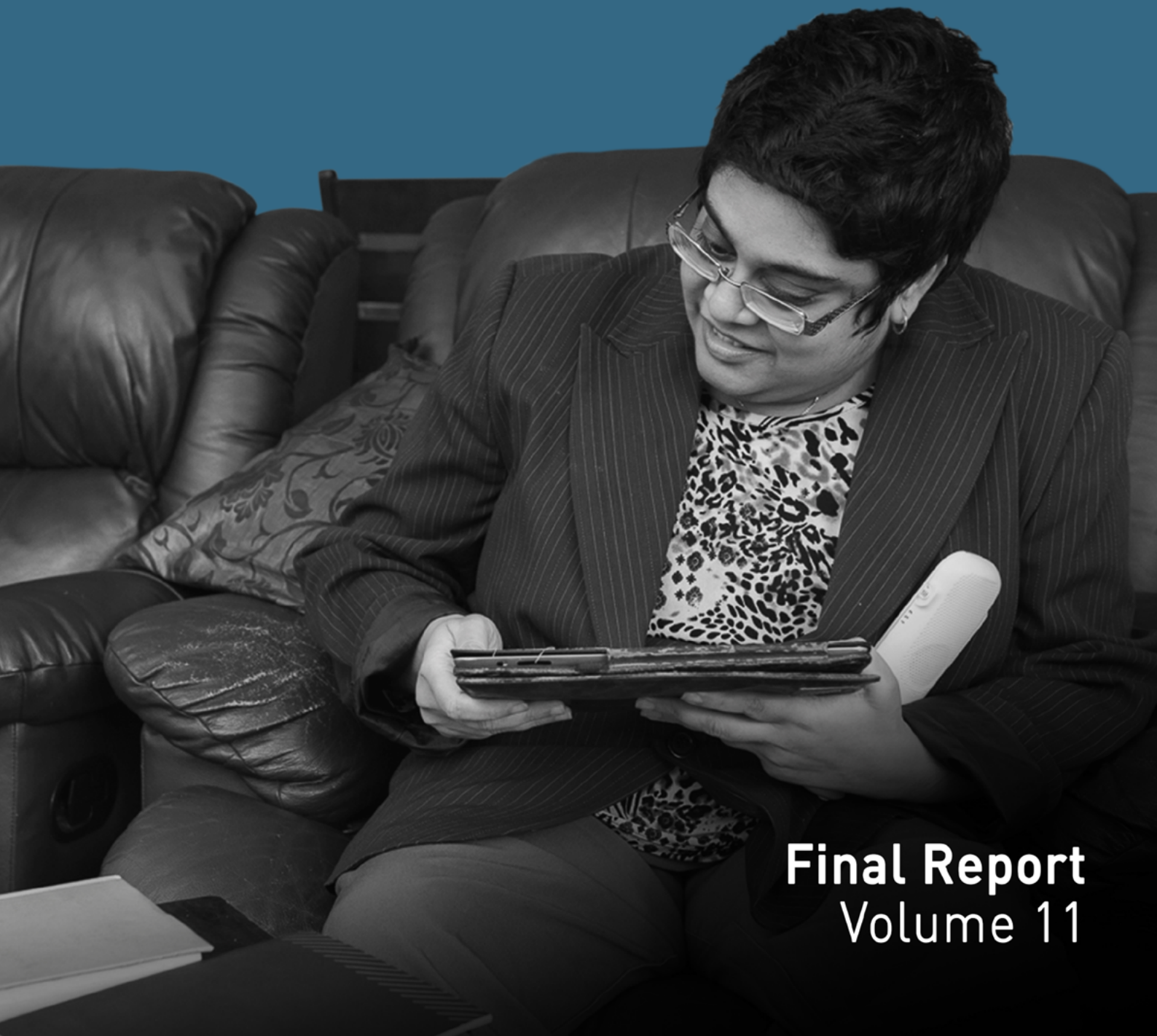
Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Independent oversight and complaint mechanisms



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Final Report

Volume 11

Independent oversight and complaint mechanisms

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

community settings

In this volume we use the term ‘community settings’ to refer to places or surroundings that are not associated with organisations or service providers. For example, private homes and public spaces are community settings.

community visitor schemes

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. A complaint may give rise to a report of unlawful conduct (see ‘report’).

complaint body

A complaint body is an agency that has a function to receive, handle, investigate and resolve complaints.

complaint mechanism

A complaint mechanism refers to the system used by an organisation to respond to a complaint. A complaint mechanism can be internal to an organisation. It may also involve complaints to external authorities, such as referrals to police and notifications to regulatory bodies responsible for overseeing and monitoring complaints involving reportable incidents or reportable conduct. Independent oversight bodies may also have a complaints mechanism under which they are required to engage in dispute resolution or provide a pathway for the identification of matters for investigation or other response.

home

A private home where a person with disability lives.

incident

The term ‘incident’ is 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.

investigation

An investigation is a fact-finding process that commences after a complaint has been received. 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 the 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.

Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

An international human rights agreement aimed at preventing the mistreatment of individuals in places of detention that fall within the jurisdiction and control of the state. The *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)* was ratified by Australia in 2017.

oversight body

An oversight body is an independent agency that has a statutory responsibility to ‘watch over’ a particular group of organisations and hold them to account in relation to specific functions, such as handling complaints and/or responding to reportable allegations or incidents. For example, Ombudsmen watch over public sector agencies and certain non-government organisations.

public place

Public places are real and virtual spaces in the community where people spend their time. They include destinations (such as parks, playgrounds, shops and entertainment venues), pathways (such as streets, shopping centres, public transport and transport hubs) and online platforms (including blogs, dating sites, video-sharing platforms, social media and messaging services).

redress

Redress may be provided to an affected person by an organisation after a complaint is substantiated. Types of redress may include an apology, counselling or medical treatment, financial compensation (for example, an ex-gratia payment or damages awarded by a court) or a change to a system, policy or process.

referral

Directing someone to a different person or organisation for information, help or action. A referral can be 'cold' or 'warm'. A cold referral involves providing a person with information about how to contact the relevant person or organisation. A warm referral involves contacting the relevant person or organisation for or with the person needing the referral. It usually involves passing on information, with the person's consent, so they don't have to tell their story again.

regulator/regulatory body

A regulator or regulatory body is an agency that has a legislative function to regulate a particular group of organisations with respect to the delivery of particular services or programs. For example, the NSW Office of the Children's Guardian regulates the provision of out-of-home care and the NDIS Quality and Safeguards Commission regulates NDIS service providers.

report

A report is a formal notification of violence against, or abuse, neglect or exploitation of a person with a disability. A report may be made internally by a person working for an organisation (for example, an incident report) or by a service recipient of an organisation or a person acting on their behalf. A report may also be made externally by an individual or a service provider to a statutory authority (for example, police or the NDIS Quality and Safeguards Commission).

reportable conduct schemes

Reportable conduct schemes now exist in most states and territories. They require the heads of relevant organisations to notify an independent oversight body of allegations of reportable conduct involving their employees. The organisations must investigate the allegation, make a finding and report the outcome to the oversight body.

'Reportable conduct' is conduct towards, against or in the presence of a child. The type of conduct covered is defined in the operating legislation for each reportable conduct scheme in the relevant state or territory. Although there are some differences in how reportable conduct is defined, all schemes include in their definition allegations of sexual abuse, sexual misconduct and physical abuse. The schemes also variously include forms of neglect, ill-treatment and psychological harm.

response

A response is a formal reaction from an organisation to a complaint. At a minimum, it consists of advice to the complainant about the outcome of the action taken, if any, in response to a complaint. A response may include conducting an investigation (see 'investigation') and/or providing redress (see 'redress').

safeguarding

Safeguarding means taking action to protect a person with disability from violence, abuse, neglect or exploitation. The term encompasses both a preventative and reactive response. As used in this volume, the term is not intended to imply any element of coercion or to undermine the autonomy of a person with disability.

systemic death reviews

Systemic death reviews methodically examine information about the deaths of a group of people (for example, people with disability). The information is obtained from relevant agencies and service providers. It is analysed to identify procedural, practice and systems issues that may have contributed to the deaths. The aim of systemic death reviews is to identify trends and recommend actions that may help to reduce deaths.

violence and abuse

Violence and abuse include assault, sexual assault, restrictive practices (physical, mechanical and chemical), forced treatments, forced interventions, humiliation and harassment, financial and economic abuse and significant violations of privacy and dignity on a systemic or individual basis. See glossary definitions 'violence' and 'abuse'.

Summary

Key points

- Mistreatment of people with disability can occur outside of settings and support provided under the National Disability Insurance Scheme (NDIS). Independent and accessible pathways for reporting violence, abuse, neglect and exploitation experienced by people with disability beyond those offered by the NDIS Quality and Safeguards Commission (NDIS Commission) are essential.
- In this volume we examine the need to strengthen independent oversight and complaint mechanisms in six areas, and the common themes that emerge.
- States and territories have a fundamental obligation to uphold the rights of people with disability and protect them from mistreatment. They are well placed to do so given they administer health, justice and a range of community and advocacy services.
- State and territory oversight functions for people with disability and the relevant functions of the NDIS Commission should be more closely aligned to promote the delivery of integrated and efficient responses, and better outcomes for individuals.
- A stronger authorising environment, created by national agreements and legislative provisions for information sharing, is required to facilitate cooperation between the Commonwealth and states and territories.
- Oversight functions must be independent, sufficiently empowered and properly resourced to enable them to be effective.
- Oversight bodies have access to unique data about the prevalence and outcomes of reported violence, abuse, neglect and exploitation. Better quality data should be consistently collected and reported to help identify, compare and address trends.
- A person-centred approach is critical to encouraging reporting of violence, abuse, neglect and exploitation and delivering effective responses. Such an approach involves listening to the needs of people with disability, and maximising their participation in safeguarding processes.

Accessible and responsive complaint pathways, combined with strong oversight, are essential to encouraging the reporting of, and effective responses to, violence against, and abuse, neglect and exploitation of people with disability.

In Volume 10, *Disability services*, we examined the NDIS Quality and Safeguards Commission's (NDIS Commission) role in this regard. However, not all people with disability are National Disability Insurance Scheme (NDIS) participants. Our hearings about education and justice demonstrated mistreatment of people with disability can occur outside NDIS service settings.

For these reasons, additional independent oversight and complaint pathways are necessary. In this volume, we discuss their establishment or further strengthening.

Adult safeguarding functions

The Royal Commission heard that violence and abuse against people with disability at home and in public places is a significant, under-reported problem. We were also told a gap exists in providing a robust and flexible 'end to end' advice and support coordination response.

There have long been statutory mechanisms, however imperfect, for responding to violence and abuse against children in the community but the same cannot be said for adults who are at risk, including adults with disability.

In 2017 the Australian Law Reform Commission recommended adult safeguarding laws be introduced to address elder abuse.[1] These laws have since been enacted in South Australia and New South Wales.[2] In these states, designated bodies receive, assess and investigate allegations of abuse against people with disability and older people, and take safeguarding action where necessary. It is clear to the Royal Commission these bodies are meeting a significant level of need. There have been strong calls for similar laws to be introduced in Victoria, Queensland and the Australian Capital Territory.[3]

We recommend all states and territories should legislate adult safeguarding laws. Such laws should empower an independent, appropriately resourced body to administer information and referral; advice and support coordination; investigation; public reporting; and community education functions.

Independent complaint reporting, referral and support mechanisms

Throughout the Royal Commission we heard there are barriers to reporting violence, abuse, neglect and exploitation of people with disability regardless of where it occurs. A significant barrier for many people is the complexity of the existing complaints landscape, which is difficult to participate in without appropriate assistance and support. The strong message we received was to remove the burden of navigating where to complain from the individual while respecting their dignity and empowering them to participate. Several witnesses described the importance of establishing a third-party reporting pathway that is clear, safe and readily accessible.[4]

We recommend each state and territory should have a highly visible 'one-stop shop' independent and accessible mechanism anyone can contact for tailored advice and information about their options for reporting violence or abuse of a person with disability. The proposed mechanism would differ from existing hotlines. It would provide warm referrals to appropriate complaint bodies, including police, and link people with local advocacy and other services that can support them to participate in the complaint process. States and territories should consider the benefits of co-locating the one-stop shop with the adult safeguarding function we also recommend.

Organisations have a responsibility to have complaint handling systems and processes in place that are accessible and responsive to people with disability, regardless of the existence of any independent complaint reporting, referral and support mechanism. The evidence received by the Royal Commission about barriers to, and experiences of, complaining suggests organisations would benefit from further guidance in this area.

We recommend the development of universal guidelines to support organisations to implement complaint handling systems and processes that are accessible and responsive to people with disability. In particular, there is a need for better guidance about how to handle more serious complaints about abuse and neglect and how to conduct investigations in a trauma-informed way that prioritises the meaningful participation of people with disability.

Optional Protocol to the Convention Against Torture

The *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*)[5] provides a means of driving compliance with the *Convention on the Rights of Persons with Disabilities* (*CRPD*). It requires independent monitoring of places the state operates where people are deprived of their liberty. The Royal Commission heard multiple examples of the mistreatment of people with disability in such places.[6] Evidence about the abuse and neglect of children in detention provided a particularly vivid illustration of why *OPCAT* is so important.

Despite ratifying *OPCAT* in 2017, Australia still does not comply with its requirements. We recommend all states and territories should urgently establish independent monitoring bodies (National Preventive Mechanisms) and ensure places of detention where people with disability are deprived of their liberty are included within their scope. Independent monitoring bodies should be sufficiently resourced to exercise their functions in a genuinely disability-inclusive way.

Community visitor schemes

Community visitors are appointed individuals who independently monitor services and facilities people with disability use. They also help resolve issues or complaints. The Royal Commission heard that community visitors play a crucial role in promoting and protecting the rights and wellbeing of people with disability by identifying issues people with disability may not otherwise raise. They also provide an early warning system to prevent abuse and neglect, as well as an escalation pathway for issues to be addressed.

Community visitors can be an especially important safeguard for people who have limited or no access to natural supports or safeguards. This includes people, such as those living in boarding house style accommodation, who are at elevated risk of poor outcomes. For these reasons, the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) and the NDIS Quality and Safeguarding Framework should be amended to formally recognise community visitors as a safeguard for people with disability.

Currently, the roles and functions of community visitor schemes operating in the states and territories are inconsistent. A nationally consistent approach is needed, including a common definition of 'visitable services'. Agreed standards and quality indicators for monitoring services and facilities, informed (where relevant) by NDIS practice standards, are also needed. The Australian Government and state and territory governments should also enter into a national agreement that establishes how community visitor schemes and the NDIS Commission will cooperate and share information to effectively exercise their different but related visiting, compliance, monitoring and investigation functions.

Disability death review schemes

Compared with the general population, many Australians with disability – especially people with intellectual disability and/or those living in supported accommodation – are much more likely to have a 'potentially avoidable death'[7] and die before the age of 65.[8] Evidence to the Royal Commission indicates systemic reviews of the deaths of people with disability are an important method for identifying and communicating the factors that contribute to this inequality.

Before the function was removed in 2022,[9] the NSW Ombudsman was required to review the deaths of people with disability living in supported accommodation and assisted boarding houses.[10] Since the introduction of the NDIS in Victoria, the Disability Service Commissioner's role to review the deaths of people using disability services has substantially diminished because of state and Commonwealth jurisdictional issues.[11] These changes have created a regrettable oversight gap in New South Wales and Victoria; no other state or territory has a disability death review scheme.

The Royal Commission has listened to leading experts who have recommended each state and territory should establish disability death review schemes. The schemes should be nationally consistent and operate with a nexus to the NDIS Commission's separate and related function to oversee reportable incidents, which includes incidents involving the deaths of NDIS participants in relevant circumstances.

Reportable conduct schemes

We heard evidence from and about young people with disability who have experienced abuse in schools, juvenile detention centres and out-of-home care. In 2017, the Royal Commission into Institutional Responses to Child Sexual Abuse found reportable conduct schemes are a best practice model for overseeing institutions' handling of child abuse allegations against their employees.[12] It recommended all states and territories establish nationally consistent reportable conduct schemes, modelled on the existing approach in New South Wales.[13]

Despite this, Queensland, South Australia and the Northern Territory are yet to establish schemes, and there are inconsistencies between the schemes that do exist, including different definitions of reportable conduct. For organisations covered by the schemes, there is limited guidance about responding to allegations that involve children with disability. For NDIS providers falling under the jurisdiction of both the NDIS Commission and the state reportable conduct scheme, there is a lack of clarity about how reportable conduct scheme operators and the Commission will work together to promote consistency and reduce duplicated oversight.

We recommend those states and territories yet to establish a reportable conduct scheme do so urgently, and governments and reportable conduct scheme operators should harmonise the schemes and make them more responsive to issues facing children with disability.

Recommendations

Recommendation 11.1 Nationally consistent adult safeguarding functions

States and territories should each:

a. introduce legislation to establish nationally consistent adult safeguarding functions, including:
   - definitions of 'adult with disability', 'violence', 'abuse', 'neglect', and 'exploitation'
   - at a minimum, the principles, functions and powers outlined in Table 11.1.1
   - data collection and public reporting, including demographic data (for example, relating to First Nations, culturally and linguistically diverse, and LGBTIQA+ people with disability)
   - a mechanism to review the legislation after a reasonable period to examine its efficacy.

b. ensure adult safeguarding functions are operated by adequately resourced independent statutory bodies

c. develop a National Adult Safeguarding Framework led by the appointed adult safeguarding bodies

d. consider whether to co-locate the adult safeguarding function with the 'one-stop shop' independent complaint reporting, referral and support mechanism (see Recommendation 11.3).

Recommendation 11.2 An integrated national adult safeguarding framework

The Australian Government should incorporate the National Adult Safeguarding Framework proposed in Recommendation 11.1 into the Safety Targeted Action Plan within Australia's Disability Strategy or another suitable authorising document.

Recommendation 11.3 'One-stop shop' complaint reporting, referral and support

States and territories should each establish or maintain an independent 'one-stop shop' complaint reporting, referral and support mechanism to receive reports of violence, abuse, neglect and exploitation of people with disability. This mechanism should perform the following functions:

a. receive complaints or reports from anyone concerned about violence, abuse, neglect and exploitation involving a person with disability in any setting

b. provide advice and information to people with disability, representative organisations and other interested parties about appropriate reporting options

c. with a person's consent:

   - make warm referrals to appropriate complaints bodies
   - make warm referrals to advocacy and other services who can support them in the complaint process

d. refer 'third party' reports to police, including anonymous reports

e. collect, analyse and publicly report annual data on complaints and reports received and on referrals.

The mechanism should be co-designed with people with disability to ensure entry points are accessible to and effective for people with a range of abilities, language and communication needs.

The mechanism should be placed, if possible, within an existing independent organisation which has appropriate expertise and relationships with services to perform its functions.

Recommendation 11.4 Creating accessible complaint pathways

The Australian Government should work with states and territories to establish a national 1800 number, website and other accessible reporting tools to direct people to the independent complaint and referral mechanism in their state or territory.

Recommendation 11.5 Complaint handling and investigative practice guidelines

The Commonwealth Ombudsman should lead a co-design process with the NDIS Quality and Safeguards Commission, state and territory ombudsmen and other bodies with complaint handling and investigation expertise, to develop guidelines for organisations on implementing complaint handling systems that are accessible and responsive to people with disability. The guidelines should reflect the ten core components:

- creating a rights-focused complaints culture
- encouraging people with disability and others to speak up
- making adjustments to enable participation
- supporting the person with disability, their family and others in complaint processes
- respecting complexity, diversity and cultural difference
- providing clear information about how to complain and multiple pathways to complain
- working respectfully and effectively alongside police
- conducting safe and inclusive investigations that are trauma-informed
- providing tailored outcomes and redress
- using complaints data to drive continuous improvement in service provision and complaint handling.

Recommendation 11.6 Enshrining key provisions of *OPCAT* in legislation

The Australian Government should revisit the Australian Human Rights Commission's recommendation and introduce legislation enshrining the key provisions of the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*) and facilitate the national coordination of Australia's *OPCAT* response.

Recommendation 11.7 Resourcing and wider definition of places of detention

The Australian Government and state and territory governments should:

a. agree to provide resources to enable National Preventive Mechanism bodies in all jurisdictions to fulfil *the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment's* core functions, including the 'preventive package'

b. enact legislation incorporating a broader definition of 'places of detention' to enable all places where people with disability may be deprived of their liberty to be monitored by National Preventive Mechanism bodies.

Recommendation 11.8 Legislating National Preventive Mechanisms

All state and territory governments should introduce legislation to establish the functions of their National Preventive Mechanism bodies and facilitate inspections by the United Nations Subcommittee on the Prevention of Torture.

