any failure to achieve an outcome is perhaps made worse when the complaint handling body fails to provide information about how the complaint will be handled, or the progress of the complaint. This effectively keeps people with disability 'in the dark' about their complaint.⁶⁸

The NDIS Commission deals with a large volume of complaints and continues to face resourcing challenges. There are also limitations with respect to the actions and outcomes the NDIS Commission can pursue within its legislative remit. It cannot be assumed that complainants fully understand the NDIS Commission's remit when they approach the body for assistance. When a concern falls outside of its jurisdiction, it is essential for the NDIS Commission to make warm referrals for complainants to help them find their way to another suitable body.

Complainants should be given realistic advice about what the NDIS Commission can and cannot do when a complaint is made, including likely timeframes for resolution, possible outcomes, and when to expect updates on progress. Setting clear and realistic expectations at the outset is more likely to lead to complainants having confidence in the transparency and fairness of the complaint process, regardless of the outcome. It may also reduce their frustration and dissatisfaction when timeframes become protracted.

Whilst we do not intend to minimise the impact of resourcing challenges and increasing complaint volumes, we consider the NDIS Commission should nonetheless make all reasonable attempts to improve its 'customer experience'. This includes utilising triaging processes to more effectively prioritise particular types of complaints; promptly referring complaints to providers for resolution and reporting back on actions taken; and fixing bottlenecks in the complaint process - from start to finish. Extended timeframes, particularly with long periods of no communication and perceived inaction, will elevate frustration and reduce confidence in the NDIS Commission's ability to broker solutions and investigate more serious matters.

To improve the complainant experience, the NDIS Commission's complaints procedures should also flag the stages in a complaint process where updates should be given, including receipt and assessment, when significant decisions are made impacting the ongoing management of the complaint, and prior to finalisation.

Timeframes for handling complaints

Data published by the NDIS Commission suggests timeframes for handling complaints have not materially improved since its first year of operation. The NDIS Commission reported that 47 per cent of complaints received during the 2018–19 year were handled within six weeks of lodgement and a further 50 per cent were handled within six months. The remaining three per cent took longer than six months.⁶⁹ Following the introduction of new performance measures under the NDIS Commission's Corporate Plan 2021–22, it reported closing 44 per cent of

complaints received in the 2021–22 financial year within 90 days, well short of its 75 per cent target for the period. In explaining this shortfall, the NDIS Commission reported a 15 per cent increase in complaints compared to the previous year, without a corresponding increase in staffing capacity.⁷⁰

Recommendation 10.18 Improved complaint handling procedures and responses

The NDIS Quality and Safeguards Commission should:

- a. ensure complainants are updated appropriately throughout key stages of the complaint process and their expectations managed
- b. ensure triage and streamlining models effectively prioritise complaints requiring a more immediate response
- c. clearly define risk categories, timeframes and procedures for handling these complaints
- d. establish realistic and achievable metrics for measuring its performance with respect to timeframes.

Requiring providers to conduct investigations

The *Complaints Rules* empower the NDIS Commissioner to undertake a range of actions as part of a resolution process, including requiring a provider to examine and attempt to resolve the complaint and report back to the NDIS Commissioner.⁷¹ However, unlike the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth), the *Complaints Rules* do not empower the NDIS Commissioner to require a provider to conduct an investigation into a complaint.⁷²

The types of complaints more likely to be suitable for a formal investigation, rather than an informal resolution process, include:

- a person is not receiving the right services or supports
- the poor quality of services
- strained relationships between participants and individual support workers or between clients residing together.

In responding to complaints of this kind, the NDIS Commission should have power to require a provider to carry out an investigation and report on the investigation findings. This power will assist the NDIS Commission's ability to assess the adequacy of a provider's response to complaints.

NDIS providers should be required to involve the person with disability in the investigation and resolution of the complaint to the greatest extent possible. The NDIS Commission should also check with the complainant if their concern was satisfactorily addressed by the NDIS provider before deciding whether the complaint should be finalised or any further action is needed.

The complaint management functions of the NSW Ombudsman under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) provide a useful precedent.⁷³

The NSW Ombudsman has power to refer a complaint (or part of a complaint) to a service provider, if it appears that the complaint raises issues that may require investigation by the service provider. The NSW Ombudsman can require a provider to report the outcome of the investigation and provide documents and information in relation to an investigation.⁷⁴

It is important to note that complaints involving allegations of violence, abuse, neglect and exploitation of a person with disability will likely meet the threshold of a 'reportable incident'.⁷⁵ And as noted previously, the NDIS Commission can direct NDIS providers to conduct an investigation into a reportable incident.

Recommendation 10.19 Requirement to investigate certain complaints

The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) to empower the NDIS Quality and Safeguards Commission to require a provider to carry out an investigation into a complaint and report on its contact with the complainant and findings.

Making complaints processes accessible

At Public hearing 32, 'Service providers revisited', we examined the complaint and incident management policies of a number of registered service providers. The issues we identified include:

- Most policies referred to the importance of the process being 'accessible' and the need for people with disability to be informed or involved in the process. Few policies explained in practical terms how providers and the frontline staff can support people with disability to make a complaint and be involved in the process.⁷⁶
- There can be limits to an individual's capacity or willingness to be involved in an ongoing complaint or investigation process. Nonetheless, providers should not exclude or limit a person with disability's involvement by making the process inaccessible. Providers should also consider whether the person should be referred to an advocate.⁷⁷

Accessibility is a requirement

It should be easy for anyone in Australia to make a complaint to a national oversight and complaint handling body such as the NDIS Commission. A simple and accessible process is particularly necessary for bodies that receive complaints from people who may have greater support or more complex communication needs, including people with disability. Accessible services and processes for people with disability is a requirement by law. The principles of accessible public services are embedded in Australian anti-discrimination legislation.⁷⁸

Failing to ensure an accessible complaint handling system may result in serious matters going unreported, harm being caused to people with disability, loss of trust in the oversight body and missed opportunities to improve services.⁷⁹

Barriers to making complaints

There are additional barriers experienced by people with intellectual or cognitive disability that impact their likelihood of making complaints to oversight bodies. For example, data from the Australian Human Rights Commission found that in 2021–22, only 3 per cent of the 3,736 complaints made under the *Disability Discrimination Act* 1992 (Cth) related to a person with an intellectual disability.⁸⁰ This is despite 18 per cent of people with disability under the NDIS reporting an intellectual disability as their primary disability.⁸¹

The Parliament of Victoria's inquiry into abuse in disability services heard there was a lack of readily available information about how to report abuse for people with disability and their families. It identified the need to improve rights education for people with disability to ensure abuse can be identified and that clients understand how to report issues to providers and oversight bodies.⁸²

The NDIS Commission's recent Own Motion Inquiry identified that people with disability living in group homes who have communication impairments or experience difficulty using the phone or internet can encounter obstacles to making complaints. It said improvements could be made to the current channels used by supported accommodation providers and the NDIS Commission itself to enable people with disability to make complaints.⁸³

It is also important for the NDIS Commission to ensure the onus on resolving complaints is not placed on people with disability and their families. It should reach out to providers, whenever possible, to ensure complaints have been dealt with. This is particularly important where the complaint came from a person with disability or someone on their behalf, and where they have requested the NDIS Commission's support or assistance.

Accessibility and the NDIS Commission's complaint processes

Making a complaint to the NDIS Commission

Complaints can be made to the NDIS Commission by completing an online complaint form, phoning the NDIS Commission's 1800 number, or using the National Relay Service for people who require assistance communicating over the phone.⁸⁴ The NDIS Commission also accepts complaints in writing and by email.⁸⁵ Its website includes information about how a disability advocate can help and how to locate an advocate.⁸⁶ In addition, complaint guidance is published in 17 different spoken languages, Auslan, and includes dedicated resources for First Nations participants.⁸⁷ 'Easy-read' versions of complaint information are also published, including the *'Handling complaints and fixing problems'* guide that includes larger text, simple explanations and images to help explain concepts.⁸⁸

Streamlining complaint processes

Publishing guidance and providing different ways of making a complaint are components of an accessible complaint handling process. The design and delivery of an accessible complaint system should also actively strive to reduce barriers experienced by people due to disability, age, geographical, language, health and cultural reasons.⁸⁹

Speech Pathology Australia (SPA) told us people with disability, especially cognitive disability, are often not aware of their rights or perceive they do not have the right to complain, and their role is simply to accept or be grateful for services.⁹⁰ Specifically in relation to the NDIS Commission, SPA said:

This (NDIS) Commission's website is also difficult to use, and not accessible for consumers, creating barriers to people with disability or complex communication needs to make complaints or provide feedback easily.⁹¹

We heard suggestions that the NDIS Commission should urgently simplify its complaints process so that people with disability can lodge complaints quickly and easily.⁹² We also heard the NDIS Commission should provide more accessible information to NDIS participants, particularly those in group homes, and warm referral processes so that a complainant does not have to repeat their complaint to a different body.⁹³

The South Australian Health and Community Services Complaints Commissioner said the NDIS Commission could improve the accessibility of its complaints handling process by increasing its visibility, having diverse staff in its complaint handling teams and offering more flexible communication methods and supports to meet individual needs.⁹⁴

The Northern Territory Health and Community Services Complaints Commissioner (NT Commissioner) said there is a lack of knowledge of rights and an inability to navigate complaint systems, particularly among First Nations people and people from culturally and linguistically diverse backgrounds. The NT Commissioner said contact rates with the

NDIS Commission in the territory are lower compared with jurisdictions elsewhere.⁹⁵ He said this could not be attributed to 'exemplary service provision' by providers, but rather, a range of barriers including communication difficulties and lack of knowledge about what constitutes substandard practice.⁹⁶

The NDIS Commission recently established a Complaints Function Advisory Committee (Complaints Committee). Members of the Complaints Committee include representatives from six different disability advocacy organisations, and a representative of the Victorian Mental Health Complaints Commissioner.⁹⁷ The Joint Standing Committee recommended the NDIS Commission progress work to consider measures to simplify the complaints process and remove barriers, including barriers faced by First Nations participants and participants with intellectual or cognitive disability.⁹⁸ The Joint Standing Committee also recommended establishing referral pathways with advocacy groups, community legal centres and Legal Aid Commissions to ensure participants are better supported through the complaint and investigation processes.⁹⁹

In its response to the Joint Standing Committee, the Australian Government said the Complaints Committee is addressing barriers to making complaints and has expanded its membership to include First Nations and culturally and linguistically diverse representatives.¹⁰⁰ It also said the NDIS Commission has established information sharing protocols with state and territory based advocacy organisations to assist people with disability who wish to have such support.¹⁰¹

Accessing advocacy and other independent advice

People with disability and advocates gave evidence about the importance of access to advocates and independent advice, particularly when going through a complaint process or investigation process.

A number of challenges prevent people with disability from accessing assistance from independent advocates. This is largely due to shortages of advocates caused by funding limitations. NDIS providers may not facilitate access to independent advocacy services because they prioritise organisational needs over the participants' rights or they lack awareness of those rights.¹⁰² We also heard about the need for First Nations people to have access to culturally appropriate advocates who are better placed to understand and support them to communicate their concerns.¹⁰³ We discuss advocacy funding in more detail in Volume 6, *Enabling autonomy and access*.

At Public hearing 20, Counsel Assisting raised concerns about potential gaps in the complaint and reportable incident management model with Ms Taylor, namely:¹⁰⁴

- People at risk, particularly in supported accommodation settings, do not have a voice but lack advocacy support to make complaints or ensure incidents are reported to the NDIS Commission.
- The model relies on NDIS participants, their families and support networks understanding of providers' responsibilities and participants' rights, including mechanisms available to enforce those rights.

Ms Taylor accepted there are gaps in the model for participants who do not have access to advocacy or who are particularly at risk such as residents in group homes.¹⁰⁵ However, Ms Taylor said the NDIS Commission provides extensive information to participants and their advocates, including through social media and its website. It is also increasing participant awareness through outreach and work with peak disability organisations such as Council for Intellectual Disability and Inclusion Australia.¹⁰⁶ One reason for the Own Motion Inquiry was the need to identify at-risk NDIS participants.¹⁰⁷

The NDIS Commission should play an active role in encouraging the use of independent advocates by people with disability and their support networks in the complaint process where appropriate. This requires complaints officers to ask the complainant about their individual needs and whether they would benefit from the support of an independent advocate, and assist in referring them to advocacy services. The NDIS Commission should also ensure providers are supporting people with disability to access advocates when they make a complaint and conduct investigations.

Making it easier to complain

We acknowledge the considerable work undertaken by the NDIS Commission since its inception to improve the accessibility of its complaint process. However, in our view more needs to be done to improve the NDIS Commission's complaints processes. Additional steps to improve accessibility of the NDIS Commission's complaint processes could include:

- **simple and easy to navigate information.** The guidance published and information made available to people with disability about the NDIS Commission must be simple, easy to navigate and user-friendly. This includes the information provided when a person makes a complaint.
- **clear messaging about violence, abuse, neglect and exploitation.** The website's 'Make a complaint' page should make it clear that complaints about violence, abuse, neglect and exploitation experienced by people with disability in, or in connection with NDIS supports and services can be made to the NDIS Commission, in addition to local police.
- **adopting a 'no wrong door approach'.** It can be difficult or confusing for people to know where to direct their complaint. Making a warm referral prevents a person having to retell their story to multiple bodies. The NDIS Commission should practice a no wrong door approach to all complaints they receive with appropriate levels of assistance offered when referring a complainant based on a person's needs. It should establish two-way warm referral arrangements with relevant bodies it frequently refers complaints to, or receives referrals from, and publish information about these arrangements on its website.
- **making adjustments to enable participation.** An accessible complaint handling approach requires built in flexibility to allow complaints officers to deviate from the usual process to make adjustments for people where appropriate. This may include allowing people to bring support persons, translators and representatives with them to any meeting or communicate with parties using different means, such as in writing, in person and via email. This also involves assisting people to secure support during the complaint process, offering such

assistance and providing appropriate information about advocates or other supports in an impartial way at the start of the process. The NDIS Commission should help connect people with disability requiring support to complain to relevant advocacy services or other bodies who can assist them. Where appropriate, it should also ensure people are referred to culturally suitable advocacy services.

- **identifying those at risk of abuse.** Reaching people at risk of abuse is often challenging for oversight and complaint handling bodies. The NDIS Commission should continue its work with the NDIA to identify people with disability who are at increased risk of violence, abuse, neglect and exploitation, by obtaining information from the NDIA at the early planning and review stages of NDIS plans.
- **a strategy for other ‘hard to reach’ groups.** It is particularly challenging to reach people whose first language is not English, or who have limited access to technology, limited involvement in the community, poor support networks or who experience difficulty communicating in writing or verbally. The NDIS Commission should make efforts to ensure that people with disability and their supporters, as well as NDIS providers, understand the power imbalance that can exist in NDIS service settings and may prevent people from making a complaint. The public also needs to know and be informed about what the NDIS Commission can do for them. This requires a multifaceted education campaign, focusing on raising awareness, sharing evidence-based information, reaching different groups within the community and increasing confidence in the ability of the body to respond to complaints it receives.

Recommendation 10.20 Making complaint processes accessible

The NDIS Quality and Safeguards Commission should further enhance the accessibility of its complaint handling processes, having regard to the following steps:

- a. making information simple and easy to navigate
- b. adopting a ‘no wrong door approach’
- c. accommodating people’s preferred means of communication and making other adjustments as needed
- d. assisting people to secure advocacy and other supports
- e. identifying people at risk of abuse
- f. implementing a strategy for ‘hard to reach’ groups
- g. ensuring complainants are involved in complaint processes and when this is not possible, recording the reasons for their non-involvement
- h. examining whether providers are supporting people with disability to access advocates when they make a complaint and where providers conduct investigations.

Participant involvement in complaints processes

People with disability who make, or are involved in, complaints must have the opportunity, wherever possible, to express their concerns directly to the complaint handling body. Doing so can lead to better complaint outcomes.

We heard from people who have made complaints to the NDIS Commission that the process favoured providers. They said the NDIS Commission relied on information from the provider without giving the complainant an opportunity to respond. The Joint Standing Committee also noted submitters had expressed concern that the NDIS Commission often appears biased, in favour of providers, and does not give sufficient attention to complaints made by participants.¹⁰⁸

At Public hearing 13, we heard evidence about people with disability who were allegedly subjected to abuse in a residential disability service leased by NDIS provider, Sunnyfield Disability Services (Sunnyfield).

Case study: Melissa and Eliza's complaint

'Melissa' was 23 years old at the time of the hearing.¹⁰⁹ Melissa resided in a house in Western Sydney with four other residents and received in-home supports from Sunnyfield.¹¹⁰

Her sister and guardian, 'Eliza' raised a number of complaints with Sunnyfield about the support Melissa was receiving. Eliza also made complaints to the NDIS Commission in 2018 and 2019.¹¹¹

Eliza told us that she does not have a lot of faith in the NDIS Commission's oversight of providers.¹¹² She felt that without clear evidence to support a complaint, 'there is little that the NDIS Commission will do' and was told this by an officer at the NDIS Commission in 2019.¹¹³

Eliza also told us that, despite the allegations she had raised, the NDIS Commission seemed to accept Sunnyfield's reports without questioning what they were doing, talking to Melissa's family or reading her behaviour support plan.¹¹⁴ She said occasionally the NDIS Commission was able to get Sunnyfield to respond to her concerns but 'that's about it'.¹¹⁵

The NDIS Commission communicated with Eliza about the incidents affecting Melissa, but made no attempt to communicate with Melissa about the matter.¹¹⁶ The Commissioners' *Report of Public hearing 13* found there was no evidence the NDIS Commission took any steps to seek or consider the views of Melissa about the incidents. Nor did the NDIS Commission document the reasons why it considered it was not reasonable or appropriate to do so.¹¹⁷

Mr Head told us the NDIS Commission receives complaints from people with disability, family members, friends, advocates and support workers, and is building its capacity around taking a trauma-informed approach to communicating with people with disability.¹¹⁸ Mr Head said it is not the case that people are required to have evidence to make a complaint.¹¹⁹ If the NDIS Commission can establish the complaint relates to matters in connection with the provision of NDIS supports and services, and sufficient information is provided to take the next step, it will examine the complaint.¹²⁰

Regardless of the strength of the information provided by a complainant, the NDIS Commission must take and be seen to take the complaint seriously in order to maintain confidence in the complaint handling process. This requires actively involving the participant in the complaints process.

At Public hearing 32, Sunnyfield's CEO Mr Andrew Hyland, spoke about the steps taken by Sunnyfield to address problems examined in Public hearing 13, including engaging with Eliza and Melissa. Mr Hyland told us Sunnyfield had provided a written and oral apology to Eliza and Melissa.¹²¹

The NDIS Commission has a role to provide support to people with disability to make complaints and raise concerns. In Public hearing 26, 'Homelessness, including experience in boarding houses, hostels and other arrangements', Ms Mackey told us that the NDIS Commission had been working for some time to assist people with disability to make complaints and raise issues, including through grants awarded to organisations that assist NDIS participants.¹²² Ms Mackey also told us that the NDIS Commission is maturing its processes around intake and triaging of complaints.¹²³ On receiving a complaint, the NDIS Commission will explore the circumstances of the person with disability involved, including whether there is an imminent risk or a serious issue that may have a significant consequence.¹²⁴

Involvement of people with disability in the complaints process should be the standard approach for every complaint the NDIS Commission receives. Where it decides it is not appropriate to seek the views of the person with disability involved in the complaint, the reasons should be documented.

Publishing reviews of complaint processes and new procedures

In light of the rapid growth of the NDIS and the increasing volume of complaints received by the NDIS Commission and its related resourcing restrictions (see Table 10.9.1), we think the NDIS Commission should commit to regular evaluation of its complaint handling processes. Reviews should also evaluate the effectiveness and practicality of the *Complaints Rules*, including whether they are sufficiently flexible to allow complaints to be handled according to an evaluation of risk.

In its November 2021 report, the Joint Standing Committee recommended the NDIS Commission work with its newly established Complaints Committee to develop and publish formal guidance and protocols that inform complainants of the progress of their complaints and timeframes for responding to complaints.¹²⁵

In line with the recommendations made by the Joint Standing Committee, we consider the NDIS Commission should publish its procedures for keeping parties to a complaint informed about the progress of a complaint and the timeframes for responding to matters. In addition, the findings from any procedural reviews conducted in relation to the complaints function should also be made public to help strengthen ongoing confidence in the NDIS Commission. This should include, but not be limited to, decisions and findings made by the Complaints Committee and improvements made as part of its complaints function redesign process.

The NDIS Commission should commit to regular and ongoing evaluation of its complaint handling as part of its standard internal review and quality assurance processes. In doing so, the NDIS Commission should consider the matters explored above.

Endnotes

- 1 Exhibit 32-001, 'Statement of Sam Petersen', 24 January 2023, p 2.
- 2 *National Disability Insurance Scheme Act 2013* (Cth) s 181G; Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [81–88].
- 3 Exhibit 4-32, 'Statement of Graeme Head', 11 February 2020, at [81].
- 4 *National Disability Insurance Scheme Act 2013* (Cth) ss 73W, 73X. Registered providers must also comply with the requirements set out in Part 2 of the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth).
- 5 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) Pt 3.
- 6 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 16(5).
- 7 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [91]; Material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 15 November 2022, CTD.7200.0040.1950.
- 8 Material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 15 November 2022, CTD.7200.0040.1950, p 3.
- 9 Material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 15 November 2022, CTD.7200.0040.1950, pp 9, 25.
- 10 Material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 15 November 2022, CTD.7200.0040.1950, p 13.
- 11 Material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 15 November 2022, CTD.7200.0040.1950, p 34.
- 12 Exhibit 13-232, 'Statement of Graeme Head', 18 December 2020, at [259].
- 13 Exhibit 13-232, 'Statement of Graeme Head', 18 December 2020, at [218].
- 14 NDIS Quality and Safeguards Commission, *Complaints management and resolution guidance*, Version 2.1, September 2019, p 12.
- 15 NDIS Quality and Safeguards Commission, *Complaints management and resolution guidance*, Version 2.1, September 2019, pp 11–12.
- 16 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 11. NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Inquiry report, January 2023, p 11.
- 17 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 52–53.
- 18 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 46–47.
- 19 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 46–47.
- 20 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 51.
- 21 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, pp 51–52.
- 22 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 52.
- 23 NDIS Quality and Safeguards Commission, *Annual report 2018–2019*, October 2019, p 19; NDIS Quality and Safeguards Commission, *Annual report 2019–2020*, October 2020, p 21; NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 28; NDIS Quality and Safeguards Commission, *Activity report 1 July to 31 December 2021*, January 2022, p 10; NDIS Quality and Safeguards Commission, *Activity report 1 January to 31 March 2022*, April 2022, p 9; NDIS Quality and Safeguards Commission, *Activity report 1 April to 30 June 2022*, July 2022, p 4.
- 24 NDIS Quality and Safeguards Commission, *Annual report 2018–2019*, October 2019, p 19; NDIS Quality and Safeguards Commission, *Annual report 2019–2020*, October 2020, p 21; NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 28;

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- NDIS Quality and Safeguards Commission, *Activity report 1 July to 31 December 2021*, January 2022, p 10; NDIS Quality and Safeguards Commission, *Activity report 1 January to 31 March 2022*, April 2022, p 9; NDIS Quality and Safeguards Commission, *Activity report 1 April to 30 June 2022*, July 2022, p 4.
- 25 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 8.
- 26 NDIS Quality and Safeguards Commission, *Annual report 2018–19*, October 2019, p 19; NDIS Quality and Safeguards Commission, *Annual report 2019–2020*, October 2020, p 21; NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 28; NDIS Quality and Safeguards Commission, *Activity report 1 July to 31 December 2021*, January 2022, p 10; NDIS Quality and Safeguards Commission, *Activity report 1 January to 31 March 2022*, April 2022, p 9; NDIS Quality and Safeguards Commission, *Activity report 1 April to 30 June 2022*, July 2022, p 4; NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 42.
- 27 For example, Submissions of Counsel Assisting following Public hearing 20, 25 March 2022, [703]; Transcript, Beth Walker, Public hearing 25, 12 July 2022, P-94 [39–45]; Transcript, Kathryn McKenzie, Public hearing 4, 26 February 2020, P-586 [14]–P-587 [6]; Exhibit 13-2, ‘Statement of Eliza’, 29 April 2021, at [106–09].
- 28 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 113.
- 29 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, February 2021, ISS.001.00561, p 6.
- 30 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, p 98, Finding 19; Exhibit 3-19, ‘Statement of Sam Petersen’, 27 November 2019, at [11], [14].
- 31 Exhibit 23-001, ‘Statement of ‘Sally’’, 26 April 2022, at [48]; Note: Sally and Jason are pseudonyms.
- 32 Transcript, Sophia, Public hearing 13, 25 May 2021, P-122 [25–46]–123 [1–12], P-124 [40–47]; Exhibit 13-3, ‘Statement of Sophia’, 29 April 2021, at [19–20]; Transcript, Eliza, Public hearing 13, 24 May 2021, P-60 [1–8].
- 33 Exhibit 13-002, ‘Statement of Eliza’, 29 April 2021, at [58–62]; Transcript, Eliza, Public hearing 13, 24 May 2021, P-73 [6–13], [40–43], P-74 [15–16]; Exhibit 14-005, ‘Statement of Karen Rogers’, 5 May 2021, at [39]; Exhibit 14-27, ‘Statement of Victoria’, 25 May 2021, at [32–48]; Transcript, AAI, Public hearing 3, 2 December 2019, P-30 [29–31].
- 34 Transcript, Dan Stubbs, Public hearing 32, 14 February 2023, P-136 [37–42]; Exhibit 32-102, CAR.9999.0007.0001; Exhibit 32-119, CIV.9999.0002.0065; Exhibit 32-126, END.9999.0002.0024; Exhibit 32-133, NTH.005.002.0036.
- 35 Transcript, Stella (Topsy) Jackamarra, Public hearing 25, 13 July 2022, P-220 [1–30]; Exhibit 25-046, ‘Statement of Stella ‘Topsy’ Jackamarra’, 22 June 2022, at [41–44]; Exhibit 25-001, ‘Statement of Daisy’, 21 June 2022, at [11–23]; Exhibit 25-008, ‘Statement of Joan’, 22 June 2022, at [79–80]; Exhibit 25-033, ‘Statement of Bakoi Namok’, 9 July 2022, at [35], [42]; Exhibit 25-034, ‘Statement of Joanne Houghton’, 21 June 2022, at [70].
- 36 Exhibit 32-127, END.9999.0002.0028, p 4.
- 37 For example, Exhibit 32-121, CIV.9999.0002.0040, pp 1–4; Exhibit 32-133, NTH.005.002.0036, pp 13–14.
- 38 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, Finding 19.
- 39 Submissions of Counsel Assisting following Public hearing 32, 31 March 2023, [548].
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- 41 See for example, Name withheld, Submission, 2 September 2020, [SUB.100.00913, pp 4–5]; Name withheld, Submission, 17 November 2020, [SUB.200.00120, pp 28, 49, 51, 59, 169–80]; Name withheld, Submission in response to *Safeguards and quality issues paper*, 18 March 2021, [ISS.001.00592, p 5]; Name withheld, Submission, 2 September 2020, [SUB.100.00913]; Queenslanders with Disability Network, Submission in response to *Safeguards and quality issues paper*, 9 March 2021, ISS.001.00582, pp 10–11; National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 6.

42 Names changed to protect identities.
 43 Transcript, Paul, Public hearing 20, 9 December 2021, P-244 [38–40]; Exhibit 20-064,
 'Statement of Paul', 17 November 2021, at [7], [9].
 44 Exhibit 20-064, 'Statement of Paul', 17 November 2021, at [22].
 45 Exhibit 20-064, 'Statement of Paul', 17 November 2021, at [134–36].
 46 Exhibit 20-1349, 'Statement of Samantha Taylor', 17 November 2021, at [30]; Exhibit 20-064,
 'Statement of Paul', 17 November 2021, at [134].
 47 Exhibit 20-064, 'Statement of Paul', 17 November 2021, at [139].
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 49 Exhibit 20-131, IND.0104.0005.0003.
 50 Exhibit 20-1349, 'Statement of Samantha Taylor', 17 November 2021, at [37].
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 52 Exhibit 20-133, IND.0104.0014.0001.
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 58 Transcript, Beth Walker, Public hearing 25, 12 July 2022, P-94 [39–45].
 59 Transcript, Beth Walker, Public hearing 25, 12 July 2022, P-94 [38–39]–P-95 [12–13].
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 62 Queensland Office of the Public Guardian, Submission in response to *Safeguards and quality
 issues paper*, 19 March 2021, ISS.001.00589, p 6.
 63 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [208].
 64 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia,
NDIS Quality and Safeguards Commission, November 2021, p 113.
 65 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia,
NDIS Quality and Safeguards Commission, November 2021, p 124.
 66 Dinesh Wadiwel, Claire Spivakovsky & Linda Steele, *Complaint mechanisms: Reporting pathways
 for violence, abuse, neglect and exploitation*, Report prepared for the Royal Commission into
 Violence, Abuse, Neglect and Exploitation of People with Disability, November 2022, pp 87–90.
 67 Dinesh Wadiwel, Claire Spivakovsky & Linda Steele, *Complaint mechanisms: Reporting pathways
 for violence, abuse, neglect and exploitation*, Report prepared for the Royal Commission into
 Violence, Abuse, Neglect and Exploitation of People with Disability, November 2022, p 65.
 68 Dinesh Wadiwel, Claire Spivakovsky & Linda Steele, *Complaint mechanisms: Reporting pathways
 for violence, abuse, neglect and exploitation*, Report prepared for the Royal Commission into
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 69 NDIS Quality and Safeguards Commission, *Annual report 2018–19*, October 2019, p 30.
 70 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 42.
 71 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018*
 (Cth) s 20.
 72 *National Disability Insurance Scheme (Incident Management and Reportable Incidents)*
Rules 2018 (Cth) s 26(c)–(d).
 73 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 25.
 74 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 25.
 75 *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4).
 76 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
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 77 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
 31 March 2023, p 183 [673].
 78 *Disability Discrimination Act 1992* (Cth) s 29; *Anti-Discrimination Act 1991* (Qld) ss 9–11, 101;
Disability Inclusion Act 2014 (NSW) ss 3(a), 4(10).
 79 Commonwealth Ombudsman, 'Better Practice Complaint Handling Guide', p 4.
 80 Australian Human Rights Commission, *2021–22 Complaint statistics*, 2022, pp 2, 14.
 81 Australian Institute of Health and Welfare, *People with disability in Australia 2022*, p 125.