Recommendation 11.9 Designating National Preventive Mechanism bodies

The governments of New South Wales, Victoria and Queensland should designate National Preventive Mechanism bodies in their jurisdictions.

Recommendation 11.10 Improved consistency and coordination

The Commonwealth Ombudsman should:

a. ensure the OPCAT Advisory Group includes people with disability

b. lead work with the National Preventive Mechanism Network to:

- develop a consistent methodology for determining National Preventive Mechanism inspection priorities
- implement a coordinated approach to prioritising inspections of places of detention that pose a high risk to people with disability, focusing on particular practices affecting people with disability across detention settings
- develop and adopt common disability inspection standards for use in all jurisdictions
- commit to nationally consistent collection and reporting of data about monitoring places of detention.

Recommendation 11.11 Disability inclusive approach to implementing *OPCAT*

National Preventive Mechanism (NPM) bodies in all Australian jurisdictions should implement their functions in a disability-inclusive way by:

- enabling people with disability in places of detention to share information and experiences with the NPM using a variety of communication forms
- ensuring staff participate in ongoing education and training about the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, human rights and issues affecting people with disability in places of detention
- ensuring staff conducting NPM inspections have the skills and experience to provide reasonable adjustments, communication supports and supported decision-making to people with disability when required
- involving people with disability in the inspection of places of detention
- collecting and publishing data about people with disability in places of detention, aligned with disability inspection standards.

Recommendation 11.12 Nationally consistent community visitor schemes

States and territories should:

a. urgently implement community visitor schemes (CVS) for people with disability, if they have not done so already

b. ensure CVS are resourced to conduct frequent visits to individuals who may be at elevated risk of abuse or harm

c. agree to make CVS nationally consistent regarding people with disability, including in relation to:

   - the scope of schemes (who community visitors should visit)
   - powers to visit people with disability, inspect records and provide information to other relevant bodies
   - common monitoring standards
   - the type of data that CVS should capture and report on

d. as a priority, define the scope of CVS with reference to:

   - 'visitable services'
   - mechanisms for identifying factors that may place a person with disability at increased risk of violence, abuse, neglect or exploitation

e. ensure CVS legislation enables relevant information to be shared between CVS, the NDIS Quality and Safeguards Commission and the National Disability Insurance Agency.

Recommendation 11.13 Integration of community visitor schemes with the NDIS

a. The Commonwealth should amend the *National Disability Insurance Scheme Act 2013* (Cth) to formally recognise community visitor schemes (CVS) as a safeguard for people with disability and provide the authorising environment for information sharing between the NDIS Quality and Safeguards Commission (NDIS Commission) and CVS.

b. The Australian Government should:

- enter into a national agreement with states and territories that commits CVS and the NDIS Commission to:
  - sharing relevant information to effectively exercise their respective functions
  - developing common standards for guiding the work of CVS relating to people with disability.
- update the NDIS Quality and Safeguarding Framework to formally recognise the important safeguarding role played by CVS.

Recommendation 11.14 Establishing disability death review schemes

States and territories should establish and appropriately resource disability death review schemes. These schemes should include:

a. functions to:

- receive, assess and record 'reviewable deaths' of people with disability, as defined in recommendation 11.15
- monitor and review reviewable deaths
- formulate recommendations about policies and practices to prevent or reduce reviewable deaths
- maintain a register of reviewable deaths
- formulate strategies to reduce or remove potentially avoidable risk factors for reviewable deaths
- establish and support the work of an expert advisory committee

b. powers to:

- scrutinise systems for reporting reviewable deaths
- undertake detailed reviews of information relating to reviewable deaths
- conduct own motion investigations into individual or groups of deaths
- analyse data on the causes of reviewable deaths to identify patterns and trends
- consult with, and obtain information from, any person or body with relevant information or appropriate expertise
- invite and consider information from the deceased person's family or guardian or advocate when reviewing and/or investigating a death
- notify the NDIS Quality and Safeguards Commission of matters relevant to the exercise of its functions
- refer identified concerns about conduct or service provision to relevant regulatory bodies for their consideration and appropriate action
- publish reports periodically on systemic findings and recommendations arising from all reviewable deaths
- make a special report to the relevant state or territory parliament about any matter that the scheme operator considers to be in the public interest.

Recommendation 11.15 Disability death review scheme requirements

States and territories should ensure legislation establishing disability death review schemes:

a. defines 'reviewable deaths' to include:
    - deaths subject to mandatory notification
    - deaths that a person or body with legitimate interest requests a scheme to review

b. requires deaths that are subject to a mandatory notification requirement include the death of a person with disability:
    - living in supported accommodation at the time of their death
    - residing in a licensed boarding house (or equivalent) at the time of their death
    - residing in custody or in an acute health facility at the time of their death (after the disability death review scheme has operated for a period).

Recommendation 11.16 National agreement on disability death reviews

The Australian Government and state and territory governments should enter into a national agreement that:

a. reflects the functions, powers and definitions outlined in recommendations 11.14 and 11.15

b. defines the respective roles of state and territory death review schemes and the NDIS Quality and Safeguards Commission (NDIS Commission) in relation to the deaths of people with disability

c. articulates the relationship between the functions of the disability death review schemes and the NDIS Commission and ensures the appropriate operational processes are in place to facilitate this

d. provides for information sharing between the death review schemes and the NDIS Commission

e. commits to nationally consistent disability death data collection and reporting requirements, and the inclusion of disability death data within the proposed National Disability Data Asset.

Recommendation 11.17 Nationally consistent reportable conduct schemes

States and territories should:

a. establish reportable conduct schemes, where not already in place, in accordance with Recommendation 7.9 of the Royal Commission into Institutional Responses to Child Sexual Abuse and make public their intended timeframe for doing so

b. take action to harmonise their reportable conduct schemes

c. introduce or amend existing legislation to:

- ensure disability service providers that deliver supports or services to children with disability, including NDIS providers, are included in their reportable conduct scheme
- include 'ill-treatment' in the definition of reportable conduct
- enable reportable conduct scheme operators to adopt a common definition of disability
- require reportable conduct scheme operators to collect and publicly report consistent data about reportable conduct notifications and outcomes relating to children with disability.

Recommendation 11.18 Dual oversight of reportable conduct and incidents

State and territory reportable conduct scheme operators and the NDIS Quality and Safeguards Commission should:

a. jointly develop guiding principles to support the efficient and effective handling of reportable incidents that are also allegations of reportable conduct

b. develop broadly consistent guidance material to assist organisations to better understand key issues relevant to notifying, managing and investigating allegations of reportable conduct and incidents involving children with disability.

Endnotes

1 Australian Law Reform Commission, *Elder abuse – A national legal response*, Final report, June 2017, Recommendation 14-1.

2 The *Office for the Ageing (Adult Safeguarding) Amendment Act 2018* (SA) amended the *Ageing and Adult Safeguarding Act 1995* (SA). The *Ageing and Disability Commissioner Act 2019* (NSW) was passed in New South Wales.

3 Office of the Public Advocate (Vic), *Line of sight: Refocussing Victoria's adult safeguarding laws and practices*, August 2022, p 87; Public Advocate (Queensland), *Adult Safeguarding in Queensland, Volume 2: Reform recommendations*, Volume 2, November 2022, Recommendations 1 and 2; Public Advocate and Children and Young People Commissioner, Submission in response to *Violence and abuse of people with disability at home issues paper*, 26 February 2021, ISS.001.00575, Recommendation 1.

4 Transcript, Nicole Asquith, Public hearing 28, 12 October 2022, P-166 [23-24]; Transcript, Jay Pickard, Public hearing 28, 13 October 2022, P-240 [13-36]; Exhibit 28-015, 'Statement of Ricki Spencer', 30 August 2022, at [52-53]. Exhibit 28-007, 'Statement of Maree Jenner', 17 September 2022, at [73-74].

5 *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006).

6 Public hearing 2, 'Inclusive education in Queensland - preliminary inquiry'; Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern'; Public hearing 7, 'Barriers experienced by students with disability in accessing and obtaining a safe, quality and inclusive school education and consequent life impacts'; Public hearing 11, 'The experiences of people with cognitive disability in the criminal justice system'; Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)'; Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)'; Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence'; Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)'; Public hearing 23, 'Preventing and responding to violence abuse, neglect and exploitation in disability services (a case study)'; Public hearing 24, 'The experience of children and young people with disability in different education settings'; Public hearing 27, 'Conditions in detention in the criminal justice system'.

7 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 4. This report used linked data to examine deaths among people with disability who used disability support services funded under the National Disability Agreement for the 5 years from 1 July 2013 to 30 June 2018. The study included 526,515 people aged under 65 who accessed disability support services, or about 23% of the 2.4 million Australians under age 65 with disability in 2018. The rates and causes of death varied by type of disability, age and sex.

8 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 4.

9 *Disability Inclusion Amendment Act 2022* (NSW).

10 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 36(1)(b).

11 Victoria Disability Services Commissioner, Occasional Paper No. 3 *Learning from reviews of Victorian disability service provision to people who have died 2017 to 2021 – A reflection for future safeguarding*, May 2021, p 2.

12 Royal Commission into Institutional Responses to Child Sexual Abuse, *Final report*, *Vol 7: Improving institutional responding and reporting*, 2017, p 27.

13 Royal Commission into Institutional Responses to Child Sexual Abuse, *Final report*, *Vol 7: Improving institutional responding and reporting*, 2017, Recommendation 7.9.

1. Adult safeguarding functions

Key points

- Violence and abuse against people with disability at home and in public places is a significant, under-reported problem. A gap exists in providing a robust and flexible 'end to end' advice and support coordination response.
- In 2017, the Australian Law Reform Commission recommended adult safeguarding laws. They have been enacted in South Australia and New South Wales. The bodies responsible for exercising adult safeguarding functions in these states are meeting a significant level of need. There have been strong calls for Victoria, Queensland and the Australian Capital Territory to introduce similar laws.
- All states and territories should introduce safeguarding laws to establish an adult safeguarding function. The body responsible for exercising the adult safeguarding function should be resourced to administer information and referral, advice and support, coordination, investigation, public reporting and community education functions.

1.1. Introduction

Volume 10, *Disability Services*, focuses on safeguarding functions for people with disability who experience violence and abuse in a National Disability Insurance Scheme (NDIS) service setting. This chapter is about relevant safeguarding functions for people with disability who experience violence and abuse outside an NDIS service setting, at home and in public places. While for some people with disability, 'home' is a group home or other type of residential accommodation operated by a service provider, 'home' in this chapter means a private home.

Violence and abuse involving known individuals such as friends, families and partners, occurs with significant frequency.[1] Rates of abuse are even higher for people with disability.[2] Although family can provide an important natural safeguard, a high proportion of perpetrators of abuse of people with disability and older people are family members.[3] Similarly, while there is limited Australian research about violence and abuse against people with disability in public places,[4] experts have described it as an under-recognised or under-reported problem[5] that is endemic in the lives of people with disability.[6]

We were told violence and abuse of people with disability at home and in public are both seriously under-reported,[7] and there is an ongoing gap in the service system for responding to it. Many responses to our issues papers identified the need for adult safeguarding laws.[8]

Adult safeguarding laws are not a new concept. In 2017, the Australian Law Reform Commission (ALRC) recommended each state and territory should legislate to give 'adult safeguarding agencies' the role of safeguarding and supporting 'at-risk adults',[9] leading and coordinating the work of other relevant agencies and services. It said adult safeguarding agencies should have certain powers, including, in some circumstances, the power to require people to answer questions and produce documents, and to seek court orders to safeguard an at-risk adult.[10]

In 2018, following the ALRC's report and events relating to the Oakden Older Persons Mental Health Service,[11] the *Office for the Ageing (Adult Safeguarding) Amendment Act 2018* (SA) was passed in South Australia. This established an Adult Safeguarding Unit (ASU) to receive reports of abuse, coordinate a multi-agency response and focus on early intervention, case coordination and information sharing. The ASU's role was originally limited to responding to the abuse of older people but now extends to the abuse of all vulnerable adults.[12]

Also in 2018, the New South Wales Law Reform Commission recommended the NSW Government establish an independent statutory position to investigate allegations of abuse against people needing decision-making assistance, and to coordinate interagency responses.[13] This was followed by a special report to Parliament by the NSW Ombudsman, *Abuse and neglect of vulnerable adults in NSW – the need for action.*[14] The Ombudsman found 'there is an urgent need for an effective, integrated framework and independent lead agency for responding to the abuse and neglect of all vulnerable adults in community settings in NSW'.[15]

In 2019, the *Ageing and Disability Commissioner Act 2019* (NSW) established an independent statutory body, the Ageing and Disability Commission (ADC). Among other responsibilities, the ADC receives, investigates and responds to allegations of abuse, neglect and exploitation of older people and adults with disability.

More recently, in August 2022, the Victorian Public Advocate called on the Victorian Government to establish a new adult safeguarding function.[16] At around the same time, the Queensland Public Advocate recommended the establishment of an adult safeguarding agency.[17] The ACT Public Advocate has also called for nationally consistent approaches to adult safeguarding underpinned by both statutory authorisation and a coordinated service response.[18]

The bodies currently responsible for exercising the adult safeguarding functions in New South Wales and South Australia are filling an important gap in responding to violence and abuse against people with disability in the community. Given this, and the strong support for adult safeguarding functions in other jurisdictions, we recommend all states and territories introduce safeguarding laws. The laws should establish adult safeguarding functions to receive and respond to reports of abuse and neglect of adults with disability in the community. The bodies operating the adult safeguarding functions should be empowered to provide information, referrals, advice and support coordination and to investigate reports and take appropriate safeguarding actions. These bodies should also provide community education and undertake public reporting.

1.2. Experiences of violence and abuse

People with disability experience violence and abuse in a range of settings and by a variety of people.[19]

We were told violence against people with disability at home is commonly hidden from view, misunderstood and mischaracterised.[20] Research commissioned by the Royal Commission emphasised that the care dependence of people with disability on those who perpetrate violence, abuse, neglect or exploitation exacerbates a 'distortion of power and control'.[21]

We were told people with disability experience all forms of violence and abuse in their homes including physical, sexual, and emotional abuse; and threats, intimidation, coercion and disability-specific abuse. This may include interference with mobility aids, equipment and medication; denigration; use of restrictive practices; forced isolation; and threats to withdraw essential care and support.[22] Several responses to the *Violence and abuse of people with disability at home issues paper* described the connection between financial abuse and other types of abuse.[23] We were told about individuals asserting complete control over all aspects of the life of a person with disability. This includes restricting the person's movement, controlling their finances, limiting their access to supports and subjecting them to emotional or physical abuse when they resist.[24] Situations can be severe and life threatening. This was illustrated by Ms Margaret Burn's evidence to the Royal Commission about her sister-in-law, 'Marceline'.

Marceline had multiple sclerosis.[25] When Marceline's condition deteriorated and she needed support, her husband, 'Dominick' isolated her from her family and rejected other supports.[26] After Margaret reported a murder-suicide note sent by Dominick, police found Marceline in a state of neglect and called an ambulance to take her to hospital. She was admitted and stayed for seven months before being discharged to Dominick's care.[27] The following year, Marceline was again admitted to hospital. After having a gastric feeding device inserted, Marceline was discharged to Dominick's care where she died seven months later of malnutrition and sepsis due to severe neglect.[28] Dominick was later convicted of her manslaughter.[29]

Women with disability are particularly likely to experience perpetrators taking advantage of their social isolation to further isolate and control them, especially in the context of domestic violence.[30] Women and girls with disability have documented their experiences of coercive control by families, parents and legal guardians.[31] During Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', Dr Jacoba Brasch QC gave evidence that 'women with disability experience distinct and particular forms of family violence, including threats and withdrawal of care, medication and other assistance'.[32] We also heard from Ms Nicole Lee, a survivor of domestic and sexual assault who uses a wheelchair. Ms Lee spoke about verbal, emotional, physical, financial and sexual abuse by her former husband, who was also her primary carer, over a decade. Ms Lee observed that part of her abuse involved her husband isolating her from family and friends.[33]

Public hearing 28, 'Violence against and abuse of people with disability in public places', heard that public places are real and virtual spaces in the community where people spend their time. They include destinations (such as parks, playgrounds, shops and entertainment venues), pathways (such as streets, shopping centres, public transport and transport hubs) and online platforms (including blogs, dating sites, video-sharing platforms, social media and messaging services). We heard about the impacts on people with disability not being able to access public places to get to work,[34] pursue education,[35] enjoy recreation and participate socially[36] and maintain their health.[37]

While Australian data is limited, Professor Nicole Asquith said, based on her professional knowledge, she believes people with disability 'commonly encounter targeted violence'.[38] A research report prepared for the Royal Commission concluded people with disability are 2.4 times more likely to be at risk of being stalked, compared with people without disability.[39]

Overwhelmingly, the evidence from witnesses with disability was relatively consistent about experiences of harassment, abuse and, sometimes, violence in public places. These experiences are common among people with different disability types, occur in various types of public places and are a continuing problem. Witnesses shared lived experiences of verbal abuse and harassment, intimidation, threatening behaviour, and sexual and physical assault. Many witnesses gave evidence that these incidents are so common they have come to expect abuse whenever they leave their homes.

We discuss abuse at home and in public further in Volume 3, *Nature and extent of violence, abuse, neglect and exploitation*.

1.3. Existing safeguarding responses

In addition to police and health services, there are a range of legal and service responses that can provide supports and safeguards for people with disability who experience violence and abuse in the community.

Hotlines/helplines

There are several hotlines/helplines for reporting violence and abuse that can provide people with disability and older people information and referrals. They include the National Disability Abuse and Neglect Hotline, 1800RESPECT (domestic, family and sexual violence counselling, information and support service) and 1800 ELDERHelp (a national, free-call number that redirects callers to the Elder Abuse Helpline in their state or territory). Hotlines/helplines generally provide information and referrals rather than end-to-end advice and support coordination. They do not have investigation or intervention powers.

Public guardians, advocates and trustees

A public guardian or public advocate can be legally appointed by a guardianship order to make decisions for a person with impaired decision-making capacity, but only as a last resort. Public

trustees provide financial and administrative services to people who cannot manage their own affairs (in addition to other public services).[40] Public advocates also promote and safeguard the rights and interests of people with disability or people with impaired decision-making capacity. In some jurisdictions this may involve both systemic and individual advocacy (such as Victoria)[41] while in others (such as Queensland)[42] the public advocate has a systemic advocacy function only. Public guardian, trustee and advocate functions may also be combined in one agency. For example, in the Australian Capital Territory, the public trustee and guardian are combined.[43]

Some of these bodies have enhanced investigation powers. In Queensland, the Public Guardian can investigate allegations of neglect, exploitation, abuse (including financial abuse) and inadequate or inappropriate decision-making arrangements for adults with impaired capacity.[44] In Australia, the Queensland Public Guardian's extensive investigation powers are unique. They can require a person to produce records or attend before the Public Guardian at a stated date and time, execute an entry and removal warrant and take a range of actions to protect the adult from further harm.[45]

In Victoria, the Public Advocate can investigate any complaint or allegation that a person is being exploited or abused, is under inappropriate guardianship, or needs guardianship.[46] In 2012, the Victorian Law Reform Commission recommended the Public Advocate's powers be expanded to allow investigations of the abuse, neglect or exploitation of 'people with impaired decision-making ability due to a disability'.[47] During Public hearing 26, 'Homelessness, including experience in boarding houses, hostels and other arrangements', the Victorian Public Advocate, Dr Colleen Pearce, told us despite this recommendation and her own requests, she still does not have the power to inspect premises on her own initiative.[48]

In Western Australia, the Public Advocate can investigate any complaint or allegation that a person needs a guardian or administrator or is under an inappropriate guardianship or administration order.[49]

We discuss public guardians, advocates and trustees further in Volume 6, *Enabling autonomy and access*.

ACT Disability and Community Services Commissioner

In the Australian Capital Territory, the Disability and Community Services Commissioner can receive complaints about the treatment of vulnerable people, including adults with disability.[50] The complainant must believe the vulnerable person is subject to, or at risk of, abuse, neglect, or exploitation.[51] The Commissioner can provide information and referral options, investigate the issues and try to conciliate[52] and refer[53] matters, or publish a report where a complaint cannot be resolved. Depending on the issues raised, the Commissioner can share information with other agencies or services. Where possible and appropriate, the Commissioner obtains the vulnerable person's consent to deal with the concerns raised about them.[54]

Adult safeguarding bodies

Only New South Wales and South Australia have adult safeguarding laws that give a specific body advisory functions and investigation and safeguarding powers[55] for responding to violence against and abuse of people with disability (and older people) in the community.

NSW Ageing and Disability Commissioner

The NSW Ageing and Disability Commissioner was established on 1 July 2019 by the *Ageing and Disability Commissioner Act 2019* (NSW). The Commissioner is an independent statutory appointee not subject to the control or direction of the Minister and is supported by staff of the ADC.[56]

A person (including a person with disability) can make a report to the Commissioner[57] about an adult with disability or older adult if they have reasonable grounds to believe the adult is subject to, or at risk of, abuse, neglect or exploitation. They can also make a report about circumstances they reasonably believe will result in the abuse, neglect or exploitation of an adult with disability or older adult.

Functions and powers

Under Part 3 of the Act, the Commissioner has a range of functions[58] to deal with allegations of abuse against, neglect and exploitation of, adults with disability and older adults. The Commissioner can refer matters to appropriate persons or bodies, conduct investigations, and take actions to protect the adult (for example, by making an application to a court or tribunal). The Commissioner also has functions to raise awareness and educate the public about matters relating to the abuse, neglect and exploitation of adults with disability and older adults, inquire into and report on relevant systemic issues, and make recommendations to the Minister.

The Commissioner has the power to make preliminary inquiries to decide how to deal with a report about abuse, neglect or exploitation of an adult with disability or older adult,[59] and whether to investigate a report.[60] The Commissioner can refer a report to another person or body[61] and give relevant information to enable them to provide a service, make a decision or assessment, or take other action about an adult with disability or an older adult, or the safety, welfare or wellbeing of adults with disability or older adults generally.[62]

In addition, the Commissioner can conduct a public inquiry for the purposes of investigating a report,[63] compel people to attend a meeting or produce a document,[64] apply for a search warrant of premises,[65] and take a range of actions when executing a search warrant (if authorised to do so).[66] If the person executing a search warrant is accompanied by a relevant health practitioner, the relevant health practitioner may inspect the premises and observe and speak with any adult with disability or older adult apparently residing at the premises. With consent, the health practitioner can also examine the adult concerned (ensuring the adult has the appropriate support to make such a decision).[67]

Mandatory requirements

If the Commissioner considers a report may provide evidence of a criminal offence, the Commissioner must refer the report, or part of the report, to police or the Director of Public Prosecutions.[68] The ADC told us they continue to be involved in many of the matters they refer to police, providing a safeguarding response that complements and does not compromise police action.[69]

If the Commissioner considers a report, or part of a report, constitutes a complaint that may be made to the Health Care Complaints Commission, the Aged Care Quality and Safety Commission, the NDIS Quality and Safeguards Commission (NDIS Commission), the Children's Guardian or any other body, the ADC must refer the report to the relevant body.[70] In these circumstances, the Commissioner can still investigate a report if they believe conducting an investigation may be necessary to protect an adult with disability or older adult from abuse, neglect or exploitation.[71]

To conduct an investigation into an allegation of abuse, neglect or exploitation of an adult with disability or older adult, the Commissioner must obtain the consent of the adult, except in limited circumstances, including where the adult is incapable of giving consent despite having the appropriate support to make such a decision.[72] (For other exceptions to the requirement to obtain consent, see section 1.5.)

Operational practice

In 2021–22, the ADC received 12,561 calls and 3,975 reports about adults with disability and older people who were subject to, or at risk of, abuse, neglect and exploitation. Of these reports, 903 were about adults with disability (who were not older people).[73] Of reports about adults with disability, 37 per cent featured psychological abuse, 27 per cent featured neglect, 16 per cent featured financial abuse, 14 per cent featured physical abuse and 3.3 per cent featured sexual abuse.[74]

Compared with the previous year, the number of reports received relating to people with disability increased by 14 per cent, higher than the growth in overall reports received of 12 per cent.[75] In 29 per cent of the 903 reports about adults with disability, the allegations pertained to the adult's parent/s. Overall, relatives were the alleged perpetrator in 49 per cent of the reports about adults with disability. In 14 per cent of matters, the adult's spouse or partner (or ex-spouse/partner) was the subject of the allegations.[76]

Over 90 per cent of contact with the ADC in 2021–22 was via the Ageing and Disability Abuse Helpline.[77] The majority of reports are handled solely by the Helpline, mainly by providing advice, information, support and making appropriate referrals. Where substantial further actions are required, reports are assigned to the Community Supports and Investigations unit.[78] In 2021–22, the Helpline alone handled three-quarters of reports. Nineteen per cent involved further work, including making inquiries; working with the adult and other parties to address risks and improve outcomes; referring the matter to NSW Police; and/or investigating the matter.[79]

The ADC referred 352 matters to NSW Police that involved potential criminal offences and made 169 referrals to other agencies.[80] It also referred 150 reports to the Aged Care Quality and Safety Commission, 69 reports to the NDIS Commission and 39 reports to the Health Care Complaints Commission.[81] The ADC commenced 42 investigations (an increase of 20 per cent on the previous year) including 16 investigations into reports about adults with disability.[82]

In 2021–22, the ADC achieved outcomes for older people and adults with disability that included:[83]

- ascertaining their will and preference
- providing referral or help to access aged care, legal, disability, health, advocacy and other supports
- reviewing or assessing needs and supports
- providing or increasing their supports
- taking police or justice action
- making accommodation changes
- reviewing or making changes to decision-making arrangements or NDIS supports
- changing services.

To drive national leadership around adult safeguarding, the ADC has proposed an iterative policy framework aimed at preventing violence against, and abuse, neglect and exploitation of, older people and adults with disability. The proposed framework highlights the interdependent components that identify and address the interactions between the individual, family and community, as well as the social systems needed to live well. Those systems include community and social inclusion; social systems, policies and institutions; family and relationship support and intervention; and individual help and advice.[84] In 2021 the ADC also established a Community of Practice with agencies in other states and territories that have a role in investigating reports or complaints of abuse against, neglect and exploitation of, adults with disability and older people.[85]

Review of the *Ageing and Disability Commissioner Act 2019* (NSW)

The *Ageing and Disability Commissioner Act 2019* (NSW) required the Minister to commission an independent review of the Act and table a report on the outcome of the review before 1 July 2022.[86] In the second half of 2022, Mr Alan Cameron AO was commissioned to conduct the review. Public consultation occurred in late 2022, but the review had not been completed at the time of writing.[87] A number of the issues identified in the review's discussion paper are examined in section 1.5.

South Australian Adult Safeguarding Unit

The ASU is established under the *Ageing and Adult Safeguarding Act 1995* (SA) and is located in the Office for Ageing Well. It commenced operation on 1 October 2019. For its first year of operation, the ASU had a mandate to respond to reports of abuse of adults aged 65 and over (or 50 and over for First Nations people). In response to Recommendation 3 of the Safeguarding Task Force's *Interim Report*, released in June 2020,[88] the South Australian Government expanded the ASU's scope to respond to reports of abuse of adults living with a disability who may be vulnerable. This change took effect on 1 October 2020. From October 2022, the ASU has been able to respond to reports about any vulnerable adult.[89] 'Vulnerable adult' is defined as 'a person who, by reason of age, ill health, disability, social isolation, dependence on others or other disadvantage, is vulnerable to abuse'.[90] To be dealt with as a report under the Act, the report must involve an ongoing risk of abuse of the adult the report is about.[91]

A Code of Practice sets out how the ASU is to fulfil its functions. This includes the actions ASU staff may take to respond to reports of suspected or actual abuse, how they will work with adults to ensure their rights are respected, and how the ASU will work with significant others, including organisations.[92]

Functions and powers

The ASU has a range of functions under section 15 of the Act.[93] It can receive, assess, and investigate reports relating to the suspected abuse of vulnerable adults. It can refer reports to appropriate persons and bodies; coordinate responses with appropriate state authorities, persons and bodies and follow up on reports that have been assessed or investigated. The ASU collates data on matters relating to the abuse of vulnerable adults. It can advise ministers, state authorities and other bodies (including non-government bodies) on systemic matters relating to the abuse of vulnerable adults. It can also publish reports on systemic matters relating to the abuse of vulnerable adults, and on issues of public importance that relate to vulnerable adults.

In carrying out its functions, the ASU must have regard, and seek to give effect to, the Charter of the Rights and Freedoms of Vulnerable Adults.[94]

The ASU has powers to refer a matter to another state authority, or another person or body[95] or to complain to the South Australian Ombudsman or the Health and Community Services Complaints Commissioner on behalf of a vulnerable adult.[96] It can report a matter that raises the possibility of professional misconduct or unprofessional conduct to the relevant regulatory body.[97]

The ASU can also directly investigate the circumstances of a vulnerable adult[98] and require a person or body to produce a written statement, or to answer questions, about a matter.[99] It can require a person to provide information or documents.[100] It can also provide a state authority, or another declared person or body, with information or documents if it reasonably believes that doing so would assist them to perform functions relating to the health, safety, welfare or wellbeing of a vulnerable adult, including to manage risks to the adult.[101]

The ASU can apply for court orders if it reasonably suspects that a vulnerable adult is at risk of abuse.[102] Court orders can be sought to protect the adult from abuse or to assess whether they have been abused, or are at risk of being abused.

In the course of an investigation, authorised officers have powers to inspect and/or enter premises, require a person to produce records for inspection or provide information relating to a vulnerable adult, and take photographs or other recordings.[103]

The ASU must not take action in response to a report unless the vulnerable adult consents to the action being taken. There are some exceptions to this,[104] including where the vulnerable adult's life or physical safety is at immediate risk (for other exceptions, see section 1.5 of this chapter). A vulnerable adult to whom court proceedings relate must, unless the Court is satisfied they are not capable of doing so, be given a reasonable opportunity to personally present to the court their views relating to the proceedings.[105]

If a person is dissatisfied with a determination by the ASU that relates to circumstances in which a vulnerable adult is, or is suspected of being, at risk of serious abuse, they can apply for an external review of the determination by the South Australian Ombudsman.[106]

Operational practice

In 2021–22, the ASU received 2,269 calls, compared with 1,886 calls in 2020–21. This represents a 20 per cent increase in calls, reflecting the enhanced scope of the ASU's role.[107] Of these calls, 1,156 were enquiry calls. For 84 per cent of calls, the ASU was able to support the caller by providing information, advice or assistance with referrals to other agencies or organisations.[108] The ASU received 1,113 reports, an increase of 16 per cent from 2020–21. In relation to people with disability, there were 580 calls (26 per cent), 261 enquiries (45 per cent) and 319 reports (55 per cent).[109] The three largest disability types were intellectual (35 per cent), neurological (15 per cent) and psychiatric (14 per cent). Most of the abuse reported involved psychological/emotional abuse (36 per cent), financial abuse (29 per cent), neglect (25 per cent) and physical abuse (19 per cent).[110]

Of the 1,113 reports received overall by the ASU in 2021–22, 82 per cent were closed following assessment, as the ASU determined no further action was required. According to the ASU, 'In many cases, because of the Unit's input and advice during the assessment phase, supports were strengthened to safeguard the adult such that the case did not need to formally progress to investigation and other safeguarding.'[111] There were 76 reports which 'required safeguarding'. Outcomes achieved in these matters included:[112]

- providing information and education
- moving clients to alternative accommodation
- appointing an administrator or guardian
- engaging/increasing NDIS supports
- referring for legal assistance
- reporting to police.

During 2021–2022, the ASU made referrals to the police, Multi Agency Protection Service, South Australian Civil and Administrative Tribunal, NDIS Local Area Coordinators, Domestic Violence Gateway and Carers SA. Most referrals were made informally; there was only one occasion when the ASU relied on the formal referral provisions in the Act.[113]

In November 2022, the South Australian Law Reform Institute published a review of the operation of the *Ageing and Adult Safeguarding Act 1995* (SA).[114] It noted the number and nature of reports dealt with by the ASU, together with generally positive feedback about the Act and the ASU, were significant. It observed near universal support for retaining the ASU and recommended this occur, while also identifying several areas for clarification and improvement.[115]

1.4. What we were told about adult safeguarding

Current gaps in oversight

Responses to the *Violence and abuse of people with disability at home issues paper* highlighted the need to improve the response to people with disability who experience violence, abuse, neglect and exploitation at home.[116] At Public hearing 17, Ms Margaret Burn identified the need for:

> a system where a third party can override the refusal of the carer to have ongoing community visits. If someone had been going to Marceline's house and seeing her and what was happening, then it is likely she would have received the proper medical attention she needed. If no one else is involved, it creates the perfect environment for neglect.[117]

During Public hearing 28, Professor Emerita Llewellyn told us, 'There are no obvious and readily available structures and processes for reporting interpersonal discrimination when people with disability are moving through the community.'[118] We heard, while incidents of violence and abuse in public places can be reported to police, not all incidents are unlawful. When perpetrators cannot be readily identified, people may not report to police out of a belief nothing can be done. Professor Asquith said some people with disability may not even know what they are experiencing is a crime or, indeed, a 'hate crime'.[119]

Police witnesses generally agreed a historic trust deficit exists between the police and people with disability.[120] Professor Asquith explained:

> there is a need for a third party, almost a liaison between police and targeted communities, where somebody can report an incident that they can receive support from people that know and understand what that violence is, that we can put in place a victim support package; all of those sorts of things. But also if it is the wish of the victim, the third party can then also report that incident to police and they can choose to have that followed up by police or just report it as an information-only report.[121]

South Australian Adult Safeguarding Unit

At Public hearing 28, Ms Cassie Mason – Director of the Office for Ageing Well which accommodates the ASU – explained the ASU was established because there was no 'single government agency with a clear statutory role for safeguarding vulnerable adults who, despite having full decision-making capacity, are experiencing abuse or neglect and are left to navigate complex systems alone'.[122]

Around 30 per cent of reports to the ASU concern suspected abuse of adults with disability. Most reports identify parents, a service provider or partner as the perpetrator.[123] Ms Mason said the ASU's role is 'to provide support to the adult specifically tailored to address and respond to the abuse they are experiencing, in line with their wishes and circumstances as far as possible'.[124]

Ms Mason accepted the legislation governing the ASU permits it to receive reports of violence and abuse against people with disability (or older people) in public places. However, she said the ASU did not promote this capacity or receive calls about public abuse.[125] She emphasised that the way the ASU is currently set up is to address situations where there is an ongoing familial or caring relationship between the adult at risk and the person reported to be abusing them.[126] She said the ASU can only take action where there is an ongoing risk of abuse[127] and referred to the challenges of responding when the alleged perpetrators of abuse are unknown.[128]

Assistant Commissioner Lisa Fellows, South Australia Police, also gave evidence during Public hearing 28 about the positive relationship between the ASU and SA Police and the Memorandum of Understanding that facilitates referrals between the two agencies.[129]

NSW Ageing and Disability Commission

In response to the *Violence and abuse of people with disability at home issues paper*, Carers NSW told us:

> the NSW Ageing and Disability Commission (ADC) is a strong accountability mechanism for older people and people living with disability in NSW experiencing, or at risk of experiencing, abuse, neglect and exploitation within their home or community … and a gateway to the right redress pathway in what is a very complex service landscape.[130]

The ACT Public Advocate and Children and Young People Commissioner similarly endorsed the ADC's strong investigative powers.[131]

During Public hearing 28 we heard evidence from Mr Robert Fitzgerald, NSW Ageing and Disability Commissioner and Ms Kathryn McKenzie, ADC Director of Operations. Mr Fitzgerald described the ADC as 'a unique model' with 'very importantly, not only … a helpline function but an absolute commitment to seeking to resolve issues where we can [and] also to hold people to account'.[132]

Mr Fitzgerald said, in his experience, people with disability are less likely to report violence and abuse to police if there is an alternative. He emphasised, however, the importance of people with disability having the option to report to police if they want to and to be treated respectfully and safely.[133]

Mr Fitzgerald told us the vast majority of reports to the ADC concern abuse against adults with disability by parents and other family members.[134] While abuse by strangers or neighbours is only a small percentage of the matters dealt with by the ADC,[135] Mr Fitzgerald confirmed the definition of abuse, neglect and exploitation in the ADC's legislation does not prevent it from dealing with reports about violence and abuse against people with disability in public places.[136] When asked why the ADC receives so few reports of this nature, Mr Fitzgerald said the ADC was established to respond to abuse in 'family and tightly held community settings' and this is how the ADC has been promoted.[137]

Mr Fitzgerald discussed the potential outcomes of reporting public abuse by an unknown perpetrator to an agency like the ADC. He said the ADC could assist the affected person to report to police or it could refer the matter to police (where appropriate). The ADC may also be able to identify underlying issues beyond the incident that has taken place and provide support, or make referrals to other agencies for support. Mr Fitzgerald said receiving reports of public abuse would also provide data 'as to what's happening in our common and public spaces in a way that isn't currently being collected'.[138]

Ms Kathryn McKenzie gave evidence about the importance of the ADC's educative function, particularly the local Collaboratives supported by the ADC which bring together local council members, health professionals, police, and community support agencies. They play an important role in raising awareness about the abuse of older people and people with disability and promoting the ADC's role.[139]

Acting Deputy Commissioner Anthony Cooke, NSW Police Force, gave evidence that the involvement of police in the Collaboratives assists in building community relationships, trust and confidence.[140] More broadly, he described a positive and effective relationship between the ADC and police. While the ADC must refer matters that reach a criminal threshold to police, police may also refer a matter to the ADC if it is appropriate to do so. The ADC also has direct read-only access to the police incident recording system, COPS. Acting Deputy Commissioner Cooke described 'a strong relationship between the two of us … with regard to reports between the two agencies directed to the ADC or from police as a reference to the ADC'.[141]

During Public hearing 30, 'Guardianship, substituted and supported decision-making', we heard other evidence about the positive work done by the ADC. Ms Justine O'Neill, CEO of the Council on Intellectual Disability, emphasised the ADC's practice of keeping the will and preference of the person with the disability at the centre of their work.[142] Ms O'Neill contrasted this with the practice of public guardians who 'can't do the same, because the law requires them to follow different principles'.[143] The NSW Public Guardian, Ms Megan Osborne, spoke about the ability of her agency to refer matters to the ADC. She said unlike the NSW Public Guardian, the ADC has investigation powers.[144]

Expanding adult safeguarding functions to other jurisdictions

During Public hearing 28, Mr Fitzgerald said other Australian jurisdictions could establish adult safeguarding functions based on the model in New South Wales.[145]

We heard leadership and integration of services is a challenge in jurisdictions without adult safeguarding laws. The ACT Public Advocate and Children and Young People Commissioner told us, 'Despite the breadth and diversity of agencies involved in adult safeguarding services in the ACT, governance, service integration and leadership remain a challenge.'[146] The Commissioner explained at present, multi-agency responses:

> are brought together reactively on a case-by-case basis when concerns are raised with one of the agencies mentioned above. Comprehensive adult safeguarding legislation and a dedicated unit to perform these functions would provide a more robust and integrated response.[147]

The Commissioner recommended the development of 'nationally consistent approaches to adult safeguarding that are underpinned by both statutory authorisation and a coordinated service response'.[148]

In response to the *Violence and abuse of people with disability at home issues paper*, the Victorian Office of the Public Advocate stated:

> We see a role for an advertised non-police contact-point, through which members of the public and service professionals can raise concerns about the well-being of at-risk adults and young adults. This needs to be housed in a body with clear authority to investigate situations of concern occurring in homes, as well as other settings. These investigations should take a supportive intervention approach.
>
> OPA, and like bodies in the states and territories, are well placed to receive complaints and investigate situations of concern involving people with disability which do not involve a crime or an immediate emergency. They will need broader powers of investigation to explore suspected abuse, including circumstances where private decision-making appointees are an alleged perpetrator. This proposal would extend the Victorian Public Advocate's current powers of investigation.[149]

In a submission, the Victorian Office of the Public Advocate recommended all state and territory governments should implement the ALRC's recommendation to establish adult safeguarding laws.[150] At Public hearing 26, the Victorian Public Advocate, Dr Pearce, noted New South Wales and South Australia had introduced such laws but Victoria and other states and territories had not.[151] Dr Pearce referred to her report*, Line of sight: Refocussing Victoria's adult safeguarding system*, which called on the Victorian Government to legislate 'a new specialist adult safeguarding function to enable an agency to receive and assess reports of abuse, neglect and exploitation of at-risk adults via a helpline, undertake investigations and make and coordinate referrals to other agencies'.[152]

1.5. Nationally consistent adult safeguarding functions should be established

Much of the evidence before the Royal Commission has pointed to the need for a clear and supported avenue for reporting violence and abuse experienced by people with disability at home and in public, including when:

- incidents may not breach criminal laws
- the identity of the perpetrator of violence or abuse is unknown to the person with disability
- the person with disability (or the person reporting in the first instance):
    - does not want to report to police or needs assistance to do so
    - does not know what support or assistance is available, or what to ask for
    - just wants to be heard and have their experience recorded.