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- 82 Parliament of Victoria, Family and Community Development Committee, *Inquiry into abuse in disability services: Final report*, May 2016, pp 45, 63, 66.
- 83 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 58.
- 84 'How to make a complaint', *NDIS Quality and Safeguards Commission*, web page. <www.ndiscommission.gov.au/contact-us/makeacomplaint>
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- 93 Name withheld, Submission, 2 September 2020, [SUB.100.00913, p 9].
- 94 South Australian Health and Community Services Complaints Commissioner, Submission in response to *Safeguards and quality issues paper*, 28 January 2021, ISS.001.00520, pp 4–5.
- 95 Northern Territory Health and Community Services Complaints Commission, Submission in response to *Safeguards and quality issues paper*, 1 March 2021, ISS.001.00578, p 2.
- 96 Northern Territory Health and Community Services Complaints Commission, Submission in response to *Safeguards and quality issues paper*, 1 March 2021, ISS.001.00578, pp 2–3.
- 97 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [74].
- 98 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p xiv, Recommendation 15.
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- 100 Australian Government, Response to the Joint Standing Committee on the National Disability Insurance Scheme report: *NDIS Quality and Safeguards Commission*, 20 April 2023, p 8.
- 101 Australian Government, Response to the Joint Standing Committee on the National Disability Insurance Scheme report: *NDIS Quality and Safeguards Commission*, 20 April 2023, p 9.
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- 103 Exhibit 25-019, 'Statement of Kunmanara Smith and Kim McRaue', 21 June 2022 at [135]; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Submission, 11 September 2020, SUB.100.00929, p 9.
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- 106 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-218 [31] – P-219 [20].
- 107 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-217 [32–47].
- 108 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 127.
- 109 Transcript, Eliza, Public hearing 13, 24 May 2021, P-23 [29–31]; Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [6]. Names changed to protect identities.
- 110 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [15], [18], [29–30].
- 111 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [38], [92]; Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [12], [16].
- 112 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [106].
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10. Provider registration

Key points

- Provider registration is a critical safeguard for people with disability. It gives the NDIS Quality and Safeguards Commission (NDIS Commission) more information about the quality and safety of a provider's service delivery.
- Limited regulation and oversight of unregistered providers can pose safety risks to people with disability.
- Encouraging new and unregistered providers to become registered National Disability Insurance Scheme (NDIS) providers should be a priority for the NDIS Commission.
- Shortfalls and regulatory burdens – particularly for small providers and sole traders – associated with the NDIS Commission's registration and quality audit processes can act as a disincentive to register.
- When a provider undergoes the quality audit process as part of registration or renewal, the NDIS Commission does not routinely share information with the quality auditor about a provider's compliance, reportable incidents and complaints history. This means quality auditors do not have a complete picture of risks. The NDIS Commission also does not publish data or information about audit outcomes to alert quality auditors to known systemic issues across the sector.
- Gaps and ambiguities in the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) and the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) should be addressed, particularly in relation to complaint and incident management, safeguarding governance and supported decision-making.
- The NDIS Commission should collect and publish information about trends and patterns identified in the unregistered provider market.

The registration framework is an important feature of the NDIS Quality and Safeguards Commission's (NDIS Commission) regulation and oversight of NDIS supports and services. The NDIS Commission's provider registration functions are established under the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*). These functions include overseeing the registration process, making decisions about registration applications, monitoring providers' compliance with the conditions of registration and approving quality auditors involved in the audit of National Disability Insurance Scheme (NDIS) providers.¹

A registered NDIS provider is a person or organisation that is registered with the NDIS Commission in accordance with section 73E of the *NDIS Act*. A person or organisation must be registered to:

- manage funding of supports under a participant's plan (that is, to be a Plan Manager)²
- provide supports to participants whose NDIS plans are managed by the National Disability Insurance Agency (NDIA)³
- deliver specialist disability accommodation⁴
- provide a class of supports to a participant if there is likely to be need to use a regulated restrictive practice⁵
- provide specialist behaviour support services (undertaking a behaviour support assessment or developing a behaviour support plan).⁶

Providers who are not involved in the above supports or services do not need to register with the NDIS Commission, unless they wish to do so.⁷

The registration and related quality audit processes should involve a comprehensive examination of NDIS providers' supports, systems and procedures. However, they should not be so onerous as to deter providers from becoming or remaining registered. Finding the right balance is not an easy task for the NDIS Commission.

We heard that a significant proportion of providers are operating unregistered due to the cost and regulatory burden associated with registration. Unregistered providers often have a competitive advantage in the market and are able to provide services at a lower cost than registered providers. We were also told that the operation of unregistered providers is seen by many people with disability as a key element of the principle of choice and control that underpins the NDIS.⁸ Witnesses told us about a shortage of experienced and qualified disability support workers and allied health professionals.⁹ Placing further obligations on these workers may have unintended consequences.

We identified examples of registered providers' governing bodies and senior management having insufficient understanding or knowledge of organisational systems and responses to complaints, incidents and risk management. This evidence highlights gaps in the existing obligations for providers and available guidance. We recommend changes to the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) (*Practice Standards*), the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) (*Quality Indicators*) and the quality auditing process to strengthen the responsibilities and accountability of providers' governing bodies.

10.1. What the data is telling us

During 2021–22, 50 per cent of registration applications were determined by the NDIS Commission within 90 days, lower than the NDIS Commission's target of 80 per cent. The NDIS Commission refused 58 registration applications.¹⁰

Table 10.10.1 shows the number of NDIS providers registered at the end of each financial year, broken down by the type of entity (individuals or sole traders, and organisations).

Table 10.10.1: Registered providers

Financial year ending date	Individuals*	Organisations	Total registered providers
30 June 2019	3,925	4,377	8,302
30 June 2020	7,779	9,474	17,253
30 June 2021	6,630	11,204	17,834
30 June 2022	7,401	12,338	19,739

* This category was known as 'Individuals and partnerships' in financial year ending 30 June 2022

Note: The NDIS Commission commenced operating in New South Wales and South Australia from 1 July 2018, with Victoria, Queensland, Northern Territory, Australian Capital Territory and Tasmania commencing on 1 July 2019 and Western Australia on 1 December 2020.

Source: NDIS Commission annual reports 2018–19, 2019–20, 2020–21 and 2021–22, and the NDIS Commission activity report 1 April to 30 June 2022.

Table 10.10.1 shows that the number of registered providers increased significantly as the NDIS Commission's jurisdiction expanded, particularly during 2019–20. The proportion of registered providers who are sole traders has decreased from 47 per cent in 2018–19 to 37 per cent in 2021–21, while the proportion of registered organisations has increased by 10 percentage points over the same period.

10.2. Safeguards provided by registration

Registration enables a provider to:¹¹

- provide supports and services to NDIS participants whose NDIS plan is managed by the NDIA ('agency-managed')
- market its services as a registered provider
- access online systems to manage service bookings and payments, and receive access to supplementary training modules offered by NDIS Commission.

As a condition of their registration, registered providers are required to:

- comply with the *Practice Standards* for the provider's relevant registration groups, based on the types of supports and services it delivers¹²
- comply with the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) (*Code of Conduct*) applicable to the provider, all persons employed or otherwise engaged by the provider, and members of key personnel¹³
- have an internal complaints management and resolution system¹⁴
- have an internal incident management system and report certain types of incidents to the NDIS Commission¹⁵
- ensure all workers have a valid worker screening check¹⁶
- comply with any other conditions imposed by the NDIS Commission, as prescribed in the provider's registration certificate or the NDIS Rules.¹⁷

Registered providers are required to demonstrate compliance by undergoing regular quality audits conducted by an approved auditor (see below).

The obligation on registered providers to notify reportable incidents to the NDIS Commission provides the NDIS Commission with important data and other information that enhances its ability to take appropriate action when compliance and systemic issues are identified.

Unregistered providers and their workers are only required to comply with the *Code of Conduct*. They may also be required to comply with regulatory requirements of some states and territories.¹⁸ The NDIS Commission can handle complaints about unregistered providers, but unregistered providers are not required to notify reportable incidents. The NDIS Commission can take enforcement action against unregistered providers, such as issuing a banning order and commencing civil penalty proceedings for breaches of the *Code of Conduct*.¹⁹

10.3. The registration process

The NDIS Commissioner may only register a person or organisation if the provider has made an application to become registered, been assessed by an auditor as meeting the *Practice Standards*, satisfied any other requirements prescribed by the NDIS Rules, and the NDIS Commissioner is satisfied that the applicant and the applicant's key personnel are suitable to provide supports and services to people with disability.²⁰

Quality audits

After submitting their application for registration, the provider must engage a quality auditor approved by the NDIS Commission to undertake the audit against the *Practice Standards*.²¹

The *Practice Standards* consist of modules that apply to a provider based on the type of supports they are registering to deliver. Each standard is supported by a series of indicators under the *Quality Indicators*.²²

The Core and Verification modules are the most frequently assessed modules.²³ Both modules cover standards concerning risk management, complaints management and resolution, incident management and human resources management.²⁴ The Core Module also covers other areas, such as those concerning the rights of participants, governance and operational management and other standards involving the provision of supports.²⁵ Providers seeking to provide specialist supports, such as behaviour support or early childhood supports, are required to be assessed against additional modules dealing with those supports.

The NDIS Commission publishes a list of 21 auditing firms approved by the NDIS Commissioner to conduct quality audits for the purposes of registration.²⁶ The *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* (Cth) (*Quality Auditors Guidelines*) provide the framework for auditing NDIS providers.²⁷ The *Quality Auditors Guidelines* set out the matters that the NDIS Commissioner may take into account when deciding whether to approve a person or body as an ‘approved quality auditor’ under the *NDIS Act*.²⁸ Those matters include whether the person or body is accredited by the Joint Accreditation System of Australia and New Zealand, an internationally recognised accreditor of auditing firms.²⁹

There are two types of audits. A ‘verification audit’ is a desktop audit of provider documentation. It applies to providers registering to deliver lower risk or less complex types of supports or services, including those from industries with established professional practice standards or regulation.³⁰

A ‘certification audit’ is for providers applying for registration to deliver more complex supports that involve higher risk to the person with disability.³¹ The audit is conducted in two stages. The ‘stage one audit’ is a verification audit.³² The ‘stage two audit’ typically involves an inspection of the provider’s facilities and equipment, and interviews with staff, NDIS participants or their support networks (with the participant’s consent).³³

Auditors consider the provider’s size, scale, type of supports delivered and any risks associated with service delivery in the audit process.³⁴ Once completed, the auditor submits the audit outcome to the NDIS Commission and the NDIS Commission assesses the application for registration.³⁵

Registration cycle and mid-term audits

Generally, an NDIS provider’s registration remains in force for three years.³⁶ Any registered provider that attracts a certification requirement must undertake a midterm audit 18 months after their registration commences.³⁷ Mid-term audits allow the NDIS Commission to appoint auditors to address any particular areas of concern.³⁸ To maintain registration, the registered provider must submit a new application before its current registration expires.³⁹ An audit is required for each new application.⁴⁰

10.4. Registration and audit processes

Provider registration is an important safeguard for people with disability. For this reason, there would be advantages in registration being sought by providers other than those for whom registration is mandatory.

Certification and verification audits are equally important. They provide an ongoing, independent quality assurance mechanism for NDIS supports and services. A robust and thorough quality audit process that both identifies and seeks to resolve practice issues benefits NDIS participants. It can also help reduce the volume of complaints and reportable incident notifications received by the NDIS Commission and limit the need for compliance activities.

Counsel Assisting in Public hearing 32, ‘Service providers revisited’, submitted that the NDIS Commission’s regulatory approach has relied on the quality auditing process to ensure registered providers meet the relevant standards within the *Practice Standards* but the process is not always effective.⁴¹

The NDIS Commission does not routinely provide the approved quality auditor with information about the provider being audited, nor does it publish data or information to alert quality auditors to known systemic issues across NDIS providers.⁴² In addition, the registration process imposes administrative and cost burdens on providers that tend to deter smaller providers from registering or renewing their registration. This may limit the services they can provide and the people they can support. More importantly, it also prevents the NDIS Commission from effectively monitoring and regulating a large segment of NDIS providers.⁴³

Information available to quality auditors

Because the NDIS Commission does not routinely provide approved quality auditors with information about providers’ compliance, reportable incidents and complaints history, auditors may have a limited appreciation of the risks involved in providers’ operations. This can affect an auditor’s selection of locations or types of supports for an audit sample.

Case study: Quality audit of Sunnyfield

In Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', we heard about allegations of abuse and neglect of people with disability by two accommodation support workers employed by Sunnyfield in the house in Western Sydney.

After the NDIS Commission commenced in New South Wales on 1 July 2018, Sunnyfield was required to submit a new application for registration and undergo a quality audit.⁴⁴

Sunnyfield's stage two audit involved an assessment of nine of its 65 sites. The house in Western Sydney was not included, despite multiple complaints to the NDIS Commission about supports and services provided at the residence.⁴⁵ Therefore, while the audit identified several instances of minor non-compliance by Sunnyfield, it was not made aware of the complaints relating to the house in Western Sydney that were examined by the Royal Commission. Sunnyfield's application for registration was ultimately approved on 10 August 2020.⁴⁶

At Public hearing 13, we heard from 'Eliza' about complaints she made to Sunnyfield. She said:

service providers only have to show they have a complaint handling system. Of course they do, but the auditors do not know about my experiences in trying to use that complaints system, nor that Sunnyfield attempted to terminate Melissa's occupancy because I was complaining on her behalf about them.⁴⁷

Mr Graeme Head AO, then NDIS Commissioner, was asked if complaints to the NDIS Commission about the house in Western Sydney triggered the inclusion of the house within the audit.⁴⁸ Mr Head told us the *Quality Auditors Guidelines* set out the selection of audit samples, but the NDIS Commission can focus an auditor's attention on particular issues in mid-term audits.⁴⁹ The guidelines set out requirements for the audit methodology, including selecting a sample of sites, reviewing NDIS participant and worker files, and conducting interviews. The guidelines include sample sizes and the need to sample from locations providing 'highest risk' supports or services, such as high intensity daily personal activities and specialist positive behaviour support.⁵⁰

Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', considered the experiences of people with disability who received accommodation and support services from Life Without Barriers (LWB) in Victoria and northern New South Wales. We also heard evidence about the quality audit process. The then Acting NDIS Commissioner, Ms Samantha Taylor, confirmed after the hearing that the 'NDIS Commission does not currently make available to quality auditors on a systematic basis information about complaints and reportable incidents relating to a registered NDIS provider that the quality auditor is auditing'.⁵¹

Ms Taylor told us about the planned creation of a 'quality auditor view' in the Commission Operating System (COS) used by the NDIS Commission, which would enable approved quality auditors to view information concerning complaints and reportable incidents about a provider they have been engaged to audit. She said the creation of a quality auditor view is listed in the NDIS Commission's schedule for future COS enhancements, but the timing depends on competing priorities and available resources.⁵²

During Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', we examined the supports and services provided by registered NDIS provider Australian Foundation for Disability (Afford) to people with disability at one of its day programs.

Case study: Quality audit of Afford

Afford applied for registration on 11 February 2020 and was subject to a certification audit by an approved quality auditor.⁵³ The stage one audit identified a number of concerns about Afford's policies and procedures, including that they did not refer to 'NDIS requirements and legislation'.⁵⁴ The auditor recommended that Afford address these areas of concern prior to the stage two audit.⁵⁵

The stage two audit involved visiting a sample of Afford sites that included sites providing day programs.⁵⁶ The auditor identified a total of 12 minor 'non-conformities'.⁵⁷ These included a lack of clarity in some of Afford's procedures, and evidence that particular procedures were not in place and certain risk-related strategies were not documented.⁵⁸ Despite these non-conformities, the auditor recommended that Afford be registered as a service provider.⁵⁹ Afford's application for registration was approved by the NDIS Commission and its registration commenced on 17 September 2020.⁶⁰

Afford's history of non-compliance with its reportable incident obligations, including the abuse perpetrated by Mr Daniel Nuumaalii, who was employed by Afford at the Mount Druitt day program in 2019, and the circumstances of Ms Merna Aprem's death while receiving NDIS supports and services from Afford in May 2019, were all raised during Ms Taylor's evidence.⁶¹ Ms Taylor confirmed that the auditor for Afford was not provided with information about its history of non-compliance with certain obligations, or the NDIS Commission's related investigations and compliance matters.⁶²

Ms Taylor said the quality auditor's role is not to assess whether a provider is delivering safe services or is complying with reportable incident obligations, since this is the NDIS Commission's role.⁶³ She said the role of quality auditors is to assess whether or not a provider is meeting the *Practice Standards* for the purposes of determining registration.⁶⁴ The quality audit is only one part of the registration process and the NDIS Commission ultimately determines whether a provider should be registered.⁶⁵ However, Ms Taylor acknowledged that the issues raised deserved further consideration by the NDIS Commission.⁶⁶

In response to Counsel Assisting's submissions following Public hearing 23, the Australian Government raised concerns about whether quality auditors should have access to confidential information held by the NDIS Commission, including information about investigations and compliance action by the NDIS Commission. It submitted that auditors are engaged by the provider rather than the NDIS Commission. It said the suggestion that auditors should be provided with such information raises significant issues, including the possible dissemination to the auditor and provider of protected NDIS Commission information, including information about whistle-blowers, complainants who have made confidential complaints and persons of interest.⁶⁷

The Australian Government said any change to the current audit process will require careful and detailed consultation and planning, and amendments to the *Practice Standards* and the *Quality Auditors Guidelines*.⁶⁸ It also said the NDIS Commission appreciates that where a regulatory framework relies on external third-party auditors, it is important to address any potential disconnection between the audit arrangements and the regulator's other regulatory functions.⁶⁹

There is nothing in the applicable NDIS Rules that suggests that an auditor should not, where relevant, have regard to a provider's history of complaints and reportable incidents in assessing the provider's performance against the *Practice Standards*.

The system for auditing NDIS providers (such as Afford) does not allow auditors to access information about complaints, reportable incidents, investigations and compliance action being pursued by the NDIS Commission. This creates a risk that auditors do not have a true picture of the extent to which service providers are delivering safe and quality services to NDIS participants in accordance with the *Practice Standards* and *Quality Indicators*.⁷⁰

In her evidence for Public hearing 32, the NDIS Commissioner, Ms Tracy Mackey, told us that the NDIS Commission has had some discussions with approved quality auditors about the information they would find useful. She said the NDIS Commission is able to give auditors information about complaints, reportable incidents and other matters on a case-by-case basis.⁷¹ A newly developed case review practice allows the NDIS Commission's compliance and registration teams to consider how the planned audits should fit in with the NDIS Commission's work in relation to particular providers or compliance issues.⁷²

Following Public hearing 32, Counsel Assisting submitted it was open to the Royal Commission to recommend that the NDIS Commission develop a framework for providing information about complaints and reportable incidents to quality auditors. Counsel Assisting said that in developing the framework, the NDIS Commission should consider the type of information that should be provided, and in what form, ensuring appropriate arrangements for the protection of sensitive personal information.⁷³

In response, the Australian Government confirmed the NDIS Commission is consulting with quality auditors about what information would assist them, and continues to provide them with information about a provider's history on a case-by-case basis. The government noted these issues will be considered by the NDIS Review.⁷⁴

We acknowledge, as the Australian Government submitted, that there will be good reasons for withholding certain confidential or protected information from quality auditors. However, as Counsel Assisting submitted, this issue should be addressed by the framework incorporating protections for confidential or protected information.

Clarifying information sharing requirements with quality auditors

The *NDIS Act* and the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018 (Cth) (Disclosure Rules)* set out the powers and obligations of the NDIS Commission in handling information, including provisions governing the use and disclosure of information.⁷⁵ The NDIS Commissioner can only disclose information⁷⁶ in accordance with these rules.⁷⁷ State and territory laws may affect a requirement under the *NDIS Act* to give information or produce a document to the NDIS Commissioner in certain circumstances.⁷⁸

The current rules do not expressly authorise the NDIS Commission to disclose specific information about reportable incidents, complaints and compliance history to quality auditors. To put this beyond doubt, the *Disclosure Rules* should be clarified.

Developing a framework for sharing information with quality auditors

In circumstances where a registered provider has a history of non-compliance, or concerns about the safety and quality of supports and services are known to the NDIS Commission, the NDIS Commission should apprise auditors of this information. The NDIS Commission should develop an information sharing framework to facilitate effective and consistent information sharing practices between the NDIS Commission and quality auditors.

In proposing such a framework, we are not suggesting that quality auditors should be provided with all the NDIS Commission's information holdings in relation to a particular provider. For certain large providers, holdings in relation to complaints and reportable incidents can be voluminous.⁷⁹ Reviewing a large volume of such material would be resource intensive and inefficient, and would extend audit timeframes for quality auditors. Disclosing information to approved quality auditors must be done in a manner that efficiently synthesises the key issues for consideration by quality auditors and is not excessively resource intensive for the NDIS Commission.

In our view, the development of an information sharing framework between the NDIS Commission and quality auditors should include:

- the numbers of reportable incident notifications and complaints received during the relevant period in relation to the provider
- data in relation to the particular types of issues identified by the NDIS Commission's oversight
- compliance and enforcement action taken by the NDIS Commission and related outcomes
- the locations where incidents have occurred

-
- any findings by the NDIS Commission that a provider, or a person employed or otherwise engaged by the provider, has failed to comply with a condition of their registration.

Regulatory burdens associated with the registration process

We heard conflicting views about the provider registration process. Some stakeholders said the process is excessively expensive, time consuming, and complex, and a disincentive to register with the NDIS Commission.⁸⁰ Others suggested the process should be more rigorous to improve the quality and safety of supports through more frequent mid-term audits.⁸¹

The NDIS Commission reported the median cost of a verification audit in 2021–22 was around \$1,000 and a certification audit between \$3,000 to \$6,000, but can vary in cost depending on several factors.⁸² Mr Jess Harper, CEO of Disability Intermediaries Australia (DIA), told us DIA members have reported registration costs between \$8,000 and \$15,000.⁸³ Mr Harper said a number of DIA members find the prospect of registration to be ‘incredibly stressful’⁸⁴ and have chosen not to re-register or continue with the process for financial reasons.⁸⁵

Ms Laurie Leigh of National Disability Services (NDS) said:

There is a live conversation within the disability service provider sector at the moment about what is the point in registration. So, if I’m a provider who has many participants who are self-managed or plan-managed, what is the point in being registered? Because it costs more money, you do a lot more reporting, you have a lot more systems in place in terms of worker screening that you would then otherwise have. And they see very clearly that many other providers doing the same sort of work are not being registered, and so what is the need for them to take on that registration, especially when it comes with all of those additional costs but no additional funding.⁸⁶

Ms Leigh’s evidence is consistent with the evidence of Ms Joanne Houghton and Ms Jody Barney, both unregistered providers who appeared at Public hearing 25, ‘The operation of the NDIS for First Nations people with disability in remote and very remote communities’. Ms Houghton said her decision to remain an unregistered provider was mainly due to the ‘significant bureaucratic red tape involved in becoming, and remaining registered’, a particular barrier for First Nations small businesses.⁸⁷ She said a \$7,000 audit was ‘not financially viable’.⁸⁸ Ms Barney said her business is an unregistered provider because it allows them to ‘deliver services in a flexible manner’ that is more appropriate for her clients.⁸⁹ She said ‘there is too heavy an administrative burden associated with being a registered provider’.⁹⁰

In a submission to the Royal Commission, Speech Pathology Australia (SPA) said that speech pathology is already a well-regulated profession through SPA and the Australian Health Practitioner Regulation Agency. SPA described the NDIS registration process as ‘overly onerous and expensive’ and said this has resulted in large numbers of speech pathologists de-registering from the NDIS or allowing their registration to lapse.⁹¹

In particular, SPA noted that speech pathologists who support children under six are required to undergo an expensive and drawn-out certification audit.⁹² It said this is resulting in members

deciding not to re-register or not providing early childhood support, reducing the overall number of registered providers for this category of support. SPA said the NDIS Commission should provide potential exemptions for allied health professionals who are already regulated through other mechanisms.⁹³

We have been told the current system of registration is designed for large providers.⁹⁴ NDS said smaller providers and providers in regional and remote areas find the cost of audits prohibitive to registration.⁹⁵

The South Australian Government's Safeguarding Task Force also noted that the length and cost of the registration process may not be viable for some smaller businesses and operators.⁹⁶ Mr Head advised the task force that many sole traders are audited at an average cost of \$1,000 every three years. He said to the extent that there have been concerns about audit costs, most related to the automatic triggering of certification audits based on organisation type, irrespective of the types of support provided. Following consultation with people with disability and providers, the NDIS Rules were amended (effective 1 January 2020) to deal with this issue.⁹⁷ Mr Head said there have been very few complaints about audit costs since this change.⁹⁸

Nonetheless, in November 2021, the Joint Standing Committee on the NDIS (Joint Standing Committee) noted concerns about the administrative burden that audits place on providers, the cost of audits, and duplication of requirements for some cohorts of practitioners or organisations, such as allied health practitioners.⁹⁹ The registration process was generally considered to deter smaller providers from registering or renewing their registration, which may limit the services they can provide or who they can support. The committee heard these factors contribute to workforce shortages and the overall problem of thin markets, felt most acutely in rural, regional and remote areas.¹⁰⁰ The committee also heard the online portal used to submit registration applications was complex, not user-friendly, and required duplication when entering information due to portal interfaces not being integrated.¹⁰¹

The committee recommended the Australian Government review provider registration requirements to ensure they do not impose unnecessary burdens on current and prospective NDIS providers, while simultaneously ensuring the provision of quality and safety services. It said particular consideration should be given to:¹⁰²

- the adequacy of current requirements for small providers that have undergone similar processes
- the classification of high-risk supports that require registration
- the impact of registration processes on areas with NDIS workforce shortages and in rural, and remote areas
- the provision of guidance to providers about the process.

In a comprehensive submission, an approved quality auditor, the Institute for Healthy Communities Australia Ltd (IHCA) said NDIS providers perceive the audit process as a cost burden and a compliance process, rather than a genuine driver of continuous improvement in the NDIS provider market.¹⁰³ In relation to verification audits, it said it is not uncommon to

hear that a small provider or sole trader has spent thousands of dollars to have key documents written for them that are often not customised or understood by the provider.¹⁰⁴

However, IHCA argued that the audit process should be more, not less, rigorous to support the safety and quality of NDIS supports and services. It said the rules relating to mid-term audits are ‘very light-touch’ and that certification audits should be undertaken more frequently.¹⁰⁵ It made several suggestions to enhance the audit process, including introducing more rigour to the scope of mid-term audits, and collecting and publishing data on audit outcomes to inform better practice.¹⁰⁶

Steps taken to improve the registration process

The NDIS Commission has a range of initiatives underway to enhance the registration process for NDIS providers, including:

- engaging additional staff and resources to process a backlog of applications¹⁰⁷
- enhancing the online application form in COS¹⁰⁸
- convening a registration roundtable to start discussing the current registration practice and arrangements¹⁰⁹
- engaging with stakeholders (including through its consultative committees) in relation to registration design and the approach to, and costs of, auditing.¹¹⁰

The NDIS Commission has been made aware by peak bodies and providers of various sizes that regulatory burden and duplication exists in the registration process.¹¹¹ Ms Mackey said the examples raised with her often relate to the NDIS Commission’s systems not being ‘user-friendly’ and she committed to undertaking a review of the registration process in 2023.¹¹² She anticipates the impending NDIS Review will look closely and deeply at issues around who may or may not need to be registered.¹¹³

Simplifying registration

We agree with the recommendations made by the Joint Standing Committee. We endorse the NDIS Commission continuing its work to:

- remove any duplication of requirements for cohorts of practitioners or organisations working within multiple schemes, and recognise other forms of accreditation or registration requiring assessment against similar criteria
- identify ways to refine the registration process so that is more efficient, timely and easier to navigate for all providers
- encourage smaller providers to register, without reducing the standard of quality and safety expected of NDIS supports and services.

The principle of choice and control underpins the NDIS Quality and Safeguarding Framework.¹¹⁴

Choice and control also mean that participants are able to make decisions about the level of risk they are prepared to take and have the tools and information they require to make informed judgements about the quality and suitability of providers.¹¹⁵

We acknowledge that the opportunity to engage both registered and unregistered providers can enhance the choices available to people with disability. Nonetheless, NDIS providers should be encouraged to register with the NDIS Commission for the reasons already discussed. We agree with Counsel Assisting that registration is a core component of the quality and safeguarding framework for NDIS funded services and any increase in the unregistered proportion of NDIS providers is likely to reduce the effectiveness of the regulatory framework.¹¹⁶

The registration process (including the quality audit process) should be proportionate and measured, with higher levels of scrutiny and rigour applied to large providers or providers delivering complex or higher risk supports and services.

We recommend the NDIS Commission conduct a comprehensive review of the provider registration process with the intention of:¹¹⁷

- Simplifying the process for smaller providers seeking to renew their registration, particularly where the provider has a proven track record of compliance with NDIS Rules and quality support provision, without reducing the standard or quality and safety expected of NDIS supports and services.
- Improving the COS portal and online application forms used to submit registration applications. Portal interfaces used for other functions of the NDIS Commission (such as reportable incidents, behaviour support and worker screening) should be integrated to avoid duplication, and further guidance should be provided within the portal about how to use the online application form.
- Removing any duplication of requirements for cohorts of practitioners or organisations working within multiple schemes and recognising other forms of accreditation or registration that require assessment against similar criteria.
- Identifying areas where there are workforce shortages or thin provider markets and encouraging the use of easier and more cost-effective certification audit processes in these areas, such as desktop audits and virtual interviews. Consideration should also be given to encouraging similar approaches for smaller providers in rural, regional and remote areas delivering lower risk types of supports and services.
- Assessing whether the number of approved quality auditors accredited for remote auditing and assessment should be increased to support the above recommendations.

The NDIS Commission should also systemically collect and annually publish an analysis of de-identified audit outcomes. This should include common issues identified by approved quality auditors during the audit process.

Recommendation 10.21 Registration and audit process

- a. To enhance the registration process, the NDIS Quality and Safeguards Commission (NDIS Commission) should:
 - develop and implement a framework for sharing relevant information with quality auditors
 - conduct a comprehensive review of the provider registration process focused on:
 - simplifying the process for smaller providers seeking to renew their registration
 - improving the NDIS Commission's operating system (COS) portal and online application forms used to submit registration applications
 - removing any duplication of requirements for cohorts of practitioners or organisations working within multiple schemes and recognising other forms of accreditation
 - identifying areas where there are workforce shortages or 'thin provider markets', and encouraging the use of easier and more cost-effective certification audit processes in these areas
 - assessing whether the number of approved quality auditors accredited for remote auditing and assessment should be increased
 - collect and publish de-identified data about quality audit outcomes to inform best practice
 - alert quality auditors to known systemic issues across the NDIS provider market.
- b. The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) to clarify the NDIS Commission is able to share relevant information with quality auditors.

10.5. Strengthening *Practice Standards* and *Quality Indicators*

The *Practice Standards* and *Quality Indicators* drive practice improvement by NDIS providers. The NDIS Commission relies on the *Practice Standards* during the registration cycle and quality audit process to measure the provider's compliance with regulatory requirements.

The NDIS Commission has refined the *Practice Standards* from time to time.¹¹⁸ It is considering other changes in response to its *Own Motion Inquiry into aspects of supported accommodation*

Inquiry report (*Own Motion Inquiry* report), including:

- requiring the NDIS Workforce Capability Framework to be considered by quality auditors when assessing compliance with the *Practice Standards*¹¹⁹
- developing new standards and indicators that incorporate elements of the best practice framework recommended by Professor Christine Bigby in research commissioned by the NDIS Commission¹²⁰
- introducing more standards under the Core Module of the *Practice Standards* and a new module with additional indicators to provide specific guidance on obligations in delivering supports.¹²¹

We support these proposals but consider additional changes are needed to the *Practice Standards*.

Complaints and incidents

The Core Module of the *Practice Standards* does not specify a dedicated standard for 'Feedback and complaints management' or 'Incident management'. Instead, both topics are identified as areas of responsibility under the standard for 'Provider governance and operational management'.¹²²

The *Practice Standards* should be amended to include discrete standards on complaint handling and incident management within the Core Module. All providers should be required to comply with and address these standards as part of their registration.

In Chapter 8, 'Reportable incidents' and Chapter 9, 'Complaints', we describe concerns raised in public hearings about providers and support workers failing to comply with complaint and incident management obligations; poor accessibility of complaint and feedback processes; inadequate provider-led investigations and failure to offer redress.

The NDIS Commissioner should amend the related indicators within the *Quality Indicators* to include specific responsibilities for NDIS providers set out in Table 10.10.2.

Table 10.10.2: Strengthening *Quality Indicators* concerning complaints and incidents

Area	NDIS provider responsibilities
Complaints and incidents	• demonstrate how they are supporting participants to actively engage in complaint and incident management processes, including making adjustments • outline the processes they have in place to ensure suitable forms of redress are offered to participants involved in complaints and incidents when they have suffered harm • demonstrate their investigative capacity to respond to allegations of abuse and neglect, and their processes for promptly dealing with concerns that are suitable for handling via informal dispute resolution • require all feedback, complaints and incidents involving allegations of violence, abuse, neglect or exploitation of a participant (including unsubstantiated allegations) to be reported to the governing body on a regular basis, no less than quarterly.

Accountable governance

It is apparent that:

- Governing body members, key personnel and support workers are often not fully aware of their obligations to report incidents to the NDIS Commission, manage and resolve complaints, and identify risks associated with their services.
- Oversight and monitoring by NDIS providers' governing bodies is often inadequate to ensure the quality and safety of services. It can also be inadequate to protect NDIS participants from experiencing violence, abuse, neglect or exploitation.

The Commissioners' *Report of Public hearing 23* found that Afford's Board of Directors were not given sufficient training about the rights of people with disability and disability service provision.¹²³ The report also found that the board and senior management failed to act on a number of indicators of the serious cultural and structural issues impacting Afford's operations,¹²⁴ and failed to effectively safeguard its clients.¹²⁵

In Public hearing 20, we heard that the Life Without Barriers' (LWB) CEO did not notify its board about the allegations of abuse and neglect of its clients, because senior leadership considered it was not necessary or appropriate for the board to be informed of certain matters.¹²⁶

The Commissioners' *Report of Public hearing 13* concerning Sunnyfield proposed that directors and board members of service providers should inform themselves of conditions at residential disability accommodation and of the needs and concerns of clients, by meeting with them and their families and supporters.¹²⁷

Submissions in response to the *Safeguarding and quality issues paper* raised similar concerns and made suggestions for improvement. For example, NDS said some providers have implemented ‘service user advisory committees’ to provide input into the leadership and governance of the organisation.¹²⁸ Dementia Australia suggested adopting standards similar to the National Safety and Quality Health Service Standards, which include a ‘Clinical Governance Standard’ that recognises the importance of governance, leadership, culture, safety systems and performance in delivering high quality care.¹²⁹

The ‘Governance and operational management’ standard within the *Practice Standards*, and the associated indicators within the *Quality Indicators*, appropriately places emphasis on proportionate and robust governance and operational management systems.¹³⁰ However, the *Practice Standards* do not make clear the responsibilities of the governing body to ensure serious incidents involving people with disability are dealt with properly and trends in complaints and incidents are identified. We think there is merit in the *Practice Standards* and *Quality Indicators* incorporating clearer standards to promote robust governance practices.

Registered NDIS providers should be required to report regularly to their governing bodies about complaints and incidents, including patterns of, and underlying reasons for, complaints and incidents, and strategies to prevent any serious issues from occurring in future. The Royal Commission into Aged Care Quality and Safety made a similar finding in relation to aged care providers.¹³¹ In Chapter 8, ‘Reportable incidents’ we recommend the development of sample safeguarding indicators for use by NDIS providers key personnel.

The *Practice Standards* and associated *Quality Indicators* should be amended to require a provider’s governing body to be accountable for the responsibilities set out in Table 10.10.3. Wider themes relating to the governance of NDIS providers are addressed in Part A of this volume.

Table 10.10.3: Strengthening *Practice Standards* and *Quality Indicators* concerning governance

Area	NDIS provider responsibilities
Accountable governance	A provider’s governing body should be accountable for: - the delivery of safe and quality supports and services and promoting a culture of safety and quality - facilitating contribution by NDIS participants and their supporters to the governance and procedures of an organisation - demonstrating they have considered the matters reported to them, and that appropriate action is taken to prevent and respond to identified risks that may impact the safety and quality of supports and services.

Worker capacity and training

The importance of an appropriately trained and well supported disability support workforce has been the subject of extensive evidence at public hearings throughout the life of the Royal Commission. Deficiencies in skills and training can lead to inadequate responses when incidents of violence, abuse and neglect occur.¹³²

At Public hearing 3, 'The experience of living in a group home for people with disability', the Royal Commission heard that education and training of disability support workers and service providers operating group homes is integral to developing a culture dedicated to preventing abuse.¹³³ Counsel Assisting the Royal Commission in Public hearing 32 referred to evidence from NDIS providers suggesting that training provided to new staff is variable in its extent, frequency and manner of delivery.¹³⁴

In relation to training on violence towards, and abuse, neglect and exploitation of people with disability, all registered providers are required to ensure workers complete the NDIS Worker Orientation module as part of their induction process under the *Quality Indicators*.¹³⁵

There is value in the *Practice Standards* containing enhanced mandatory training requirements. This should include training that enables employees to identify the warning signs and indicators of violence, abuse, neglect and exploitation.

The NDIS Commissioner should amend the *Quality Indicators* including by extending the scope of section 17 of the *Quality Indicators*, Human Resource Management, to ensure all workers complete the online training modules developed and published by the NDIS Commission (described in Chapter 14, 'Engagement and capacity building') as part of their orientation and induction process. This training should cover the responsibilities set out in Table 10.10.4. Broader issues around workforce training are dealt with in Part A of this volume.

Table 10.10.4: Strengthening *Quality Indicators* concerning worker capacity and training

Area	NDIS provider responsibilities
Worker capacity and training	• identify forms and possible indicators of violence, abuse, neglect, exploitation and discrimination, including domestic, family and sexual violence • understand the principles of the <i>Convention on the Rights of Persons with Disabilities</i> • identify participants who are at risk of experiencing violence, abuse, neglect and exploitation.

Supported decision-making

In Part A we recommended supported decision-making could be strengthened by amending the *Quality Indicators*. NDIS providers need more information, guidance and training on supported decision-making to improve the way people with disability are supported to make decisions about day to day matters and arrangements for the delivery of disability services.

In its *Own Motion Inquiry* report, the NDIS Commission suggested that the Independence and Informed Choice Practice Standard could include quality indicators to show how a participant is supported to exercise control over their supports when they live in a group setting, and ‘include additional indicators about individual support with decision-making, and access to advocacy and informal supports’.¹³⁶ We agree with this proposal.

These additional indicators should apply to all people with disability receiving NDIS services, regardless of the support setting, and should be reflected in the relevant standard in the *Practice Standards*. As the risk of violence, abuse, neglect and exploitation is not limited to NDIS participants living in supported accommodation, the additional indicators proposed by the NDIS Commission should apply to all people with disability receiving NDIS services, regardless of the support setting, and should be reflected in the relevant standard.

We discuss supported decision-making, advocacy and informal supports in the context of suitable quality indicators further in Volume 6, *Enabling autonomy and access*.

Recommendation 10.22 Strengthened regulatory requirements

- a. The Minister for the National Disability Insurance Scheme should, in consultation with states and territories, amend the Core Module of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) to issue further standards that address complaint handling and incident management.
- b. The NDIS Quality and Safeguards Commissioner should amend the Core Module of the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) to strengthen the requirements relating to complaints and incidents (see Table 10.10.2), accountable governance (see Table 10.10.3), and worker capacity and training (see Table 10.10.4).

10.6. Unregistered providers

An ‘unregistered provider’ is a provider that supports an NDIS participant, but is not registered as an NDIS provider.¹³⁷ Only NDIS participants who self-manage or plan-manage their NDIS funding are able to choose to receive supports and services from unregistered providers.¹³⁸ Above, we explained that unregistered providers and their workers are not subject to the same requirements as registered NDIS providers.

During Public hearing 14, ‘Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)’, Mr Head advised:

the operation of unregistered providers in the NDIS market is a feature of the NDIS [Quality and Safeguarding] Framework. It was considered in the detailed consultation that informed the final design of the NDIS Framework. It was considered during the parliamentary debate on the *NDIS Act*. It is seen by many people with disability and

others, including many advocates, as a key element of the principle of choice and control that underpins the NDIS. I expect that the issue of unregistered providers will be raised and considered again in the course of the upcoming review of the NDIS Framework.¹³⁹

Mr Head pointed out that providers are required to be registered if they deliver specified classes of supports, and 'agency-managed' NDIS participants can only use registered providers. Participants are only permitted to self-manage their NDIS funding if the NDIA is satisfied that self-management would not present an unreasonable risk to the participant.¹⁴⁰

When it was released in 2016, the NDIS Quality and Safeguarding Framework noted that opinions were divided about registration. Some stakeholders argued that providers supporting self-managing participants should be required to comply with the same requirements as registered providers to ensure a 'level playing field' and better protections for participants. Others suggested the emphasis should be on capability building, and that self-managing participants should be allowed to choose any provider other than close family members.¹⁴¹ They believed this would best reflect the NDIS principle of choice and control, enable participants to choose the provider that best meets their needs and preferences, and maximise access to support. However, there was general agreement on the importance of providing information and supports to self-managing participants to help reduce any potential risks.¹⁴²

In 2020, the South Australian Safeguarding Task Force expressed a view that the NDIS Commission does not adequately consider the risk factors associated with the use of unregistered providers in delivering personal support, particularly for participants at risk of experiencing violence, abuse, neglect and exploitation.¹⁴³

Peak body NDS told the Royal Commission that the competitive nature of the market, combined with high registration costs, may incentivise operating unregistered, which can have impacts on quality and safeguarding.¹⁴⁴

Hireup told us the NDIS Quality and Safeguarding Framework had essentially enabled a 'two-tiered' system, where the majority of the market can operate unregistered, with less scrutiny and obligations and beyond the safeguard mechanisms designed to prevent abuse and neglect.¹⁴⁵

An unregistered provider has the option of asking their workers to demonstrate they have an NDIS Worker Screening clearance, or they can ask them to obtain a clearance by undergoing an NDIS Worker Screening Check.¹⁴⁶ From 1 February 2021, self-managing participants can also require their direct employees or chosen unregistered provider to have a worker screening clearance.¹⁴⁷ Workers who do not hold a clearance are not subject to ongoing monitoring by state and territory worker screening units.¹⁴⁸

Unlike registered NDIS providers, unregistered providers are not required to notify the NDIS Commission of incidents that meet the definition of 'reportable incidents'. Unregistered providers and their workers are only required to comply with the *Code of Conduct*.¹⁴⁹

Ms Mackey explained that the question of whether all providers should be required to register is not simple to address.¹⁵⁰ She pointed out that many allied health professionals are unregistered providers but are subject to other regulatory frameworks.¹⁵¹

Ms Mackey recognised the importance of drawing on complaints and reportable incidents data in considering whether the criteria governing registration of providers are appropriately based on risk.¹⁵² She described the system of reportable incidents as a ‘very critical part’ of the NDIS Commission’s function. However, she was ‘not sure’ she would characterise unregistered providers being exempt from having to notify reportable incidents as ‘a gap’ in the safeguarding framework.¹⁵³ At Public hearing 32, Ms Mackey said the NDIS Commission is considering extending reportable incident obligations to unregistered providers.¹⁵⁴ She also said the NDIS Review will examine the registration framework and she anticipates it will look ‘closely and deeply at these issues’.¹⁵⁵

We acknowledge that imposing additional regulatory obligations on unregistered providers could have unintended consequences for the supply of support workers and the ability of people with disability to exercise choice and control over who provides their NDIS supports and services. In our view, any decision to change the existing regulatory obligations of unregistered providers should be informed by the views of people with disability and their family members, advocates and disability rights organisations who represent their interests.

To inform the public’s ongoing understanding of the unregistered provider market, the NDIS Commission should collect and publish data about trends, risks and contraventions it identifies through its activities in relation to both registered and unregistered providers. In Chapter 13, ‘Data and intelligence’, we further examine data about registered and unregistered providers that the NDIS Commission should collect and publish.

Recommendation 10.23 Publishing data about the unregistered provider market

The NDIS Quality and Safeguards Commission (NDIS Commission) should collect and publish data relating to trends and risks identified within the unregistered provider market, including a breakdown of:

- the number of complaints received involving unregistered providers
- quality and safety issues identified by the NDIS Commission through its oversight of complaints in relation to unregistered providers
- the number of compliance matters and investigations commenced by the NDIS Commission in relation to unregistered providers
- the number of unregistered providers involved in contraventions identified by the NDIS Commission and the type of breach identified
- the number and type of compliance and enforcement actions taken in relation to unregistered providers
- the number of workers engaged by unregistered providers involved in complaints, compliance matters or investigations without a worker screening clearance at the time of the alleged conduct or issue.

Endnotes

- 1 *National Disability Insurance Scheme Act 2013* (Cth) s 181F and ch 4, pt 3A, div 2.
- 2 *National Disability Insurance Scheme Act 2013* (Cth) ss 42(2)(b), 73E(2).
- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 33(6).
- 4 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) s 7(1).
- 5 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) s 7(2).
- 6 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) s 7(3).
- 7 Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [30–31].
- 8 Exhibit 14-183, 'Statement of Graeme Head AO', 14 May 2021, at [110].
- 9 Exhibit 32-72, ARA.9999.0003.0001, [53]; Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-284 [38–47]; Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, P-106 [12–15]; Exhibit 32-49, LBS.9999.0001.0001, [5].
- 10 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 44.
- 11 'Becoming an NDIS provider', *National Disability Insurance Agency*, web page. <www.ndis.gov.au/providers/becoming-ndis-provider>
- 12 *National Disability Insurance Scheme Act 2013* (Cth) s 73F(2)(c).
- 13 *National Disability Insurance Scheme Act 2013* (Cth) ss 73F(2)(b), 73V(1).
- 14 *National Disability Insurance Scheme Act 2013* (Cth) s 73F(2)(e)–(f); *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth).
- 15 *National Disability Insurance Scheme Act 2013* (Cth) s 73F(2)(g)–(h); *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).
- 16 *National Disability Insurance Scheme (Practice Standards – Worker Screening) Rules 2018* (Cth) ss 4, 13.
- 17 *National Disability Insurance Scheme Act 2013* (Cth) ss 73G, 73H.
- 18 For example, it is an offence in Queensland for an unregistered provider to engage a person subject to a suspension, interim ban or exclusion under s 55 of the *Disability Services Act 2006* (Qld).
- 19 *National Disability Insurance Scheme Act 2013* (Cth) ss 73V, 73ZK.
- 20 *National Disability Insurance Scheme Act 2013* (Cth) s 73E(1).
- 21 Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [58]; *National Disability Insurance Scheme Act 2013* (Cth) s 73E(1).
- 22 Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [33].
- 23 NDIS Quality and Safeguards Commission, *Activity report: 1 July 2022 to 30 September 2022*, October 2022, p 6.
- 24 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) s 20, schs 1, 8.
- 25 *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) sch 1.
- 26 'Find an auditor', NDIS Quality and Safeguards Commission, web page, last updated 19 January 2023. <www.ndiscommission.gov.au/resources/find-auditor-additional-text>
- 27 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [16–19].
- 28 *National Disability Insurance Scheme Act 2013* (Cth) s 73U; *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* (Cth) s 6; See also, Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [18].
- 29 *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* (Cth), s 6(3)(b).
- 30 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 50.
- 31 Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [38].
- 32 *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* s 14.
- 33 *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* s 15.
- 34 Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [57–58].

35 'Registered provider obligations and requirements', *NDIS Quality and Safeguards Commission*,
web page, 22 December 2022. <[www.ndiscommission.gov.au/providers/registered-ndis-providers/
registered-provider-obligations-and-requirements](http://www.ndiscommission.gov.au/providers/registered-ndis-providers/registered-provider-obligations-and-requirements)>

36 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [22].

37 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-170 [43–47];
Exhibit 4-32, 'Statement of Graeme Head AO', 11 February 2020, at [61].

38 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-172 [32–34].

39 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [22].

40 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [22].

41 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
31 March 2023, p 258 [979].

42 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
*Report of Public hearing 20: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (two case studies)*, February 2023, p 110 [370];
Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,
*Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and
exploitation in disability services (a case study)*, March 2023, p 106 [306], Finding 29;
Exhibit 32-7, 'Statement of Tracy Mackey', 15 November 2022, at [59–60].

43 Submissions of Counsel Assisting the Royal Commission following Public hearing 32,
31 March 2023, p 258 [980].

44 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [24–25].

45 Exhibit 13-005, 'Statement of Graeme Head AO', 23 May 2021, at [28–29]; Transcript,
Graeme Head, Public hearing 13, 28 May 2021, P-495 [32]–P-496 [14].

46 Exhibit 13-005, 'Statement of Graeme Head', 23 May 2021, at [41–42].

47 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [113].

48 Transcript, Graeme Head, Public hearing 13, 28 May 2021, P-496 [16–22].

49 Transcript, Graeme Head, Public hearing 13, 28 May 2021, P-496 [19–20].

50 *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* (Cth)
Annex B.

51 Exhibit 20-1862, CTD.9999.0040.0001, p 1 [1].

52 Exhibit 20-1862, CTD.9999.0040.0001, p 2 [4].

53 Exhibit 23-070, 'Statement of Ms Samantha Taylor', 22 April 2022, at [155].

54 Exhibit 23-070, 'Statement of Ms Samantha Taylor', 22 April 2022, at [161].

55 Exhibit 23-074, CTD.7200.0037.0248, p 19; Exhibit 23-070, 'Statement of Ms Samantha Taylor',
22 April 2022, at [161–62].

56 Exhibit 23-087, AFF.0006.0001.0251, pp 6, 21, 28; Exhibit 23-161, AFF.0005.0001.1933, p 8.

57 Exhibit 23-087, AFF.0006.0001.0251, p 4; Exhibit 23-070, 'Statement of Ms Samantha Taylor
PSM', 22 April 2022, at [164].

58 Exhibit 23-087, AFF.0006.0001.0251, pp 14–15, 21, 23, 29, 36, 41–42, 50, 54, 58, 62.

59 Exhibit 23-087, AFF.0006.0001.0251, p 5.

60 Exhibit 23-070, 'Statement of Ms Samantha Taylor PSM', 22 April 2022, at [11]; Transcript,
Samantha Taylor, Public hearing 23, 18 May 2022, P-209.

61 Exhibit 23-070, 'Statement of Ms Samantha Taylor PSM', 22 April 2022, at [14], [18–19], [24–25],
[114–115], [119].

62 Exhibit 23-070, 'Statement of Samantha Taylor', 22 April 2022, at [176].

63 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-253 [17–22].

64 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-252 [48–50], P-253 [19–20].

65 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-253 [28–33].

66 Transcript, Samantha Taylor, Public hearing 23, 18 May 2022, P-261 [44–59].

67 Submissions by the Australian Government in response to Counsel Assisting's submissions in
Public hearing 23, 16 September 2022, SUBM.0033.0001.0001, p 9 [34].

68 Submissions by the Australian Government in response to Counsel Assisting's submissions in
Public hearing 23, 16 September 2022, SUBM.0033.0001.0001, p 11 [43].

69 Submissions by the Australian Government in response to Counsel Assisting's submissions in
Public hearing 23, 16 September 2022, SUBM.0033.0001.0001, p 11 [44].

- 70 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 23: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, March 2023, p 106 [306], Finding 29.
- 71 Exhibit 32-007, 'Statement of Ms Tracy Mackey', 15 November 2022, at [60–61].
- 72 Exhibit 32-007, 'Statement of Ms Tracy Mackey', 15 November 2022, at [62].
- 73 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 259 [983].
- 74 Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, pp 20–21 [71].
- 75 *National Disability Insurance Scheme Act 2013* (Cth) ss 67A, 67E; *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) pt 3.
- 76 'Protected Commission information', under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act), means information about a person (including a deceased person) that is or was held in the records of the Commission, but does not include the following: if there is publication of the NDIS Provider Register in whole or part as mentioned in paragraph 73ZS(7)(b) – information covered by that publication; if there is publication of specified information entered on that Register as mentioned in that paragraph – that information: NDIS Act s 9 definition 'protected Commission information'. 'NDIS information' is used under the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) (Disclosure Rules), which means information obtained by a person in the performance of the person's functions or duties or in the exercise of the person's powers under the *NDIS Act: Disclosure Rules* s 4 definition 'NDIS information'.
- 77 *National Disability Insurance Scheme Act 2013* (Cth) s 67E(2).
- 78 *National Disability Insurance Scheme Act 2013* (Cth) s 58; *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) pt 2, sch 1.
- 79 During 2021–22, the NDIS Commission received almost 8,000 complaints and 17,000 reportable incident notifications (excluding notifications relating to the unauthorised use of restrictive practices), as well as notifications concerning over 1.4 million uses of unauthorised restrictive practices: NDIS Quality and Safeguards Commission, *Activity report 1 July to 31 December 2021*, January 2022, pp 10, 14–15; NDIS Quality and Safeguards Commission, *Activity report 1 January to 31 March 2022*, April 2022, pp 9, 14–15; NDIS Quality and Safeguards Commission, *Activity report 1 April to 30 June 2022*, July 2022, pp 4, 7–8.
- 80 For example, Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-296 [42–45], P-297 [7–9]; Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-286 [8–15]; Exhibit 25-034, 'Statement of Joanne Houghton', 21 June 2022, at [57]; Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, p 10; National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 8; Dementia Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00529, pp 10–11.
- 81 Institute for Health Communities Australia, Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, pp 4–5.
- 82 Exhibit 32-196, CTD.7200.0040.1814, p 6; Submissions by the Australian Government in response to Counsel Assisting's submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 20 [69].
- 83 Exhibit 32-006, 'Statement of Jess Harper', 6 February 2023, at [77].
- 84 Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-296 [42].
- 85 Transcript, Jess Harper, Public hearing 32, 15 February 2023, P-296 [43–45], P-297 [7–9].
- 86 Transcript, Laurie Leigh, Public hearing 32, 15 February 2023, P-286 [8–15].
- 87 Exhibit 25-034, 'Statement of Joanne Houghton', 21 June 2022, at [56], [65].
- 88 Exhibit 25-034, 'Statement of Joanne Houghton', 21 June 2022, at [57].
- 89 Exhibit 25-012, 'Statement of Jody Ann Barney', 11 June 2022, at [15].
- 90 Exhibit 25-012, 'Statement of Jody Ann Barney', 11 June 2022, at [15].
- 91 Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, p 10.
- 92 Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, p 17.

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- 93 Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, pp 10, 17.
- 94 Exhibit 32-143, HUP.9999.0001.0001, p 46.
- 95 National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 13.
- 96 Exhibit 14-217, SAG.0002.0023.0114, p 12.
- 97 Exhibit 14-186, CTD.7200.0008.3828, p 5; *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth); *National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2019 Measures No. 1) Rules 2019* (Cth).
- 98 Exhibit 14-186, CTD.7200.0008.3828, p 5.
- 99 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp 88, 90–92.
- 100 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp 88, 95.
- 101 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp 88, 91–92.
- 102 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp 104–05.
- 103 Institute for Healthy Communities Australia, Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, p 3.
- 104 Institute for Healthy Communities Australia, Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, p 3.
- 105 Institute for Healthy Communities Australia, Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, p 4.
- 106 Institute for Healthy Communities Australia, Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, p 5.
- 107 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 20 [69].
- 108 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 20 [69].
- 109 Exhibit 32-007, ‘Statement of Ms Tracy Mackey’, 15 November 2022, at [55].
- 110 Australian Government, Response to the Joint Standing Committee on the National Disability Insurance Scheme report: *NDIS Quality and Safeguards Commission*, 20 April 2023, p 6.
- 111 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [1–5].
- 112 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-451 [5–19].
- 113 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-450 [28–32].
- 114 Australian Government Department of Social Services, *NDIS Quality and Safeguarding Framework*, 9 December 2016, p 4.
- 115 Australian Government Department of Social Services, *NDIS Quality and Safeguarding Framework*, 9 December 2016, pp 6, 8–9; Australian Government Department of Social Services, *NDIS Quality and Safeguarding Framework: Consultation Report*, 31 August 2015.
- 116 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 258 [980].
- 117 Note: A stage two audit of a provider undergoing certification may be conducted remotely in certain circumstances, and when the approved quality auditor is accredited to ‘IAF MD4’. Refer to the *National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018* (Cth), s 15(11).
- 118 For example, Amendments came into effect as a result of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2019 Measures No. 1) Rules 2019* (Cth), and the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Amendment (2021 Measures No. 1) Rules 2021* (Cth).
- 119 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 92.

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11. Behaviour support

Key points

- The NDIS Quality and Safeguards Commission's (NDIS Commission) behaviour support function extends to building the capacity of specialist behaviour support providers, behaviour support practitioners and implementing providers. It also includes improving the quality of positive behaviour support plans through education, engagement and compliance activities.
- In Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', we heard about issues with both the quality of positive behaviour support plans and the availability of qualified and experienced behaviour support practitioners, particularly in rural, regional and remote areas. The NDIS Commission has since taken significant steps to address these issues.
- We make recommendations to improve access to behaviour support practitioners, particularly in regional and remote areas, which are intended to complement the initiatives and interventions already underway.

The NDIS Quality and Safeguards Commission (NDIS Commission) has primary responsibility for regulating the use of restrictive practices and the implementation of positive behaviour support by National Disability Insurance Scheme (NDIS) providers.¹ It is responsible for leading the reduction and elimination of the use of restrictive practices and assisting states and territories to develop a nationally consistent regulatory framework.²

The NDIS Quality and Safeguards Commissioner (NDIS Commissioner) is also responsible for developing and implementing a competency framework for providers involved in behaviour support assessments and developing behaviour support plans, and assessing the skills and experience of such providers against the competency framework.³

In this chapter, we explore evidence heard at Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', concerning shortages of suitably qualified and experienced behaviour support practitioners, particularly in rural, regional and remote areas. We also note the considerable efforts that have been made to address practitioner supply issues. This has included the development and implementation of a national competency framework for behaviour support practitioners, and the implementation of a national action plan to address the issues of capacity, quality and thin markets. We focus on what else can be done to improve access to behaviour support and the future work needed to ensure quality.

11.1. Behaviour support function

The NDIS Commission's statutory behaviour support function includes:⁴

- building capability relating to behaviour support by developing and implementing a competency framework for behaviour support practitioners, and assessing their skills and experience against the framework
- providing education, training and advice, including developing policy and guidance materials on behaviour supports and the reduction and elimination of the use of restrictive practices
- overseeing the use of behaviour support and restrictive practices, including monitoring registered NDIS provider compliance with the conditions of registration relating to positive behaviour support plans; and collecting, analysing and disseminating data and other information relating to the use of behaviour supports and restrictive practices
- undertaking and publishing research about behaviour supports, and developing strategies to encourage the reduction and elimination of restrictive practices
- assisting states and territories to develop a regulatory framework, including nationally consistent minimum standards in relation to restrictive practices.

The Senior Practitioner at the NDIS Commission is responsible for leading the behaviour support function and reducing and eliminating restrictive practices by NDIS providers.⁵

The then NDIS Commissioner, Mr Graeme Head AO, explained in Public hearing 6 that the NDIS Commission regulates restrictive practices in the following ways:⁶

- **Registration requirements** – NDIS providers who use or are likely to use a regulated restrictive practice in relation to a participant on an interim or ongoing basis, and providers who provide specialist behaviour support to participants, must be registered providers with the NDIS Commission.
- **Behaviour support** – This focuses on person-centred interventions to address the underlying causes of behaviours of concern.
- **Reportable incidents** – NDIS providers must notify the NDIS Commission of the use of unauthorised restrictive practices (URP) or a restrictive practice that might constitute abuse or neglect, or that might cause or contribute to the death or serious injury of a person with disability.
- **Complaints** – Any person can make a complaint to the NDIS Commission about an issue arising out of, or in connection with, supports and services provided to an NDIS participant, including the use of restrictive practices.

Restrictive practices

A 'restrictive practice' is any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability.⁷ In some circumstances, restrictive practices are regulated and permitted as a last resort to protect a person with disability and/or others from harm.⁸

The NDIS Commission does not authorise the use of restrictive practices. Authorisation remains the responsibility of the state and territory governments in which the restrictive practice is used.⁹ However, The NDIS Commission does have primary responsibility for regulating NDIS providers' use of restrictive practices and implementation of positive behaviour support.¹⁰ We discuss the authorisation of restrictive practices further in Volume 6, *Enabling autonomy and access*.

A regulated (or permitted) restrictive practice can include seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.¹¹ It must also be:¹²

- authorised within the state or territory in which it occurs
- undertaken in accordance with a behaviour support plan
- recorded by the NDIS provider implementing the restrictive practice (the implementing provider) and reported to the NDIS Commission.

NDIS providers involved in restrictive practices

Three types of NDIS providers or persons engaged by NDIS providers are involved in the use of regulated restrictive practices:¹³

- **Specialist behaviour support providers** are responsible for behaviour support assessments and developing positive behaviour support plans. They may employ or engage NDIS behaviour support practitioners to undertake this work.
- **NDIS behaviour support practitioners** undertake functional behaviour assessments and write positive behaviour support plans that may contain regulated restrictive practices for NDIS participants.
- **Implementing providers** are any NDIS providers that use regulated restrictive practices when delivering NDIS supports to a person with disability.

Implementing providers and specialist behaviour support providers must both be registered with the NDIS Commission.¹⁴ They must also meet the requirements outlined in the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) (*Restrictive Practices and Behaviour Support Rules*).

Behaviour support plans

Behaviour support focuses on developing individualised strategies that are responsive to the needs of a person with disability in a way that reduces and eliminates the need for the use of regulated restrictive practices.¹⁵ A behaviour support plan is a document prepared in consultation with the person with disability, their family, carers, and other support people that addresses the needs of the person identified as having behaviours of concern.¹⁶ A behaviour support plan can only be developed by practitioners considered suitable by the NDIS Commissioner.¹⁷ These plans are often commonly referred to as ‘positive behaviour support plans’ (PBSPs).