In submissions following Public hearing 28, Counsel Assisting said the evidence had identified a need for 'alternative reporting pathways' for people with disability who may be reluctant to report public incidents of violence and abuse to police.[153] Counsel Assisting further submitted the National Disability Abuse and Neglect Hotline does not meet this need[154] and the Royal Commission should consider the potential utility of an independent safeguarding mechanism, similar to the Ageing and Disability Commissioner in New South Wales, in every Australian state and territory.[155] We agree.

We recommend nationally consistent adult safeguarding functions should be established. Legislation in each state and territory should task an appropriate independent body to receive, assess and investigate allegations of violence against, and abuse, neglect and exploitation of, adults with a disability. The body should also coordinate safeguarding responses and take further safeguarding action when required.

It is important to emphasise we are not suggesting a compulsory pathway or one that excludes any other support mechanism available to the general population such as the police and criminal justice system. Rather, the intention is to ensure there are a range of options for reporting violence against and abuse of people with disability. Also, that there are clearly identified, adequately resourced and sufficiently empowered bodies with responsibility for responding to reports. Where another agency, such as police or a statutory oversight body, might be able to investigate and respond to the matter, the adult safeguarding body should also be able to make preliminary inquiries, discuss the matter with the person concerned and support them to decide whether or not they wish the matter to be referred elsewhere.

Principles, functions, and powers

Adult safeguarding bodies should be required to have regard to legislated guiding principles when exercising their functions and powers. Table 11.1.1 sets out the principles, functions and powers that adult safeguarding bodies should have at a minimum. Legislation should also incorporate protections for people who make a report to the adult safeguarding bodies in good faith.

Table 11.1.1: Principles, functions and powers of adult safeguarding bodies

Key element	Minimum requirements
Principles	At a minimum, the principles should: • recognise adults with disability have the right to live free from violence, abuse, neglect, and exploitation • recognise adults with disability have the right to be treated with respect for their dignity, privacy, cultural and linguistic diversity, age, gender, sexual orientation and religious beliefs • assume an adult with disability has decision-making ability, unless there is evidence to rebut this presumption (see Recommendation 6.7 in Volume 6) • recognise adults with disability have the right to make their own decisions, to the full extent of their ability, and to be supported in making those decisions if they want or require it • recognise adults with disability have the right to exercise choice and control about the planning and delivery of safeguarding decisions and actions, and to dignity of risk • require the adult safeguarding body to consider the will and preference of the adult with disability, to be determined by supported decision-making where necessary, when exercising the safeguarding function • require safeguarding decisions and actions to be the least interventionist and least intrusive to safeguard the adult with disability.
Functions	Adult safeguarding bodies should have the following functions: • receiving, assessing and investigating reports where there are reasonable grounds to believe an adult with disability is or may be subject to violence, abuse, neglect, or exploitation in a community setting – regardless of whether the risk is ongoing • providing advice and assistance, including referrals to independent advocacy and legal services, police or other regulatory authorities or appropriate bodies • coordinating safeguarding responses tailored to the circumstances of the adult with disability

Key element	Minimum requirements
Functions	• taking direct safeguarding action, including action in a court or tribunal, where the adult safeguarding body reasonably believes it is necessary • collecting, analysing and publicly reporting data about contacts and reports of violence against, abuse, neglect, or exploitation of, adults with disability in community settings • inquiring into and reporting on systemic issues relating to safeguarding adults with disability from violence, abuse, neglect, or exploitation of adults in community settings • promoting and assisting in the development of coordinated best practice strategies for preventing, and early intervention on, violence, abuse, neglect, or exploitation of adults with disability in community settings • raising public awareness about matters relating to violence against, and abuse, neglect, and exploitation of, adults with disability in community settings • advising and making recommendations to the relevant minister about violence against, and abuse, neglect and exploitation of, adults with disability in community settings.
Powers	Adult safeguarding bodies should, at a minimum, have the following powers: • dealing with a matter as a report if the adult safeguarding body reasonably believes it relates to violence against, and abuse, neglect and exploitation of, a person with disability • making preliminary inquiries to decide how to deal with a report • referring a report to another relevant person or body • investigating a report • when investigating a report, compelling any person to attend a meeting or produce a document • conducting a public inquiry, when investigating a report, if it is in the public interest. The adult safeguarding body should consider the seriousness of the matter and the will, preference and privacy of the affected person with disability • applying for and executing an authorised search warrant[156] • enforcing undertakings that the perpetrator of the alleged abuse entered into • applying for a court order if it is necessary to safeguard an individual. Adult safeguarding bodies and relevant prescribed bodies should also have the power to exchange information if doing so is necessary to safeguard an adult with disability.

Additional considerations

Violence and abuse in public places

The ADC has the independence and powers to respond in a flexible manner to violence and abuse in public places. This includes being able to receive reports of, and to respond to, such violence and abuse.

In contrast, the ASU is more confined and has less flexibility to provide a framework capable of responding to the issues explored in Public hearing 28.[157] As explained in section 1.3, the *Ageing and Adult Safeguarding Act 1995* (SA) specifies a report to the ASU will not be taken as a report under the Act if 'there is no ongoing risk of abuse in respect of the vulnerable adult to whom the report relates (whether because the vulnerable adult no longer resides in particular premises or for any other reason)'.[158] Ms Mason emphasised this provision, and its effect, during her evidence.[159]

We consider adult safeguarding bodies should have the power to receive and respond to reports about violence against, or abuse, neglect or exploitation of, adults with disability in public places. However, we stress that adult safeguarding bodies must be adequately resourced to do so. We note the Ageing and Disability Commissioner advised the Independent review of the *Ageing and Disability Commissioner Act 2019* (NSW) that its existing recurrent budget was 'insufficient to meet current and increasing demand' and presents 'ongoing sustainability issues and significant risks' to its ability to meet its legislated functions.[160]

Reporting pathways

Reporting pathways to adult safeguarding bodies should be co-designed with people with disability to ensure they are fit for purpose. Ideally, there will be multiple accessible pathways for the diverse preferences and communication needs of people with disability. The ADC and ASU both operate a phone helpline.[161] The ADC also provides an online reporting option and the ASU has a dedicated email address for enquiries and reports.[162]

There should also be capacity to report anonymously. However, safeguarding bodies should make it clear anonymity may limit the action they can take. At a minimum, anonymous reports could help to identify reporting trends.

Consent

Adult safeguarding requires balancing the principles of autonomy and dignity with protection and risk. Safeguarding measures should be the least intrusive and restrictive option. The adult should be involved in all decisions or actions taken to support and safeguard them.

The ALRC recommended adult safeguarding agencies should obtain consent from an individual before they further investigate or take action about suspected abuse. However, it said in particularly serious cases, such as those involving physical abuse, sexual abuse or neglect,

the safety of the person may need to be secured, even against their wishes. It also said consent should not be necessary where adult safeguarding agencies cannot contact the at-risk adult, despite extensive efforts to do so, or where an adult lacks the decision-making ability to provide consent.[163]

In South Australia, the ASU must obtain the consent of the affected person before it takes action in response to a report, except in limited circumstances. These circumstances include if the action is authorised by a court order,[164] or if:[165]

- the vulnerable adult's life or physical safety is at immediate risk
- the report consists of an allegation that a serious criminal offence has been, or is likely to be, committed against the vulnerable person
- the vulnerable adult has impaired decision-making capacity to consent to action of the relevant kind being taken
- the ASU has not been able to contact the vulnerable adult after reasonable inquiries
- the Director of the ASU approves taking action.

Action does not include assessment[166] but includes referring or investigating a report.[167]

The Independent review of the *Ageing and Adult Safeguarding Act 1995* (SA) recommended widening the circumstances where the ASU can take action without the consent of the affected individual to include 'serious financial or physical abuse'.[168] It also recommended defining 'consent', for clarity, to mean 'a free and voluntary decision and free from coercion'.[169]

In New South Wales, the ADC must obtain consent from a person with disability to investigate a report. This requirement does not apply if the adult is incapable of giving consent, despite being provided with the appropriate support to make such a decision; or it is not necessary to obtain consent due to the seriousness of the allegation or the risk to the personal safety of the adult.[170]

At the time of writing, the Independent review of the *Ageing and Disability Commissioner Act 2019* (NSW) is considering in what circumstances the Commissioner should be able to investigate an allegation without the consent of the relevant individual. In its submission to the review, the ADC recommended that the Act be amended to include, as a ground to investigate without consent, where the ADC, after reasonable inquiries, has not been able to contact the vulnerable adult.[171] Additionally, the ADC raised concerns about the requirement in subsection 13(9) of the Act that, if it receives a report which may provide evidence of the commission of a criminal offence, it must refer the report to police or the Director of Public Prosecutions. The ADC said:

> It is important to recognise that some adults with disability and older people and other parties are contacting the Helpline to obtain information, support and guidance to help inform their next steps. Knowing that the ADC will refer information to police regardless of the adult's wishes works against the other aspects of the Act that are designed to encourage reporting, and acts to dissuade adults and others from contacting the Helpline to get the help they are seeking.[172]

People with Disability Australia's submission to the review of the Act stated:

> The ADC should have the power to conduct investigations without the consent of the adult under certain circumstances. Firstly, if the matter concerns the actual or perceived safety of the adults or other persons, the Commissioner must have regard to any known will and preferences of the adult, as well as consider critical privacy issues. Additionally, the Commissioner should make every effort to provide decision-making support available to ensure inform[ed] consent is provided, and the ADC should be adequately resourced to make decision-making support available.
>
> Secondly, the Commissioner should also have the power to conduct investigations without the consent of the adult where the matter warrants the need to look into systemic failures. In these cases, the Commissioner should take all reasonable steps to protect the person's privacy and de-identify them where possible.
>
> Lastly, where an adult cannot be contacted after reasonable efforts ha[ve] been made, the ADC should have the power to conduct investigations without the consent of the adult. However, the Act must prescribe that the Regulations outline and define what is meant by 'reasonable effort'.[173]

The Council for Intellectual Disability summarised the views of people with intellectual disability consulted for the review:

> One participant stated the Commissioner should be able to help if a person has been badly abused and they are 'not able to talk about it' or if they 'are not ready to say yes but the Commissioner can see'. This participant also stated that if there is proof of abuse but the person denies it, or if they cannot make their own decisions, the Commissioner 'should look into it to make them safe'. Other participants also expressed that the Commissioner should be able to help people who may not be able to speak for themselves, or feel comfortable to say yes. One participant stated that 'Every case should be individualized.' Participants agreed that it is important the person understands what 'yes' and 'no' mean as some people may not know this. Participants stated the person should be supported to understand the meaning and consequences of giving, or not giving, consent. … Participants agreed that the person should firstly be informed if the Commissioner is going to share any of their information.[174]

The Physical Disability Council of NSW and Family Advocacy recommended there should be clear guidelines in the regulations 'as to all relevant factors the Commissioner should consider when determining if an individual has the capacity to provide consent and factors to be considered in determining whether to pursue a complaint without consent'.[175]

Following Public hearing 28, Counsel Assisting submitted:

> while referring matters to police may be appropriate in some circumstances, any adult safeguarding mechanism should respect the wishes and autonomy of people

> with disability. Thus, we consider it would be appropriate for the Royal Commission to consider safeguarding mechanisms which provide warm referrals and support for people with disability wishing incidents to be reported to police, as a form of third-party reporting, only when agreed.[176]

States and territories should consider the above observations and recommendations when legislating adult safeguarding functions, including those of the Independent review (when published) of the *Ageing and Disability Commissioner Act 2019* (NSW).

Assistance and support

When an adult safeguarding body receives a report, it should be able to provide assistance and support directly or by referral to relevant bodies or individuals. Providing direct assistance and support may involve helping a person make a report to police or another regulatory body. It may also involve actively linking the person, with their consent, with peer-support groups, disability advocacy organisations, and other appropriate supports.

Where a referral to another agency is appropriate, the safeguarding body should make a warm referral, with the person's consent, that does not require the person to repeat their experiences. This model is an example of bringing the systems of support to the person.[177]

For safeguarding bodies to provide a useful assistance and support service, they need to be connected to the various local support networks and know the relevant centralised regulatory and complaint handling bodies and service agencies. We discuss access to support and advocacy further in Volume 6.

Information sharing

Adult safeguarding bodies should have appropriate and sufficient information sharing powers to effectively discharge their functions.

In South Australia, section 43 of the *Ageing and Adult Safeguarding Act 1995* (SA) enables information sharing between prescribed agencies where an agency reasonably believes it would assist another agency to either:

- perform official functions relating to the health, safety, welfare or wellbeing of a vulnerable adult or class of vulnerable adults
- manage any risk to a vulnerable adult or class of vulnerable adults that might arise in the agency's capacity as an employer or provider of services.

By contrast, in New South Wales, section 14 of the *Ageing and Disability Commissioner Act 2019* (NSW) enables the ADC to share relevant information with relevant agencies. In response to our *Criminal justice system issues paper*, the ADC explained:

> While these information sharing provisions are important, they require the ADC to be at the centre of any information exchange. To enable an effective and integrated response to alleged abuse, neglect and exploitation of vulnerable adults, it is vital that certain agencies are able to provide and receive information to promote and improve the safety of the alleged victim – without the ADC having to facilitate all of the information exchange.[178]

The ADC said it supported the position expressed in the NSW Ombudsman's 2018 report, *Abuse and neglect of vulnerable adults in NSW: The need for action*. The NSW Ombudsman said legislation should enable bodies that have responsibilities relating to the safety of vulnerable adults to exchange information promoting the safety of vulnerable adults.[179]

We share the ADC's views. We recommend legislation establishing adult safeguarding functions should include information sharing arrangements to enable the adult safeguarding body and relevant prescribed bodies to receive and share information. This should promote and improve the safety of an at-risk adult with disability.

Community awareness

Regular community awareness, media engagement, and education campaigns about any new adult safeguarding function should be conducted to promote the function, encourage reporting, and build trust within the community.

In addition, adult safeguarding bodies must be adequately resourced to raise public awareness of matters relating to violence against, and abuse, neglect, and exploitation of, adults with disability. We commissioned research about changing community attitudes to improve inclusion of people with disability. The research consistently showed that interventions based on information and education are key to changing attitudes, behaviours and outcomes. Long-term approaches with adequate resourcing were identified as a critical facilitator of attitude change.[180]

Many witnesses at Public hearing 28 described the importance of education programs and campaigns to address the ableist attitudes that underlie violence against and abuse of people with disability in public places.[181] Ms Maree Jenner, Vice President of Short Statured People of Australia and Professor Asquith stressed the importance of any such programs or campaigns being part of a well-developed framework, rather than being tokenistic or a 'one-off'.[182]

Several witnesses at Public hearing 28 spoke of the important role of bystanders. Ms Jenner referred to the need for 'upstanders' or 'allies' for people with disability when they are out in public places.[183] Professor Llewellyn explained many bystanders may be 'totally unaware' of what to do when they witness abuse of a person with disability in a public place, saying this requires an educational campaign to equip everyone with the skills to respond appropriately and safely.[184] As part of executing their public awareness role, safeguarding bodies could have responsibility for developing and promoting 'bystander' awareness and education in the community.

Safeguarding bodies could also act as central repositories in each state and territory for identifying, developing and distributing best-practice resources about preventing and responding to violence against, and abuse, neglect and exploitation of, adults with disability in community settings, and more generally. Data collected by the safeguarding bodies and other relevant research shared between the safeguarding bodies should inform the development of these resources.

It is also critical for data collection and public reporting to include demographic data about the backgrounds of people with disability involved in referrals and reports (for example, relating to women, and First Nations, culturally and linguistically diverse, and LGBTIQA+ people with disability), which in turn, can be relied on to inform community outreach, education and awareness activities.

External review option

When legislating for adult safeguarding functions, states and territories should consider whether decisions by the complaint body should be externally reviewable. This is not presently the case in New South Wales. If the Independent review of the *Ageing and Disability Commissioner Act 2019* (NSW) recommends decisions by the ADC be subject to review, other jurisdictions should consider following suit.

Where should adult safeguarding functions be located?

In our view, adult safeguarding functions should be conferred on an independent statutory authority, as in New South Wales. We do not suggest adult safeguarding functions be located with public guardians or public advocates. Bodies exercising adult safeguarding functions should avoid real or perceived conflicts of interest.

During Parliamentary debate in South Australia on the Office for the Ageing (Adult Safeguarding) Amendment Bill 2018, the South Australian Minister for Health and Wellbeing was asked why the Office of the Public Advocate was not the preferred option for the location of the ASU. The Minister's response pointed to governance complexity and potential conflicts of interest.[185]

As part of its 2017 inquiry into elder abuse, the ALRC asked for feedback on the possible benefits of giving the new adult safeguarding role to public advocates. It observed that:

> most public advocates already have a role in investigating abuse, and would only require an extension of this role to adults without impaired decision making; this would also limit the number of state agencies; public advocates could also build on their existing working relationships with the police, government departments, helplines and other bodies.[186]

During the ALRC's inquiry, many stakeholders strongly opposed public advocates taking on a wider adult safeguarding role for these reasons:[187]

- it would represent a significant departure from the current business of public guardians
- public advocates may tend to be too 'paternalistic' towards older people

- it may lead to unnecessary guardianship orders as a response to violence against people with disability
- the dual role of investigator and guardian could create conflicts of interest.[188]

The ALRC's final report observed that guardianship bodies:

> play a crucial role in protecting people with limited decision-making ability and there is a case for giving them additional powers to investigate the abuse of these people, as recommended by the Victorian Law Reform Commission.[189] However, many vulnerable and older people do not have such decision-making limited ability but nevertheless also need support and protection.[190]

The ALRC concluded:

> Given these concerns, the ALRC does not suggest that the recommended adult safeguarding function should necessarily be given to public advocates, but rather that the states and territories decide which of their agencies might perform this role, or whether a new agency might need to be created. One option might be to give new coercive powers to public advocates, so that they can better investigate people in their current jurisdiction, while giving another agency the role of investigating the abuse of other at-risk adults.[191]

Following the NSW Ombudsman's 2018 report, which emphasised the need for any new safeguarding body to have adequate scope to establish a person's circumstances and need for decision-making assistance,[192] the NSW Government decided to establish a new independent statutory body: the ADC.

Should older people be included in adult safeguarding mechanisms?

Adults with disability may be 'older people' and, as such, older people with disability should be covered by adult safeguarding mechanisms. It should be a matter for each state and territory to decide if they wish to incorporate violence against, and abuse, neglect and exploitation of, 'older people' more broadly within the scope of their adult safeguarding function.

1.6. A national adult safeguarding framework

The role of adult safeguarding functions should be articulated in a national adult safeguarding framework. The framework should provide common definitions and a mandate for each state and territory adult safeguarding body to systematically collect, analyse and publicly report data about violence against, and abuse, neglect and exploitation of, adults with disability in community settings.

The proposed policy framework developed by the ADC (see section 1.4) could form the basis of the new adult safeguarding framework, which should be settled via a partnership between the adult safeguarding bodies across the country. The Australian Government should incorporate the Adult Safeguarding Framework in Australia's Disability Strategy or another suitable authorising document.

When designing the legislation to establish the adult safeguarding function, states and territories should consider whether to co-locate the function with the 'one-stop shop' independent complaint reporting, referral and support mechanism recommended in Chapter 2, 'Independent complaint reporting, referral and support mechanisms'. The Australian Government should also have regard to the National Adult Safeguarding Framework in Recommendation 11.1 in the development of a new National Disability Agreement which should clearly set out roles and responsibilities of parties to the agreement (Recommendation 5.1). We discuss the National Disability Agreement further in Volume 5, *Governing for inclusion.*

Recommendation 11.1 Nationally consistent adult safeguarding functions

States and territories should each:

a. introduce legislation to establish nationally consistent adult safeguarding functions, including:
    - definitions of 'adult with disability', 'violence', 'abuse', 'neglect', and 'exploitation'
    - at a minimum, the principles, functions and powers outlined in Table 11.1.1
    - data collection and public reporting, including demographic data (for example, relating to First Nations, culturally and linguistically diverse, and LGBTIQA+ people with disability)
    - a mechanism to review the legislation after a reasonable period to examine its efficacy.

b. ensure adult safeguarding functions are operated by adequately resourced independent statutory bodies

c. develop a National Adult Safeguarding Framework led by the appointed adult safeguarding bodies

d. consider whether to co-locate the adult safeguarding function with the 'one-stop shop' independent complaint reporting, referral and support mechanism (see Recommendation 11.3).

Recommendation 11.2 An integrated national adult safeguarding framework

The Australian Government should incorporate the National Adult Safeguarding Framework proposed in Recommendation 11.1 in the Safety Targeted Action Plan within Australia's Disability Strategy or another suitable authorising document.

Endnotes

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5 Exhibit 28-8, 'Statement of Gwynnyth Llewellyn', 22 September 2022, at [9(a)], [35]; Exhibit 28-14, 'Statement of Nicole Asquith', 23 September 2022, at [52].

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2. Independent complaint reporting, referral and support mechanisms

Key points

- Violence, abuse, neglect and exploitation towards people with disability are likely to be under-reported. This has numerous consequences for people with disability and impacts the effectiveness of public policy responses.
- Multiple barriers to reporting include an existing complaints system that is too complex to participate in without appropriate assistance and support.
- Each state and territory should have an independent one-stop shop providing information and advice about options for reporting violence or abuse towards a person with disability. The one-stop shop should link people to advocacy and other services and make warm referrals to these services and complaint mechanisms.
- The one-stop shop should preferably be established in an existing organisation that has appropriate expertise and resources. Reporting pathways should be co-designed with people with disability to ensure they meet a range of communication needs.
- The Commonwealth Ombudsman and other oversight agencies should develop universal complaint handling guidelines to assist organisations to better respond to complaints of abuse and neglect involving people with disability. The guidelines should be co-designed with people with disability and their representative bodies.

2.1. Introduction

The Australian Bureau of Statistics' *Personal Safety Survey* reports that people with disability were almost one and a half times as likely to have experienced violence compared with people without disability (55 per cent compared to 38 per cent).[1] While people with disability experience violence, abuse, neglect and exploitation at a higher rate than the general population, these experiences are likely to be significantly under-reported.[2]

We received considerable evidence of barriers to reporting violence and abuse and the difficulties people face when they do report.

The complaints system is complex. The setting in which violence or abuse occurs influences whether it is likely to be reported. This is especially the case if the conduct does not rise to the level of a criminal offence, or the person with disability does not want or is unable to report it to police or the responsible organisation. Complaint handling, regulatory and investigative bodies

each have their own jurisdiction and responsibilities and varying degrees of visibility. This can be difficult to navigate. Frustrating and exhausting complaint processes and inadequate access to advocacy support are further disincentives.

Research we commissioned shows there are many other factors that prevent people with disability from reporting violence and abuse. These include threats from perpetrators, fears about the repercussions of complaints and previous negative experiences of complaining. Other catalysts for under-reporting include a lack of awareness of one's rights or what constitutes criminal violence.[3] A recent report found people with disability may be denied access to evidence necessary to pursue their complaint.[4] Some are characterised as 'unreliable witnesses'.[5]

For those who are abused or exploited at home, especially women and girls who experience domestic violence, barriers to reporting include feelings of shame or self-blame, the normalisation of violence and fear of adverse consequences (such as getting the perpetrator in trouble or having one's children removed). Dependence on the perpetrator for care and not being believed or helped after previous attempts at reporting also play a role.

Failing to tackle barriers to reporting has many repercussions. Violence against, and abuse, neglect and exploitation of people with disability will continue to be under-reported, and people with disability will not get the support they need. This can be dangerous and in the most extreme circumstances even fatal.[6] Under-reporting also conceals the full extent of the problem and limits the evidence base to inform well-targeted and effective public policy responses.

It clearly needs to be much easier for people with disability to report violence and abuse and get the right support when they do. Achieving this means removing the onus on the individual to navigate the complaints system while still enabling them to exercise choice and control. In each state and territory, there should be a visible and accessible complaint referral and support mechanism for reporting violence and abuse of people with disability. This should act as a one-stop shop where people can obtain tailored advice and information about reporting options. It should also connect people with advocacy and other services to assist them through the complaint process, and provide warm referrals to organisations that can handle their complaint. A 'warm referral' involves contacting the relevant person or organisation for or with the person needing the referral, rather than just providing contact information. It can involve passing on information, with the person's consent, so they don't have to tell their story again.

A mechanism of this type is not intended to discourage people from directly approaching the most suitable complaints body to handle their concern. Rather, it is there to assist people with disability who are unsure of where to turn and need help finding the right place.

To be trusted and effective, a complaint reporting, referral and support mechanism should be independent and have comprehensive knowledge of the scope and functions of relevant complaint resolution bodies. It must also have strong relationships with local advocacy and support groups and state and territory policing agencies. The organisation charged with operating the mechanism should be aware of issues affecting people with disability who are exposed to violence and abuse. It should offer a variety of options for people to communicate concerns according to their needs and preferences.

States and territories are best placed to identify who should operate the one-stop shop in their jurisdiction. Existing bodies with complementary expertise are one possibility. In Chapter 1, 'Adult safeguarding functions', we recommend that states and territories introduce adult safeguarding laws, empowering a suitable body to receive and respond to reports of violence and abuse of adults with disability in community settings (Recommendation 11.1). States and territories may find merit in locating the proposed mechanism for complaint referral and support, and that of adult safeguarding, within the same body.

Irrespective of independent complaint reporting mechanisms, organisations have a responsibility to implement complaint handling systems that are accessible and responsive to people with disability, particularly to address reports of violence, abuse neglect and exploitation. How an organisation handles individual feedback or complaints of violence, abuse, neglect and exploitation contributes to the efficacy of its measures to prevent future incidents.

We therefore recommend the development of universal guidelines for inclusive and responsive complaint handling to support organisations in this endeavour. The Commonwealth Ombudsman should lead this project, using a co-design process, in collaboration with the NDIS Quality and Safeguards Commission (NDIS Commission), other oversight bodies and people with disability and their representative organisations.

2.2. Navigating a complex complaints system

> Another challenge is the complete fragmentation of legislation, oversight bodies and complaints mechanisms across Australia ...[7]

Commissioned research identified an overwhelming number of different complaint mechanisms for reporting violence and abuse against people with disability.[8] By complaint mechanisms we mean 'the diverse range of public bodies and agencies that are made responsible for handling complaints; this includes various commissions, ombudsmen, government departments and bespoke complaint or oversight agencies'.[9]

Most people know criminal violence and abuse can be reported to police but they may not know how to go about reporting it. In some jurisdictions police have specialist officers or units to liaise with people experiencing domestic violence, sexual assault or elder abuse. These roles are discussed further in Volume 8, *Criminal Justice and people with disability*. Knowing who to address is important.

Not all violence and abuse, however, meet the threshold of a criminal offence or is perceived as a crime by the affected person. Additionally, a person may not wish or be able to report to police for various reasons. In these circumstances, it can be difficult for them to know where else to turn. Even where reporting to police is appropriate and desired, other processes are

often also activated when certain allegations of violence or abuse are reported. For example, organisations may conduct internal investigations of 'reportable incidents'[10] and 'reportable conduct' allegations.[11] The person who reported the violence or abuse may not be immediately aware of this.

Ombudsmen

All states and territories have ombudsmen who can investigate complaints about government agencies in their jurisdiction. Usually this includes educational institutions (including public schools and public universities), prisons and juvenile justice centres, child protection services, housing authorities and local councils.

Some ombudsman offices (for example, those in the Northern Territory and Australian Capital Territory) also handle complaints about police.[12] (In other states and territories, this is the responsibility of different specialist bodies). Depending on the seriousness of the allegations, the matter may be referred back to the police.

While ombudsmen generally handle individual complaints about prisons, some jurisdictions also have inspectors of custodial services whose job is to investigate systemic prison issues.[13] If a complaint involves a health worker or service within the prison, it may be handled by a health complaints body.

Health complaints bodies

Several organisations consider complaints and concerns about health practitioners. The Australian Health Practitioner Regulation Agency (AHPRA) is a national body that investigates complaints or concerns about health practitioners whose conduct may place the public at risk. Some states also have their own bodies to deal with such complaints. All states and territories have agencies handling general complaints about health services. AHPRA works with these agencies to decide whether they or the state agency will handle particular complaints about health practitioners.

Disability complaints bodies

The NDIS Commission handles complaints involving NDIS service providers and the Aged Care Quality and Safety Commission those about aged care providers.[14] The Australian Human Rights Commission (AHRC) can receive complaints about discrimination on the grounds of a person's disability, including complaints that may also have elements of violence, abuse, neglect and exploitation.[15] We discuss anti-discrimination legislation and the AHRC's role further in Volume 4, *Realising the human rights of people with disability*.

In Victoria, the Disability Services Commissioner deals with complaints about government or government funded disability services only, while the Victorian Disability Workers Commission can handle any complaint.[16]

In New South Wales, the Ageing and Disability Commission (ADC) works to 'protect adults with disability and older adults from abuse, neglect and exploitation'.[17] South Australia's Adult Safeguarding Unit within SA Health responds to reports of abuse of adults living with a disability.[18] In Queensland, the Office of the Public Guardian has powers to investigate reports of neglect, exploitation and abuse of people with impaired decision-making capacity.[19] In the Australian Capital Territory, the Discrimination, Health Services & Disability and Community Services Commissioner within the Human Rights Commission can receive, investigate or conciliate complaints about disability services, carers and providers.[20]

Workplace complaints bodies

A range of organisations have the scope to assist with allegations of violence or abuse in the workplace. Unions, the Fair Work Ombudsman, the AHRC and state and territory work health and safety authorities are among them. The complaint mechanisms available to employees of Australian Disability Enterprises (ADEs) vary depending upon how their employment supports are funded.

Child abuse and cyber abuse complaints bodies

All states and territories have mandatory child abuse reporting schemes. Jurisdictions differ as to the types of abuse and neglect that must be reported.

New South Wales, Victoria, the Australian Capital Territory and Western Australia[21] also have reportable conduct schemes to monitor employment related child abuse and ensure it is reported and acted on appropriately by organisations that provide services to children. Each scheme works differently, though the Royal Commission into Institutional Responses to Child Sexual Abuse recommended they should operate in a nationally consistent way.[22] Reportable conduct schemes are discussed further in Chapter 6, 'Reportable conduct schemes'.

Every state and territory has a Commissioner for Children and Young People or an equivalent role that has various other child protection functions.

Nationally, the e-Safety Commissioner can receive and investigate complaints about cyberbullying, adult cyber abuse and image-based abuse (sharing intimate images without the consent of the person shown).[23]

Other organisations

People who have experienced violence or abuse can complain directly to the organisation where the incident occurred. Even when incidents are reported to complaint handling or investigative bodies such as police, an ombudsman or a regulatory body, the organisation concerned still needs to internally investigate the matter.

Handballing of complaints

> You're reaching out for help, and begging someone to help and look at it and support, and you get referred back to the situation that you're in already ...[24]

Problems with the complaint handling system are also illustrated by the 'handballing' of complaints between multiple agencies.[25] People with Disability WA told us in a submission: '[t]here can … be confusion as to which complaints body has jurisdiction over certain matters and in some cases, people are referred from place to place without ever finding a resolution'.[26]

The father of a man with an intellectual disability told us about his attempts to report the sexual assault of his son and poor medical treatment in short-term accommodation. The father tried to file a police report but they referred him to other bodies. He then attempted to file a complaint with the Department of Health and Human Services and the Health Complaints Commissioner but was again referred on to other bodies. It was only when he called on a disability rights legal service that police investigated the matter and interviewed his son.[27]

Women with Disabilities ACT recounted the story of a woman who reported being abused in a group home:

> One woman, an NDIS participant, tried to report the abuse occurring in their group home in January 2019 and was told by the National Disability Abuse and Neglect Hotline that they would not take any more NDIS cases. They then directed her to the NDIA. The NDIA responded that there was no way to report the provider and directed her to their fraud line.[28]

The South Australian Office of the Public Advocate said feedback received by the Safeguarding Task Force revealed that people who contacted the NDIS Commission often found it confusing or never heard back about the outcome of their complaint.[29]

Referral helplines

A range of helpline services have been established at a national and state and territory level in an effort to make it easier for people to report violence and abuse. Most of these are not disability-specific services.

The National Disability Abuse and Neglect Hotline

The National Disability Abuse and Neglect Hotline (the hotline) is a free, independent and confidential service for reporting abuse and neglect of people with disability. It helps callers find appropriate ways of dealing with abuse and encourages them to seek advocacy support if needed. If a caller reports abuse or neglect in a government-funded service, the hotline will refer the report to the relevant funding body to investigate. If they report abuse or neglect in any other situation, it will refer the report to an agency able to investigate or address it such as an ombudsman or complaint handling body.[30]

During Public hearing 28, 'Violence against and abuse of people with disability in public places', we heard about the history of the hotline. Ms Debbie Mitchell, Deputy Secretary, Disability and Carers, at the Department of Social Services (DSS),[31] said since 2001 it has been operated by 'independent organisations' yet is government funded.[32] The hotline was originally intended for reporting abuse and neglect of people with disability in disability services nationwide.[33] Its scope eventually expanded to fielding reports of abuse and neglect in any context.[34]

Ms Mitchell said WorkFocus Australia has had the contract to operate the hotline since July 2012.[35] From 2015, it joined the array of services accessed via the JobAccess Gateway[36] and is part of the JobAccess website.[37]

The hotline can either give a caller details of the appropriate body to respond to their report or make a referral, with their consent.[38] In 2021–22 it received 400 calls, of which 310 included a report of abuse or neglect.[39] A 2019 evaluation of the JobAccess services, found the hotline performs an important function but questioned its effectiveness.[40] We discuss the use of the hotline further in Section 2.3.

Other helplines

The Australian Government through DSS also funds 1800RESPECT, a national domestic, family and sexual violence counselling service.[41] Reachable by phone or online chat, callers speak to a trained counsellor who can help them find the right services or support.

Every state and territory has an elder abuse helpline that can provide information, support and referrals to people who experience, witness or suspect elder abuse. Most of these helplines are run by community-based organisations. Following the Australian Law Reform Commission's report on elder abuse in 2017, the Australian Government promised to establish a national elder abuse hotline.[42] 1800 ELDERHelp was launched in March 2019. The free call (to 1800 353 374) redirects callers to the helpline in their state or territory.[43]

Elder abuse helplines do not provide a disability-specific service. In New South Wales, callers are redirected to the Ageing and Disability Helpline operated by the ADC. In South Australia, they are redirected to the South Australian Abuse Prevention Phone Line operated by the Adult Safeguarding Unit (ASU). Both of these have safeguarding functions for people with disability, as described in Chapter 1.

2.3. Additional barriers to reporting

People with disability wishing to report violence and abuse and obtain support face a range of additional barriers. We heard considerable evidence about these.

Language and cultural barriers

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 about the barriers people with disability from culturally and linguistically diverse communities encounter while accessing different complaints systems. Language barriers can impair a person's ability to fill out forms[44] or understand correspondence from an agency or service.[45] The lack of interpreters and information in different languages may prevent people from understanding their right to complain[46] or pursuing a complaint once made.[47] Evidence suggested access to interpreters can be very poor, even at a 'very basic level'.[48]

A further barrier identified by witnesses was the absence of culturally responsive and trauma-informed practice in providing services and information. Many people from refugee and asylum seeker backgrounds may feel uncomfortable asking for support or are unaware of their rights to supports.[49]

Low awareness of the National Disability Abuse and Neglect Hotline

Most witnesses who described their experiences of violence and abuse in public places in Public hearing 28 had not heard of the National Disability and Abuse Hotline.[50] One witness had heard of it but not used it.[51] Ms Mitchell acknowledged this was concerning[52] and an indication people lack an understanding 'that this is an avenue for them to report abuse and neglect'.[53] She said it was 'timely to be looking at the way in which we do promote the hotline' and 'where it's best fit within the Commonwealth'.[54]

Other evidence also hinted at low awareness of the service. Baptist Care SA said 'the National Disability Abuse and Neglect Hotline is a fantastic tool', but that it is not visible enough.[55] During Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', 'Claire' told us that the hotline needs to be better publicised and should be 'front and centre of the Disability Gateway website'.[56]

In contrast to the 310 reports of abuse or neglect received by the National Disability and Abuse Hotline nationally in 2021–22,[57] there were 903 reports of abuse and neglect of adults with a disability to the ADC in New South Wales alone in the same year.[58]

Poor outcomes with previous complaints

Throughout our public hearings, witnesses told us of negative experiences and poor outcomes when complaining to organisations. Only in a few cases were these experiences positive with appropriate action taken.[59] Most people expressed dissatisfaction with responses to complaints.[60] Some examples include:

- At Public hearing 2, 'Inclusive education in Queensland – preliminary inquiry', dedicated to inclusive education in Queensland, 'AAA', a parent of a child with disability, said she raised incidents with the principal of her child's school 'almost every day'.[61] She said instead of helping, 'the principal blamed me and that I had a – a problem or a relationship issue with the teacher'.[62]
- At Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a Case Study)', focusing on abuse in a group home run by Sunnyfield, 'Eliza' and 'Sophia' said they felt 'brushed off' or ignored when they raised concerns with staff.[63]
- At Public hearing 21, 'The experience of people with disability engaging with Disability Employment Services', looking at people's experiences with Disability Employment Services, 'Mzia' said, 'I raised my issues of things not only with the company but with outside places to report complaints. I've never heard anything from them. Nothing got resolved. I'm still getting pushed through a system where I'm not getting listened to.'[64]
- At Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)', examining abuse and neglect in disability services, 'Sally' said she never received a response from disability services provider Afford to her complaint about her son's treatment at day programs.[65]
- At Public hearing 32, 'Service providers revisited', Sam Petersen told us that '[t]he responses from management to complaints or negative feedback from myself and others was inconsistent, inadequate, and untimely'.[66]

Negative experiences of police

Commissioned research found that many people with disability have had negative interactions with police and courts. For example, one report cites research suggesting women with intellectual disability who report violence to the police regularly have their reliability questioned.[67] A further research report, *Police responses to people with disability*, found:

> While some individual police demonstrate good practices and approaches, on a systemic basis police do not respond effectively to promote safety and protect people with disability who are victim-survivors, witnesses and alleged offenders.[68]

Respondents to our *Violence and abuse of people with disability at home issues paper* pinpointed many factors that impact on reporting to police. Among them are police perceptions that people with disability lack credibility; their attitudes and stereotypes about disability; poor practices; and reporting pathways.[69]

In Public hearing 17, we heard about mixed experiences of reporting to police. 'Clarisse' described how police responded to a report about the sexual assault of her daughter, 'Romi':

> The police came to our house and supported [her] in her own environment. They made a really big effort to establish a rapport with her. Like, she loves computers so she – he brought a computer game and talked to her about the game and just established that rapport before she had to do the next step of an interview. He was very understanding and very compassionate about the whole thing and did his utmost to get it further than it got.[70]

'Chloe' too said the police officer who dealt with her matter was friendly, understanding and listened to her. The charges against the alleged perpetrator went to court.[71]

Despite having many previous negative experiences of police,[72] Nicole Lee told us:

> I remember the police officer came in on her day off to take my statement because she understood not to miss that moment in time while I was willing to do it. My case was handled by the Victoria police Sexual Offences and Child Abuse Investigation Team and they were good. I had a single point of contact and I could meet them in the police station. They understood domestic violence. I worked with three detectives who were familiar with trauma, abuse and manipulation. They were much better than uniformed officers. They knew not to wait.[73]

By contrast, 'Clarisse' said once when Romi was being interviewed by police, they would not allow her or Romi's father or disability support case manager to be in the room to support her.[74] On this occasion, police were quite intimidating.[75] When Clarisse asked them if she should get a lawyer, they said, 'This is not your case. This is the state versus this person and you don't need a lawyer.'[76] Clarisse also asked about a referral for Romi to the Sexual Assault Unit, and police refused.[77] She said the police 'were so intimidating and not approachable' and 'there was no empathy … there was no support really'.[78]

During Public hearing 28, 'Elissa' said she was told by the police that they couldn't do anything because she was not hurt.[79] 'Jenni' said that people with disabilities fear police after being in trouble for other incidents.[80] 'Marie', who works in an autism support organisation, said autistic people have shared with her their negative experiences making reports to police. They described not being believed, being misunderstood or treated as the cause of the abuse. Often, they are told to ignore or avoid the abuse.[81] Julie Butler, Advocacy Practice Leader of Speak Out Advocacy Tasmania, said the groups' members fear either retribution, not being believed or a lack of action when reporting to the police.[82]

Women with disability face particular challenges in reporting family violence to police.[83] We heard about this in Public hearing 11, 'The experiences of people with cognitive disability in the criminal justice system'. Dorothy Armstrong told us about negative dealings with police throughout her life. She described how their responses to family violence in her home led her to be terrified of police. Poor support and follow up when reporting, being disbelieved and hostility from police contributed to her fear and lack of trust.[84] Michael Haralambous, a senior

lawyer from Victoria Legal Aid, said people often describe negative contact with police due to inappropriate responses, inaction, or misidentification of perpetrators. All of this contributes to reduced trust in police.[85]

WWILD Sexual Violence Prevention Association told us that although women with intellectual disabilities experience extremely high rates of sexual violence, few victim-survivors file reports with police.[86] Advocacy Tasmania said people with disability may fear retribution, or experience re-traumatisation or shame, preventing them from making a complaint or police report.[87]

No trusted pathway for reporting abuse in public places

At Public hearing 28, witnesses with disability gave accounts of reporting incidents of public violence and abuse in public places. Sometimes the results were positive and action was taken. For example, Peta Stamell told us after being verbally harassed by a group of young men in Tamworth, she reported the episode to police and gave them a video she had taken of it. The video showed a number plate which allowed police to identify the car's owner. They attended the man's home, confiscated video footage the group had made and issued a warning. Ms Stamell said, 'I actually really appreciated that they did give them a stern warning because they didn't have to, and I really felt like they had my back.'[88]

Most people however did not make a report or felt their reports were dealt with in an unsatisfactory manner.[89] Common reasons for people with disability not reporting instances of violence and abuse included:

- not knowing who to report to[90]
- trauma, shame or fear of getting into trouble[91]
- the conduct being normalised or not understanding that it is abusive[92]
- fearing they will not be taken seriously or believed if they report[93]
- previous reporting being ineffective[94]
- a lack of trust in police in general or in police taking appropriate action[95]
- being told to ignore the problem or to simply 'walk away' in past cases of abuse[96]
- seeing no value in reporting, particularly if they cannot identify perpetrators[97]
- not having the time or energy to report abuse that is ongoing.[98]

Professor Nicole Asquith told us research indicates people with disability are the least likely of all victims of hate crimes to report it.[99] The research also found that:

> issues in getting police to take disabled people's complaints seriously is exacerbated for those who already face scepticism about their ability to know what is happening to them, to advocate for themselves, or, in some instances, to be believed.[100]

Professor Asquith explained some people with disability may be unaware that the abuse they are experiencing is a crime or indeed a 'hate crime'.[101] Similarly, Professor Gwynnyth Llewellyn said it is not always clear to people, particularly young people, they have experienced something they can report.[102]

Professor Asquith said high levels of distrust in police in the disability community can hinder reporting.[103] Even when reports are made to the police, 'there is no guarantee that that police officer will recognise it as targeted violence and will record it as such and investigate it as such'.[104] Previous interactions with police can influence the likelihood of people with disability reporting violence and abuse in public places. Police witnesses at the hearing widely agreed that a historic trust deficit exists between police and people with disability.[105] Senior Sergeant Jay Pickard from Queensland Police observed that a failure to report means police can't investigate, respond to or take preventive measures against criminal activity.[106]

If a person with disability does not wish to report public violence or abuse to police, their choices are limited. Many complaint mechanisms described in section 2.2 only handle reports about violence and abuse in institutional settings. As explained in Chapter 1, the ADC in New South Wales and ASU in South Australia largely respond to violence and abuse at home. Neither are promoted as handling calls relating to cases of public violence and abuse.