The *Restrictive Practices and Behaviour Support Rules* set out a number of requirements for the development and content of PBSPs that contain a regulated restrictive practice.¹⁸ If a PBSP contains a regulated restrictive practice it must be lodged with the NDIS Commission.¹⁹ Following the authorisation and the development of a PBSP, the registered NDIS provider must only use a regulated restrictive practice in accordance with that plan.²⁰

Reporting obligations for implementing providers

A condition of registration is that a registered provider must report monthly to the NDIS Commission about the use of regulated restrictive practices.²¹

If there is no PBSP in place for the restrictive practice(s) used, or where the use is not authorised (where authorisation is required), this use becomes a ‘reportable incident’ and must be reported to the NDIS Commission within five days of the incident occurring.²² This contributes to the vast number of incident notifications about URPs received by the NDIS Commission.

The number of NDIS participants and volume of restrictive practices falling within the NDIS Commission’s oversight has continuously increased since it commenced operating. Around 99 per cent of all reportable incident notifications made to the NDIS Commission between 1 July 2019 and 30 June 2022 related to the use of URP.²³ In the 2021–22 financial year alone, the NDIS Commission received more than 1.4 million ‘reportable incident’ notifications concerning such use.²⁴

At Public hearing 32, ‘Service providers revisited’, the current NDIS Commissioner, Ms Tracy Mackey, was asked to explain the causes for the significant rise in numbers of regulated (authorised) restrictive practices. She referred to the growth in numbers of NDIS participants, the increase in number of PBSPs being lodged with the NDIS Commission and the higher level of compliance from providers around reporting these arrangements.²⁵ Ms Mackey explained ‘these increase in numbers, although quite significant ... are not necessarily related to an increase in use; rather, an increase in number of participants and increase in the reporting of those’.²⁶ Ms Mackey also told us the NDIS Commission is ‘doing a range of things’ to try and reduce these numbers.²⁷

We discuss issues relating to the publication of data about the disability sector’s use of both regulated and unauthorised restrictive practices in Chapter 13, ‘Data and intelligence’.

Reduction and elimination of restrictive practices

The National Framework for Reducing and Eliminating the Use of Restrictive Practices (National Framework) was endorsed by Commonwealth, state and territory disability ministers in 2014 to reduce the use of restrictive practices in disability services. It focuses on understanding the nature and function of a person's behaviour and formulating strategies to address behaviour to reduce the need for restrictive practices.²⁸

The NDIS Commission has a role to assist states and territories develop a regulatory framework for restrictive practices, including nationally consistent minimum standards, consistent with the National Framework and the *Convention on the Rights of Persons with Disabilities*.²⁹ Mr Head told us that states and territories were developing action plans based on the 10 draft national principles formulated for the Nationally Consistent Authorisation of Restrictive Practices agreed in July 2020.³⁰

In February 2023, Ms Mackey told us the NDIS Commission continues to advance this work and that a number of states and territories have made changes to their authorisation processes.³¹

11.2. Accessing quality behaviour support

The NDIS Commission is responsible for determining the suitability of NDIS behaviour support practitioners. However, PBSPs are often of poor quality and ineffectively implemented.

Evidence at Public hearing 6 identified:

- problems with the quality of PBSPs and deficiencies in the development process³²
- poor implementation of PBSPs
- inadequate qualifications and expertise of NDIS behaviour support practitioners³³
- problems with the NDIS Commission's monitoring of the quality of PBSPs.³⁴

We also heard concerns about the availability of suitably qualified and experienced behaviour support practitioners, particularly in rural and remote areas. A shortage of behaviour support practitioners with appropriate qualifications and experience, particularly in rural and remote areas, is a major contributing factor to problems with PBSPs.³⁵

Quality of positive behaviour support plans

Witnesses at Public hearing 6 raised a number of issues related to quality.³⁶ The then Acting Public Guardian of Queensland, Ms Shayna Smith, said PBSPs do not always comply with regulatory requirements and also 'do not always reflect a positive and strengths-based approach to people with a disability'.³⁷

Dr Catherine Franklin, Director and a Consultant Psychiatrist at the Mater Intellectual Disability and Autism Service, at the Mater Hospital in Brisbane, said she and her medical colleagues had seen PBSPs that were significantly below the expected standard. In some cases, they appeared to be a cut and paste.³⁸

The lack of formal qualifications or training for behaviour support practitioners responsible for preparing these plans can contribute to their poor quality.³⁹ Professor Leanne Dowse pointed out there is no independent professional body responsible for regulating the qualifications needed to become a behaviour support practitioner.⁴⁰

The NDIS Commission Senior Practitioner, Dr Jeffrey Chan accepted there were no particular requirements a person had to satisfy to be considered a suitable behaviour support practitioner by the NDIS Commission.⁴¹ Dr Chan referred to the Positive Behaviour Support Capability Framework (Capability Framework), which was being rolled out at the time of Public hearing 6, and was designed to raise the standard of practice.⁴² When asked if behaviour support practitioners are expected to have expertise across all types of restraints, such as seclusion and environmental and chemical restraints, Dr Chan agreed practitioners should have this capability.⁴³ However, he thought a capable behaviour support practitioner would have the necessary skills.⁴⁴

The Commissioners' *Report of Public hearing 6* found:⁴⁵

- the arrangements (at the time of the hearing in September 2020) for determining the suitability of behaviour support practitioners were inadequate to ensure that PBSPs were uniformly of high quality
- people with cognitive disability who have the most complex needs often do not receive assistance from appropriately skilled and experienced behaviour support practitioners.

The Australian Government's submission in response to Counsel Assisting's submissions following Public hearing 6 recognised the need for a substantial improvement in the availability and implementation of behaviour support assessments and related plans if it is to achieve the goal of reducing or eliminating the use of restrictive practices in Australia.⁴⁶

Implementation of positive behaviour support plans

Once a plan has been developed, implementing providers are responsible for putting the plan into action. The *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) require each NDIS participant has a current PBSP that:⁴⁷

- (a) reflects their needs, improves their quality of life and supports their progress toward positive change; and
- (b) progresses toward the reduction and elimination of the use of the regulated restrictive practice, where one is in place for the participant.

The *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth) provide that to achieve this outcome, the following indicators (amongst others) should be demonstrated:⁴⁸

- monitor implementation of behaviour support plans through a combination of formal and informal approaches, including feedback from the participant, team meetings, data collection and record keeping, other feedback and supervision
- contribute to reviewing the strategies in the plan, with the primary focus of reducing or eliminating restrictive practices based on observed progress or positive changes in the participant's situation.

The mere existence of a PBSP does not necessarily assist in supporting a person with disability and in reducing behaviours of concern.⁴⁹ Even if PBSPs are carefully prepared, they are often not well implemented by disability support workers and are often not monitored or reviewed.⁵⁰

We also heard evidence in other hearings about inadequate training provided to NDIS provider staff to implement PBSPs. In Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', we heard that 'Sophie' was allegedly assaulted by her support worker while residing in a home operated by Life Without Barriers (LWB).⁵¹ The Commissioners' *Report of Public hearing 20*, for example, found LWB failed to adequately train Sophie's support workers to manage her behaviours of concern and effectively implement her PBSPs.⁵²

Similarly, the Commissioners' *Report of Public hearing 23* found that Australian Foundation for Disability (Afford) staff could not implement effective behaviour support strategies and risk management for participants in a day program operated by Afford because they were not provided with up-to-date information about the participants.⁵³

Monitoring of behaviour support plans

At Public hearing 6, Dr Chan told us about an audit of the quality of PBSPs performed by the behaviour support function using the Behaviour Support Plan Quality Evaluation Version II (BSP-QEII) tool. Dr Chan noted, among other things, the concerns identified as a result of the audit including that many plans were lengthy and lacked clear structure and that one third did not contain a review schedule. Some plans demonstrated a lack of practitioner understanding of the principles of positive behaviour support, and some contained 'derogatory language and punitive measures'.⁵⁴ Dr Chan stated:

In summary, the preliminary findings indicate that the majority of plans were 'under-developed' and there is a need to build the capability of specialist behaviour support providers and NDIS behaviour support practitioners.⁵⁵

In October 2022, Dr Chan gave further evidence to the Royal Commission about a broader national project undertaken by the NDIS Commission to evaluate the quality of PBSPs lodged between 1 November 2020 and 31 December 2021, again using the BSP-QEII tool.

The assessment produced similar findings to those Dr Chan summarised in his earlier evidence, some two years prior, with 80 percent of evaluated plans falling in the underdeveloped or weak quality categories.⁵⁶

Dr Chan said that in light of these results, the NDIS Commission is developing further resources for specialist behaviour support providers and practitioners to improve the quality of PBSPs, including:⁵⁷

- practice guidance on developing high quality plans that focus on problem areas identified in the evaluations
- a checklist to help providers and practitioners to ensure they meet the conditions of restrictive practice use under the *Restrictive Practices and Behaviour Support Rules*
- an updated PBSP template that includes clearer requirements to address problem areas.

Dr Chan also said the NDIS Commission intends to intensify compliance activity to address the problem areas identified in the evaluations.⁵⁸

Access to behaviour support practitioners

Ms Joanna Mullins, an advocate and NDIS Appeals Support Officer at Independent Advocacy NQ, told us there has been a huge increase in the number of people requiring PBSPs, particularly in regional and remote areas, without a corresponding increase in the number of practitioners with expertise in behaviour support and writing PBSPs.⁵⁹ Dr Franklin told us that, in her experience:

lack of access to less restrictive means of managing behaviours of concern (for example, behavioural analysis and high quality positive behaviour support) is often the reason support persons (paid and unpaid) seek chemical restraint for the person they support.⁶⁰

Ms Courtney Wolf of Queensland Advocacy Incorporated said the lack of practitioner availability is particularly acute in rural and remote areas.⁶¹

Submissions have also suggested that the current shortage of experienced behaviour practitioners nationally can delay the development of PBSPs.⁶²

In September 2020, Dr Chan told us providers had reported that the market for behaviour support practitioners was thin and that participants and providers were unable to engage practitioners to develop interim or comprehensive PBSPs.⁶³

In its November 2021 report on the NDIS Commission, the Joint Standing Committee on the NDIS (Joint Standing Committee) also expressed concern about the shortage of behaviour support practitioners. The Joint Standing Committee observed that this is 'resulting in delays or an inability to put in place appropriate PBSPs for NDIS participants who are subject to repeated instances of unauthorised restrictive practices', which may put these participants at risk.⁶⁴

Although noting a need for coordination across a range of stakeholders, the Joint Standing Committee considered the NDIS Commission's functions in relation to behaviour support still make it the most appropriate body to lead work to increase the behaviour support workforce.⁶⁵ The Joint Standing Committee recommended the NDIS Commission 'develop a specific strategy to increase the number of behaviour support practitioners'.⁶⁶ The Australian Government supported this recommendation and advised that it is already making steps to expand and develop the capability of the behaviour support provider market in collaboration with states and territories.⁶⁷

11.3. Efforts to enhance quality and accessibility

Since Public hearing 6, a number of developments have addressed concerns raised in evidence.

The practitioner suitability assessment now involves an assessment of a behaviour support practitioner against the Capability Framework. The Capability Framework was published by the NDIS Commission in July 2019 and outlines the capabilities required of practitioners who provide behaviour support services to NDIS participants.⁶⁸

The NDIS Commission intends to review and evaluate the implementation of the Capability Framework in late 2023 to early 2024. This will include consultations with stakeholders including NDIS participants, providers, advocates, and relevant state and territory agencies.⁶⁹

The *National Disability Insurance Scheme (NDIS Behaviour Support Practitioner Application) Guidelines 2020* (Cth) also describe the application process and the criteria the NDIS Commission considers when considering whether a person is suitable to be an NDIS behaviour support practitioner.⁷⁰

In December 2020, disability ministers developed and endorsed the National Action Plan Developing the NDIS Specialist Behaviour Support Market (National Action Plan).⁷¹ The National Action Plan is governed by a joint working group convened by the Australian Government Department of Social Services and comprises representatives from the NDIS Commission, state and territory governments and the National Disability Insurance Agency.⁷²

The National Action Plan's objectives are to:⁷³

- help understand the behaviour support market
- build market capacity to ensure there are enough practitioners to meet demand
- ensure practitioners have the skills and knowledge to deliver quality behaviour support
- develop market settings to attract and retain quality behaviour support providers and practitioners.

Under the National Action Plan, the NDIS Commission has lead responsibility for interventions, including the Capability Framework Pilot, and for identifying practitioner cohorts for specialised

training, such as cultural training so that services can be delivered safely and appropriately for First Nations Australians.⁷⁴ The NDIS Commission has also developed fact sheets and resources to improve the planning and implementation of PBSPs.⁷⁵

In addition, the NDIS Commission is developing resources for specialist behaviour support providers and NDIS behaviour support practitioners to improve the quality of PBSPs. These resources include a PBSP checklist to ensure plans meet the requirements for the use of restrictive practices specified in the *Restrictive Practices and Behaviour Support Rules*.⁷⁶

The NDIS Commission has indicated it will conduct a review of certain PBSPs as part of its quality assurance process.⁷⁷ There are no requirements regarding the number of plans audited or the frequency of reviews. The NDIS Commission currently relies on patterns and data trends, information provided by other areas of the NDIS Commission, including complaints received, and 'random audits' to determine which PBSPs need to be reviewed.⁷⁸ Given the current low quality of PBSPs, an expansion of the NDIS Commission's auditing role in this area would be useful.

11.4. Building sector capacity

The level of expertise and skills among behaviour support practitioners, combined with the supply and demand problem discussed earlier, directly affect the quality of PBSPs. Interventions undertaken to address practitioners' skill levels or the issue of thin markets are actions that can help raise the standard of PBSPs.

We acknowledge the work undertaken by the NDIS Commission to improve the skills and capabilities of behaviour support practitioners under the Capability Framework. However, neither the National Action Plan nor the Capability Framework provides specific incentives for practitioners and NDIS providers to begin providing behaviour support.

Despite this gap, the NDIS Commission has carried out work to increase the availability of behaviour support, including the development of a national curriculum. However, we consider that more can be done to provide incentives for practitioners and NDIS providers to provide behaviour support services especially where 'thin markets' have been identified. For example, to address behaviour support shortages in regional and remote areas, there would appear to be merit in the NDIS Commission working in partnership with First Nations leaders from the disability services and employment sectors.

We note the Capability Framework will be the subject of a review in late 2023 or early 2024 and will include broad consultation with NDIS participants, providers, advocates, and relevant state and territory agencies.⁷⁹ Given the issues identified concerning the expertise and experience of behaviour support practitioners and the availability of practitioners in certain areas, the NDIS Commission should work with key stakeholders to explore a suite of options to expand the potential workforce in this critical area.

The NDIS Commission should also help NDIS participants and their support networks to locate suitably qualified and experienced practitioners. In the Commissioners' *Report of Public hearing 6*, we expressed the view that the NDIS Commission should create a publicly accessible list (similar to the general Provider Lists) of registered behaviour support practitioners. The list should include the practitioner's name, gender and location; brief details of their education, skills and experience in positive behaviour support; and the assessment they have received under the Capability Framework.⁸⁰ We maintain this view and consider that the NDIS Commission is best placed to publish this list given its role in regulating behaviour support practitioners and developing capability.

Recommendation 10.24 Improved access to behaviour support practitioners

The NDIS Quality and Safeguards Commission should, by December 2024, improve access to behaviour support practitioners by:

- a. providing incentives for practitioners and National Disability Insurance Scheme providers to provide behaviour support services, including in regional and remote areas in which 'thin markets' operate
- b. forming a partnership with First Nations leaders from the disability and employment services sectors to develop a recruitment strategy targeting First Nations people and others with experience in working with First Nations communities to address behaviour support shortages in regional and remote areas
- c. exploring with behaviour support practitioners, service providers and people with disability, the merits of an 'on-the-job' professional development and accreditation model for behaviour support practitioners
- d. creating a publicly accessible list of all individual behaviour support practitioners.

Endnotes

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- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 181H(a).
- 4 *National Disability Insurance Scheme Act 2013* (Cth) s 181H.
- 5 Transcript, Dr Jeffrey Chan, Public hearing 6, 25 September 2020, P-369–370; Exhibit 6-24, 'Statement of Jeffrey Chan', 4 September 2020, at [8], [15].
- 6 Exhibit 6-25, 'Statement of Graeme Head AO', 4 September 2020, at [9]; *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) s 7; *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) ss 16, 18.
- 7 *National Disability Insurance Scheme Act 2013* (Cth) s 9.
- 8 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 21(3); NDIS Quality and Safeguards Commission, 'Regulated restrictive practice guide', Version 1.1, Penrith, October 2020, p 4.
- 9 Exhibit 6-25, 'Statement of Graeme Head', 4 September 2020, at [74].
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- 11 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 6.
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- 18 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) ss 18–21.
- 19 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 24.
- 20 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 10(2)(a).
- 21 *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 14(1).
- 22 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 21.
- 23 NDIS Quality and Safeguards Commission, *Activity report: 1 July 2019 to 30 June 2020*, July 2020, p 5; NDIS Quality and Safeguards Commission, *Activity report: 1 July 2020 to 30 June 2021*, July 2021, p 5; NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, Report, February 2023, p 6; NDIS Quality and Safeguards Commission, *Activity report: 1 July to 31 December 2021*, January 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 January to 31 March 2022*, April 2022, pp 14–15; NDIS Quality and Safeguards Commission, *Activity report: 1 April to 30 June 2022*, July 2022, pp 7–8.
- 24 NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, Report, February 2023, p 6.
- 25 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-458 [46] – P-459 [4].
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12. Compliance and investigations

Key points

- The NDIS Quality and Safeguards Commission (NDIS Commission) has broad powers to monitor National Disability Insurance Scheme (NDIS) providers and address non-compliance.
- People with disability have expressed concerns the NDIS Commission does not actively 'monitor' the sector or engage with NDIS participants. The NDIS Commission's own data also indicates scope for increased monitoring, compliance and enforcement action.
- Where appropriate, the NDIS Commission should transition from its primary education and capacity building approach to compliance towards more active monitoring and enforcement.
- The NDIS Commission should increase site visits to, and face-to-face engagement with, people with disability and NDIS providers in the exercise of its compliance and enforcement powers. Holding providers accountable in this way will help to improve the safety of NDIS participants and lift the quality of services and supports.
- NDIS participants are more likely to raise concerns with the NDIS Commission if they have confidence that it can and will take appropriate action.

A core function of the NDIS Quality and Safeguards Commissioner (NDIS Commissioner) is ensuring National Disability Insurance Scheme (NDIS) providers comply with statutory requirements. The NDIS Commissioner has a range of compliance and enforcement powers under the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*).¹

During the life of the Royal Commission, we have observed that the NDIS Quality and Safeguards Commission (NDIS Commission) has taken an increasingly active approach to monitoring NDIS providers and exercising its compliance and enforcement powers. Nonetheless, people with disability and other stakeholders told us that the NDIS Commission:

- is not sufficiently active in identifying people with disability at heightened risk of violence, abuse, neglect and exploitation, or in monitoring and regulating NDIS providers
- is reluctant to use its compliance and enforcement powers, or take regulatory action against NDIS providers who are not meeting their obligations.

To deter non-compliance and encourage people with disability and others to complain about maltreatment, the NDIS Commission should more actively monitor NDIS providers. This should involve increased site visits and more face-to-face engagement with people with disability and NDIS providers.

The NDIS Commission needs to strike the right balance between educating and building the capacity of providers and the disability sector, and enforcing the law. At present the NDIS Commission's compliance and enforcement policy prioritises education of NDIS providers and workers as the primary approach to achieving ongoing compliance.² Education is appropriate to build compliance capacity when providers are faced with complex new laws and regulatory requirements, or in response to minor instances of non-compliance. Now that the NDIS Commission is in its fifth year of operating, we consider it is time for it to review its approach to compliance and enforcement. This should be done with a view to taking stronger compliance action in response to serious or repeat non-compliance, particularly if non-compliance has caused serious harm to an NDIS participant.

12.1. Compliance and enforcement activities

The NDIS Commission's compliance and enforcement policy is based on a philosophy of being 'proportionate, appropriate and responsive'. This means deploying the right tool for the right circumstance, being fair in when to deploy these tools and being responsive when needed.³ According to the NDIS Commission, its compliance activities have captured 'thousands of providers and initiated hundreds of actions'. This has occurred through 'show cause' notices, education and high-level compliance and enforcement outcomes in serious matters, such as issuing banning orders.⁴

The NDIS Commission's investigation and compliance role has steadily expanded, largely due to the growing number of reportable incidents and complaints it receives. During 2019–20, the first year the NDIS Commission publicly reported those metrics, it commenced 365 compliance matters and 168 investigations.⁵ During 2020–21, it commenced over 1,700 compliance matters and 291 investigations.⁶ In 2021–22, the NDIS Commission did not publicly report on the numbers of compliance matters and investigations commenced but reported that 1,901 compliance matters and 462 investigations were 'underway'.⁷

There are a number of methods available to the NDIS Commission to investigate matters and request or compel the production of information. It also has a range of monitoring and investigation powers under the *Regulatory Powers (Standard Provisions) Act 2014* (Cth) (*Regulatory Powers Act*). These include the ability to apply for and exercise monitoring warrants and investigation (search and seizure) warrants, and enter premises to exercise monitoring powers.⁸ The NDIS Commissioner's compliance and enforcement powers under the *NDIS Act* and the *Regulatory Powers Act* include:⁹

- education, persuasion and compliance support
- compliance notices
- enforceable undertakings
- infringement notices
- injunctions
- variation, suspension or revocation of registration

-
- banning orders
 - civil penalty proceedings.

Excluding variation, suspension or revocation of registration, these powers can be exercised in relation to registered as well as unregistered providers.¹⁰

When determining how to respond to non-compliance, the NDIS Commission considers a range of factors, such as:¹¹

- the impact of non-compliance on the person with disability and the broader community
- whether there is any immediate or ongoing risk to the well-being of the NDIS participant
- the seriousness of any non-compliance, and of the actual or potential harm or consequences
- how far below acceptable standards the conduct falls and the extent to which the provider contributed to the risk, including whether it was intentional, reckless, negligent or a mistake
- the potential to return the provider to full compliance as soon as possible.

Other considerations include whether the provider has a history of non-compliance and understands and has demonstrated a willingness to address the problem, and whether the non-compliance is serious or systemic.¹² The NDIS Commissioner must have regard to procedural fairness,¹³ and use best endeavours to:¹⁴

- provide opportunities for people with disability to participate in matters that relate to them and take into consideration their wishes and views
- conduct compliance and enforcement activities in a risk-responsive and proportionate manner
- support and maintain a diverse and sustainable NDIS market.

Compliance priorities

In 2021–22, the NDIS Commission's compliance and enforcement priorities were:¹⁵

- prevention of harm
- incident management and response
- unauthorised restrictive practices (URPs)
- safeguards for NDIS participants receiving assistance in their homes
- COVID-19 preparedness and response
- quality and safety in mealtime supports
- management of conflicts of interest.

The NDIS Commission aims to direct more effort into targeted campaigns to gradually reduce the need for high-intensity responses and regulatory activities. In its Corporate Plan 2022–23, the NDIS Commission noted an opportunity to take a more active regulatory approach to promoting the rights of people with disability.¹⁶ It also intends to work with NDIS providers and participants to create shared knowledge, resolve systemic issues and ultimately reduce incoming complaint volumes and the time taken to manage reportable incidents.¹⁷

Compliance activities

The NDIS Commission also reported that in 2020–21 it targeted registered NDIS providers who implemented URPs, demonstrated systemic non-compliance with reportable incident obligations, and delivered intensive support services (concerning compliance with COVID-19 vaccine mandate obligations).¹⁸

In 2021, the NDIS Commission established the National URP Taskforce to focus on participants subjected to the most URPs, specialist behaviour support providers that prepared the behaviour support plan for those participants, and registered NDIS providers using URPs.¹⁹ In February 2023, the NDIS Commission reported that it continues to focus its URP-related compliance activities on participants subject to the highest number of URPs, providers implementing URPs, behaviour support practitioners, and the NDIS workforce.²⁰

Another significant compliance focus of the NDIS Commission is on NDIS providers registered to deliver support for daily personal activities to participants who live alone. On 31 August 2020, the Honourable Mr Alan Robertson SC provided the NDIS Commissioner with the report on his independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith (*Robertson* report).²¹ Ms Smith lived alone in her own home and received services from an NDIS provider. She died on 6 April 2020, in what Mr Robertson described as ‘appalling’ circumstances, after being neglected for a substantial period.²² The *Robertson* report recommended that no vulnerable NDIS participant should have a sole carer providing services in their own home and that the relevant statutory instruments and guidelines should be amended accordingly.²³

In response to the *Robertson* report, the NDIS Commission imposed an additional condition of registration for providers registered to deliver support with daily personal activities to participants who live alone.²⁴ It also requested information from almost 2,500 providers, made further inquiries with almost 500,²⁵ and took compliance action in some cases.²⁶

Ms Tracy Mackey, the current NDIS Commissioner, gave evidence in Public hearing 26, ‘Homelessness, including experience in boarding houses, hostels and other arrangements,’ about a compliance strategy to address quality and safety issues in supported residential services (SRS) in Victoria. Ms Mackey said there is an overlap between SRS supports and NDIS-funded supports that potentially increases risks for participants residing in SRS.²⁷ The compliance strategy was informed by, among other things, the analysis of complaints and reportable incidents data.²⁸ It included expanded education and targeted site visits to SRS that were the subject of multiple complaints.²⁹

The NDIS Commission publishes information about compliance and enforcement outcomes involving NDIS providers and certain individuals in the NDIS Provider Register on its website.³⁰ Part 2 of the NDIS Provider Register, Compliance and Enforcement Actions includes the names of individuals and providers who are subject to a banning order, and any person who has been the subject of compliance action such as an enforceable undertaking, compliance notice or revocation of registration.³¹ Table 10.12.1 shows that warning letters and refusals of registration are the most frequent compliance and enforcement outcomes, followed by banning orders.³² By February 2023, the NDIS Commission had not concluded any enforceable undertakings with an NDIS provider or any other person.³³

Table 10.12.1: Compliance and enforcement outcomes

Compliance and enforcement outcome type	2019–20	2020–21	2021–22	Total in the three-year period
Banning order	17	22	34	73
Revocation of registration	3	3	2	8
Suspension of registration	4	7	6	17
Registration refusals	3	149	64	216
Infringement notices	1	19	9	29
Compliance notices	2	9	17	28
Warning letters	29	121	99	249
Civil penalty proceedings*	0	0	2	2

Note: 'Civil penalty proceedings' refers to an application made by the NDIS Commission to a court for an order that an NDIS provider or person pay a pecuniary penalty on the basis that they have contravened a civil penalty provision under the *NDIS Act*. Note, a third civil penalty proceeding was commenced in March 2023, outside of the three-year period referred to in this table.

Source: NDIS Quality and Safeguards Commission³⁴

Own motion inquiries

The NDIS Commission can initiate an 'own motion' inquiry about supports or services delivered by NDIS providers that were the subject of a complaint or a reportable incident, or a series of complaints or reportable incidents.³⁵

In its *Own Motion Inquiry into aspects of supported accommodation* Inquiry report, the NDIS Commission said it would initiate a compliance campaign in 2023 to eliminate psychological or emotional abuse of a person with disability, including verbal abuse.³⁶ Ms Mackey told us that the NDIS Commission is implementing an action plan that includes a compliance campaign targeted at Supported Independent Living providers.³⁷ The NDIS Commission is also considering a campaign targeting specialist disability accommodation providers and focusing on their obligations under the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) (*Practice Standards*), particularly in relation to tenancy management.³⁸

Civil penalty proceedings

The NDIS Commission has initiated civil penalty proceedings against three service providers following the deaths of NDIS participants:

- In December 2021, against the Australian Foundation for Disability (Afford) in relation to the death of Ms Merna Aprem.³⁹
- In March 2022, against Integrity Care (SA) Ltd in relation to the death of Ms Ann-Marie Smith.⁴⁰ The proceedings have been stayed pending criminal proceedings that were subsequently initiated.⁴¹
- In March 2023, against LiveBetter Services Limited in relation to the death of Ms Kyah Lucas.⁴²

12.2. Views about the NDIS Commission's approach to monitoring and compliance

Monitoring activities

In Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', we heard about the reports of the South Australian Safeguarding Task Force (Task Force) published in 2020. The Task Force was established following the death of Ms Ann-Marie Smith in April 2020. It found the NDIS Commission does not routinely inspect premises to monitor the performance of NDIS providers.⁴³ The Task Force observed that 'The [NDIS] Commission needs to reach out to these potentially vulnerable participants and not assume that the participant will know how to find the Commission when needed.'⁴⁴

Public hearing 14 also considered the findings and recommendations of Mr Robertson's independent review of the adequacy of the NDIS Commission's regulation of the supports and services provided to Ms Smith. The *Robertson* report found that the NDIS Commission could not have identified concerns about Ms Smith's safety in the absence of any complaint or reportable incident being reported, and without a proactive system of identifying and visiting vulnerable participants.⁴⁵ It said the NDIS Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect.⁴⁶ It said:

Because of the inherent limitations in record-based systems in preventing harm or the risk of harm to vulnerable participants, the [NDIS] Commission should conduct occasional visits to assess the safety and wellbeing of selected individual NDIS participants, whether or not a complaint has been made or a “reportable incident” notified. The [NDIS] Commission should miss no opportunity for face-to-face assessment of vulnerable participants.⁴⁷

Mr Graeme Head AO, the then NDIS Commissioner, gave evidence at Public hearing 14 about site visits recorded by the NDIS Commission in South Australia. He told us that most site visits conducted by its compliance function have been to providers and some to participants.⁴⁸ Mr Head told us site visits can involve interaction with providers’ key personnel, workers, participants and family members or guardians. He acknowledged that site visits can be particularly valuable when the provider is large and supports many participants, allowing the NDIS Commission to address a number of issues in one visit.⁴⁹

At Public hearing 32, ‘Service providers revisited’, Ms Mackey acknowledged that the NDIS Commission’s ability to monitor the sector is not as strong as in ‘other regulatory systems’.⁵⁰ Ms Mackey stated that the NDIS Commission does not systematically collect data about the number of site visits it conducts.⁵¹ Counsel Assisting the Royal Commission submitted:

the NDIS Commission’s reliance on reportable incident notifications and complaints has demanded a significant proportion of its resources to be focused on a reactive, rather than proactive, approach to monitoring compliance issues. This is particularly concerning where the NDIS Commission’s systems and processes are not capable of dealing with the volume of complaints it receives.⁵²

In response, the Australian Government noted that the NDIS Commission is ‘undertaking work to develop a monitoring program’.⁵³ It said the NDIS Review ‘may consider issues relating to community visiting, site visits and monitoring programs’.⁵⁴

Many respondents to our issues papers said the NDIS Commission should play a more active role in monitoring NDIS providers and enforcing compliance with the *Practice Standards* and *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth).

For example, the Queensland Office of the Public Guardian (OPG) argued that proactive monitoring is particularly important for people with impaired decision-making capacity who may not understand their entitlements or know what to do if a service provider fails to meet its obligations. The OPG proposed the NDIS Commission should undertake more intensive monitoring activities, including unannounced visits and on-the-ground performance checks for all registered NDIS providers.⁵⁵

Queenslanders with Disability Network told us that many of its members lack confidence in the NDIS Commission’s ability to safeguard participants, particularly given it does not regularly undertake inspections to monitor the performance and quality of NDIS providers.⁵⁶ Advocacy for Inclusion criticised the NDIS Commission for not effectively monitoring closed institutional settings.⁵⁷ People with Disability Australia said the NDIS Commission should have enhanced resources and powers to undertake spot checks.⁵⁸

The Joint Standing Committee on the NDIS (Joint Standing Committee) also identified a clear consensus among stakeholders that the NDIS Commission should take a more active approach to engagement with participants and to compliance and enforcement.⁵⁹ The Joint Standing Committee noted that the NDIS Commission is perceived as relying heavily on complaints and reportable incidents to initiate investigations and compliance processes, rather than actively monitoring the quality and safety of services and supports.⁶⁰

The Joint Standing Committee said the NDIS Commission should be adequately funded to carry out and support proactive monitoring and enforcement.⁶¹ It recommended the NDIS Commission review its compliance and enforcement model to determine how to take a more active approach, particularly through regular, face-to-face contact with ‘vulnerable participants and visits to NDIS providers’ sites’.⁶²

In its response to the Joint Standing Committee, the Australian Government stated that for most of the period since the NDIS Commission’s role commenced, its ability to engage in face-to-face contact with participants has been limited by the COVID-19 pandemic. It said that staff undertake ‘a range of activities which involve face-to-face contact with people with disability and visits to locations where supports and services are delivered’. It also said ‘opportunities for enhanced monitoring and site visits are being incorporated in the exercise of the Commission’s current legislative responsibilities’.⁶³ The response also noted that the NDIS Commission and the National Disability Insurance Agency have worked together to enhance face-to-face contact with participants and that it is consulting on a policy position to identify and respond to risks to NDIS participants. The NDIS Review would be an opportunity to look more broadly at ‘improved outreach and proactive engagement with at-risk participants’ as well as the role of community visitor schemes.⁶⁴

Compliance activities

Case study: Afford

Mr Daniel Nuumaalii was arrested in May 2020 and charged with a number of offences involving the abuse of people with disability at a day program run by Afford.⁶⁵ The NDIS Commission received eight notifications from Afford between April and September 2020 about Mr Nuumaalii’s abuse of seven NDIS participants.⁶⁶

Shortly after receiving a reportable incident notification from Afford on 1 May 2020, the NDIS Commission proposed issuing a banning order to Mr Nuumaalii.⁶⁷ The order would have permanently prohibited Mr Nuumaalii from being involved in the provision of supports and services to people with disability.⁶⁸ The banning order did not proceed after Afford terminated Mr Nuumaalii’s employment in early May 2020.⁶⁹ This was because the *NDIS Act* at the time only allowed the NDIS Commissioner to make a banning order against a person employed or otherwise engaged by an NDIS provider.⁷⁰

The *NDIS Act* was amended in November 2021 so that a banning order can be made against a 'person *who is or was* employed or otherwise engaged by an NDIS provider'.⁷¹ Despite this, at the time of Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', in early May 2022, the NDIS Commission had not issued Mr Nuumaalii with a banning order and advised us that the matter was still under consideration.⁷²

The NDIS Commissioner eventually made a banning order against Mr Nuumaalii in September 2022.⁷³

The Australian Government submitted that the Royal Commission should not make an adverse finding about the delay in issuing the banning order against Mr Nuumaalii. It argued that the NDIS Commission was not obliged to issue a banning order and that mechanisms were in place to prevent Mr Nuumaalii from gaining further employment in the disability sector, including worker screening and criminal record checks.⁷⁴

We acknowledge that Mr Nuumaalii's criminal record would likely prevent him from becoming employed or engaged by a registered NDIS provider in future.

More broadly, it is important to note that unregistered providers and their employees are not required to undergo worker screening checks. Mr Nuumaalii would not necessarily be prevented from obtaining employment with an unregistered provider or operating as an unregistered independent contractor or 'self-employed' support worker providing supports, either directly or indirectly, to people with disability. A banning order is the only enforcement measure available to the NDIS Commission that would prohibit Mr Nuumaalii from providing supports or services to any NDIS participant, regardless of the type of supports and services he provided or his registration status.

We consider banning orders, which are public and attract civil penalties for breaches, to be a very strong and effective safeguard that the NDIS Commission should be willing to impose when appropriate.⁷⁵

Public hearing 26 heard evidence about the NDIS Commission's Supported Residential Services Strategy (SRS Strategy) to address concerns about SRS residents who are NDIS participants. These concerns include residents being at risk of financial exploitation and coercion and limited in their choice of other providers. Other concerns are poor or non-existent record keeping by SRS operators, and significant conflicts of interest between SRS operators and other providers involved in supporting residents.⁷⁶ The SRS Strategy is intended to provide a 'plan for an ongoing proactive compliance approach to SRS'.⁷⁷

In response to an assertion that the SRS Strategy appears to be directed towards 'building capacity' in the SRS sector, and improving services rather than imposing sanctions or suspending or cancelling registrations, Ms Mackey said the NDIS Commission always tries to improve quality.⁷⁸ She acknowledged the SRS Strategy does not set any targets, saying, 'Until we do some of this work, we won't have a good sense of what type of compliance action we might take.'⁷⁹

In Public hearing 6, ‘Psychotropic medication, behaviour support and behaviours of concern’, we heard of a perceived lack of enforcement relating to non-compliance by behaviour support practitioners. We were told the NDIS Commission does not have the resources to assess the quality of positive behaviour support plans lodged with it and that these plans are not routinely reviewed.⁸⁰ The Commissioners’ *Report of Public hearing 6* found the NDIS Commission has not taken sufficient action to enforce compliance with the behaviour support rules by behaviour support practitioners (or compliance with appropriate use of chemical restraint by NDIS providers).⁸¹ As detailed above, the NDIS Commission continues to focus its compliance activities on the use of URPs.

Stakeholders who responded to our issues papers also expressed concern about a perceived reluctance by the NDIS Commission to hold providers accountable for non-compliance.⁸² People with Disabilities Western Australia told us people with disability want the NDIS Commission to hold providers accountable for not delivering value for money and tangible outcomes.⁸³ People with Disability Australia said there is an urgent need to strengthen the accountability of providers operating group homes.⁸⁴

12.3. Strengthening monitoring and compliance

The evidence and information before the Royal Commission indicates wide support for the NDIS Commission to adopt a more active approach to monitoring, and a stronger approach to compliance and enforcement.

Increased monitoring

As part of its monitoring function, the NDIS Commission should engage more regularly with participants who are at greater risk of experiencing violence, abuse, neglect and exploitation, such as those who do not have support networks or who receive NDIS supports in segregated settings. It should incorporate face-to-face interaction with NDIS participants, providers and workers into its regular compliance and monitoring activities wherever possible. The frequency of site visits to locations where NDIS supports and services are provided should be increased. Targeted campaigns and compliance checks in relation to providers of concern should be prioritised. These actions will encourage the use of the NDIS Commission’s investigative powers.⁸⁵

Increased announced and unannounced site visits, regular compliance checks and direct (in-person) engagement with NDIS participants, workers and NDIS providers will be critical to increasing the NDIS Commission’s visibility within the sector.

In Volume 11, *Independent oversight and complaint mechanisms*, we recommend that the Australian Government and states and territories work together to implement nationally consistent community visitor schemes.

Compliance and enforcement

The NDIS Commission has undertaken a range of compliance and enforcement activities since its inception. These activities have increased as its operations commenced across jurisdictions and as its capacity and resourcing have developed.

However, the information set out above about the NDIS Commission's approach to monitoring and compliance, together with the data provided in Table 10.12.1, indicate there is scope for the NDIS Commission to increase its use of compliance and enforcement actions.

At Public hearing 32, Ms Mackey acknowledged that enforceable undertakings have not been used by the NDIS Commission,⁸⁶ but said it was considering using them. Ms Mackey stated:

It is certainly my experience in previous regulator roles that they can be incredibly effective, including making sure that there is the right arrangements around reflecting the impact that has occurred, as well as preparing for future arrangements of the same ilk. So, we are currently working in that space as well.⁸⁷

The *NDIS Act* empowers the NDIS Commissioner to accept a written undertaking committing a person to:⁸⁸

- particular action (or inaction) in order to prevent, or respond to, a contravention or alleged contravention of the *NDIS Act*
- pay another person an amount worked out in accordance with the undertaking, in order to provide compensation for loss or damage suffered as a result of a contravention or alleged contravention.

The undertaking may be enforced in a court.⁸⁹

An enforceable undertaking may include:⁹⁰

- an acknowledgement by the person that a contravention has occurred
- an agreement specifying how the person will address the relevant contravention, such as a commitment to cease the conduct and not to recommence the conduct
- a period within which compliance with undertakings will be met
- a commitment by the person to future compliance measures (for example, regular reporting to the NDIS Commissioner, training for providers or regular internal audits)
- an acknowledgement that the undertaking may, in whole or in part, be published on the NDIS Commission's website.

Another compliance tool available to the NDIS Commission is compliance notices. A compliance notice is a written direction given to an NDIS provider by the NDIS Commissioner. A compliance notice requires the provider to take certain action, or not take action, within a reasonable timeframe to address one or more issues of identified or possible non-compliance with the *NDIS*

Act. It may also require the NDIS provider to produce evidence that it has taken, or refrained from taking, the specified action.⁹¹

The NDIS Commissioner can give a compliance notice to a provider if:⁹²

- they are satisfied the provider is not complying with the *NDIS Act*
- they are aware of information that suggests the provider may not be complying with the *NDIS Act*.

A civil penalty applies if a provider fails to comply with a compliance notice.⁹³

In our view, the NDIS Commission should review its position on the use of enforceable undertakings and compliance notices, and in doing so consider using these tools to require NDIS providers to take actions such as:

- engaging independent and suitably qualified experts to review, audit or carry out compliance-related work
- providing key personnel, governing body members, managers and support workers with specific forms of training
- providing forms of redress such as apologies, assistance, advice or compensation to people with disability who experience violence, abuse, neglect or exploitation through the provision of NDIS services.

Recommendation 10.25 Strengthened monitoring, compliance and enforcement

The NDIS Quality and Safeguards Commission should review its compliance and enforcement policy and in doing so have regard to:

- a. where appropriate, transitioning its primary compliance approach from educational and capacity building strategies to stronger compliance and enforcement activities
- b. increasing its face-to-face engagement with National Disability Insurance Scheme (NDIS) participants who are at greater risk of experiencing violence, abuse, neglect and exploitation, and site visits to speak with providers and workers
- c. increasing the use of its enforcement powers and monitoring tools in relation to NDIS providers that:
 - have a history of non-compliance or repeatedly fail to meet their obligations to provide safe and quality supports and services
 - have demonstrated a disregard for the safety of people with disability
 - have caused serious harm to a person or people with disability
- d. the availability of enforceable undertakings and compliance notices to address non-compliance by NDIS providers.

Endnotes

- 1 *National Disability Insurance Scheme Act 2013* (Cth).
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- 3 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-227 [26–43].
- 4 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-228 [13–18].
- 5 NDIS Quality and Safeguards Commission, *Annual report 2019–2020*, October 2020, p 31; Note: ‘Investigation’ is the process of seeking information about alleged or potential non-compliance and is carried out by the NDIS Commission’s investigations team. A ‘compliance matter’ is an assessment by the compliance team – it may involve an appropriate regulatory response to non-compliance and emerging issues.
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- 7 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 47.
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- 9 Exhibit 4-32, ‘Statement of Graeme Head AO’, 11 February 2020, at [52].
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- 22 Exhibit 14-216, DRC.2000.0008.0673, p 4.
- 23 Exhibit 14-216, DRC.2000.0008.0673, p 69.
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- 26 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [125(c)–(e)]; NDIS Quality and Safeguards Commission, ‘Additional condition of registration (Registration group 0107)’, January 2021.
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- 28 Exhibit 26-099, CTD.7200.0038.0002, p 8.
- 29 Exhibit 26-099, CTD.7200.0038.0002, p 9.
- 30 *National Disability Insurance Scheme Act 2013* (Cth) s 73ZS.
- 31 ‘NDIS provider register and compliance and enforcement actions’, *NDIS Quality and Safeguards Commission*, web page, last updated 12 October 2022. <ndiscommission.gov.au/about/compliance-and-enforcement/ndis-provider-register-and-compliance-and-enforcement-actions>
- 32 *National Disability Insurance Scheme Act 2013* (Cth) s 73ZN.
- 33 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-456 [1–3].
- 34 NDIS Quality and Safeguards Commission, *Activity report: 1 July 2019 to 30 June 2020*, July 2020, p 8; NDIS Quality and Safeguards Commission, *Activity report: 1 July 2020 to 30 June 2021*, July 2021, p 8; NDIS Quality and Safeguards Commission, *Activity report: 1 April 2022 to 30 June 2022*, July 2022, p 9; NDIS Quality and Safeguards Commission, *Annual report 2019–2020*, October 2020, p 31.
- 35 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 27; *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) s 29.

- 36 NDIS Quality and Safeguards Commission, *Own Motion Inquiry into aspects of supported accommodation*, Final inquiry report, January 2023, p 68.
- 37 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-446 [4–21]. Ms Mackey also told us Public hearing 32 that she and other staff of the NDIS Commission conducted a ‘place based’ compliance campaign in Cairns, Queensland. This was triggered by the relatively low number of complaints made to the NDIS Commission from the region. The campaign involved visiting local providers to remind them of their obligations, and engaging with participants, their families and carers to explain people’s rights and the role of the NDIS Commission. Ms Mackey said the campaign is being evaluated but that she anticipates the NDIS Commission will continue to develop place-based campaigns: Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [86–87].
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- 43 Exhibit 14-217, SAG.0002.0023.0114, p 22, Safeguarding Gap 6.
- 44 Exhibit 14-217, SAG.0002.0023.0114, p 13.
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- 47 Exhibit 14-216, DRC.2000.0008.0673, pp 7–8, Recommendation 5.
- 48 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [217(d)].
- 49 Exhibit 14-183, ‘Statement of Graeme Head AO’, 14 May 2021, at [218].
- 50 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, P-456 [32–34].
- 51 Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [101].
- 52 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 258 [981]; Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2023, at [97].
- 53 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 22 [75].
- 54 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 32, 28 April 2023, SUBM.0056.0003.0005, p 22 [77].
- 55 Queensland Office of the Public Guardian, Submission in response to *Safeguards and quality issues paper*, 19 March 2021, ISS.001.00589, p 10.
- 56 Queenslanders with Disability Network, Submission in response to *Safeguards and quality issues paper*, 9 March 2021, ISS.001.00582, p 4.
- 57 Advocacy for Inclusion, Submission in response to *Safeguards and quality issues paper*, 23 December 2020, ISS.001.00513, pp 4, 6.
- 58 People with Disability Australia, *Submission in response to Group homes issues paper*, 12 June 2019, ISS.001.00217, p 32.

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60 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 68.

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62 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 80, recommendation 5.

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66 Exhibit 23-070, ‘Statement of Samantha Taylor’, 22 April 2022, at [120].

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83 People with Disabilities (WA), Submission in response to *Safeguards and quality issues paper*, 3 February 2021, ISS.001.00538, p 24.

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13. Data and intelligence

Key points

- The Australian Government has obligations under the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*), the *Convention on the Rights of Persons with Disabilities* and Australia's Disability Strategy 2021–2031 to collect, analyse and share data about people with disability.
- The NDIS Quality and Safeguards Commission (NDIS Commission) is in a unique position to contribute to meeting these obligations, but has not fully realised its intelligence capability.
- The shortfalls in the NDIS Commission's information, communications and technology capacity, combined with restrictions on information sharing imposed by the *NDIS Act*, affect the quality of the NDIS Commission's intelligence holdings and its ability to share and receive information with other agencies.
- NDIS providers have called for the NDIS Commission to regularly share data relating to trends and systemic issues to improve the quality and safety of services and supports across the disability sector.
- The NDIS Commission should publish additional information about its activities and related outcomes to strengthen public confidence in the value of its oversight and regulatory role.

In this chapter we discuss the value of the data that the NDIS Quality and Safeguards Commission (NDIS Commission) receives and identify shortfalls in its current capacity to collect, analyse and use data to inform its operational decisions. We examine the adequacy of arrangements between the NDIS Commission and other oversight bodies and mechanisms such as community visitor schemes to share information and promote the safety of people with disability, who may be at greater risk of violence, abuse, neglect and exploitation.

13.1. Why better data is needed

In our *Interim report*, we noted that the call for better data is not new.¹ Article 31 of the *Convention on the Rights of Persons with Disabilities* (CRPD) requires Australia to collect appropriate information, including statistical and research data, to formulate and implement policies that give effect to the CRPD.² It also requires the information to be disaggregated, as appropriate, and used to help identify and address the barriers faced by persons with disabilities in exercising their rights.³ Under the CRPD, Australia is responsible for disseminating these statistics and ensuring it is accessible to people with disability and others.⁴

Data helps the public hold governments and organisations to account, track progress on important action plans such as Australia's Disability Strategy 2021–2031, and assess whether Australia is meeting its responsibilities under the *CRPD*.⁵ Without sufficient data, it is not possible to understand the effect of a program on a specific group, such as First Nations people with disability, women, young people, culturally and linguistically diverse communities, and LGBTIQ+ communities.⁶

In February 2023, over 570,000 Australians were National Disability Insurance Scheme (NDIS) participants.⁷ This figure is projected to exceed one million by June 2032.⁸ The NDIS Commission has an important role in ensuring Australia complies with its obligations under the *CRPD*. The NDIS Commission also has a responsibility to collect, analyse and disseminate data in relation to its reportable incident, complaint and behaviour support functions under the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*).⁹ It is in a unique position to collect and report on safeguarding data of value to people with disability, disability service providers, researchers and governments.

13.2. What's published and what's missing

In Volume 4, *Realising the human rights of people with disability*, we highlight that data collection plays an important role in realising human rights. Volume 4 also notes concerns raised by the Committee on the Rights of Persons with Disabilities, which monitors the implementation of the *CRPD*, in relation to the lack of nationally consistent measures for the collection of data on the full range of obligations contained in the *CRPD*.¹⁰

The NDIS Commission publicly reports on its activities in annual reports and quarterly activity reports.¹¹ While it provides a general overview of the number and broad categories of matters it deals with, generally speaking it does not publish disaggregated data and information about its operations, nor does it routinely provide an analysis of data to inform the disability sector about trends and systemic issues.

The Australian Government has acknowledged 'the importance of data collection in driving action and enhancing accountability to ultimately improve outcomes for all people with disability'.¹² The NDIS Commission has acknowledged there are significant gaps in the data it collects and shortfalls in its overall data analytics capability.

Publishing more refined quarterly and annual data sourced through its operations will help inform NDIS providers about deficiencies in safeguarding practices and service delivery.

Disaggregated data about complaints and reportable incidents

The launch of the NDIS Commission in all states and territories was completed on 1 December 2020. It established, for the first time, national oversight and consistent arrangements for making complaints about NDIS providers and workers. This facilitates the reporting of serious incidents, including abuse and deaths of people with disability that occur in connection with the provision of NDIS services.¹³

The Victorian Disability Services Commissioner (VDSC) told us the establishment of the NDIS Commission provided a critical opportunity to implement nationally consistent measures for collecting and integrating disaggregated data about violence, abuse, neglect and exploitation within NDIS funded services. The VDSC recommended the Australian Government develop such measures for collecting government data, broken down into groups such as First Nations people, women and girls, older people and non-NDIS participants, to ensure ongoing policy and system improvements.¹⁴

Peak industry body, National Disability Services (NDS), told us the NDIS Commission's annual reports 'primarily focus on activity it has undertaken and statistics regarding complaints and reportable incidents, with little further interpretation'.¹⁵ NDS said highlighting key themes and issues would set benchmarks for its members to understand their level of competency in respect of other organisations and provide greater transparency about the NDIS Commission's priorities.¹⁶

The Commonwealth Ombudsman told us 'a complaint handling system is most effective when complaints data is collected, analysed and reported on as a means to address systemic issues, as well as inform policy settings'.¹⁷

The Joint Standing Committee on the NDIS (Joint Standing Committee) heard that the NDIS Commission should play a greater role in facilitating data collection and reporting about safeguarding issues, as well as improving data collection and access to data about its activities.¹⁸ The First Peoples Disability Network and Family Advocacy told the Joint Standing Committee that complaints and reportable incident data is ambiguous and not disaggregated by matters affecting First Nations peoples with disability.¹⁹

In its report, the Joint Standing Committee said it:

further encourages the NDIS Commission to actively work with the disability sector and other agencies to explore the ways in which the Commission can support increased data collection and reporting to improve understanding of quality and safeguarding issues for people with disability.²⁰

What data the NDIS Commission publishes

Currently, the NDIS Commission publishes a range of data that reflects the types of the complaints and reportable incident notifications it receives. For example, in its quarterly activity report for 1 October 2022 to 31 December 2022 it included:²¹

- the total number of complaints and reportable incidents received
- who made the complaint
- the complaint type or reportable incident type (such as alleged abuse and neglect or the death of a person with disability)
- reportable incidents on the use of unauthorised restrictive practices (URP), their frequency and restraint type (such as chemical or environmental).

The NDIS Commission's reporting on its behaviour support function and the use of URP has been significantly enhanced over time. In early 2022 and 2023, the NDIS Commission published a comprehensive analysis about the reported use of URP within the NDIS for 2021–21 and 2021–22, respectively.²²

What data is missing?

Disaggregated data

The NDIS Commission does not publish disaggregated data about people with disability affected by violence, abuse, neglect or exploitation. This means demographic data about people with disability involved in complaints or incidents is not published. Data that is currently missing includes type of impairment, age, gender, First Nations people, people from culturally and linguistically diverse backgrounds, members of LGBTIQ+ communities and women and children.

Nor does the data provide insights into the environments in which abuse is occurring, the types of abuse and neglect most frequently reported or the outcomes of any investigations into allegations.

Data collected by the NDIS Commission on 'reportable incidents' includes incidents (and alleged incidents) of abuse or neglect of people with disability.²³ The *NDIS Act* and the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) (*Incident Management Rules*) do not provide any additional sub-categories of reportable incident types.²⁴ The published data does not identify different types of abuse and neglect such as verbal abuse, physical abuse, sexual abuse, emotional abuse or financial exploitation.

Similar limitations exist in relation to complaints data, which is not broken down into sub-categories of maltreatment, beyond the category of 'alleged abuse and neglect'.²⁵

In our view, the NDIS Commission does not publish any data about complaints it receives involving unregistered providers, including breaches of quality and safety issues it identified through its oversight of these matters.

Reportable incident investigation outcome data

The NDIS Commission regularly reports on 'front-end' data, such as the volume and types of reportable incidents received, however, 'back-end' data about outcomes is less transparent. Reporting information about the outcomes and actions taken on reportable incidents that are overseen by the NDIS Commission would give a fuller picture of the disability sector's overall approach to responding to incidents of abuse and related sector trends.

The value of collecting and publishing data about the outcomes of provider investigations is illustrated by the approach used by the New South Wales Office of the Children's Guardian (OCG) under the child-related reportable conduct scheme.

Reportable conduct investigation outcomes published by the OCG

The OCG administers the reportable conduct scheme in New South Wales. The reportable conduct scheme oversees investigations, inquiries and responses to reportable conduct matters by entities delivering services to children such as non-government schools, early childhood services and out-of-home care providers.²⁶ The scheme covers conduct relating to the abuse and neglect of children by employees of these entities.²⁷

The OCG publishes a range of data. Its most recent annual report included a comprehensive analysis of identified trends, including:²⁸

- primary allegation rates and type broken down by industry group
- notable trends in notification rates and type
- gender breakdown for subjects of allegation against primary allegation type
- patterns relating to method of disclosure (such as alleged victim disclosed to staff member, parent or teacher)
- demographic data of alleged victims against notifications, including age, gender, whether they identify as Aboriginal or have a disability
- time taken by agencies to investigate allegations.

The legislative framework guiding the reportable conduct scheme in New South Wales has some important differences to the NDIS Commission's reportable incident function. For example, under the reportable conduct scheme, entities are required to investigate any 'reportable allegations'²⁹ and prepare a report for the Children's Guardian once the investigation is completed.³⁰ The report must make findings about the reportable allegation and provide reasons for those findings.³¹ The entity is required to provide a copy of its investigation report and notify the findings to the OCG.³²

Under the *Incident Management Rules*, a registered NDIS provider must assess the incident in relation to whether it could have been prevented and how well it was managed and resolved.³³

The NDIS Commission could capture the outcomes of matters investigated by a provider. The NDIS Rules currently do not require providers to report the outcomes of their investigations of reportable incidents if the NDIS Quality and Safeguards Commissioner (NDIS Commissioner) has not required them to do so.³⁴ However, providers should report the outcomes of primary investigations to the NDIS Commission.

The reporting requirements in the *Incident Management Rules* should be amended to enable provider investigation outcome data to be collected on a routine basis from NDIS providers. The NDIS Commissioner should ensure that any amendments are supported by administrative changes to the provider portal.

Health and mortality data

In Public hearing 4, ‘Health care and services for people with cognitive disability’, we heard evidence about the role the NDIS Commission could play in collecting mortality data about people with disability, including causes of death and gaps in the health and disability sectors. Mr Jim Simpson from the Council for Intellectual Disability said the NDIS Commission has ‘the capacity to review whether failures in disability support contributed to deaths’.³⁵

Professor Julian Trollor, Chair of Intellectual Disability Mental Health at the University of New South Wales, also said the NDIS Commission has an opportunity to develop Australia’s first national arrangement for reporting deaths of people with disability.³⁶ Professor Trollor added that a national platform is needed to track mortality data for people with disability, not only for NDIS participants, but also for people with disability who do not qualify for NDIS services.³⁷

We examine the broader operation of disability death review schemes in Volume 11, *Independent oversight and complaint mechanisms*, and their potential interaction with the reportable incident function. We make recommendations to enhance the collection and reporting requirements of disability mortality data.

In Public hearing 4, then NDIS Commissioner, Mr Graeme Head AO, referred to two pieces of research relevant to this, namely:

- a scoping review of causes and contributors to deaths of people with disability in Australia (Scoping Review)³⁸
- a report by the Australian Institute of Health and Welfare (AIHW) on mortality patterns among people using disability support services between 1 July 2013 and June 2018 (AIHW report).³⁹

The Scoping Review and the AIHW report each identified gaps and inconsistencies in how statistics on mortality are captured across jurisdictions.⁴⁰ The Scoping Review researchers recommended the NDIS Commission develop data collection and coding to enable cause of death (underlying, contributing and direct) to be captured along with risk identification factors such as age, gender, Indigenous status and health conditions.⁴¹ In response, the NDIS Commission reported that the Scoping Review and AIHW report would be used to establish a national baseline against which it can review the data it collects on the deaths of NDIS participants.⁴²

While the AIHW and Australian Bureau of Statistics maintain national datasets on people with disability, well-defined disaggregated data is not routinely collected, reported and shared by the NDIS Commission and other relevant state and territory bodies. This limits the ability to develop a robust data framework or identify risk factors. Without such data, identifying areas for legislative or policy change is difficult.

Restrictive practices

The Commissioners’ *Report of Public hearing 6* found that the NDIS Commission did not systematically collect data on complaints it receives about the provision of positive behaviour support and the use of chemical restraints.⁴³

In Public hearing 32, 'Service providers revisited', NDIS Commissioner Ms Tracy Mackey explained that the NDIS Commission does not categorise complaints in a manner that enables it to identify concerns raised about the use of chemical restraint or regulated restrictive practices generally.⁴⁴

The Commissioners' *Report of Public hearing 6* also found that Australia does not collect reliable national data on the extent to which psychotropic drugs are prescribed for people with cognitive disability, or the purposes for prescription, such as treatment of a diagnosed condition or responding to behaviours of concern.⁴⁵ The NDIS Commission's oversight of the use of chemical restraint on NDIS participants means there is potential to collect this important data.⁴⁶

Finally, the NDIS Commission does not publish data reported by providers about the use of regulated restricted practices authorised under a positive behaviour support plan. It is a condition of registration that a provider who uses regulated restrictive practices on an NDIS participant (an 'implementing provider') must report monthly to the NDIS Commission.⁴⁷ NDIS Senior Practitioner, Dr Jeffrey Chan, told us the NDIS Commission's Data Analytics team has developed a Behaviour Support Team Business Intelligence Tool, which analyses data reported by implementing providers and responds to identified risk factors.⁴⁸ However, the NDIS Commission does not publish this data or any analysis of trends or patterns, either quarterly or annually.

The NDIS Commission should collect, analyse and publish the additional data outlined in Table 10.13.1 in its quarterly activity and annual reports.

Table 10.13.1: Additional disaggregated and trend data

Area	Data
Disaggregated data	For complaints and reportable incidents involving violence, abuse, neglect and exploitation, additional data should include: • demographic data about the affected person with disability • sub-categories of reportable incidents and the type of abuse, neglect or exploitation where relevant; for example, physical abuse, psychological or emotional abuse or financial abuse • location where the incident occurred, including the suburb and state or territory • setting in which the incident or concern arose, such as private residence, supported independent living environment or day program • the class of support provided at the time of the incident or complaint • whether harm was caused to the person with disability, and its nature, such as physical injury, death or psychological harm • the provider's registration status • if the conduct was substantiated by the NDIS provider • police involvement or criminal proceedings • the role of any individual who is the subject of allegations, such as a support worker or allied health professional, and whether the individual had a valid worker screening clearance at the time.

Area	Data
Reportable incident investigation outcome data	• whether the NDIS provider has investigated and substantiated that the conduct occurred⁴⁹ • any remedial action taken by the provider, such as termination of a support worker's employment, changes to procedure or policy or offers of redress • whether there has been police involvement or criminal proceedings instituted as a consequence of the investigation • the outcome of a provider's assessment as to whether an incident was viewed as 'preventable'.
Health and mortality data	• the direct, underlying and (where relevant) associated causes of death • medication, preventative health care, general health and decision-making data.
Restrictive practices	For both unauthorised and regulated restrictive practices: • the number of restrictive practices reported, including a breakdown of both the unauthorised and regulated restrictive practices • the type of restrictive practice used, such as seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint, and the sub-types of restrictive practices⁵⁰ • for reportable incidents and complaints involving the unauthorised use of chemical restraints and reported use of regulated chemical restraints, medication data should be collected, including the class of medication and whether the prescription is for the treatment of a diagnosed condition or a response to behaviours of concern.