Barriers to reporting violence and abuse at home

Responses to our *Violence and abuse of people with disability at home issues paper* revealed that people with disability facing domestic or family violence often do not know how and where to seek support.[107] The Sex Discrimination Commissioner and the National Children's Commissioner told us a lack of access to information among women with disability and their carers is a key reason why violence often goes unreported.[108]

Sometimes, behaviour is not recognised as abusive or criminal. During Public hearing 17, 'Claire' told us that when a former partner stalked and harassed her, she didn't report it to anyone. Claire said, '[I] didn't feel comfortable ringing the police because I didn't really see that it was a crime … I didn't really know that what I was experiencing were abusive behaviours at the time.'[109] As commissioned research highlighted:

> Understanding that an experience of violence is an issue that is reportable is a key precondition for a complaint being made. If people do not understand that they have been wronged, or that they can report a wrong, then the complaint cannot happen.[110]

At other times, a failure to report stems from negative experiences people with disability have when disclosing or reporting violence and abuse at home. The ADC told us that people with disability who approach them may have previously received a poor response from police and may be reluctant to contact them again.[111] Women with Disabilities Victoria told us that women with disability who disclose experiences of violence are often discredited or ignored.[112] Tasmania's Speak Out said many people choose not to go through with reporting because they are not understood or believed or face discrimination due to their disability.[113]

In Chapter 1, we discussed how people with disability who are abused at home may be socially isolated. In some instances, they may rely on a carer who is also the perpetrator of abuse. In this case, they may fear retaliation or having no one to care for them if they report the abuse. As Nicole Lee told us:

> I had no choice but to stay due to the lack of care and support, the dislocation from friends and family and the total reliance I had on my ex left me stuck. People think it is a woman with a disability's choice to stay in a domestic violence relationship. They do not look at the person and their situation as a whole. Leaving means she can lose her child/children to Child Protection, not be able to look after herself and be put in residential care. It is all of those factors. My ex had made me completely reliant on him and he'd broken down my relationships with family and friends. I had no close friends. I had no one. He isolated me and made me reliant on him because of my disability.[114]

Poor knowledge of how or who to complain to

Submissions have stressed that the main barrier to reporting faced by people with disability is a general lack of knowledge or information about how to lodge a complaint.[115] This is explained partly by the complexity of the complaints system already outlined.

Queenslanders with Disability Network told us that many of its members reportedly do not understand the complaints processes including who to take a complaint to.[116] Similarly, the Northern Territory Health and Community Services Complaints Commission considered vast under-reporting of complaints is partly due to challenges identifying and navigating complaints systems.[117] On this point, the Royal Australian College of General Practitioners told us:

> It may be difficult to identify the appropriate channels to report suspected violence, abuse, neglect or exploitation. While reports to police may be obvious if a crime has clearly been committed, guidance on reporting where matters are less certain is needed.[118]

People with disability registered with Disability Employment Services told us they are often ill-informed of their rights and ways of complaining about abuse from a provider or employer.[119] We heard there is confusion about which complaint handling bodies are responsible for responding to abuse in ADEs.[120]

Commissioned research identified numerous examples of people with disability not making a complaint simply because they were unaware they could or didn't know where to begin.[121] The research also indicates that generally, the only complaint handling bodies to openly solicit complaints about abuse, neglect and exploitation are those with a disability-specific focus.[122] Few non-disability-specific complaint bodies do so. The abuse reporting facility of the Victorian Government Department of Education and Training is an exception.[123]

Frustrating and exhausting complaint processes

> I felt that nothing was happening. I was making complaints, I was talking to people, I was trying to get somewhere, but I think they call it the deafening silence. When they answered, they said they would ring, they never rang. It would go ages, I didn't know what was happening, I didn't know where to go.[124]

The authors of *Complaint mechanisms: Reporting pathways for violence, abuse, neglect and exploitation* prepared for the Royal Commission reported that:

> our analysis of websites, including where appropriate and available, legislation, policies and procedures, showed that potential complainants with disability, along with parents of children and young people with disability, are frequently expected to navigate their way through sometimes convoluted and unclear processes … those who navigate these processes can become exhausted, and can feel like the hurdles to complain are insurmountable.[125]

Academic research, reports and submissions examined in this report gave examples of times when complex complaint processes appeared to deter complainants.[126] The *Complaint mechanisms* report noted that 'it is clear that unless the complainant "keeps on" the complaints process, then a fair outcome will not eventuate'.[127] To illustrate this, cases of extensive lobbying and advocacy by parents on behalf of children with disability in educational settings were cited. In one instance, the mother of a child with a disability had to complain to the school principal and the education department, and use the language of 'human rights', so that her son could freely access the toilets:

> even then when I was having the discussion with this senior person from the Department of Education and the principal, they were trying to tell me that it wasn't – it was permitted by law, what they were doing, under the Disabilities Discrimination Act – and I had to say … I don't care about the Disabilities Discrimination Act – this is a Human Rights issue.[128]

Across hearings and submissions, we have been told that negotiating complaint processes often requires constant efforts. We heard of the emotional investment demanded of families to hold schools to account while already managing the trauma of their child being abused.[129] During Public hearing 2, 'AAC' spoke of the emotional toll from having to continually intervene to ensure her child's school made reasonable adjustments to support their learning. She described the experience as 'absolutely exhausting and frustrating and unnecessary'.[130]

Similar issues arise regarding complaints about disability services. In Public hearing 13, 'Sophia' told us the regional manager of her child's disability service rarely responded to her emails raising issues of concern.[131] She said, 'You would wait to hear back and every now and again we would get an email that "we are going to follow this up" … But I guess it felt like, when is this going to happen, when are we going to get any answers?'[132] In Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', 'Jennifer' spoke of her attempts to complain about the provider, Life Without Barriers (LWB). 'One of the reasons I did not wish to continue my complaint against LWB was because it had been so exhausting making complaints to different people and agencies over a period of 10 years and feeling like no action was being taken in response.'[133]

Insufficient access to advocacy support to complain

People who are well informed and capable of navigating systems are most likely to benefit from complaint mechanisms, whereas they are often inaccessible to the people who most need them.[134]

JFA Purple Orange told us that current complaints systems rely on 'articulate, assertive and empowered complainants'.[135] Relationships Australia, in response to our *Safeguards and quality issues paper,* said:

> Corrective measures such as complaints systems and processes can be complex, daunting and formidable for people with disability and their supporters. Most of our clients have been unsuccessful in achieving a resolution to their complaints about their service experiences. Their trauma is exacerbated by the complaints system itself as they attempt to negotiate some acknowledgement of, and remedy for, their experiences.[136]

Ms Esther Simbi, who works with people with disability from culturally and linguistically diverse backgrounds, told us 'many people do not have the voice or confidence to articulate their needs, provide feedback, report something that is not correctly done, or request a new support worker'.[137] Ms Kylie Scoullar, General Manager of The Victorian Foundation for Survivors of Torture (Foundation House), spoke of trauma affecting people's ability to self-advocate and make complaints.[138]

At Public hearing 3, 'The experience of living in a group home for people with disability', we heard about people with disability having inadequate access to advocacy or other support in order to negotiate the complaints system. Some witnesses said they were not told how to engage the help of an external advocate when they needed to.[139] Ms Sarah Forbes, Advocacy Manager at VALID, an organisation that advocates for people with intellectual disability, spoke of these challenges.[140] She said information about accessing advocates is often not passed on to residents of group homes.[141] Residents may also face many other practical difficulties if they wish to make a complaint or contact an advocate. For example, they may not have a phone they can use without asking for permission.[142]

The Royal Australian College of General Practitioners agreed that limited support exists for people with a disability wanting to report.[143] Advocacy Tasmania told us that people with cognitive disability are often treated as 'unreliable witnesses' in the health system and their complaints are not taken seriously. The organisation said 'while accessibility issues can be mitigated through referral to advocacy services, these referrals do not occur as often as they should'.[144] People with disability in supported employment settings receive a similar lack of support engaging with complaints systems.[145]

Submissions have suggested there needs to be more upfront support for people with disability when engaging with the NDIS Commission.[146] The Joint Standing Committee on the National Disability Insurance Scheme also explained the importance of access to independent advocacy and specialist legal assistance for people with disability making a complaint to the NDIS Commission.[147]

In Public hearing 20, Samantha Taylor, the then Acting Commissioner of the NDIS Commission, spoke of the rules that require all providers to have complaints and incident management systems. They aim to empower people with disability with the right to remedy things, without a fear of repercussions from the providers they have chosen to deliver their supports.[148] However, Ms Taylor acknowledged this is the 'aspiration' and 'there is a significant way to go in attaining that'.[149] She also acknowledged this still leaves gaps for participants without sufficient advocacy, or vulnerable persons, particularly those in group homes.[150] Ms Taylor said this was one reason the NDIS Commission decided to conduct the Own Motion Inquiry into supported accommodation.[151]

2.4. Solutions to reporting barriers

Submissions suggested there should be better access to online reporting via an easy to use webpage anyone can access to make a complaint or report.[152] The NSW Disability Council recommended '[a]ccess to a triage service to increase reporting as people are often unsure whether to report'. They suggested the service could be accessible by text, phone, online and in person.[153] The AED Legal Centre told us 'options should be provided to access groups who can then provide or refer additional supports such as advocates, translators and/or any other appropriate additional assistance for people with high support needs'.[154]

During Public hearing 17, Claire told us about the importance of being able to easily find online information about violence, abuse, neglect and exploitation 'so that people with disability can identify that these things are forms of violence or abuse and find out what their options are and where they can go'.[155] Claire explained:

> If you are isolated in a relationship and you are not connected to other services or to the community and your person – and your partner is the person providing the physical assistance – you don't know how your personal and private support needs will be met. This is the reality, and this is why there needs to be these kinds of resources.[156]

At the same hearing, Nicole Lee said there should be 'a more proactive system' for linking people who have experienced abuse with supports. She said, 'I did not know what to ask for to get the support I needed. They put the responsibility on the person in crisis to work all of this out.'[157]

Several witnesses who gave evidence at Public hearing 28 stressed the need for clear, safe and readily accessible reporting pathways for targeted abuse in public places.[158] For example, apps and online reporting forms that could be used in conjunction with telephone helplines. Mariam Veiszadeh provided evidence about the establishment in 2014 of the Islamophobia Register Australia in response to increasing incidents of anti-Muslim abuse, the majority of which were not being reported. She explained that there was a lot of hesitancy within the Australian Muslim community at that time to come forward to report incidents of abuse.[159] Consequently, Ms Veiszadeh decided to set up a mechanism that would allow incidents to be reported to a register, which could then be used to generate data for analysis and reporting in order to provide the 'evidence' necessary for the development of appropriate policy reforms in response.[160]

Professor Asquith spoke about the need for a third-party reporting model which keeps police at 'arm's length' until the person with disability wants them to be involved. The person may choose to have the report referred to police for further action or for information only.[161] A third party reporting mechanism should provide 'the victim the power to make a decision about what justice looks like for them'.[162]

Some witnesses agreed with the idea of a third-party reporting option that is independent from the police. Ms Maree Jenner, Vice President of Short Statured People of Australia said:

> people should be able to make reports through a phone or messaging service (like the Lifeline crisis online chat service) so that people do not have to physically attend the police station. This would increase the likelihood of our members reporting conduct on the lower end of the spectrum of seriousness. We would also like to have an organisation or phone line that we can refer people to receive support and advice, separate from the police.[163]

Ms Ricki Spencer, a First Nations transgender woman living with physical and psychosocial disabilities, had a similar view. To address the fear of retribution many people with disability have when reporting violence and abuse, they should be able to anonymously report details of the abuse to a third party.[164] She said:

> I think that a good place to start would be establishing alternative reporting avenues for victims of violence and abuse. This could be through trusted community groups or advocacy organisations. I think that if these organisations could act as a link between victims and the police, it might lead to people like me feeling more comfortable reporting our experiences.[165]

Mr Tim Marks, President of the Tasmanian Amputee Society and Tasmanian Director of Physical Disability Australia, had a different view. He gave evidence about his own experience as a person with disability. He told us, 'I think it would be very helpful if the police had a specific disability unit or hotline that people with disability could call to report incidents including threats, harassment and intimidation by strangers.'[166]

Witnesses from police services gave evidence on the benefits and features of a collaborative reporting model between the police and community organisations. Senior Sergeant Pickard expressed support for a third-party reporting model as described by Professor Asquith, while noting that there are already various avenues for reporting to the Queensland Police Service.[167] He also stressed that 'working within a co-responding model is absolutely critical to address problems that are multifaceted'.[168] Acting Deputy Commissioner Cooke highlighted the beneficial relationship that the New South Wales Police Force has with the ADC, in terms of third-party reporting.[169] However, this model relies on legislation that requires the ADC to report potentially criminal matters to the police, without any consultation with, or consent from, the person affected.[170]

The police witnesses each agreed an effective third-party reporting mechanism needs the following:[171]

- expertise
- community trust and engagement
- connections with the right organisations and to be well co-ordinated with those organisations
- to be capable of analysing information to identify trends or hotspots.

The South Australian Office of the Public Advocate in its submission highlighted the widened scope of the Adult Safeguarding Unit (ASU) to receive reports about people with disabilities.[172] This followed a 2020 recommendation by the South Australian Safeguarding Task Force. The ASU can now treat reports of abuse about 'a person who, by reason of age, ill health, disability, social isolation, dependence on others or other disadvantage, is vulnerable to abuse'.[173]

During Public hearing 30, 'Guardianship, substituted and supported decision-making', the Victorian Public Advocate, Dr Colleen Pearce, called for a similar adult safeguarding mechanism. This should include a 'central helpline' to receive calls about violence, abuse, neglect or exploitation and functions and powers to investigate where appropriate.[174] In a separate submission, the Victorian Office of the Public Advocate explained:

> We see a role for an advertised non-police contact-point, through which members of the public and service professionals can raise concerns about the well-being of at-risk adults and young adults. This needs to be housed in a body with clear authority to investigate situations of concern occurring in homes, as well as other settings. These investigations should take a supportive intervention approach.[175]

After Public hearing 28, Counsel Assisting submitted that it was open to the Royal Commission to find modified or additional reporting and response frameworks are required to encourage reporting. On top of ensuring that people with disability receive appropriate supports, increased reporting would permit data analysis and in turn, the design of better preventive and responsive strategies.[176] We agree.

2.5. A one-stop shop for independent complaint reporting, referral and support

We have identified the value of establishing, in each state and territory, a one-stop shop: a highly visible, independent and accessible mechanism that:

- anyone can contact to get tailored advice and information about their options for reporting violence or abuse of people with disability
- links people with advocacy and other services that can support them to access and participate in the complaint process
- provides warm referrals to appropriate complaint mechanisms and shares relevant information with these organisations with the person's consent.

This mechanism would differ from existing services, such as the National Disability Abuse and Neglect Hotline in important ways. It would be situated in, and have extensive knowledge of, the local jurisdiction and complaints system. This would include knowledge about the functions and powers of agencies able to assist, so that the best reporting options can be identified. The mechanism would also have strong, practical links to local advocacy and support options, as well as police, to streamline and provide a supported pathway to accessing these services. There is no similar reporting pathway in Australia. Commissioned research found that:

> While improvements to existing mechanisms are possible, there remains a need for an independent complaint mechanism to respond to violence, abuse, neglect and exploitation, with strong perceived independence, neutrality, transparency, trustworthiness, effectiveness and capacity to support and recognise the voice of complainants. At present, this independent, dedicated, pathway … does not appear available within the existing terrain of relevant Australian complaint mechanisms.[177]

Given the evidence we have received about the need to, and benefits of, making it easier for people to report violence and abuse to police, a key aspect of the mechanism's work would be providing (with consent) a supportive third-party pathway for reporting to police. The focus of police-reporting is generally on holding perpetrators to account but this is not the only reason for wanting to make a report. Some people may simply want to be heard or have their experience recorded. The mechanism should be able to receive and refer anonymous reports for this purpose.

In recommending such a mechanism, we recognise that:

> rights to equal treatment and access to justice will be undermined if a complaint mechanism is designed with the intent that it be the primary or exclusive forum for responding to violence, abuse, neglect and exploitation of people with disability (including if such design becomes a justification for not transforming courts and justice systems).[178]

We do not suggest an independent complaint reporting, referral and support mechanism is a 'silver bullet' for overcoming all the barriers to reporting discussed in Section 2.4. Rather, it is proposed as a way of making it easier for people to take the first step towards reporting violence and abuse. They can then be informed about the most appropriate places to report it, assisted to establish contact with that place, and linked with any supports they need to proceed through the complaint process.

Where should the function be located?

States and territories should determine where to locate the mechanism. Where possible it should be placed within an existing organisation well equipped to discharge the responsibilities and adopt a human rights based and person-centred approach.

Like the state and territory elder abuse hotlines, which operate under the banner of 1800ELDERhelp, the mechanism could be publicised as a single, national, entry point. This includes providing a 'national' 1800 number, website and other accessible reporting tools (such as an app) and diverting people to the mechanism in their state or territory.

The ADC in New South Wales and the ASU in South Australia may be well placed, with appropriate legislative amendments and sufficient resourcing, to perform the functions of an independent complaint referral and support mechanism. In Chapter 1, we recommended that all states and territories establish similar adult safeguarding mechanisms (Recommendation 11.1). States and territories should also consider whether to co-locate this mechanism with the adult safeguarding function.

Recommendation 11.3 'One-stop shop' complaint reporting, referral and support

States and territories should each establish or maintain an independent 'one-stop shop' complaint reporting, referral and support mechanism to receive reports of violence, abuse, neglect and exploitation of people with disability. This mechanism should perform the following functions:

a. receive complaints or reports from anyone concerned about violence, abuse, neglect and exploitation involving a person with disability in any setting

b. provide advice and information to people with disability, representative organisations and other interested parties about appropriate reporting options

c. with a person's consent:

   - make warm referrals to appropriate complaints bodies
   - make warm referrals to advocacy and other services who can support them in the complaint process

d. refer 'third party' reports to police, including anonymous reports

e. collect, analyse and publicly report annual data on complaints and reports received and on referrals.