Operational performance data

Measuring performance

Currently, the NDIS Commission reports more information about its performance than in previous years, including planned compliance activities, projects and organisational priorities.⁵¹ However, it has not published consistent and measurable performance data to enable a full assessment of year-on-year progress.⁵²

The NDIS Commission's Corporate Plan for 2022–23 for the first time adopts quantitative measures in three impact areas.⁵³ Progress will be reported in the Annual Performance Statements which will be published in the NDIS Commission's annual reports.⁵⁴ Ms Mackey said the new performance measures 'have been developed and adopted on the basis that they represent what the NDIS Commission should achieve' and do not take into account the effects of limited funding and system issues on performance.⁵⁵ The plan sets more robust qualitative and quantitative targets to measure performance.

The NDIS Commission's *Annual report 2021–22* contained performance data on complaints, including the percentage of complaints closed within 90 days and the percentage made by people with disability. It also included the percentage of reportable incidents reported by a registered provider within statutory timeframes.⁵⁶ The report included data on the number of compliance or enforcement actions taken by outcome type (for example banning order, and/or compliance notice)⁵⁷ and the number of compliance and enforcement actions taken in relation to its compliance priorities.⁵⁸

What's missing?

While the NDIS Commission reports useful data about some of its activities, we consider it should have a stronger focus on publicly reporting compliance and enforcement outcomes. This should include data on breaches, systemic issues and outcomes of complaints and reportable incidents, to better inform the public and deter non-compliance.

A number of NDIS providers said 'benchmark' data, such as data about reportable incidents and complaints and the issues raised by them, assists providers to reflect on practice and potential quality issues. For example, at Public hearing 32, 'Service providers revisited', the Endeavour Foundation said benchmarking data was one example of a resource the NDIS Commission could provide organisations with, to better understand their performance and improve the prevention, detection and response to abuse and neglect.⁵⁹ Hireup told us there is an absence of both qualitative and quantitative assessments of unregistered service providers, which is crucial to monitoring the implementation of the NDIS.⁶⁰ The Northcott Society said while the NDIS Commission understandably has a strong focus on compliance obligations, smaller providers would welcome a sample of 'best practice case studies' to assist with responses and early detection of abuse and neglect.⁶¹

Organisations responding to our *Safeguards and quality issues paper* raised concerns about the transparency of the NDIS Commission's operations. For example, the Northern Territory Office of the Public Guardian told us the NDIS Commission should publish jurisdiction-specific data on its activities, including the number, type and outcome of investigations.⁶²

NDS said the NDIS Commission should analyse and publish data including audit findings.⁶³ It suggested the NDIS Commission should release information about the specific breaches it identified, any actions taken and any penalties applied. NDS also said publishing this information could act as a general deterrent to other disability service providers, and may also help them understand how the regulator expects disability services to be delivered.⁶⁴

The Joint Standing Committee recommended the NDIS Commission review its approach to publishing information about compliance activities to ensure it is easily accessible to the public. The Joint Standing Committee also recommended providing more detail about breaches and compliance activity to allow providers and participants to better understand how to improve practice.⁶⁵ The committee stated its strong view that increasing the visibility and transparency of compliance and enforcement activities is important for accountability purposes and to build confidence in the NDIS Commission's work.⁶⁶

The Joint Standing Committee said the NDIS Commission should regularly publish more comprehensive and consistent data on the number of closed complaints and reportable incidents, the actions taken and average case handling timeframes.

Ms Mackey told us the time needed for a provider to manage a response to a reportable incident and for the NDIS Commission to oversee that response can vary. For example, because of criminal proceedings or involvement by a coroner. The *Incident Management Rules* do not require the NDIS Commission to ‘close’ a reportable incident when it has completed its oversight of the provider’s management of the incident.⁶⁷ However, to address the concerns we noted in Chapter 8, ‘Reportable incidents’, about poor communication with providers and lengthy timeframes, the NDIS Commission should report regularly on the time taken to oversee reportable incidents. Matters that are the subject of criminal or coronial processes can be recorded and reported separately.

The operational data we believe the NDIS Commission should collect, analyse and publish in its quarterly and annual reports is outlined in Table 10.13.2.

Table 10.13.2: Additional operational performance data

Area	Data to be collected
Complaints, reportable incidents, compliance and enforcement	• the number of reportable incidents and complaints closed • any actions resulting from the NDIS Commission’s processing of complaints or reportable incidents • the time taken to close reportable incidents and complaints • the number of times the NDIS Commission has required a provider to undertake remedial action • the number of times the NDIS Commission has required a provider to undertake an internal or independent expert investigation regarding a reportable incident⁶⁸ • the number of investigations and compliance matters commenced, finalised and that remain open (distinguishing matters subject to criminal or other proceedings) • the number of site visits conducted overall • compliance or enforcement action taken in response to complaints and reportable incidents • compliance or enforcement action resulting from compliance strategies • the types of breaches or contraventions substantiated by the NDIS Commission • the number of registered and unregistered providers involved in contraventions • for workers employed or otherwise engaged by unregistered providers, the number of individuals involved who had, or did not have, a valid worker screening clearance.

Recommendation 10.26 Expanded data reporting and publication

- a. In addition to data currently published, the NDIS Quality and Safeguards Commission should publish in quarterly activity reports and annual reports:
 - ‘disaggregated data’ relating to complaints, reportable incidents and behaviour support, having regard to suggested data in Table 10.13.1
 - a comprehensive analysis of data trends, identifying systemic issues relating to the quality and safety of National Disability Insurance Scheme (NDIS) supports and services
 - ‘operational performance data’ relating to complaints, reportable incidents, compliance and enforcement, having regard to the suggestions in Table 10.13.2.
- b. The Minister for the NDIS should, in consultation with states and territories, amend the reporting requirements in the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) to enable provider investigation outcome data to be collected on a routine basis from NDIS providers.

13.3. Enhancing data systems

Inefficiencies and limitations

Many of the problems identified in this chapter about data collection, analysis and reporting appear to stem from systems that are ill-suited to discharging the functions of the NDIS Commission.

Mr Head acknowledged the way the NDIS Commission categorised information was ‘not optimal’.⁶⁹ He said this is ‘a function of the way some of the aspects of our operating system were designed before the [NDIS] Commission was in place’.⁷⁰

The Community and Public Service Union told the Joint Standing Committee that in a survey of NDIS Commission staff among its members, around 70 per cent said information and communication technology (ICT) systems limited their ability to effectively perform their role. Issues identified included:⁷¹

- poor search functionality
- multiple entries of the same information, affecting the accuracy of data analytics
- staff having to use work-arounds such as spreadsheets to manage caseloads, datasets and undertake analyses
- a lack of real-time data
- complaints only being able to be analysed individually or on a case-by-case basis.

The Joint Standing Committee recommended the Australian Government review the NDIS Commission's current ICT systems and replace or update them if necessary to ensure they are fit-for-purpose.⁷² In its response to the Joint Standing Committee, the Australian Government supported this recommendation.

While the system may be stable, both Mr Head and Ms Mackey gave the Royal Commission detailed evidence about the operations and limitations of the Commission Operating System (COS) used by the NDIS Commission, including its ability to collect data.

Despite steps taken to enhance COS, Ms Mackey said in November 2022:

I have observed that the NDIS Commission's systems, particularly COS, do not support or facilitate many of the steps that officers need to take to identify relevant information, share information, analyse data and coordinate across different functions. Much of this work currently has to be done through labour-intensive "work arounds" outside COS. Current approaches are inefficient, cannot support increasing workloads and involve risks of things being missed and opportunities lost.⁷³

At Public hearing 32 in February 2023, Ms Mackey confirmed that she had been made aware of concerns by peak bodies and providers about the regulatory burden and duplication in the compliance and registration processes. She said the examples given often relate to the NDIS Commission's systems.⁷⁴

we would be the first to acknowledge that our system is not necessarily user friendly, and the ability of our system to connect to systems that providers have, or use is non-existent. So if some of those things play out, then that will help inform what we do in terms of further investment around data and digital.⁷⁵

The *Own Motion Inquiry into aspects of supported accommodation* Inquiry report (*Own Motion Inquiry* report) noted a number of challenges associated with its data collection systems. The report highlighted that the NDIS Commission's systems currently cannot:⁷⁶

- clearly identify settings in which the allegations or issues raised in reportable incidents and complaints occurred (the information is sometimes unclear or incomplete)
- make links across different reportable incidents and complaints to enable systemic analysis of trends or risks
- consistently record the settings in which an incident or issue has occurred in a way that would readily enable analysis.

The *Own Motion Inquiry* report states:

Improving the collection of reportable incident and complaint data to capture the setting in which the issue or incident occurred, and to identify and consistently assign a sub-category of incident or issue, and an outcome, would significantly enhance the ability of the NDIS Commission to better analyse and risk assess data across its functions.⁷⁷

The NDIS Commission reflected that it should refine its approach to classifying matters, including recording potential breaches under the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) or *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth), to better inform its education and compliance functions.⁷⁸ Subject to resource availability, the NDIS Commission committed to:

- improving systems to analyse reportable incident data, including to enable it to analyse information from its reportable incidents function with information gleaned from its other functions⁷⁹
- adjusting data collection practices to better identify supported accommodation settings.⁸⁰

Enhanced ICT capability

Despite considerable efforts by the NDIS Commission to enhance its data, intelligence and reporting capacity, it appears to be still unable to break down its data to provide results for specific groups, limiting the utility of its reporting. Its ICT systems are a key contributor to this problem.

It is not for the Royal Commission to recommend how the NDIS Commission should improve its ICT systems. It would be helpful, however, if the Australian Government were to assess whether the NDIS Commission is adequately resourced to rectify the system or replace the COS with a more sophisticated case management and reporting system. Any new or enhanced system should have the functionality to allow for the collection and reporting of the data we specified in Recommendation 10.26.

13.4. Establishing a robust intelligence function

Many of the issues explored in this chapter have a direct bearing on the NDIS Commission's capacity to gather and analyse data to inform operational decisions.

In this section, we discuss the NDIS Commission's current approach to gathering intelligence and make recommendations designed to strengthen its intelligence capability.

Identifying at-risk participants

A number of organisations that responded to our *Safeguards and quality issues paper* told us about the need to ensure the NDIS Commission can identify at-risk individuals and situations. For example, the Northern Territory Office of the Public Guardian emphasised the need to have 'a clear, transparent concept of "vulnerability" for NDIS participants'.⁸¹ The NDIS Independent Advisory Council provided a submission that identifies factors by which an individual's degree of risk might be assessed and how to assist those participants.⁸²

Identifying and acting upon risks is not the responsibility of the NDIS Commission alone. The National Disability Insurance Agency (NDIA) plays an important role in collecting information

about participants to inform these assessments. Access to NDIS participant data held by the NDIA is critical for the NDIS Commission to identify at-risk participants receiving specific supports or services.

As discussed in Chapter 5, 'Areas for systemic change', since its commencement, the NDIS Commission has improved arrangements with the NDIA to share information about at-risk participants. The new arrangements arose as a result of the independent review into circumstances relating to the death of Ms Ann-Marie Smith conducted by the Honourable Alan Robertson SC. The *Robertson* report observed that the NDIS Commission did not have real-time access to participant data, including NDIS plans, which would allow it to ascertain immediately the supports a participant is receiving without having to ask the provider or the NDIA.⁸³

In May 2021, Mr Head told us about joint work by the NDIS Commission and the NDIA to identify participants at risk of abuse, neglect or other forms of harm. He referred to this as the NDIA's 'vulnerable participants framework'.⁸⁴ Mr Head said at-risk participants would be identified based on the type of supports they receive and risk factors such as age, known health issues and whether they live alone or are supported by a single provider.⁸⁵

Ms Mackey confirmed the NDIS Commission and the NDIA adopted an Operational Protocol for NDIS Participants At Risk (Operational Protocol) in July 2022. The Operational Protocol addresses how and when the NDIA and the NDIS Commission will share information and adopts joint operational responses to participants at risk.⁸⁶

Other intelligence methods

In November 2022, Ms Mackey told us the NDIS Commission had developed 'very strong and cooperative working arrangements' with the NDIA, including in relation to 'tip-offs' concerning issues relevant to integrity and allegations of fraud.⁸⁷

Ms Mackey also said the NDIS Commission now has a close working relationship with other regulators, which 'contributes significantly to the ability of the NDIS Commission to gather and analyse intelligence'.⁸⁸ Ms Mackey explained this cooperation can occur in relation to a particular complaint or incident or broader issues.⁸⁹

In relation to using complaints and reportable incidents data, Ms Mackey said:

I am pleased with what the NDIS Commission has been able to achieve through analysing complaints and reportable incidents to identify systemic quality and safeguarding issues and using those analyses to take actions to address risks ... However, I am concerned that the NDIS Commission's current data and ICT systems are not sufficient to support the level of analyses required to enable the delivery of the NDIS Commission Strategic Plan 2022–2027.⁹⁰

Strengthening intelligence capacity

Given the multi-faceted nature of the NDIS Commission's safeguarding functions, we consider it should establish a dedicated intelligence unit to complement its existing data analytics and market oversight functions. The NDIS Commission's data and analytics function was established to report and comment on the participant experience, the effect of the regulatory activities and market changes.

As the NDIS Commission's intelligence sources improve and the NDIS market continues to expand, the volume of incoming reports and intelligence is likely to escalate, amplifying the need for a dedicated intelligence unit. The intelligence function should deliver strategic briefings that inform operational decisions to commence targeted and proactive monitoring, educational, compliance and enforcement activities.

Establishing dedicated resources for this function in conjunction with the other recommendations made in this chapter will enhance the NDIS Commission's capacity to collect intelligence for the purposes of more effectively identifying and responding to systemic issues across its functions.

We are not in a position to form a firm view about whether or not the NDIS Commission has sufficient resources to establish an intelligence unit. If it does not, the Australian Government should consider providing the funding required to establish the unit.

Recommendation 10.27 Strengthened intelligence capacity

The NDIS Quality and Safeguards Commission (NDIS Commission) should establish a dedicated intelligence unit within the NDIS Commission to enhance its capacity to collect intelligence, identify and respond to higher risk participants, take action relating to providers where necessary and identify systemic issues.

13.5. Sharing risk-related information

There are strong arguments for having robust information sharing arrangements in place between Commonwealth, state and territory bodies that have a role to safeguard children and adults at risk of experiencing abuse. An effective intelligence model must be underpinned by information sharing arrangements between relevant bodies to enable risk-related information to be shared efficiently and without creating onerous administrative burdens on these bodies.

We acknowledge the importance of protecting the personal and private information of all citizens. However, while an individual's privacy must be considered when disclosing information, this should not prevent the sharing of information to promote the safety of people with disability who may be at risk. Such information must be able to be shared with relevant bodies quickly and easily, with appropriate safeguards.

A number of recent inquiries have highlighted the importance of information sharing arrangements for bodies that have a role in safeguarding people who are at risk of experiencing abuse and neglect. For example, the Royal Commission into Institutional Responses to Child Sexual Abuse (Child Abuse Royal Commission) acknowledged that failing to share information about risks posed to a child (or class of children) can have serious consequences. The Child Abuse Royal Commission made recommendations to strengthen the exchange of information between relevant prescribed bodies, both ‘intrastate’ and ‘across borders’.⁹¹

The Child Abuse Royal Commission emphasised the need for a nationally consistent approach to information sharing powers and practices. In this regard, it recommended that:

The Australian Government and state and territory governments should make nationally consistent legislative and administrative arrangements, in each jurisdiction, for a specified range of bodies (prescribed bodies) to share information related to the safety and wellbeing of children, including information relevant to child sexual abuse in institutional contexts (relevant information). These arrangements should be made to establish an information exchange scheme to operate in and across Australian jurisdictions.⁹²

The Australian Government and state and territory governments accepted this recommendation, and the Australian Government’s *Annual progress report 2022* indicates that the National Office for Child Safety is ‘working on a national child safety and wellbeing information sharing scheme’.⁹³

The Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory (NT Royal Commission) also commented on the importance of information sharing between agencies at an operational level to support vulnerable families. The NT Royal Commission made recommendations to develop systems for the efficient exchange of information.⁹⁴

The importance of information sharing was raised with us by organisations who responded to our *Safeguards and quality issues paper*. The Commonwealth Ombudsman told us an integrated approach that encourages information sharing between relevant agencies where a person with disability may be at risk is an important part of safeguarding.⁹⁵

The New South Wales Trustee and Guardian told us the disability sector would benefit from a nationally consistent approach to sharing critical information and promoting the safety of the person with disability, particularly where there is an identified risk in relation to the person.⁹⁶ The Queensland Office of the Public Guardian observed that having multiple organisations involved in the regulation of disability support systems can lead to a compromise on safeguards for people with impaired decision-making capacity. It recommended stronger collaboration between all parties with a role in the disability support system to ensure positive outcomes for people with a disability.⁹⁷

The South Australian Health and Community Services Complaints Commissioner (HCSC Commissioner) told us a clear area for improvement is the sharing of information by the NDIS

Commission with relevant state authorities. The HCSC Commissioner observed that in recent high-profile cases, the provision of information by the NDIS Commission has been slow or not provided in a timely way to assist state processes. It has also been heavily redacted. The HCSC Commissioner noted this may be related to the protected information provisions of the NDIS Commission's authorising legislation.⁹⁸

In a paper prepared for the Royal Commission by the OCG, the Children's Guardian highlighted the need for a national legislative framework that ensures that critical information can be obtained by NDIS worker screening bodies (including the OCG) across state and territory borders.⁹⁹ The Children's Guardian stated that it is:

critical that the Australian Government and state and territory governments develop an information exchange regime that provides for nationally consistent legislative and administrative arrangements that, inter alia, allow for the exchange of information by prescribed bodies in circumstances that relate to promoting the safety of people with disability.¹⁰⁰

Current information sharing arrangements

Ms Mackey informed us that the NDIS Commission has 78 memoranda of understanding (MOUs) with state and territory government agencies and is negotiating a further 65 to govern the way it shares and receives information.¹⁰¹ Ms Mackey described MOUs as 'useful, but not essential, for the sharing of information'. She said the MOUs do not displace any legislative obligations or prohibitions under the *NDIS Act* or other laws.¹⁰²

Information¹⁰³ may only be disclosed if the NDIS Commission has met certain requirements specified in the *NDIS Act and the National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018 (Cth) (Disclosure Rules)*.¹⁰⁴

Much of the information held by the NDIS Commission is 'protected Commission information'.¹⁰⁵ Protected Commission information is defined under the *NDIS Act* to mean 'information about a person (including a deceased person) that is or was held in the records of the Commission', with exclusions for information published in the NDIS provider register.¹⁰⁶ Ms Mackey explained that for the NDIS Commission to share information, it must ensure that it is able to do so without committing an offence under the *NDIS Act*.¹⁰⁷

A number of provisions in the *NDIS Act* and NDIS Rules authorise or require the disclosure of protected Commission information. Disclosure may be made:¹⁰⁸

- for the purposes of the *NDIS Act*¹⁰⁹
- to a state or territory in relation to NDIS worker screening checks or NDIS worker screening laws¹¹⁰
- to a person or body prescribed by the NDIS Rules made for the purposes of section 67A(1) (db) of the *NDIS Act*, for the purposes prescribed in those rules¹¹¹

-
- where the disclosure is reasonably believed to be for the purposes of, or in relation to:
 - preventing or lessening a threat (where current or future) to an individual's life, health or safety¹¹²
 - reporting a past threat to an individual's life, health or safety.¹¹³

The *NDIS Act* also permits the NDIS Commission to disclose information acquired by a person in the performance of their functions or duties or in the exercise of their powers under the *NDIS Act*.¹¹⁴ This applies to a wider category of information than 'protected Commission information' and broadly includes disclosure in the public interest and to various Australian Government, state and territory officials and agencies.¹¹⁵ Any such disclosures must be made in accordance with the *Disclosure Rules*.¹¹⁶

State and territory laws may also affect a requirement under the *NDIS Act* to give information, produce a document or give evidence to the NDIS Commission where:¹¹⁷

- a state or territory law would otherwise prevent a person from giving information or evidence, or producing a document to the NDIS Commission
- that law is prescribed by the *Disclosure Rules*.

A number of changes have been made to the *NDIS Act* and the *Disclosure Rules* to authorise the NDIS Commission to share information with other bodies. For example, the *Disclosure Rules* were amended in 2021¹¹⁸ to create an exception to the requirement to consult a person whose personal information is proposed to be disclosed, where the disclosure is to agencies with functions related to national worker screening.¹¹⁹

Enhancing information sharing

We consider that the information disclosure framework should be amended to allow the sharing of information between the NDIS Commission and a wider range of state and territory safeguarding bodies. This can be done by prescribing bodies in the manner authorised by the *NDIS Act*.¹²⁰

'Prescribed bodies' should include those exercising safeguarding functions relating to people with disability as outlined in Table 10.13.3.

Table 10.13.3: Types of ‘prescribed bodies’

‘Prescribed bodies’	Description
Safeguarding bodies	Safeguarding bodies with the following types of functions: • handling and investigating reports and complaints relating to people with disability at risk of violence, abuse, neglect or exploitation • administering child-related reportable conduct schemes • administering reportable incident schemes in relation to people with disability • administering community visitor schemes • administering disability death review schemes • regulating supported residential services or boarding houses where people with disability may reside.
NDIS providers	An NDIS provider as defined in the <i>NDIS Act</i> .

In addition, state and territory legislation may need to be amended to enable bodies within their jurisdiction to share information with the NDIS Commission for the purposes of safeguarding people with disability.

In its 2018 report to Parliament, *Abuse and neglect of vulnerable adults in NSW – the need for action*, the NSW Ombudsman stated:

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 ...

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 ...¹²¹

A similar approach is embedded within the *Children and Young Persons (Care and Protection) Act 1998* (NSW), which enables agencies that have responsibilities relating to the safety, welfare or wellbeing of children to share information that promotes their safety, welfare and wellbeing. The relevant provision recognises the safety, welfare and wellbeing of children and young persons as taking precedence over the protection of confidentiality or of an individual’s right to privacy.¹²²

Recommendation 10.28 Information sharing between prescribed bodies

- a. The Minister for the National Disability Insurance Scheme (NDIS) should, in consultation with states and territories, amend the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) to include safeguarding bodies with the type of functions described in Table 10.13.3 as ‘prescribed bodies’ for the purposes of section 67A(1)(db) of the *National Disability Insurance Scheme Act 2013* (Cth).
- b. States and territories should introduce legislative and administrative arrangements that would allow prescribed bodies in each jurisdiction to exchange risk-related information with the NDIS Quality and Safeguards Commission, where the exchange of information will promote the safety of NDIS participants who may be at risk of experiencing violence, abuse, neglect or exploitation.

Endnotes

- 1 Royal Commission into Violence, Abuse, Neglect and Exploitation of People With Disability, *Interim report*, October 2020, p 298.
- 2 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), art 31(1).
- 3 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), art 31(2).
- 4 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), art 31(3).
- 5 Australian Government Department of Social Services, Australia's Disability Strategy 2021–2031, December 2021, p 47; Royal Commission into Violence, Abuse, Neglect and Exploitation of People With Disability, *Interim report*, October 2020, p 9, pp 297–298.
- 6 Royal Commission into Violence, Abuse, Neglect and Exploitation of People With Disability, *Interim report*, October 2020, p 298.
- 7 'The NDIS in each state', *National Disability Insurance Agency*, web page, 20 February 2023. <www.ndis.gov.au/understanding/ndis-each-state>
- 8 National Disability Insurance Agency, *Projected participant by state and territory data*, Dataset, 30 June 2022.
- 9 *National Disability Insurance Scheme Act 2013* (Cth) ss 181F(g), 181G(e), 181H(d)(ii).
- 10 Committee on the Rights of Persons with Disabilities, *Concluding observations on the combined second and third periodic reports of Australia*, 22nd sess, UN Doc CRPD/C/AUS/CO/2-3 (15 October 2019), [57–58].
- 11 'Corporate documents', NDIS Quality and Safeguards Commission, web page, 8 May 2023. <ndiscommission.gov.au/about/corporate-documents>; 'NDIS Commission Activity Reports', NDIS Quality and Safeguards Commission, web page, 15 May 2023. <ndiscommission.gov.au/resources/reports-policies-and-frameworks/ndis-commission-activity-reports>
- 12 Exhibit 18-21, CTD.9999.0030.0001, p 52 [302].
- 13 NDIS Quality and Safeguarding Commission, 'Research: Deaths of people with disability', web page. <www.ndiscommission.gov.au/resources/reports-policies-and-frameworks/research-deaths-people-disability>
- 14 Victorian Disability Services Commissioner, Submission, 30 June 2020, SUB.100.00805, p 48.
- 15 National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 7.
- 16 National Disability Services, Submission in response to *Safeguards and quality issues paper*, 2 February 2021, ISS.001.00532, p 7.
- 17 Commonwealth Ombudsman, Submission in response to *Safeguards and Quality issues paper*, February 2021, ISS.001.00561, p 6 [7].
- 18 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 188.
- 19 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 188. The Queensland Department of Communities, Disability Services and Seniors raised similar concerns with the joint standing committee. It said collecting and analysing disaggregated data will help identify modifiable risk factors in the lives of people with disability.
- 20 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 201.
- 21 NDIS Quality and Safeguards Commission, *NDIS Quality and Safeguards Commission activity report: 1 October 2022 to 31 December 2022*, January 2023, p 4; NDIS Quality and Safeguards Commission, *NDIS Quality and Safeguards Commission activity report: 1 October 2022 to 31 December 2022*, January 2023, pp 7–8.
- 22 NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, January 2022; NDIS Quality and Safeguards Commission, *Unauthorised uses of restrictive practices in the National Disability Insurance Scheme*, February 2023.

- 23 *National Disability Insurance Scheme Act 2013* (Cth) 73Z(4); *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).
- 24 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).
- 25 NDIS Quality and Safeguards Commission, *NDIS Quality and Safeguards Commission Activity report: 1 1 October to 31 December 2022*, January 2023, p 4.
- 26 New South Wales Government Office of the Children's Guardian, *Annual report 2021-22*, p 31.
- 27 New South Wales Government Office of the Children's Guardian, *Annual report 2021-22*, p 34.
- 28 New South Wales Government Office of the Children's Guardian, *Annual report 2021-22*, pp 31–37.
- 29 *Children's Guardian Act 2019* (NSW) s 34.
- 30 *Children's Guardian Act 2019* (NSW) s 36.
- 31 *Children's Guardian Act 2019* (NSW) s 37(1)(a).
- 32 *Children's Guardian Act 2019* (NSW) pt 4, div 5.
- 33 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) s 10(3).
- 34 Section 24 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) provides that the NDIS Commissioner can require a registered NDIS provider to produce a final report, including details of any internal or external investigation or assessment that has been undertaken in relation to the incident. Section 26 of the Rules provides that the NDIS Commission can require a registered NDIS provider to carry out an internal or external (independent expert) investigation and provide a report on the investigation to the NDIS Commissioner.
- 35 Exhibit 4-20, 'Statement of James Simpson', 12 February 2020, at [122–123].
- 36 Exhibit 4-09, 'Statement of Professor Julian Trollor', 11 February 2020, at [293].
- 37 Exhibit 4-09, 'Statement of Professor Julian Trollor', 11 February 2020, at [296], [298].
- 38 Carmela Salomon & Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia*, Findings, Report for the NDIS Quality and Safeguards Commission, August 2019.
- 39 Australian Institute of Health and Welfare, for the NDIS Quality and Safeguards Commission, *Mortality patterns among people using disability support services: 1 July 2013 to June 2018*, Technical Report, September 2020.
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14. Engagement and capacity building

Key points

- The NDIS Quality and Safeguards Commission (NDIS Commission) is involved in a range of capacity building and engagement activities to enhance the quality and safety of National Disability Insurance Scheme (NDIS) supports and services. This should remain a priority.
- Many people with disability, including First Nations people, are still unclear about the role of the NDIS Commission. This can deter people with disability from making complaints.
- To improve its engagement and capacity building activities with First Nations people with disability, the NDIS Commission should establish a dedicated First Nations Unit.
- The NDIS Commission should also routinely share more of its data analysis and insights from its oversight activities with providers, to promote improvements in the quality and safety of services delivered.
- NDIS providers want more regular and strategic engagement with the NDIS Commission to work through systemic issues and wider challenges facing the disability sector.

Engagement and capacity building are effective regulatory strategies that support providers to comply with their obligations. These strategies are particularly important for National Disability Insurance Scheme (NDIS) providers who are operating in an environment where relatively new laws and obligations are in place.

The NDIS Quality and Safeguards Commission's (NDIS Commission) primary approach to achieving compliance and building sector capacity has been to 'educate, advise and encourage NDIS providers and workers to identify and understand their obligations and improve their practice'.¹

While we have previously highlighted the importance of the NDIS Commission taking strong action in response to serious instances of provider non-compliance, this should not be at the expense of engagement and capacity building remaining priority activities. This is of particular importance to smaller providers that are new to the NDIS and need more guidance to achieve full compliance.

It is equally important for the NDIS Commission to build the capacity of NDIS participants. Many people with disability are relatively new to the NDIS and need support to understand their rights and options and how the NDIS Commission can help them when things go wrong.

14.1. Engagement and capacity building functions

The NDIS Quality and Safeguards Commissioner (NDIS Commissioner) has a number of ‘core functions’ relating to engagement and capacity building under the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*). These include:

- promoting the provision of advice, information, education and training to NDIS providers and people with disability²
- promoting continuous improvement among NDIS providers and the delivery of progressively higher standards of supports and services to people with disability.³

The *NDIS Act* requires the NDIS Commission to provide education, support NDIS providers to comply with their obligations, and build the capacity of providers and people with disability.⁴ Responsibility for these functions is allocated to various teams within the NDIS Commission. The NDIS Commission also has two dedicated teams for ‘stakeholder engagement’ and ‘communications, public affairs and education’.⁵

The NDIS Commission has produced an extensive range of guidance materials and other resources, including fact sheets, videos and online learning modules for NDIS participants, providers and disability support workers. It awards grants to organisations to produce further educational and guidance materials. For example, five grants totalling nearly \$5 million were awarded by the NDIS Commission through the Support for NDIS Providers Program in 2021–22.⁶ It has also delivered various training modules and implemented capacity building programs.⁷

14.2. Critical issues

The NDIS Commission develops valuable resources and programs for participants, support workers and providers. We have outlined the case for stronger sector engagement and capacity building in earlier chapters:

- In Chapter 8, ‘Reportable incidents’, we examined evidence suggesting several large NDIS providers were not complying with, or were unaware of, their obligation to report incidents.
- In Chapter 9, ‘Complaints’, we described how many people with disability do not understand their right to make a complaint or the role of the NDIS Commission.
- In Chapter 13, ‘Data and intelligence’, we observed that the NDIS Commission is not routinely sharing valuable data and analysis obtained through its oversight and regulatory functions.