The mechanism should be co-designed with people with disability to ensure entry points are accessible to and effective for people with a range of abilities, language and communication needs.

The mechanism should be placed, if possible, within an existing independent organisation which has appropriate expertise and relationships with services to perform its functions.

Recommendation 11.4 Creating accessible complaint pathways

The Australian Government should work with states and territories to establish a national 1800 number, website and other accessible reporting tools to direct people to the independent complaint and referral mechanism in their state or territory.

2.6. Developing guidelines for inclusive and responsive complaint handling

Regardless of whether there are independent complaint reporting, referral and support mechanisms, organisations have a responsibility to provide complaint handling systems and investigation processes that are accessible and responsive to people with disability. The evidence received by the Royal Commission about barriers to, and experiences of, complaining suggests that organisations would benefit from further guidance in this area.

Existing guidance

Guidance is available for organisations to develop effective complaint handling practices, as well as responding to complaints relating to particular service settings or regulatory contexts.

The International Organization for Standardization,[179] has produced a global complaint handling standard for organisations, *Quality management – Customer satisfaction – Guidelines for complaints handling in organizations.*[180] This is considered authoritative and Standards Australia has produced an Australian adaptation, which articulates a set of guiding principles.[181]

The Commonwealth Ombudsman has published a *Better Practice Complaint Handling Guide.*[182] Among the complaint handling resources developed by the NSW Ombudsman are the *Effective complaint handling guidelines*,[183] a *Complaint Management Framework* and *Complaint handling Model Policy*,[184] and with the NSW Customer Service Commissioner, the *Commitments to Effective Complaint Handling* which all NSW Government agencies are required to implement.[185] The Victorian Ombudsman has published a *Handling Complaints* guide[186] and a *Good Practice Guide: Handling complaints in a crisis.*[187] Other state and territory Ombudsmen have also published complaint handling guidelines.[188] Many other bodies have published complaint handling guidance and resources targeted at particular sectors and/or topics.[189]

Existing standards and guidelines promote the need for complaint handling processes to be easy to use and flexible, and to treat complainants with dignity and respect. They generally do not specifically address the accessibility and responsiveness of these processes to people with disability and their supporters. Or, they may provide some guidance for disability service providers but not for other types of organisations. There are limited practical examples that organisations can apply to their own context.

These may help to explain disparities between objectives set out in an organisation's policy and what happens in practice.[190] Most service provider policies on complaints or incident reporting provided to the Royal Commission stressed the importance of processes being 'accessible' and the need to keep people with disability informed and involved.[191] However, few providers could actually explain how frontline staff support people with disability to formulate a complaint, provide feedback or participate in an internal process. There is little guidance about the steps service providers should take to encourage and respond to individual feedback or complaints.[192]

Examples of universal guidelines

We think there should be 'universal' guidelines in place for organisations to support complaint handling systems and investigation processes that are accessible and responsive to people with disability. In particular, better guidance is required about processing more serious complaints and conducting investigations in a trauma-informed manner. The guidance should encourage the active participation of people with disability in the process.

The *Complaint Handling Guide: Upholding the Rights of Children and Young People* published by the National Office for Child Safety[193] is an example of universal guidelines. The guidelines were commissioned in response to the recommendation of the Royal Commission into Institutional Responses to Child Sexual Abuse that organisations consistently respond to complaints and concerns in a child-focused way.[194] Developed by the NSW Ombudsman in consultation with the Office of the e-Safety Commissioner, the AHRC and children's guardians, commissioners, and ombudsmen's offices across Australia, the guidelines can be used by any organisation, large or small. They include practical advice about topics such as involving children in a complaints process, responding to trauma during the complaints process, and interviewing children during investigations.

We consider organisations of all types, not just disability service providers, would benefit from similar universal guidelines for handling complaints about violence, abuse, neglect and exploitation of people with disability.

Guidance must be authoritative and co-designed

It would be appropriate for the Commonwealth Ombudsman in partnership with the NDIS Commission and state and territory complaint oversight bodies (such as ombudsmen and commissioners), to lead the development of universal guidelines. Bodies with substantial experience in complaints handling and investigative practice should also participate. The guidelines should be co-designed with people with disability and their representative organisations. A recent example of a co-design approach is the NDIS Participant Safeguarding Policy. The development of the policy involved many people with disability, families, carers and other representatives[195] and was informed by a Participant Safeguarding Co-Design Steering Committee which provided strategic advice, governance and oversight over the co-design approach, co-design workshops and consultations with the disability community.[196]

Core components of guidelines

In Volume 10, *Disability services,* we recommended that the NDIS Commission should develop guidelines on accessible and responsive complaint handling and investigative practice for use by the NDIS Commission and NDIS providers (Recommendation 10.14). We said they should be informed by the ten core components outlined in Table 11.2.1.

The core components are also applicable to organisations more generally and should be reflected in the recommended universal guidelines. The core components identified in Table 11.2.1 are intended to complement, rather than replace, the key elements of effective complaint handling that are identified in more generic standards and guidelines, such as those identified earlier in Section 2.6. The universal guidelines should also include practical examples demonstrating how the guidelines apply to organisations which may receive (or oversee the handling of) complaints from or on behalf of people with disability about violence, abuse, neglect and exploitation.

In relation to making adjustments (Core component 3), we discuss what this entails further in Volume 4, *Realising the human rights of people with disability*.

Table 11.2.1: Core components needed to uphold the rights of people with disability in complaint and investigation processes

Core component		Description
1	Creating a rights-focused complaints culture	Organisations should communicate and promote a person's right to make a complaint. Leaders and senior managers should adopt a non-defensive attitude to complaints and prioritise resolving complaints in a way that upholds the rights of people with disability. Staff should receive training and support in the handling of complaints involving people with disability.
2	Encouraging people with disability and others to speak up	Organisations should implement practical measures to encourage people with disability, their families, supporters and staff to speak up about concerns, whether minor or serious. They should regularly ask people with disability of any concerns they may have and take steps to protect them from any harm if they speak up.
3	Making adjustments to enable participation	Organisations should make adjustments to allow people with disability full participation in all stages of the complaint handling and investigation process. They should check on the adjustments required by an individual and demonstrate flexibility in accommodating these.
4	Supporting the person with disability, their family and others in complaint processes	Organisations should ask people what support they need during the complaint process, respecting their views and preferences. This includes regularly checking in and recognising their support needs may change.
5	Respecting complexity, diversity and cultural difference	Organisations should recognise that people with disability like others have multifaceted lives and ensure their complaint and investigative procedures cater to their diverse backgrounds, abilities, needs and experiences.

Core component		Description
6	Providing clear information about how to complain and multiple pathways to complaints processes	Organisations should ensure multiple pathways exist to make complaints, answering to the varying communication needs and preferences of people with disability. This also means providing clear information about the right to complain and how to make a complaint.
7	Working respectfully and effectively alongside police	Organisations should refer potential criminal matters to police and provide necessary information to support police investigations. They should ensure their complaint responses do not interfere with any ongoing criminal investigation and arrange supports (including decision-making supports) to assist people with disability to participate in police investigations.
8	Conducting safe and inclusive investigations that are trauma-informed	Organisations should ensure investigations are trauma-informed, involving people with disability in the process by seeking their views, explaining actions and addressing any safety risks. This also means meeting communication support requirements and making necessary referrals to counselling, advocacy, legal services or other services. Individuals with safeguarding investigative expertise should conduct investigations with clear guidance on interviewing people with communication support needs. Investigations should address the impact of the causes of complaints on the person with disability, the environment in which they arose, and make recommendations to reduce the likelihood of them reoccurring.
9	Providing appropriate outcomes and redress	Organisations should communicate fully with people with disability, their families and supporters when determining the outcome of complaints. This includes explaining the reasons for decisions, actions that will be taken and review options. When required, they should provide redress adjusted to the individual and the nature and severity of the complaint. Forms of redress include apologies, referrals to counselling and support and ex gratia payments. They should be clearly set out in an organisation's complaints policy with guidance on when these options should be considered.
10	Using complaints data to drive continuous improvement in service provision and complaint handling	Organisations should collect and analyse data about complaints to identify trends and causes and inform continuous improvement. Data should include the number and type of complaints received, systemic issues identified, complaint outcomes and requests for review where a complainant was dissatisfied with the outcome. Where possible, it should also capture information on a complainant's disability and communication and support needs.

Recommendation 11.5 Complaint handling and investigative practice guidelines

The Commonwealth Ombudsman should lead a co-design process with the NDIS Quality and Safeguards Commission, state and territory ombudsmen and other bodies with complaint handling and investigation expertise, to develop guidelines for organisations on implementing complaint handling systems that are accessible and responsive to people with disability. The guidelines should reflect the ten core components:

- creating a rights-focused complaints culture
- encouraging people with disability and others to speak up
- making adjustments to enable participation
- supporting the person with disability, their family and others in complaint processes
- respecting complexity, diversity and cultural difference
- providing clear information about how to complain and multiple pathways to complain
- working respectfully and effectively alongside police
- conducting safe and inclusive investigations that are trauma-informed
- providing tailored outcomes and redress
- using complaints data to drive continuous improvement in service provision and complaint handling.

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3. Optional Protocol to the Convention Against Torture

Key points

- The *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*) is a national and international oversight mechanism. *OPCAT* provides a means of driving compliance with the *Convention on the Rights of Persons with Disabilities* by helping to identify and prevent violence, abuse, neglect and exploitation of people with disability in places of detention.
- Australia ratified *OPCAT* in 2017 but is yet to comply with the requirement to establish National Preventive Mechanisms (NPMs) in all states and territories to independently monitor places of detention.
- The Australian, state and territory governments should urgently cooperate to ensure NPMs are established and adequately resourced in all jurisdictions so that *OPCAT* is fully implemented. They should adopt an expansive approach to interpreting *OPCAT* to ensure all places of detention where people with disability are deprived of their liberty fall within the monitoring scope of NPMs.
- NPMs in all jurisdictions should take a disability-inclusive approach to monitoring places of detention. All governments should ensure these bodies have the resources, commitment and skills needed to identify and focus on issues that affect people with disability in places of detention, and to effectively engage people with disability in places of detention.

3.1. Introduction

The *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*) is an international human rights agreement ratified by Australia on 21 December 2017.[1] *OPCAT* is aimed at preventing the mistreatment of individuals in 'places of detention' that fall within the jurisdiction and control of the State Party. States that ratify the agreement are required to establish an independent mechanism, known as a National Preventive Mechanism (NPM), to inspect all places of detention.[2] States also agree to periodic inspections of places of detention by the United Nations Subcommittee on the Prevention of Torture (SPT).[3]

An important theme that emerged during the Royal Commission was the 'criminalisation of disability'. This is where people with disability become 'caught in a cycle of social exclusion and criminalisation, resulting in their incarceration and re-incarceration in the criminal justice system' rather than supported through community-based programs.[4] People with disability, particularly

people with mental illness or cognitive disability, are disproportionately represented in prisons, juvenile detention centres and police cells.[5] They are also more likely than other people to reside in institutional or 'closed settings' – such as residential accommodation, mental health facilities and hospitals. While intended to provide support, these are also places where people may be deprived of their liberty.[6]

People with disability have experienced mistreatment in places of detention including indefinite detention and solitary confinement. They have also faced neglect and sexual abuse in justice settings,[7] and the inappropriate use of restrictive practices in education settings[8] and disability services.[9] Others have experienced physical abuse, sexual abuse and neglect within disability services.[10]

Evidence emphasised that if implemented effectively, *OPCAT* is 'a very important safeguarding process'[11] with the potential to help prevent the mistreatment of people with disability in places of detention.[12] At the same time, submissions have questioned the level of genuine commitment by governments to implementing *OPCAT* in Australia.[13]

The Australian approach to establishing an NPM is based on all governments determining an independent body or bodies to perform NPM functions in their respective jurisdictions.[14] At the time of writing, the three largest jurisdictions – New South Wales, Victoria and Queensland – still had not nominated bodies to perform their NPM functions. These states indicated they do not intend to prioritise *OPCAT* until a funding agreement to support implementation is reached with the Australian Government. Meanwhile, the Australian Government and some states and territories have started to established the necessary infrastructure to implement *OPCAT*, but overall progress has been slow and inconsistent.

When *OPCAT* was ratified, the then Minister for Foreign Affairs described it as a 'significant human rights achievement'[15] demonstrating 'Australia's unwavering commitment to international scrutiny and accountability'.[16] Yet half a decade later, the Australian Human Rights Commissioner has expressed concern that Australia is at risk of joining countries such as Burundi, the Democratic Republic of the Congo and South Sudan for failure to comply with the obligations set out in article 17 of *OPCAT*.[17] Article 17 requires States to 'maintain, designate or establish, at the latest one year after the entry into force of the present Protocol or of its ratification or accession, one or several independent national preventive mechanisms for the prevention of torture at the domestic level'.[18]

In October 2022, the SPT suspended their visit to Australia because New South Wales and Queensland refused to provide unrestricted access to all places of detention. In February 2023, the SPT announced that they had terminated the visit as the issue of unrestricted access had still not been resolved.[19] Rwanda is the only other country to have had an inspection visit by the SPT terminated.[20]

We agree with the Human Rights Commissioner's assessment that full implementation of *OPCAT* in Australia is well overdue and urgently needed.[21] The Australian Government should seek to resolve outstanding funding issues with state and territory governments as soon as possible and the states and territories should participate in this process in good faith.

All governments should implement legislation in their jurisdiction which clarifies and facilitates the full implementation of *OPCAT*, including monitoring of places of detention by NPMs and the SPT. The legislation should include a broad definition of places of detention, ensuring that other places of detention where people with disability are deprived of their liberty fall within the scope of NPMs.

To establish a disability inclusive approach to implementing *OPCAT*, all governments should ensure the bodies appointed as NPMs have the skills and resources needed to identify issues affecting people with disability in places of detention. They must also demonstrate a commitment to effectively engage with people with disability in places of detention.

The input from people with disability and their representative organisations should inform the work of NPMs. Through the NPM Network, chaired by the Commonwealth Ombudsman, NPMs should work collaboratively to adopt common disability standards for inspections and commit to reporting relevant data in a nationally consistent way.

3.2. How *OPCAT* works

OPCAT provides for independent, proactive monitoring of institutional and closed settings with the aim of preventing and addressing the 'concealed and authorised' nature of mistreatment that can occur in these settings.[22] This approach differs from the complaint-driven model of many oversight bodies. It aims to remedy a power imbalance that exists for people in places of detention and the multiple barriers that prevent or discourage them from seeking redress.[23]

Places of detention

OPCAT was drafted to apply to any place within a State's jurisdiction where individuals are deprived of their liberty under the direction of a public authority, or with their consent. Article 4 provides that 'deprivation of liberty' means 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority'.[24]

As the time of writing, the SPT was preparing a general comment on article 4 with the aim of clarifying the obligations of State Parties to *OPCAT* regarding the definition of places of deprivation of liberty. For the SPT, this is a 'crucial issue', as *OPCAT's* key monitoring mechanism is the system of preventive visits by the SPT and the NPMs to all places of deprivation of liberty.[25]

National Preventive Mechanism

OPCAT requires State Parties to have a National Preventive Mechanism (NPM) for the prevention of torture and other cruel, inhuman or degrading treatment at a domestic level.[26] While each jurisdiction may choose how it operationalises the NPM, the designated body or bodies must have functional independence and be adequately resourced to comply with *OPCAT*.[27]

OPCAT requires NPMs to have power to:[28]

- regularly examine the treatment of the persons deprived of their liberty in places of detention and strengthen where necessary protection against torture and other cruel, inhuman or degrading treatment or punishment
- make recommendations to relevant authorities with the aim of improving the treatment and conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, according to United Nations norms
- submit proposals and observations concerning existing or draft legislation.

OPCAT states that NPMs must be empowered to choose the places they want to visit and people they want to interview to fulfil their mandate. They must also have the right to access all places of detention, privately interview all persons deprived of their liberty, and access all information concerning their treatment and conditions of detention.[29]

The SPT has recommended that NPMs should also have the power to deliver the 'preventive package', which includes:[30]

- examining patterns of practices from which risks of torture may arise
- commenting on legislation and human rights action plans and other advocacy
- providing public education
- undertaking capacity building
- actively engaging with State authorities.

UN Subcommittee on Prevention of Torture

States which ratify *OPCAT* must facilitate international inspections of places of detention by a delegation of the United Nations Subcommittee on the Prevention of Torture (SPT). The SPT is composed of 25 independent and impartial members drawn from countries which are parties to the Protocol. Members serve in their personal capacity and are drawn from a variety of backgrounds, including lawyers, medical professionals and detention and inspection experts. Members do not work for any government and do not receive any instructions from State authorities.[31]

The full mandate of the SPT is detailed in article 11 of *OPCAT*. Its primary role is to:[32]

- visit places of detention and make recommendations to States about protecting people deprived of their liberty from mistreatment, and strengthening the capacity and mandate of NPMs
- maintain contact with NPMs and advise and support them to strengthen their capacity.

SPT visits are carried out according to the principles of cooperation and confidentiality. The delegation visits a variety of places of detention and speaks in confidence with the

people held there as well as staff and other relevant people. The delegation also meets with relevant government officials, NPMs, human rights institutions, non-government organisations and others. In addition to providing immediate feedback, the SPT provides a confidential formal report to the State after the visit. The State is asked to respond to any recommendations or requests for further information in the report. The report remains confidential until the State requests its publication, together with any comments the State might wish to make. The SPT may undertake follow up visits to learn of new developments and monitor the implementation of recommendations.[33]

3.3. Why *OPCAT* matters for people with disability

OPCAT provides a means to uphold the rights articulated in the *Convention on the Rights of Persons with Disabilities* (*CRPD*)[34] by preventing and addressing the mistreatment of people with disability in places of detention.

In 2019, the United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee) raised serious concerns about Australia's compliance with article 14 of the *CRPD* (Liberty and security of person). It cited evidence of the arbitrary and indefinite detention and forced treatment of people with disability, disproportionately affecting First Nations people and people with cognitive or psychosocial disability. The CRPD Committee also raised serious concerns about Australia's compliance with article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment), including the use of restrictive practices against people with disability in justice, education, health, psychosocial and aged care settings.[35] We have also heard evidence about the mistreatment of people with disability in places of detention.[36]

Restrictive practices

One of the most frequent ways that the rights of people with disability are breached in places of detention is through the use of restraint and seclusion practices.[37] Submissions have highlighted problems with laws, regulations and guidelines on restrictive practices, including that they are inconsistent, unclear and contravene the *CRPD* and other international human rights treaties.[38] The Australian Human Rights Commission (AHRC) suggested that if implemented effectively, *OPCAT* will provide an 'umbrella' oversight and monitoring mechanism. This will help prevent and reduce the use of restrictive practices against people with disability and better identify how practices such as seclusion and restraint are used in various settings. It will also inform data about the type and prevalence of these practices.[39] Other submissions proposed that NPM inspections prioritise the monitoring of restrictive practices in social care and residential settings,[40] as well as restraint and seclusion in school settings.[41]

During consultations to support *OPCAT* implementation, the AHRC heard that monitoring seclusion and restraint practices in places of detention should be a priority.[42] In New Zealand, this had reportedly led to more effective management of these practices.[43]

Oversight of restrictive practices through *OPCAT* inspections would address recommendations made by previous inquiries. For example, in 2015 the Senate Community Affairs References Committee recommended the Australian Government work with state and territory governments to implement a national framework to eliminate restrictive practices. It should apply to all service delivery contexts and be a mandatory, reviewable and enforceable scheme.[44] In 2019, the CRPD Committee made a similar recommendation to Australia.[45]

We discuss the use of restrictive practices further in Volume 6, *Enabling autonomy and access*.