In Part A, we identified some gaps in the knowledge and skills of the NDIS workforce. These concerned conducting safe and inclusive investigations, identifying the warning signs of violence, abuse, neglect and exploitation, and upholding the rights of people with disability in complaint processes.

In the following sections we make recommendations to address these issues.

Enhancing capacity building for people with disability

The NDIS Commission engages with NDIS participants to build their knowledge of their rights and how to make a complaint. The NDIS Commission has awarded grants to disability advocates and other support services for the purpose of building the capacity of people with disability.⁸ It has also developed a range of resources for people with disability that explain its different functions in a range of formats and languages.⁹ Despite these initiatives, people with disability and their support networks lack awareness of the role of the NDIS Commission and the avenues available to raise concerns.¹⁰

Limited awareness of rights and the role of the NDIS Commission

In several hearings, witnesses gave evidence that NDIS providers did not tell them how to make a complaint or provide feedback.¹¹ At Public hearing 29, 'The experience of violence against, and abuse, neglect and exploitation of people with disability from culturally and linguistically diverse communities', 'ZA' shared her experience trying to make a complaint about her daughter's support coordinator.¹² ZA is from Iraq and migrated to Australia around 15 years ago.¹³ ZA gave evidence that she called what she understood to be the NDIS; however, her evidence suggests she did not understand the difference between it and the National Disability Insurance Agency (NDIA), and had not heard of the NDIS Commission.¹⁴ ZA had actually first called the NDIA and then submitted a web-based complaint form to the NDIS Commission.¹⁵ However, the NDIS Commission did not have enough information and was unable to address her complaint.¹⁶

The *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) provide that registered NDIS providers must ensure that information about how to make a complaint is readily available and accessible to the public.¹⁷ At Public hearing 32, 'Service providers revisited', witnesses from providers Scope, Melba and Synapse agreed there is a need to build awareness of rights and resources for the whole sector, not just frontline support workers and for people with disability.¹⁸

In Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', Acting NDIS Commissioner, Ms Samantha Taylor, accepted that the NDIS Commission's complaints and reportable incidents models rely on NDIS participants, their families and support networks and advocates understanding the responsibilities of providers and the rights of participants.¹⁹ She said the NDIS Commission's role:

is very focused on building and educating the capability of people with disability to have a strong voice and to have choice and control, not only over what they receive and how they receive it, but to respond to issues they are not satisfied about.²⁰

Past reports have highlighted similar concerns about the low level of awareness of the NDIS Commission's role and functions. In a report released in September 2020, the South Australian Safeguarding Task Force said:

the general population is unlikely to know of the existence of the Commission or how to approach it. The title “Quality and Safeguards Commission” may not be easily associated with where the general population would report abuse or neglect. For people with a cognitive impairment, understanding who and where to report matters is problematic. The Commission needs to reach out to these potentially vulnerable participants and not assume that the participant will know how to find the Commission when needed.²¹

In its November 2021 report on the NDIS Commission, the Joint Standing Committee on the NDIS recommended the NDIS Commission develop a communications and engagement strategy for building visibility of its work and building capacity among providers and people with disability.²²

Engagement and capacity building with people with disability

The NDIS Commission’s Strategic Plan for 2022–27 commits to ensuring NDIS participants, their families and supporters know their rights and are supported to make complaints.²³

As discussed in Chapter 10, ‘Provider registration’, in April 2023 the NDIA released the Participant Safeguarding Policy and an associated implementation plan.²⁴ Under this policy, the NDIS Commission is responsible for building the capacity of people with disability to understand and advocate for their rights.²⁵ While this is a positive development, we consider there is scope for the NDIS Commission to engage in more capacity building activities, including direct engagement with people with disability.

We agree with the observation in Counsel Assisting submissions following Public hearing 17, ‘The experience of women and girls with disability with a particular focus on family, domestic and sexual violence’, that:

Effective implementation of a rights-based approach requires the needs of people with disability to be prioritised in system design, interventions, and service responses. Implementation of this approach should occur across prevention, early intervention, response and recovery, in collaboration with people with disability and the disability services sector. This draws on the principle of “nothing about us without us”, and the requirement to consult and work alongside people with disability.²⁶

We acknowledge that it may be challenging to reach certain groups of people. This includes people whose first language is not English and those who have limited access to technology, limited support networks or difficulty with written or spoken communication. To ensure people with disability from diverse backgrounds and experiences are involved in engagement and capacity building activities, the NDIS Commission should explore new and innovative ways of engaging directly with them. For example, the NDIS Commission could host regular online forums and attend or hold information and awareness events in local communities. The NDIS Commission could also regularly undertake site visits and face-to-face engagements with NDIS participants, which have a focus on participant education and rights awareness. Close and more diverse partnerships with disability groups in the community should inform these new ways of engagement and act as ‘conduits’ between people with disability and the NDIS Commission.²⁷

Reaching First Nations people with disability

At the time of the 2021 Census, 3.8 per cent of the Australian population under the age of 65 identified as First Nations (765,050 people).²⁸ Of the same age group, approximately 7.3 per cent of First Nations people reported living with severe or profound disability (53,160 people).²⁹ This represents 25 per cent more people than the number of First Nations NDIS participants. At 31 December 2022, there were 42,679 First Nations NDIS participants (7.4 per cent).³⁰

First Nations people with disability are at risk of experiencing violence, abuse, neglect and exploitation; yet First Nations participants are even less likely than other NDIS participants to understand their rights and protections that should be in place. This includes their right to access the NDIS and the right to complain to the NDIS Commission. These issues are explored in detail in Volume 9, *First Nations people with disability*.

The NDIS Commission publishes a range of resources specifically tailored for First Nations people with disability.³¹ The Australian Government told us the NDIS Commission has awarded two grants focusing on service provider capability for First Nations participants in rural and remote communities, and a grant focusing on supporting First Nations services to become NDIS providers.³² The NDIS Commission has also undertaken work with First Nations and non-First Nations NDIS providers focusing on NDIS service provision in remote communities.³³ A specific strategy for First Nations participants is also in development.³⁴

Despite these developments, engagement with First Nations people, particularly in regional and remote communities, requires further initiatives.

Lack of adequate engagement with First Nations people and communities

In Public hearing 25, ‘The operation of the NDIS for First Nations people with disability in remote and very remote communities’, we heard that First Nations people with disability often experience language barriers and have difficulty understanding how the NDIS works or where to go for help.³⁵ We also heard criticisms of the quality of NDIS support coordinators.³⁶ These issues can be raised with, and addressed by, the NDIS Commission’s complaints function.³⁷

Representatives from the First Peoples Disability Network called for comprehensive education and training for First Nations people on the NDIS. Questions that need addressing include: what is disability, how to access the scheme, what is a plan, how to achieve choice and control, and what are participant rights.³⁸

Past reports and inquiries have also observed that many First Nations people with disability may not be aware of their rights, and knowledge of the NDIS remains limited for First Nations people with disability in remote communities.³⁹

First Nations Unit

We consider there is a strong case for establishing a dedicated First Nations Unit within the NDIS Commission, ideally incorporating a strong state and territory presence. This First Nations

Unit should be established in addition to the NDIS Commission's work on NDIS service provision in remote communities and the development of a specific strategy for First Nations participants.

The Royal Commission into the NSW Police Service identified 27 years ago the need for an 'Aboriginal unit' to be established within the NSW Ombudsman's Office to better serve the needs of the Aboriginal community in that state.⁴⁰ This unit has existed for more than two decades⁴¹ and has continued to expand and evolve, partly through the establishment in 2014 of a dedicated Aboriginal Deputy Ombudsman role.⁴² Since then, several states have established independent statutory roles for Aboriginal Children's Commissioners (or deputies) and Guardians.⁴³

Other agencies have similar units and committees that specialise in engagement with First Nations people. The NSW Police Force engages with First Nations community members through dedicated Police Aboriginal Consultative Committees.⁴⁴ The Queensland Police Force has established a First Nations and Multicultural Affairs Unit that aims to promote and maintain positive relationships with communities, and engages through Indigenous Community Consultative Groups.⁴⁵

A dedicated First Nations Unit within the NDIS Commission comprising First Nations people with and without disability will be well placed to develop engagement and capacity building activities, mentor non-Indigenous colleagues, deliver training to the disability sector and influence the NDIS Commission to meet the needs of First Nations people with disability.

Recommendation 10.29 Establishing a First Nations Unit

The NDIS Quality and Safeguards Commission should establish a dedicated First Nations Unit to develop its engagement with and understanding of the issues facing First Nations participants in the National Disability Insurance Scheme, particularly in regional and remote communities.

Enhancing provider practice and compliance

A successful strategy to build the capacity of NDIS providers and promote national consistency will involve several components, including training, resource development and sector engagement. NDIS providers who gave evidence at Public hearing 32 made clear there is a strong appetite to collaborate and to share information, experiences and examples of good practice and innovative safeguarding and service models across the disability sector.

Industry forums and communities of practice

In Chapter 13, we recommended the NDIS Commission should enhance its data analytics capacity and regularly publish data and trend analysis. It is also necessary to regularly collaborate with key stakeholders to work through systemic issues identified from the data and wider challenges facing the disability sector.

NDIS providers have told us they are keen to hear more from the NDIS Commission about systemic issues, trends within the sector and effective models of practice. At Public hearing 32, Ms Carol Berry, CEO of The Disability Trust, suggested the creation of a best practice working group made up of service providers who could work in collaboration with the NDIS Commission to improve provider practice.⁴⁶ In a statement, The Disability Trust said:

Many organisations are eager to see better codesign of quality processes and systems with service users to advance the evolution of best practice informed by critical data which is captured, analysed and shared by the NDIS Quality and Safeguards Commission. We would therefore support a more dynamic and collaborative approach to safeguarding. It is our opinion that there would be considerable scope for improvement of quality and safeguards practice across the entire sector if there were a standing committee established involving the NDIS Quality and Safeguards Commission and a range of key service providers with the joint aim of considering initiatives that would drive improvements to policy and practice including developing best practice safeguarding policies, procedures, guidelines and shared resources in this critical area.⁴⁷

The evidence at Public hearing 32 indicates many providers have invested in innovative ways to improve their practices⁴⁸ and the sector as a whole would benefit from sharing this information. The NDIS Commission has acknowledged the value of collaboration across the sector regarding providers' insights from their own 'synthesised' incidents and complaints data.⁴⁹

In its paper to the Royal Commission, the New South Wales Office of the Children's Guardian (OCG) said that with over 19,000 registered NDIS providers nationally, the 'provider-by-provider' approach to developing procedures and strategies is intrinsically inefficient. The OCG suggested that a community or communities of practice should be established comprising the NDIS Commission, the NDIA, NDIS providers, peak bodies and relevant experts to share knowledge, resources and expertise across the sector.⁵⁰ This would assist providers to comply with relevant regulatory requirements and provide a collaborative model that:

highlight[s] the potential safety and quality gains that can be achieved by regulators, funders and key service providers working together on critical service quality and safety issues for the benefit of the whole sector and community.⁵¹

The NDIS Commission leads two consultative committees with providers and people with disability and is in the process of combining these into one consultative committee.⁵² The primary function of these committees is to provide advice and feedback at a national level on emerging and complex issues in the NDIS market, aspects of continuous improvement, matters that affect system-level interventions and other issues raised by key stakeholders.⁵³ The NDIS Commission also engages with disability advocates through the annual Disability Advocacy Forums and its Complaints Function Advisory Committee.⁵⁴

The use of forums, theme-based roundtables and consultative committees is a highly effective way of canvassing issues identified by the NDIS Commission with NDIS providers and people with disability. These types of capacity building activities are essential to understanding complex problems and trends facing the sector. They can provide valuable insights into operational

practice ‘on the ground’, beyond what can be observed in data alone. They also provide an opportunity for the NDIS Commission to receive feedback and advice from the sector.

We consider that the NDIS Commission should build on its engagement with participants and providers by regularly convening forums and roundtables with a focus on addressing safeguarding practice issues. The NDIS Commission should also establish communities of practice that involve people with disability, NDIS providers, disability peak bodies, representatives of intersectional groups and regulators in collaborative discussions. Communities of practice should include representatives of intersectional communities in the disability community. These forums could focus on:

- disseminating oversight and regulatory trend data across areas such as complaint, incident and behaviour support
- identifying opportunities to strengthen oversight and practice development and where further training, guidance or other capacity building is needed
- barriers experienced with oversight processes.

Key topics discussed, outcomes and any resulting advice and resources from industry forums and communities of practice should be published on the NDIS Commission’s website to ensure the whole sector benefits.

Additional and enhanced training for NDIS providers and workers

Knowledge and skill gaps persist among some NDIS providers, including in relation to obligations to recognise and report incidents, appropriately investigate incidents and deal with complaints. NDIS providers would like to see more training programs developed by the NDIS Commission.⁵⁵

At Public hearing 32, a panel consisting of the CEOs from Cara, the Northcott Society and Civic Disability Services told us it would help them to have further training on their external reporting obligations and best practice in complaint handling and incident management.⁵⁶

Ms Liz Forsyth, CEO of the Northcott Society, told us the NDIS Commission could have a useful role in training on best practice complaint handling. She said:

[the NDIS Commission] has the opportunity to gain insights around broader issues and trends for all of us. And I think that that information could be valuably put back into an education or information approach for the industry.⁵⁷

Submissions identified the need for the NDIS Commission to ensure there is adequate training and capacity building of service providers and disability support staff.⁵⁸ The Institute for Healthy Communities Australia Ltd, an approved quality auditing organisation, said governing bodies often do not understand their accountability responsibilities. Some have not undertaken any training in relation to risk and preventing harm because ‘[t]his is viewed as the role of the workforce’.⁵⁹

In earlier chapters, we made recommendations that need to be accompanied by a broader suite of safeguarding training offerings delivered by the NDIS Commission:

- In Chapter 8 we made recommendations to enhance the guidelines available to NDIS providers to improve the quality of investigations and their obligations to follow it.
- In Chapter 10 we made recommendations to strengthen the *National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018* (Cth), used to assess the compliance of registered providers in making sure its workers are able to recognise the warning signs and indicators of violence, abuse, neglect and exploitation and how to identify participants more likely to experience it.

We consider there is merit in the NDIS Commission developing further training and guidance material to address some of the issues we have identified, including meeting external reporting obligations. For example, the NDIS Commission could develop a separate reportable incidents module, which provides clear definitions and thresholds about the types of incidents that are reportable, with simple and practical scenarios to help demonstrate the different types of matters that should be reported. The NDIS Commission could promote training via a targeted campaign and through engagement with registered NDIS providers, disability support workers, unions and peak industry bodies.

A training and resource hub

As we have identified earlier in this chapter, NDIS providers and workers are eager to see improved training and relevant resources in one central location.

The NDIS Commission publishes a range of information for providers and workers on its website.⁶⁰ The Workforce Capability Framework is a key resource for disability support workers. It provides clear, practical examples and establishes ‘what good looks like’ for participants when they receive NDIS services and support.⁶¹ However, it does not include all guidance relevant to workers developed by the NDIS Commission or by other credible bodies.

For example, the NDIS Commission awarded a grant to the peak body for non-government disability service providers, National Disability Services (NDS), to develop complaint and incident management systems, tools and resources for small-to-medium NDIS providers.⁶² The grant resulted in NDS publishing a series of resources on NDS’s website.⁶³ At Public hearing 32, NDIS Commissioner, Ms Tracy Mackey, acknowledged the NDIS Commission should also host this type of information on its website. She said:

we tried to look at the arrangements in place initially by letting a range of the grantees provide it separately, but we now know we need to also provide that ourselves.⁶⁴

NDIS providers at Public hearing 32 also said that having a central repository of best practice guidance, advice and materials would assist them in meeting their obligations, learning from the sector, sharing knowledge and reducing costs associated with researching and exploring best practice. Ms Berry of The Disability Trust told us there is the opportunity for the NDIS Commission to create a repository of best practice examples from across the sector to improve

provider practice.⁶⁵ Ms Kate MacRae, CEO of Scope, said:

I think there is a point in time now with all of the – that we have learnt through the DRC that perhaps we could consider a central repository of policy and contemporary practice. We spend, in the disability sector, an enormous amount of time and resources looking at evidence-based practice, each organisation writing their policy. There's a lot of duplication of effort there. And there is some – there is some stunning innovation as well within disability, and I think it would be excellent to have that innovation curated and available for all so that it doesn't just exist in pockets and that we can all learn from each other in a collaborative way.⁶⁶

The Endeavour Foundation suggested the NDIS Commission should disseminate sector-wide information on trends, issues, best practice and examples of innovative service delivery:

The NDIS Commission is uniquely positioned to understand trends and issues for the sector and could play a stronger role in capability building for providers, as well as helping providers to respond better to specific issues that have arisen.⁶⁷

A central repository of resources would also alleviate financial pressures on providers to undertake this work. Ms Hayley Dean, CEO of Melba, said accessing support, research and learnings across the NDIS, together with a repository of best practice, would be highly valuable for providers.⁶⁸

We consider the NDIS Commission should now bring together resources (including those developed under grants) and training materials in a central location on the NDIS Commission's website. A training and resource 'hub' of this kind should be for use by people with disability and their supporters, as well as NDIS providers and the disability support workforce.

Recommendation 10.30 Engagement and capacity building activities

The NDIS Quality and Safeguards Commission should enhance its engagement and capacity building activities with National Disability Insurance Scheme (NDIS) providers by:

- a. routinely sharing data analysis and insights from its oversight activities with NDIS providers to promote improvements in the quality and safety of services
- b. facilitating regular industry forums and communities of practice to raise and address critical safeguarding practice issues and share best practice
- c. expanding its training offerings to NDIS providers, particularly in relation to fulfilling their obligations to recognise, report and investigate incidents and deal appropriately with complaints
- d. developing a training and resources hub for use by people with disability and their supporters, as well as the NDIS provider workforce.

Endnotes

- 1 Exhibit 4-231, CTD.7200.0001.0197, p 4; NDIS Quality and Safeguards Commission, Compliance and Enforcement Policy, Version 3, November 2022, p 7.
- 2 *National Disability Insurance Scheme Act 2013* (Cth) s 181E(c).
- 3 *National Disability Insurance Scheme Act 2013* (Cth) s 181E(e).
- 4 *National Disability Insurance Scheme Act 2013* (Cth) ss 181F(d), (f), 181G(b)–(d), 181H(a)–(e).
- 5 NDIS Quality and Safeguards Commission, ‘NDIS Quality and Safeguards Commission Structure’, 16 February 2023.
- 6 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 30.
- 7 NDIS Quality and Safeguards Commission, *Annual report 2021–22*, October 2022, p 14.
- 8 Exhibit 4-32, ‘Statement of Graeme Head’, 11 February 2020, at [119–22]; Exhibit 32-008, ‘Statement of Tracy Mackey’, 3 February 2023, at [21–25], [28].
- 9 Exhibit 4-32, ‘Statement of Graeme Head’, 11 February 2020, at [109], [112], [124–26]; ‘Make it known, make it better’, NDIS Quality and Safeguards Commission, web page. <www.ndiscommission.gov.au/makeitknown>; ‘SAFEGuard Newsletter’, NDIS Quality and Safeguards Commission, web page, 2 December 2022. <www.ndiscommission.gov.au/resources/participant-resources/safeguard-newsletter>; ‘Participant Information Pack – Aboriginal and Torres Strait Islander’, NDIS Quality and Safeguards Commission, web page. <www.ndiscommission.gov.au/resources/language-and-formats/aboriginal-torres-strait-islander-resources/participant-information>
- 10 See, for example, South Australian Office of the Public Advocate, Submission in response to *Safeguards and quality issues paper*, 18 March 2021, ISS.001.00592, p 12; Queenslanders with Disability Network (QDN), Submission in response to *Safeguards and quality issues paper*, 9 March 2021, p 4; People with Disability Australia, Submission in response to *Safeguards and quality issues paper*, 1 March 2021, ISS.001.00579, pp 9–10.
- 11 Exhibit 23-001, ‘Statement of Sally’, 26 April 2022, at [24]; Exhibit 14-027, ‘Statement of Victoria’, 25 May 2021, at [33]; Transcript, James, Public hearing 14, 7 June 2021, P-23 [18–25].
- 12 Exhibit 29-020, ‘Statement of ZA’, 21 October 2022, at [30]; name changed to protect identity.
- 13 Exhibit 29-020, ‘Statement of ZA’, 21 October 2022, at [1].
- 14 Transcript, ZA, Public hearing 29, 27 October 2022, P-304 [18–39].
- 15 Transcript, Amy Munro, Public hearing 29, 28 October 2022, P-332 [19–31].
- 16 Transcript, Amy Munro, Public hearing 29, 28 October 2022, P-332 [26–33]; Exhibit 29-053, CTD.9999.0085.0001, p 2.
- 17 *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth) ss 5, 8(7).
- 18 Transcript, Hayley Dean, Jennifer Cullen & Kate MacRae, Public hearing 32, 13 February 2023, P-89 [46]–P-90 [35].
- 19 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-218 [10].
- 20 Transcript, Samantha Taylor, Public hearing 20, 9 December 2021, P-217 [1–5].
- 21 Exhibit 14-217, SAG.0002.0023.0114, p 13.
- 22 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 50.
- 23 NDIS Quality and Safeguards Commission, *Strategic plan 2022–2027*, 2022, p 9.
- 24 National Disability Insurance Agency, Participant Safeguarding Policy, April 2023; National Disability Insurance Scheme Agency, Participant Safeguarding Policy Implementation Plan, April 2023.
- 25 National Disability Insurance Agency, Participant Safeguarding Policy, April 2023, p 11.
- 26 Submissions of Counsel Assisting the Royal Commission following Public hearing 17, 25 January, p 203 [628].
- 27 Groups in the community should include disability support networks, peer support groups, disability rights and advocacy organisations, local government and Aboriginal Community-Controlled Organisations.
- 28 Australian Bureau of Statistics, *Census of Population and Housing*, 2021, Results accessed using TableBuilder by AGE5P age in five-year groups (0–64); by INGP Indigenous status; ‘Not stated’ was excluded from the INGP Indigenous status total.

29 Australian Bureau of Statistics, *Census of Population and Housing*, 2021, Results accessed using TableBuilder by AGE5P age in five-year groups (0–64); by INGP Indigenous status; ASSNP core activity need for assistance; ‘Not stated’ was excluded from the ASSNP core activity need for assistance total; ‘severe or profound’ disability is defined as people who always or sometimes need assistance with self-care, mobility and or communication because of a long-term health condition or disability lasting six months or more, or old age.

30 National Disability Insurance Agency, *NDIS Quarterly Report to disability ministers*, 31 December 2022, p 22.

31 ‘Aboriginal and Torres Strait Islander peoples resources, *NDIS Quality and Safeguards Commission*, web page. <<https://www.ndiscommission.gov.au/firstnations>>

32 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 25, 14 December 2022, SUBM.0042.0001.0001, p 12 [43(b)]; Grant Award View, Australian Government Grant Connect (Grant references GA257453 and GA257454), web page. <www.grants.gov.au/ga/list>

33 Submissions by the Australian Government in response to Counsel Assisting’s submissions in Public hearing 25, 14 December 2022, SUBM.0042.0001.0001, p 17 [65].

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42 *Ombudsman Act 1974* (NSW) pt 3B; NSW Ombudsman, *OCHRE review report*, October 2019.

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- 55 See, for example, Exhibit 32-117, CIV.9999.0001.0001, p 19 [36]; Transcript, Annie Doyle, Public hearing 32, 16 February 2023, P-399 [10–12].
- 56 Transcript, Sonya Furey, Liz Forsyth and Annie Doyle, Public hearing 32, 16 February 2023, P-398 [16] – P-399 [12]; Ms Zelda Riddell, a support worker employed by an NDIS provider, also gave evidence about concerns that NDIS providers cannot afford to provide adequate training for support workers due to NDIS funding limitations: Transcript, Zelda Riddell, Public hearing 32, 14 February 2023, at P-106 [15–19]; Exhibit 32-002, 'Statement of Zelda Riddell', 25 January 2023, at [55].
- 57 Transcript, Liz Forsyth, Public hearing 32, 16 February 2023, P-399 [1–5].
- 58 See, for example, Melbourne East Disability Advocacy (MEDA), Submission in response to *Restrictive practices issues paper*, 7 October 2020, ISS.001.00485, p 6; Victorian Office of the Public Advocate, Submission in response to *Rights and attitudes issues paper*, 28 August 2020, ISS.001.00405, pp 3, 18–19; Institute for Health Communities Australia (IHCA), Submission in response to *Safeguards and quality issues paper*, 5 February 2021, ISS.001.00540, pp 4–5; Victorian Disability Services Commissioner, Submission, 30 June 2020, SUB.100.00805, p 55.
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- 61 'NDIS Workforce Capability Framework', *NDIS Quality and Safeguards Commission*, web page, 7 November 2022. <www.ndiscommission.gov.au/workers/worker-training-modules-and-resources/ndis-workforce-capability-framework>
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- 65 Transcript, Carol Berry, Public hearing 32, 15 February 2023, P-268 [20–24].
- 66 Transcript, Kate MacRae, Public hearing 32, 13 February 2023, P-90 [14–21].
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15. Worker screening

Key points

- An effective worker screening system is essential to safeguard people with disability at risk of experiencing violence, abuse, neglect and exploitation.
- Efficient screening requires a rigorous assessment and consideration not only of a worker's criminal history, but also of any alleged or substantiated misconduct in the workplace, including disciplinary action taken by employers.
- The national NDIS Worker Screening Check began in February 2021, bringing disability worker screening under a nationally consistent framework for the first time. The NDIS Quality and Safeguards Commission (NDIS Commission) is responsible for the design of this new worker screening system and maintaining the associated national screening database.
- State and territory worker screening units and oversight bodies, including the NDIS Commission, should have access to worker screening information when they need it.
- There are opportunities to strengthen the NDIS Worker Screening Check, including that of Australia's largest screening body, the New South Wales Office of the Children's Guardian.

We heard evidence from people with disability and their families about violence, abuse, neglect and exploitation perpetrated by disability support workers on the very people they should be supporting. To prevent such abuse, a rigorous worker screening process combined with careful monitoring of worker conduct is essential.

It is a core function of the NDIS Quality and Safeguards Commissioner (NDIS Commissioner) to develop and oversee the broad policy design for a nationally consistent screening framework for workers involved in the provision of supports and services to people with disability.¹ The *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) also requires that the NDIS Commissioner must 'establish, operate and maintain a database for the purposes of this Act, to be known as the NDIS worker screening database' (Screening Database).²

Worker screening bodies need to obtain information about the risks particular workers may pose to people with disability, including children. This includes information relating to a person's criminal history and records about past and more recent workplace misconduct.

We have had the benefit of considering a paper provided by the New South Wales Office of the Children's Guardian (OCG) about how the NDIS Worker Screening Check is operating. The OCG is the largest screening body in Australia. The paper suggests ways to further

strengthen the practical arrangements between worker screening units and the NDIS Quality and Safeguards Commission (NDIS Commission). The OCG's suggestions are informed by its operation of the scheme to date.³

As the NDIS worker screening scheme is due for review in mid-2024, we recommend that the issues identified in this chapter be considered during that review. In the interim, they should be considered by the NDIS Commission in consultation with worker screening units.⁴

15.1. The NDIS Worker Screening Check

The NDIS Worker Screening Check commenced on 1 February 2021 in all states and territories, apart from the Northern Territory, where it commenced on 1 July 2021.⁵ The NDIS Worker Screening Check is defined in the *NDIS Act* as 'an assessment under NDIS worker screening law, of whether a person who works, or seeks to work, with people with disability poses a risk to such people'.⁶ The NDIS Worker Screening Check is the outcome of the commitment of the Australian Government and state and territory governments, made through the Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme (Intergovernmental Agreement).⁷

While the NDIS Commission operates the Screening Database, the actual screening assessment is undertaken by state and territory worker screening units in accordance with state and territory government laws.⁸ Applications for an NDIS Worker Screening Check are made directly to the worker screening unit in the state or territory where the work will be performed. These units conduct the assessment and make decisions on applications in accordance with a nationally consistent process.⁹ The information assessed by worker screening units includes:¹⁰

- national criminal history information held by law enforcement agencies
- disciplinary and misconduct information supplied by the NDIS Commission to worker screening units
- the outcomes of previous NDIS Worker Screening Checks.

The NDIS Worker Screening Check is portable, meaning the outcomes of screening assessments are recognised nationally, not only in the state or territory where the screening assessment was performed.¹¹

To facilitate efficient information sharing between the NDIS Commission and state and territory worker screening units, changes were made to the *NDIS Act* and the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) on 7 April 2021. Those amendments related to the disclosure of protected information. The changes created an exception to the requirement to consult a person whose personal information is proposed to be disclosed, where the disclosure is to certain government agencies with specific functions related to national worker screening.¹²

The NDIS Commission has also entered into information sharing arrangements for disciplinary or misconduct information with worker screening units in each state and territory.

The NDIS Worker Screening Database

The Screening Database is a register of NDIS workers from all states and territories who have undertaken the NDIS Worker Screening Check. The database:¹³

- shows all cleared and excluded workers from all states and territories to enable national portability of clearances
- supports national ongoing monitoring of the conduct of workers with clearances
- allows NDIS providers across the country to sponsor applications and directly check the clearances of prospective workers
- helps NDIS providers with record-keeping requirements on worker screening.

The Screening Database may include information on people who have applied for an NDIS Worker Screening Check and their applications, their cleared or excluded status, and any other decisions about those applicants made under an NDIS Worker Screening law.¹⁴

Obligations for providers

It is a condition of registration that registered NDIS providers ensure all workers in 'risk assessed roles' have an NDIS Worker Screening Check.¹⁵ Risk assessed roles include:¹⁶

- key personnel of an NDIS providers¹⁷
- roles for which the normal duties include the direct delivery of supports or services specified by the NDIS Commission¹⁸ (for example, nursing care, early childhood intervention and specialist positive behaviour support)
- roles that or are likely to require more than incidental contact with people with disability.¹⁹

Registered NDIS providers are automatically given access to the Screening Database and can view the clearance status of their workers in the database.²⁰

It is not mandatory for an unregistered provider, or a person employed or engaged by an unregistered provider, to hold a valid NDIS Worker Screening Check.²¹ However, self-managed and plan-managed NDIS participants can ask unregistered providers and their workers to demonstrate they have a clearance, or ask them to obtain a clearance by undergoing an NDIS Worker Screening Check.²²

How information is shared with worker screening units

The NDIS Commission has entered into a number of formal information sharing arrangements with state and territory worker screening units.²³

In 2021, then NDIS Commissioner, Mr Graeme Head AO, gave evidence about information sharing arrangements with worker screening units. He said these arrangements include the following provision:

WSUs [worker screening units] will assess, amongst information from a range of other sources such as the Police, disciplinary and misconduct information supplied by the NDIS Commission, including any adverse and substantiated findings of formal investigation (such as in relation to reportable incident notifications, complaints or breaches of the NDIS Code of Conduct) and adverse actions by the NDIS Commission including banning orders.²⁴

These arrangements focus on the NDIS Commission sharing information with worker screening units for two main purposes:²⁵

- notification where the NDIS Commission is satisfied a worker has engaged in conduct that is relevant to an NDIS Worker Screening Check
- disclosure of information when a worker screening unit requests further information following a notification by the NDIS Commission.

If after receiving a notification, a worker screening unit wishes to obtain more information about the worker, it can request it from the NDIS Commission.²⁶ Worker screening units have access to the Screening Database portal. They do not have access to the NDIS Commission's Operating System (COS).²⁷

15.2. Opportunities to enhance worker screening

Prior to February 2021, the screening of disability support workers occurred under multiple different schemes operated by state and territory government bodies.

The implementation of the NDIS Worker Screening Check has considerable advantages. It has resulted in a nationally consistent approach to assessing workers who seek to provide NDIS supports and services to people with disability. The portability of the national clearance can also minimise costs and the administrative burden associated with obtaining and processing worker screening checks for workers, NDIS providers and worker screening units.

Sharing risk-related information

A number of government bodies beyond worker screening units and the NDIS Commission hold information relevant to the decision as to whether a person should be granted or continue to have a worker screening clearance.

Sharing information between the national, state and territory bodies can present challenges. Each body operates within the laws of its own jurisdiction, including in relation to privacy and disclosure requirements. As we explained in Chapter 13, 'Data and intelligence', these laws often create barriers to sharing information in a timely and efficient way, and in certain instances prevent any sharing of information. We acknowledge the need to protect personal and private information. However, this should not prevent the sharing of information between agencies where it is necessary to ensure the safety of NDIS participants.

Sharing information between bodies

The following case study highlights the need for oversight bodies exercising safeguarding functions in relation to adults with disability and children to receive, share and act upon information that indicates safety risks for people with disability, and the consequences of failing to do so.

Case study: Sunnyfield

At Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', 'Eliza' told us about the supports and services provided to her sister 'Melissa' by Sunnyfield Disability Services (Sunnyfield).²⁸ Melissa resided in a home operated by Sunnyfield in Western Sydney with other people with disability.²⁹

Eliza raised a number of complaints with Sunnyfield about the support Melissa was receiving.³⁰ She also made a complaint about a support worker, 'SP1', to the NSW Ombudsman in December 2017.³¹ She subsequently made a complaint to the NDIS Commission in July 2018.³²

The NSW Ombudsman was aware of an extensive history of alleged misconduct by SP1 dating back to 2003. The history involved allegations of abuse, neglect and sexual misconduct towards children and people with disability, and of falsifying documents. The evidence suggests the NSW Ombudsman had knowledge of SP1's history at the time Eliza made her complaint.³³

The NSW Ombudsman did not share this information with Sunnyfield. The current NSW Ombudsman told us that under the relevant legislative provisions at the time, the Ombudsman could only disclose the information if there were reasonable grounds to believe disclosure was necessary to prevent or lessen the likelihood of harm being done to any person.³⁴ He explained the 'most probable reason' for not notifying Sunnyfield of

SP1's history was that there 'may have been doubt' as to whether disclosure met this threshold.³⁵

The Commissioners' *Report of Public hearing 13* found there was no plausible explanation for the apparent failure of the relevant decision-maker to form the belief that the disclosure of the information was necessary to prevent or lessen the likelihood of harm being done to any person.³⁶

The NSW Ombudsman also did not share its relevant information holdings with the Children's Guardian (which conducts working with children checks in New South Wales) until January 2019, 13 months after it received Eliza's complaint.³⁷ During this time, SP1's alleged misconduct continued until his employment was suspended on 25 June 2019.³⁸

The Commissioners' *Report of Public hearing 13* found that the NSW Ombudsman should have disclosed to Sunnyfield the available information about SP1's employment history, including the allegations that had been made against him. This should have been done, at the latest, by December 2018.³⁹

The current information sharing arrangements authorise the NDIS Commission to share information about a worker's history, including misconduct, and any enforcement or administrative actions taken by the NDIS Commission against the person.

Mr Head told us that the NDIS Commission has broader information sharing arrangements with state and territory governments, and has a 'specific schedule' relating to the NSW Ombudsman.⁴⁰ The schedule sets out the types of information the NDIS Commission can request from the NSW Ombudsman and vice versa, and how each body will process these requests. However, it does not provide for notifications without a 'request' between the two bodies.⁴¹

In addition, information holdings pre-dating the introduction of NDIS Worker Screening were not transferred to the NDIS Commission and are therefore not captured by the Screening Database.⁴²

The timely exchange of information about misconduct and disciplinary outcomes relating to workers outside the NDIS setting is also a significant issue worthy of close consideration. This is particularly important given the reported high degree of movement of workers across the disability, health, child and family and aged care sectors.

In response to our *Safeguards and quality issues paper*, Speech Pathology Australia (SPA) told us there is a lack of liaison between the areas of disability, aged care and health. SPA raised concerns that the new national system was introduced without real consideration of existing screening systems that might serve the same or a similar function.⁴³ For example, SPA said there is no centralised system to flag or check workers who may have been the subject of a professional investigation, or even dismissed due to their conduct. SPA said:

This lack of consistency increases the risk of a worker who is not suitable or has been sanctioned in one system or geographical area moving on to another and continuing

to provide services. There is also the significant risk of people with disabilities ‘falling through the cracks’ when it is unclear who has jurisdiction, or responsibility for governance. A nationally consistent system, with the same rules for each state and territory, and clear accountability pathways may help to ameliorate these issues.⁴⁴

There are clear benefits for worker screening units readily having access to historical and recent misconduct information held by reportable conduct scheme and complaint handling bodies, rather than requesting information (and awaiting a response) after becoming aware of a misconduct issue involving a worker. There is scope in the future for holdings of this type to be included within the Screening Database and accessed by worker screening units as appropriate.

Information sharing across jurisdictions

Applicants for a worker screening check have frequently spent time living and working in other Australian jurisdictions.⁴⁵ In its paper to the Royal Commission, the OCG raised concerns about the sharing of information from bodies outside the worker screening unit’s state or territory. The OCG explained that NDIS worker screening units have the authority to require information that is relevant to an assessment of whether a person poses a risk of harm to people with disability from a person within New South Wales.⁴⁶ However, there are currently no nationally consistent information sharing provisions that enable it (or other worker screening units) to obtain information from relevant government and non-government bodies in other states and territories.⁴⁷

The OCG argued that ‘to adequately and efficiently discharge our screening function, a national legislative information sharing framework is required. This would facilitate inter-jurisdictional information exchange for NDIS screening purposes’.⁴⁸

The OCG pointed out the Royal Commission into Institutional Responses to Child Sexual Abuse recognised that information sharing powers and practices need to be addressed through a nationally consistent approach. The OCG recommended a ‘national legislative framework be enacted that ensures that critical information can be obtained by screening agencies across state and territory borders’.⁴⁹

The Joint Standing Committee on the NDIS heard similar concerns in relation to the effectiveness of the Screening Database in screening workers who operate across different schemes and jurisdictions, and whether there should be increased oversight and regulation of workers who freely move between organisations.⁵⁰

In Chapter 13, we recommended that the Commonwealth, states and territories should introduce nationally consistent legislation to enable the efficient and timely exchange of risk-related information, within and across borders, to promote the safety of people with disability who may be at risk. If adopted, this would enable relevant bodies to exchange information with the NDIS Commission and screening units to inform the NDIS worker check. At a minimum, worker screening units should be able to obtain information from all relevant government and non-government bodies in other states and territories.⁵¹

Monitoring and Commonwealth offences

The Intergovernmental Agreement provides that ongoing monitoring involves monitoring of criminal history and other relevant records.⁵² Ongoing monitoring involves workers who hold a clearance being the subject of ‘continuous monitoring for new charges for a set of specified offences’.⁵³ The ongoing monitoring and ‘alert’ processes involve the exchange of criminal records with state and territory policing services.

Each state and territory worker screening unit has arrangements in place, which have the effect of any new charges laid against a clearance holder being communicated to the worker screening unit responsible for assessing that person.⁵⁴

The OCG told us there would be merit in the Intergovernmental Agreement clarifying the role of the Australian Federal Police (and other national relevant bodies) in sharing information about criminal offences with state and territory worker screening units, as is the case with state and territory policing services.⁵⁵

The Intergovernmental Agreement does not expressly refer to the many Commonwealth offences, such as those created by the *Criminal Code Act 1995* (Cth). Nor does it specify the role of the Australian Federal Police (or other national bodies) in relation to sharing information about criminal charges with NDIS worker screening units.⁵⁶

Recommendation 10.31 Continuous monitoring of criminal charges

The Australian Government and state and territory governments should amend the Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme to clarify the role of the Australian Federal Police (or other national bodies) in monitoring new charges relating to disability support workers who hold a clearance, and sharing information with state and territory worker screening units.

Strengthening arrangements between the NDIS Commission and worker screening units

Information sharing arrangements under the Intergovernmental Agreement and individual agreements between the NDIS Commission and worker screening units were the result of consultation and agreement between the Australian Government and state and territory governments. Some operational issues have emerged from the operation the NDIS worker screening process since its roll-out in February 2021.

In its paper to inform the Royal Commission’s consideration of worker screening, the OCG highlighted several opportunities for the Australian Government and state and territory governments to enhance the worker screening system. In this regard, the OCG proposed

establishing an operational framework between the state and territory screening units and the NDIS Commission.⁵⁷

In broad terms, the purpose of the proposed framework would be to enable the staff of worker screening units to better understand the risk to people with disability and the sector oversight processes of the NDIS Commission. It would also help to drive more efficient information sharing processes and effective management of risks, as well as mitigate the risk of information not being disclosed, being disclosed too late, or being used inappropriately.⁵⁸ As an illustration, the OCG suggested that the provision of 'initial monitoring advice' is one area where the screening units and the NDIS Commission could strengthen their practices.

At any point in the worker screening process, the NDIS Commission may provide a worker screening unit with initial monitoring advice where it considers they should be alerted to information.⁵⁹ The initial monitoring advice currently received by worker screening bodies from the NDIS Commission is shared through the Screening Database, which interacts with the NDIS Commission's Operating System (COS).⁶⁰ In the COS, NDIS Commission officers record a short description of the issue that might be relevant to a worker screening unit's assessment.⁶¹ The information recorded in the worker screening flag is then shared with the screening unit. As the information or 'alert' shared is brief and does not contain set fields for completion, this means the screening unit will almost always have to seek further details from the NDIS Commission.⁶²

The OCG has suggested the system would be improved by establishing set criteria to inform the provision of initial monitoring advice to screening bodies to promote consistency and help better inform initial screening actions. Such advice could include:⁶³

- date of the incident
- duration of alleged conduct (if applicable)
- description, nature and circumstances of matter
- whether the police are involved (noting that the screening unit will only be alerted via the monitoring system at the point at which charges are laid)
- critical information relating to the available evidence (for example, an investigation report from an employer)
- information relating to the NDIS Commission's oversight of the matter (for example, whether the matter is open, closed, substantiated or not, and whether further outcomes are pending).

On a proposed framework, the OCG stated:

Establishing a clear framework which will ensure that critical information is provided to screening units, will not only reduce the need for follow up requests by screening units to the NDIS Commission, it will also ensure that applications are processed more efficiently.⁶⁴

The OCG also stressed the importance of screening units being routinely advised of the outcomes relating to reportable incident investigations in certain circumstances.

In Chapter 13, we recommended that the NDIS Commission capture reportable incident outcome data from NDIS providers, regardless of whether or not they were required by the NDIS Commission to conduct an investigation under the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).⁶⁵

Recommendation 10.32 Operational framework to guide worker screening

The NDIS Quality and Safeguards Commission (NDIS Commission) should, in consultation with state and territory worker screening units, develop an operational framework to guide the efficient and effective provision of information to worker screening units to inform their assessments. In doing so, it should establish criteria to inform the provision of initial monitoring advice to screening bodies to promote consistency and help better inform initial screening actions. Such advice could include:

- date of the incident
- duration of alleged conduct (if applicable)
- description, nature and circumstances of the matter
- whether the police are involved (noting that the screening unit will only be alerted via the monitoring system at the point at which charges are laid)
- critical information relating to the available evidence (for example, an investigation report from an employer)
- relevant information relating to the NDIS Commission's oversight of the matter (for example, whether the matter is open, closed, substantiated or not and whether further outcomes are pending).

Recommendation 10.33 Reviewing information sharing arrangements

As part of the National Disability Insurance Scheme worker screening review, the Australian Government, and state and territory governments, should consider the adequacy of information sharing arrangements with regard to:

- a. the ability of worker screening units to obtain relevant risk-related information from bodies outside of their operating jurisdiction to inform their assessments
- b. the ability of the NDIS Quality and Safeguards Commission and worker screening units to obtain and share relevant risk-related information (such as misconduct and disciplinary investigation outcomes) held by other safeguarding and complaint handling bodies to inform worker screening decisions.

Endnotes

- 1 *National Disability Insurance Scheme Act 2013* (Cth) s 181E(f).
- 2 *National Disability Insurance Scheme Act 2013* (Cth) s 181Y(1).
- 3 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 4 *The Intergovernmental Agreement on Nationally Consistent Worker Screening* (Intergovernmental Agreement) includes a provision for a review of the worker screening arrangements three years after implementation; Australian Government, Response to the Joint Standing Committee on the NDIS: NDIS Quality and Safeguards Commission, 20 April 2023, p 7.
- 5 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 22.
- 6 *National Disability Insurance Scheme Act 2013* (Cth) s 9.
- 7 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [146].
- 8 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [151].
- 9 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [145–148]; Exhibit 13-047, CTD.7200.0016.0212.
- 10 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [152].
- 11 Exhibit 13-047, CTD.7200.0016.0212, p 17 [71].
- 12 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [161]; *National Disability Insurance Scheme Act 2013* (Cth) s 67A(1)(da); *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth) ss 8, 11(8)(iv).
- 13 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 22; 'Worker screening requirements (registered NDIS providers)', NDIS Quality and Safeguards Commission, web page, 12 August 2022. <www.ndiscommission.gov.au/providers/registered-ndis-providers/registered-provider-obligations-and-requirements/worker>
- 14 *National Disability Insurance Scheme Act 2013* (Cth) s 181Y(5).
- 15 *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) s 13.
- 16 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021 at [144]; *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) ss 5–7.
- 17 *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) s 5.
- 18 *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) ss 5–6.
- 19 *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018* (Cth) ss 5–6.
- 20 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 24.
- 21 State and territory requirements may apply if the provider is working with children, aged care clients or persons receiving supports or services under other programs (outside of the NDIS).
- 22 NDIS Quality and Safeguards Commission, 'NDIS Worker Screening Database: What self-managed & plan-managed NDIS participants need to know', p 1.
- 23 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [156]; Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [292]; Exhibit 13-046, CTD.7200.0016.0192.
- 24 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [156–57]; Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [294].
- 25 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [157]; Exhibit 13-046, CTD.7200.0016.0192, pp 6–7, 10; Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [294].
- 26 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [161]; NSW Office of Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 27 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 28 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [18–30]. Melissa and Eliza's names have been changed to protect their identity.

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- 29 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [15].
- 30 Exhibit 13-002, 'Statement of Eliza', 29 April 2021, at [38–44].
- 31 Exhibit 13-223, NOM.0001.0389.0001.
- 32 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [16–17].
- 33 Exhibit 13-009, 'Statement of Paul Richard Miller', 10 May 2021, at [44–47]; Exhibit 13-229, NOM.0001.0443.0023_E.
- 34 Exhibit 13-010, 'Supplementary statement of Paul Richard Miller', 19 May 2021, at [7–14]; Ombudsman Act 1974 (NSW), s 34(1)(b2).
- 35 Exhibit 13-010, 'Supplementary statement of Paul Richard Miller', 19 May 2021, at [6], [14].
- 36 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, [256].
- 37 Exhibit 13-009, 'Statement of Paul Richard Miller', 10 May 2021, at [59]; Exhibit 13-230, NOM.0001.0474.0001.
- 38 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, [118–42].
- 39 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, 5 April 2022, p 65, Finding 5.
- 40 Exhibit 13-232, 'Statement of Graeme Head', 18 December 2020, at [199–201], [206–08].
- 41 Exhibit 13-232, 'Statement of Graeme Head', 18 December 2020, at [206–08]; material obtained by the Royal Commission from the NDIS Quality and Safeguards Commission in response to Cth notice, 18 December 2021, CTD.7200.0002.1976.
- 42 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 4.
- 43 Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, pp 9–10.
- 44 Speech Pathology Australia, Submission in response to *Safeguards and quality issues paper*, 1 February 2021, ISS.001.00528, p 9.
- 45 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 4.
- 46 *National Disability Insurance Scheme (Worker Checks) Act 2018* (NSW) s 30.
- 47 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 4.
- 48 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 4.
- 49 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 5.
- 50 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, pp 108–09.
- 51 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 4.
- 52 Exhibit 13-047, CTD.7200.0016.0212, p 17 [78].
- 53 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 5.
- 54 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 5.

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- 55 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 5.
- 56 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 5.
- 57 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, pp 2–4.
- 58 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 59 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 60 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [158].
- 61 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [158], [160], [162]; NSW Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 62 Exhibit 13-004, 'Statement of Graeme Head', 30 April 2021, at [159]; NSW Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 2.
- 63 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 3.
- 64 New South Wales Government Office of the Children's Guardian, Critical issues paper to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 31 March 2023, p 3.
- 65 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).

16. Resourcing

Key points

- Since the rollout of the National Disability Insurance Scheme (NDIS), the number of NDIS participants has grown and continues to do so.
- The volume of complaints and reportable incident notifications made to the NDIS Quality and Safeguards Commission (NDIS Commission) is increasing at a steady rate.
- Despite its considerable safeguarding responsibilities and high workload, the NDIS Commission says it does not have the resources needed to progress much of its work in a timely manner.
- Working through a high caseload with limited resources is likely to present issues with quality and timeliness in any regulatory environment. It also limits proactive compliance and investigative work, as well as stakeholder engagement and capacity building activities that can be carried out.

The NDIS Quality and Safeguards Commission (NDIS Commission) told us its current resources are not sufficient for it to fully discharge its functions. This is particularly an issue with respect to its complaint handling and reportable incidents functions. Both the former and current NDIS Quality and Safeguards Commissioner (NDIS Commissioner) told us that the NDIS Commission does not have the resources to deal with complaints in a timely manner.¹

In submissions following Public hearing 32, ‘Service providers revisited’, Counsel Assisting observed that the NDIS Commission’s reliance on reportable incident notifications and complaints has required a significant proportion of its resources to be allocated to a reactive, rather than a proactive approach to monitoring compliance issues.² We agree with this view. The increasing volume of complaints and reportable incidents limits the capacity of the NDIS Commission to undertake other important work including sector engagement and training.

16.1. Staff numbers and budget

On 30 June 2019, after its first year in operation, the NDIS Commission employed a total of 194 staff with 62 per cent based in New South Wales.³ In October 2020, following an extension of the NDIS Commission’s jurisdiction to all states and territories, the Australian Government announced an additional \$92.9 million in funding over four years for the NDIS Commission.⁴ The funding formed part of the Australian Government’s response to the 2019 independent review of the *National Disability Insurance Scheme Act 2013* (Cth), undertaken by David Tune AO PSM. This resulted in \$60.1 million being allocated for additional staff, including more than 100 permanent employees.⁵ Recruitment focused on operational roles that would deliver outcomes for the community.⁶

By 30 June 2021, the NDIS Commission employed 332 staff nationally.⁷ As part of the Budget for 2022–23, the Australian Government announced a 66 per cent increase in the NDIS Commission’s average staffing levels from 340 in 2021–22 to 565 in 2022–23.⁸

Despite a steady increase in staffing levels, the current NDIS Commissioner, Ms Tracy Mackey, gave evidence in November 2022 that the NDIS Commission has recognised for some time that its funding is not sufficient to support its operations.⁹ Ms Mackey said the NDIS Commission has had to obtain ministerial approval to operate at a loss for three of the five years it has operated, including the current financial year 2022–23.¹⁰

Ms Mackey explained:

the original budget assumptions for the NDIS Commission, which were formed before the NDIS Commission was established, did not take account of the NDIS Commission’s need to scale-up in line with growth in the NDIS or the diversification of the NDIS market. Some core functions were not funded in the original budget and nor were essential enabling functions. Since it commenced operating in 2018–19, the NDIS Commission has had to allocate at least a minimum level of funding for essential enabling functions such as corporate, data and analytics, policy, and legal capability, in addition to establishing national compliance capacity and improved compliance and investigations capability, in spite of these areas not being funded in the original budget.¹¹

16.2. Resourcing of critical functions

In Chapter 8, ‘Reportable incidents’, and Chapter 9, ‘Complaints’, we examine the increasingly high workload of these functions and related concerns about the reach of the NDIS Commission’s oversight in these areas. We also considered evidence from the NDIS Commission in other chapters that suggests it is not able to progress other important work, such as data analytics, compliance action and information and communication technology enhancements as a result of resourcing issues.

In relation to complaint handling, Ms Mackey said the NDIS Commission is not consistently able to respond to complaints in a timely manner with its current resources,¹² and current complaint handling processes and systems are unable to deal with the volume of complaints it receives.¹³ She outlined work underway to address these issues, including a review and redesign of the complaints function to reduce timeframes and improved intake and triaging processes.¹⁴

Evidence heard in the course of Public hearing 6, ‘Psychotropic medication, behaviour support and behaviours of concern’, also raised questions about the adequacy of the NDIS Commission’s resourcing with respect to its behaviour support function.¹⁵

Professor Karen Nankervis from the University of Queensland stated:

the rollout of the NDIS Quality and Safeguards Commission requires significant investment in building sector capability and if the resourcing of the (NDIS) Commission only enables monitoring and compliance, service quality and protection and safeguarding of the rights and well-being for people who engage in challenging behaviours may not be realised.¹⁶

In Public hearing 32, Ms Mackey told us that increased resources would enable the NDIS Commission to improve its safeguarding of people with disability, but noted decisions concerning its budget were made by the Australian Government.¹⁷ She also said the NDIS Commission's funding model is not 'demand' driven so its capacity to deliver based on how it is funded is quite challenging.¹⁸

The Joint Standing Committee on the NDIS (Joint Standing Committee) heard similar issues about the NDIS Commission's staffing levels and resources, including that the NDIS Commission does not have sufficient staff to effectively perform its functions.¹⁹ The Joint Standing Committee recommended the Australian Government review the NDIS Commission's current staffing levels and provide additional resources to increase staff numbers if necessary.²⁰ It stressed the importance of adequate resourcing to ensure that the NDIS Commission is able to investigate complaints thoroughly and promptly, and initiate more of its own investigations and inquiries if needed.²¹

The Australian Government responded to the Joint Standing Committee's report in April 2023. The government supported these recommendations and noted its commitment to ensuring the NDIS Commission receives the necessary funding to undertake its functions. The government also advised that it will continue to monitor and make adjustments to the NDIS Commission's resourcing to ensure it can perform its functions effectively.²²

We commend the Australian Government for its commitment to adequately resource the NDIS Commission. We consider that the Australian Government should arrange for a comprehensive review to be undertaken of the NDIS Commission's capacity to fulfil its wide-ranging regulatory and oversight remit within its existing funding allocation. Such a review should have regard to the resourcing implications of recommendations made in this report.

Endnotes

- 1 Transcript, Samantha Taylor, Public hearing 20, 8 December 2021, P-177 [42]–P-178 [22]; Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [97], [208].
- 2 Submissions of Counsel Assisting the Royal Commission following Public hearing 32, 31 March 2023, p 258 [981].
- 3 NDIS Quality and Safeguards Commission, *Annual report 2018–19*, October 2019, p 42.
- 4 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 24; Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [199].
- 5 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 24; Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [200].
- 6 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, pp 21, 24.
- 7 NDIS Quality and Safeguards Commission, *Annual report 2020–21*, October 2021, p 61.
- 8 Commonwealth of Australia, Budget Paper No. 4: Agency Resourcing, October 2022, p 157.
- 9 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [204].
- 10 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [204].
- 11 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [205].
- 12 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [208].
- 13 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [97].
- 14 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [94–99].
- 15 Exhibit 6-19, ‘Statement of Professor Karen Nankervis’, 10 September 2020, at [123–24]; Exhibit 6-07, ‘Statement of Joanna Mullins’, 4 September 2020, at [47]; Exhibit 6-08, ‘Statement of Joyce-Lyn Smith’, 14 September 2020, at [91]; Transcript, Joanna Mullins, Public hearing 6, 23 September 2020, P-108 [26–28], P-109 [10–12].
- 16 Exhibit 6-19, ‘Statement of Professor Karen Nankervis’, 10 September 2020, at [111].
- 17 Exhibit 32-007, ‘Statement of Tracy Mackey’, 15 November 2022, at [208–209].
- 18 Transcript, Tracy Mackey, Public hearing 32, 17 February 2023, at P-454 [3–5].
- 19 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, p 165.
- 20 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, Recommendation 24.
- 21 Joint Standing Committee on the National Disability Insurance Scheme, Parliament of Australia, *NDIS Quality and Safeguards Commission*, November 2021, Recommendation 25.
- 22 Australian Government, Response to Joint Standing Committee on the National Disability Insurance Scheme report: *NDIS Quality and Safeguards Commission*, April 2023, p 11.

Acronyms and abbreviations

ACNC – Australian Charities and Not-for-profits Commission

ADE – Australian Disability Enterprise

Afford – Australian Foundation for Disability

AICD – Australian Institute of Company Directors

AIHW – Australian Institute of Health and Welfare

AIHW report – Australian Institute of Health and Welfare, for the NDIS Quality and Safeguards Commission, *Mortality patterns among people using disability support services: 1 July 2013 to June 2018*, Technical Report, September 2020

ASU – Australian Services Union

BET Group – BET Group Global

BSP – Behaviour Support Plan (also sometimes referred to as positive behaviour support plan)

BSP-QEII – Behaviour Support Plan Quality Evaluation Version II

CAG – Customer Advisory Group (Uniting Care Queensland)

Capability Framework – NDIS Quality and Safeguards Commission, Positive Behaviour Support Capability Framework, July 2019

CCTV – closed-circuit television

CEO – Chief Executive Officer

Child Abuse Royal Commission – Royal Commission into Institutional Responses to Child Sexual Abuse

CIDP – Cognitive Impairment Diversion Program

Code of Conduct – National Disability Insurance Scheme (Code of Conduct) Rules 2018 (Cth)

Complaints Rules – National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018 (Cth)

Corporations Act – Corporations Act 2001 (Cth)

COS – Commissions Operating System used by the NDIS Commission

COVID-19 – Coronavirus, Disease, discovered in 2019

CRPD – Convention on the Rights of Persons with Disabilities

CRS – Coastal Residential Services

Cth – Commonwealth

CXO – Chief Experience Officer

DES – Disability Employment Services

DIA – Disability Intermediaries Australia

DIA Professional Standards – Professional Standards of Practice for Support Coordination developed by Disability Intermediaries Australia

DHS – South Australian Department of Human Services

Disclosure Rules – National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018 (Cth)

DPO – Disabled people's organisation

DRA – Proposed Australian Disability Rights Act

DRO – Disability representative organisation

DSW Cost Model – National Disability Insurance Scheme, Disability Support Worker Cost Model

DWRS – Disability Worker Regulation Scheme (Victoria)

EBA – Enterprise Bargaining Agreement

FWC – Fair Work Commission

Guiding Principles – *Guiding Principles on Business and Human Rights*, published by the UN Office of the High Commissioner for Human Rights in 2011

HCSC Commissioner – South Australian Health and Community Services Complaints Commissioner

ICT – Information and communication technology

Incident Management Rules – National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 (Cth)

Intergovernmental Agreement – Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme

Joint Standing Committee – Joint Standing Committee on the National Disability Insurance Scheme

LAC – Local Area Coordinator

LWB – Life Without Barriers

Melba – Melba Support Services

MOUs – Memoranda of understanding

MWRC – Marninwarntikura Women’s Resource Centre

National Action Plan – National Action Plan Developing the NDIS Specialist Behaviour Support Market

National Framework – National Framework for Reducing and Eliminating the Use of Restrictive Practices

NDIA – National Disability Insurance Agency

NDIS – National Disability Insurance Scheme

NDIS Act – National Disability Insurance Scheme Act 2013 (Cth)

NDIS Commission – NDIS Quality and Safeguards Commission

NDIS Commissioner – NDIS Quality and Safeguards Commissioner

NDIS Framework – NDIS Quality and Safeguarding Framework

NDIS Review – Independent review of the NDIS, announced in October 2022 with the final report to be provided by October 2023

NDIS Rules – legislative instruments for the *National Disability Insurance Scheme Act 2013 (Cth)*

NDS – National Disability Services

NSW – New South Wales

NT Royal Commission – Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory

OCG – New South Wales Office of the Children’s Guardian

Operational Protocol – Operational Protocol for NDIS participants at risk

OPG – Queensland Office of the Public Guardian

Own Motion Inquiry – NDIS Commission’s Own Motion Inquiry into Aspects of Supported Accommodation

Own Motion Inquiry report – Inquiry report: Own Motion Inquiry into aspects of supported accommodation, January 2023

PBSP – Positive behaviour support plan

PIR – Post incident review (Northcott)

Practice Standards – National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 (Cth)

QCG Committee – Quality and Care Governance Committee (Uniting Care Queensland)

Quality Auditors Guidelines – National Disability Insurance Scheme (Approved Quality Auditors Scheme) Guidelines 2018 (Cth)

Quality Indicators – National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018 (Cth)

Regulatory Powers Act – Regulatory Powers (Standard Provisions) Act 2014 (Cth)

Restrictive Practices and Behaviour Support Rules – National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth)

Robertson report – Independent review of the adequacy of the regulation of supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020 undertaken by the Honourable Alan Robertson SC

SA – South Australia

SACS – Social and community services sector

SCHADS – Social, Community, Home Care and Disability Services Award

Scope – Scope (Australia) Ltd

Scoping Review – Carmela Salomon & Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia*, Report for the NDIS Quality and Safeguards Commission, August 2019

Screening Database – NDIS worker screening database

SDA – Specialist Disability Accommodation

SIL – Supported Independent Living

SILC – Supporting Independent Living Co-operative

SRS – Supported residential services

SRS Strategy – NDIS Commission’s Supported Residential Services Strategy

Sunnyfield – Sunnyfield Disability Services

Task Force – South Australian Safeguarding Task Force

Tune Review – Review of the National Disability Insurance Scheme Act 2013: *Removing red tape and implementing the NDIS participant service guarantee*, completed by David Tune AO PSM in 2019

URP – Unauthorised restrictive practices

VDSC – Victorian Disability Services Commissioner

YCPAC – Yooralla Community Partnership Advisory Committee



Royal Commission
into Violence, Abuse, Neglect and
Exploitation of People with Disability