Children in detention

In Public hearing 11, 'The experiences of people with cognitive disability in the criminal justice system', we heard about people with disability being held indefinitely within prisons or forensic facilities often in seclusion and unsatisfactory conditions. This evidence included the stories of 'Melanie' and 'Winmartie', which Counsel Assisting described as 'unfortunately not isolated cases'.[46]

Case study: 'Melanie' and 'Winmartie'

'Melanie' and 'Winmartie' (pseudonyms) were both known to child protection services from an early age and entered the criminal justice system as teenagers. They have been detained indefinitely since being found unfit to plead to charges of manslaughter.[47]

Melanie, a 38-year-old First Nations woman, has received varying diagnoses but is presently described as having an intellectual disability, borderline personality disorder and extreme self-harming behaviour. She has a background of severe childhood trauma including sexual abuse. As a teenager Melanie was found unfit to be tried for two serious acts of violence. Instead she was ordered to be detained for 13 years, yet at the time of Public hearing 11 (February 2021) been held for over 20 years. Melanie was first held in prison, and then detained as an involuntary civil patient at Sydney's Forensic Hospital as it was determined there was no alternative location to adequately meet her needs.[48]

Melanie was held at the Forensic Hospital for seven years almost constantly in seclusion, sometimes spending more than 23 hours a day in her cell.[49] A forensic psychiatrist described the conditions Melanie lived in as 'Dickensian'. While the Mental Health Review Tribunal called it 'filthy and degrading – the area was substandard and clearly not conducive to any form of recovery'.[50]

Winmartie, a 30-year-old First Nations man, had severe childhood epilepsy and continues to suffer frequent seizures. He has also been diagnosed with an acquired brain injury and an intellectual disability. Winmartie experienced significant childhood abuse and trauma including isolation and bullying by members of his community.[51]

As a teenager, Winmartie was found not fit to plead for an act of serious violence. After he was found guilty of manslaughter by reason of diminished responsibility,[52] a custodial supervision order was made for an indefinite period of time as permitted by Northern Territory legislation. Winmartie was incarcerated in an adult prison for several years then transferred to the Alice Springs Secure Care Facility.[53] In 2014, the Australian Human Rights Commissioner described Winmartie as having been 'subject to the most severe treatment while in prison, including frequent use of physical, mechanical and chemical restraints, seclusion, and shackles when outside his cell'.[54] Both Melanie and Winmartie continued to be detained at the time of the hearing.

During Public hearing 27, ‘Conditions in detention in the criminal justice system’ we heard of children with disability detained in Banksia Hill Detention Centre and their exposure to squalid conditions, solitary confinement, physical and emotional abuse and medical and educational neglect.[55] Research conducted between May 2015 and December 2016 found that of 99 young people at Banksia Hill Detention Centre who were assessed, 89 per cent had severe neurodevelopmental impairment and 36 per cent were diagnosed with with Fetal Alcohol Spectrum Disorder.[56]

Case study: 'Nathan' and 'Maison'

The Royal Commission heard about First Nations men, 'Nathan' and 'Maison' (pseudonyms), who were both detained as children at Banksia Hill Detention Centre in Western Australia.

Nathan has a diagnosis of ADHD and a history of trauma. He first went into youth detention when he was 11 years old and cycled in and out of detention in his teenage years.[57] Nathan's evidence described his harrowing time at Banksia Hill. He suffered physical abuse at the hands of detention staff, including while in handcuffs, resulting in injuries. He experienced strip-searching, the use of mechanical restraints, isolation and extended lockdowns.[58]

Nathan described the physical conditions in segregation as 'dirty and disgusting'. The multipurpose unit cells were cold and dark with concrete floors and walls. They smelt of urine.[59] Some days he would not be let out for fresh air, at others he was allowed out for 20 minutes.[60] Nathan also spoke of inadequate mental health care. His first self-harm attempt was at Banksia. Following that incident, he was left naked on the floor of his cell. He felt that his cries for help were not being taken seriously.[61]

Maison first went to Banksia when he was 15 years old. Like Nathan, he experienced extended periods of isolation and engaged in self-harm. Whilst in isolation Maison told his mother that he had no psychiatric visits or medical attention and rarely showered.[62] He complained of being strip searched and having insufficient access to medical and mental health care. Once he suffered grazes to his face when staff handcuffed his hands behind his back, cuffed his feet, then attached his hands and feet with a third set of handcuffs.[63]

Dr Adam Tomison, Director-General of the Western Australian Department of Justice, also gave evidence at Public hearing 27. Asked about the treatment of detainees at Banksia Hill's Intensive Support Unit, Dr Tomison said, 'Would I have called it cruel, inhuman or degrading? I wouldn't have, but I certainly accept it wasn't acceptable and we needed to do something about it.'[64]

Human rights and other civil society bodies[65] have expressed concern about the mistreatment of children within juvenile detention centres and advocated for stronger safeguards. In calling on Australian governments to urgently comply with *OPCAT*, the Human Rights Commissioner highlighted evidence of serious mistreatment at Banksia Hill and juvenile detention centres in other states and territories.[66] The OPCAT Advisory Group (OAG) convened by the Commonwealth Ombudsman noted 'significant issues raised in the evidence of the Western Australian Inspector of Custodial Services at Public hearing 27 of the Royal Commission'. These included:[67]

- the lack of a trauma-informed approach to supporting detained children
- the impact of lockdowns and isolation
- shortcomings in identifying disability support needs
- the impact of staffing shortages on treatment and conditions.

Members of the OAG expressed concern that similar issues are likely to be occurring in other places across Australia where children are or may be detained.[68]

On 18 November 2022, members of the Australian NPM Network nominated by the Australian Government, the Australian Capital Territory, the Northern Territory, South Australia, Tasmania and Western Australia released a joint statement stressing:

> incidents of grave concern in youth justice centres in Western Australia, the Northern Territory and Tasmania – incidents that continue to occur despite the findings of the 2017 report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory. This includes children being subjected to extended periods in solitary confinement or being confined to cells 23 hours a day, and incidents of physical and sexual abuse.[69]

The members said they were concerned about reports of similar incidents occurring in youth justice centres elsewhere in Australia. They called on governments 'to ensure that children and young people are safe from torture, cruel, inhuman or degrading treatment in youth justice centres' and 'to protect the rights of children and young people who are deprived of their liberty, and ensure their safety and dignity, consistent with the international human rights standards Australia has committed to uphold'.[70]

3.4. Australia's implementation of *OPCAT*

Although Australia ratified *OPCAT* in 2017[71] the then Government invoked article 24[72] to postpone its obligation to establish an NPM until January 2022, saying the timeframe was necessary to accommodate negotiation with the states and territories.[73] Article 24 allows for a three-year period to introduce measures to fully implement the treaty and the possibility to extend this by a further two years after consultation with the SPT.[74]

In December 2021, the Australian Government requested a one-year extension citing the COVID-19 pandemic and Australia's federated system of government.[75] The United Nations Committee Against Torture granted an extension to meet the obligation until 20 January 2023.[76] This deadline was not met.

Submissions have expressed concern about the level of genuine commitment to implementing *OPCAT* in Australia.[77] According to the Human Rights Commissioner, as of January 2023 none of the 17 recommendations (see below) on how Australia should implement *OPCAT* have been fully implemented and only six have been partially implemented.[78] As noted earlier, the three largest jurisdictions – New South Wales, Queensland[79] and Victoria – have yet to designate an NPM and legislation to facilitate compliance with *OPCAT* has not yet been passed across the country. Submissions urged successive Australian Governments to work with state and territory governments to implement *OPCAT* as a matter of urgency.[80]

On 20 January 2023, members of the four Australian jurisdictions who have nominated NPMs and the Australian Government released another joint statement. In it they called on remaining governments to appoint NPMs and introduce legislation to support their function to carry out preventive visits to places of detention.[81]

Initial consultations and recommendations

In February 2017, the then Commonwealth Attorney-General asked the Human Rights Commissioner to lead a consultation process with civil society and others on how *OPCAT* should be implemented in Australia.[82] A report, including 17 recommendations addressed to the Australian Government, state and territory governments and the Commonwealth Ombudsman was published in June 2020. Key recommendations included:

- Each NPM should ensure relevant officers receive training and education regarding the needs of vulnerable people in places of detention, including the impact of intersectional disadvantage for people with disability and others.
- The Australian Government should adopt an *OPCAT* implementation strategy that includes:
    - a measurable timeframe for implementation, identifying key dates and milestones
    - the process for ensuring that each body designated with an NPM function is *OPCAT* compliant
    - an education and awareness-raising program targeting the public, relevant civil society organisations and the bodies responsible for places of detention
    - areas or issues of priority focus for *OPCAT* inspections.
- The Australian Government should adopt national principles that guide how detention inspections should take place.
- The Australian Government should adopt national principles regarding minimum conditions of detention to protect the human rights of detainees.

- In implementing *OPCAT*, Australian governments should ensure NPMs have the power to inspect all places of detention in accordance with articles 1 and 4 of *OPCAT*.
- The Australian Government should introduce legislation incorporating the key provisions of *OPCAT*. State and territory governments should also consider introducing legislation to give effect to *OPCAT* in their respective jurisdictions.
- The Australian Government should establish an intergovernmental agreement as soon as possible to guide the establishment and operation of NPMs.

At the time of writing, there had been no official response to the report by either the previous or current Australian Government.

Places of detention

While individuals, particularly those with disability, may experience deprivation of their liberty in a wide range of settings, the previous Australian Government opted to prioritise the monitoring of so-called 'primary places of detention' through *OPCAT*. It defined these places as being:[83]

- adult prisons
- juvenile detention facilities (excluding residential secure facilities)
- police station cells where people are held for 24 hours or more
- closed facilities or units where people may be involuntarily detained for mental health assessment or treatment for 24 hours or more
- closed forensic disability facilities where people may be involuntarily detained for care for 24 hours or more
- immigration detention centres
- military detention facilities.

The former Australian Government stated that it considered aged care facilities and offshore immigration detention facilities to be outside of the scope of *OPCAT*, for these reasons:[84]

> The initial focus on these primary places of detention reflects the position that the challenges posed by the deprivation of peoples' liberty are at their most significant in these places of detention. The Government considers the implementation of *OPCAT* to be an iterative process and is mindful of the principle of proportionality when determining prioritisation and focus, consistent with advice from the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[85]

The AHRC and other stakeholders have emphasised that many other places of detention exist where people with disability may be deprived of their liberties. These include:[86]

- compulsory care facilities
- disability group homes
- closed community-based accommodation and residences for people with disability
- 'time out' and seclusion rooms and other segregated areas in educational settings
- rehabilitation facilities
- aged care facilities, dementia units and nursing homes
- emergency departments and hospitals
- child welfare institutions and out-of-home care arrangements
- special schools and boarding schools.

The AHRC and others have also noted that *OPCAT* does not classify a place of detention according to the amount of time a person is deprived of their liberty. The decision of the previous Australian Government to do so, excludes places where people may be detained for less than 24 hours.[87]

National Preventive Mechanisms and related legislation

The SPT advises that:

> While the institutional format of the NPM is left to the State Party's discretion, it is imperative that the State [P]arty enact NPM legislation which guarantees an NPM [be] in full compliance with *OPCAT* and the NPM Guidelines. Indeed, the SPT deems the adoption of a separate NPM law as a crucial step to guaranteeing this compliance.[88]

The previous Australian Government stated that it did not intend to enshrine the NPM model in legislation, nor did it consider it necessary to legislate to enable inspections by the SPT.[89] It elected to adopt a national monitoring system made up of NPMs selected by the Australian Government and state and territory governments. In 2017, it created a statutory instrument defining the National Preventive Mechanism Network as 'the persons and bodies separately appointed or established by the Commonwealth and each State and Territory to give effect to Australia's obligations under *OPCAT*'.[90]

The AHRC noted stakeholders have strongly recommended the Australian Government should introduce a dedicated statute to implement *OPCAT*, in addition to states and territories having corresponding legislation.[91]

Commonwealth

The then Australian Government announced the Commonwealth Ombudsman as the NPM for places of detention controlled by the Australian Government effective from 1 July 2018.[92] The Commonwealth Ombudsman also commenced as NPM Coordinator on the same date.[93]

In its role as NPM Coordinator, the Commonwealth Ombudsman will not oversee state and territory inspections.[94] Instead, it will 'work with existing bodies to share experience, undertake research, identify gaps and overlaps and coordinate interactions' with the SPT.[95]

In that role, the Ombudsman provides secretariat support to the NPM Network. The NPM Network supports each NPM body to fulfil its functions and responsibilities to give effect to *OPCAT* through engagement, information sharing and collaboration. It meets formally three times a year. The Commonwealth Ombudsman is required by law to report to the public and Australian, state and territory ministers on the implementation of *OPCAT* and the activities of the NPM Network.[96]

The Commonwealth Ombudsman also chairs the OAG which provides expert advice and guidance on the Ombudsman's roles and responsibilities within the NPM Network. Established in 2020, the OAG includes civil society representatives.

States and territories

In 2019, the Commonwealth Ombudsman assessed the readiness of Australian jurisdictions to implement *OPCAT* by identifying the various entities in each state or territory that could act as NPMs. The assessment found that one or more existing bodies in each jurisdiction were likely ready to meet the NPM obligations.[97] These bodies included ombudsmen, the AHRC, children's commissioners, public guardians and advocates, inspectors of custodial services and community visitor schemes.

The current status of NPMs and related legislation is summarised below.

- **Australian Capital Territory**: A 'multi-body' NPM composed of the ACT Inspector of Correctional Services, ACT Human Rights Commission and ACT Ombudsman. The *Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Act 2018* (ACT) came into force on the 30 April 2018. It establishes the necessary legislative arrangements for the SPT to inspect places of detention in the Australian Capital Territory but does not deal with NPM functions. On 10 March 2022, the ACT Government entered into a funding agreement with the Australian Government to support the establishment of the NPM.
- **Northern Territory**: The Ombudsman NT, Office of the Children's Commissioner and the Principal Community Visitor. The *Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Act 2018* (NT) came into force on 1 November 2018. It provides a statutory regime for the SPT to inspect places of detention. In October 2022 the *Monitoring of Places of Detention* (*Optional Protocol to the Convention against Torture*) *Amendment Act 2022* (NT) was passed, providing for the establishment and functions of the NPM.
- **Tasmania**: The Ombudsman Tasmania and the Inspector of Custodial Services. The *OPCAT Implementation Act 2021* (Tas) came into effect on 20 January 2022. It provides for the establishment and functions of the NPM and inspections by the SPT of places of detention. In the 2022–23 Tasmanian Budget, $344,000 was allocated for the purpose of additional resourcing and consultancy services to scope the requirements for Tasmania's compliance with *OPCAT*.[98]

- **Western Australia**: The Ombudsman WA for mental health and other secure facilities and Office of the Inspector of Custodial Services for justice-related facilities including police cells. No legislation has been passed to facilitate the NPM nor have additional resources been allocated to either body to undertake their NPM roles.
- **South Australia**: Official Visitors of Correctional Institutions, The Training Centre Visitor, Principal Community Visitor. The *Correctional Services* (*Accountability and Other Measures*) *Amendment Act 2021* (SA) was passed on 8 April 2021. The OPCAT Implementation Bill 2021 (SA) was introduced on 24 August 2021 but was not debated in the Legislative Council before the state election in March 2022. The Bill has not been re-introduced.
- **Victoria**: An NPM has not been nominated. The *Monitoring of Places of Detention by the United Nations Subcommittee on Prevention of Torture* (*OPCAT*) *Act 2022* (Vic) was passed on 20 September 2022 to facilitate visits to places of detention by the SPT. The Act does not deal with the appointment of an NPM. In the 2021–22 State Budget, $500,000 was allocated towards the implementation of *OPCAT*.[99]
- **Queensland**: The *Inspector of Detention Services Act 2022* (Qld), which is designed to be *OPCAT*-compliant, was passed on 7 September 2022. The Queensland Government has not formally confirmed that the Inspector, located within the office of the Ombudsman, will be the NPM. The Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Bill 2022 (Qld) to facilitate visits to places of detention by the SPT was introduced on 1 December 2022. The 2022–23 Queensland Budget allocated additional funding for the Office of $9.4 million over four years and $3 million per annum ongoing to establish the new function.[100]
- **New South Wales**: The NSW Government has not provided any public comment on its NPM designation intentions to date.

In March 2022, the Commonwealth Ombudsman stated that it was critical for all jurisdictions to 'crack on' with the progressive implementation of *OPCAT* by determining NPMs.[101]

Resourcing

The issue of adequately resourcing NPMs and in particular, the Australian Government's role in providing funding for this purpose, appears to have been a barrier to achieving *OPCAT* compliance. One-off Commonwealth funding to states and territories to support implementation of *OPCAT* was announced under Outcome 10 of the *Closing the Gap Implementation Plan* in August 2021, but this did not deal with future resourcing of the NPM.[102]

In the 2018–19 Budget, the Commonwealth Ombudsman was provided ongoing funding of approximately $300,000 per year for its new functions under *OPCAT*.[103]

In October 2021, the Victorian and New South Wales Attorneys-General wrote jointly to the Australian Government, explaining that Victoria and New South Wales would be unable to take steps to implement *OPCAT* in the absence of an accompanying sufficient and ongoing funding commitment from the Commonwealth.[104] Similarly, the Queensland Government has said it will make no formal commitment to implement *OPCAT* until ongoing funding for NPMs is resolved with the Commonwealth government, consistent with every other jurisdiction.[105]

The ACT Government entered into a funding agreement with the Commonwealth Government on 10 March 2022 under which the latter will provide the former with $143,000 over 2022–2023 to support the establishment of the ACT NPM.[106]

Article 18(3) of *OPCAT* requires States to provide adequate resourcing to fulfil the NPM functions. This is crucial to *OPCAT's* success. When agreeing to Australia's request for an extended timeframe to establish an NPM, the UN Committee Against Torture stated NPMs should 'receive sufficient resources to discharge their prevention mandate independently and effectively, in accordance with the Optional Protocol and the guidelines on national preventive mechanisms'.[107]

A clear theme emerging internationally is that where other developed nations have already established NPMs, insufficient resourcing of NPM bodies, regardless of whether they are pre-existing or newly created, will ultimately restrict the scope of investigations.[108] Inadequate resources, including staffing and financial support, can also lead to States Parties being in breach of their *OPCAT* obligations.[109] At a meeting of the nation's Attorneys-General in December 2022, the states and territories agreed to provide the federal government with the costings to establish oversight bodies to perform NPM functions.[110]

Subcommittee on the Prevention of Torture visits

The SPT had initially planned to visit Australia in April 2020.[111] Due to the COVID-19 pandemic the visit was rescheduled to the second half of 2022.[112] A delegation of the SPT subsequently visited Australia in October 2022, intending to stay for a 12-day period. On 23 October 2022, it announced it was suspending the visit due to obstructions of its *OPCAT* inspection mandate, particularly noting a lack of cooperation by the governments of New South Wales and Queensland.[113] According to media reports, the NSW Government refused access to prisons arguing that unannounced visits present safety concerns and that UN inspections are redundant because there is already local scrutiny of prisons. The delegation also pointed to the lack of an agreement by the Australian Government addressing who will fund the cost of the visit or any upgrades the SPT may recommend.[114]

In February 2023, the SPT terminated its visit to Australia because the issue of unrestricted access to places of detention in two states had still not been resolved.[115] A spokesperson for the Commonwealth Attorney-General expressed disappointment at the decision which 'does not reflect the Australian government's commitment to protecting and promoting human rights, and does not change our commitment to implementing Australia's *OPCAT* obligations and to facilitating future visits from the SPT'.[116] Patrick McGee, the national coordinator for Australians for Disability Justice, said the terminated UN visit had left detainees across the country feeling 'voiceless' and removed pressure on Australia to account for itself.[117]

The SPT said it would still share a confidential report with the Australian Government based on what it observed during its October visit.[118] At the time of writing, this report has not been made public.

3.5. Achieving *OPCAT* compliance

In October 2022, the AHRC published a 'road map' outlining the following actions needed for Australia to achieve *OPCAT* compliance:[119]

- All national, state and territory governments finalising the process of designating oversight mechanisms as the NPMs for their respective jurisdictions, including any changes necessary to broaden their mandates and meet the requirements of *OPCAT*.
- Governments ensuring NPMs are designed and operate in a way that addresses particular needs, and are inclusive of people who are disproportionately represented in places of detention, including First Nations people, children and young people, and people with disability.
- The Australian Government introducing dedicated legislation to give full effect to the key provisions of *OPCAT* around Australia, and ensure the national coordination of Australia's *OPCAT* response.
- Governments adopting an inclusive approach to the interpretation of 'places of detention', ensuring that both 'primary' and 'secondary' places of detention are included within the scope of all NPMs.
- Governments resourcing NPMs sufficiently to allow them to effectively fulfil their *OPCAT* functions, including outward-facing functions contained in the 'preventive package'.

The AHRC summarised its position in a separate submission to the Royal Commission.[120]

Incorporating *OPCAT* into legislation

We note the clear guidance provided by the SPT about the 'imperative' for States to 'enact NPM legislation which guarantees an NPM be in full compliance with *OPCAT* and the NPM Guidelines'.[121]

One of the AHRC's key recommendations in 2020 was that the Australian Government should incorporate the core provisions of *OPCAT* in a dedicated federal statute, and state and territory governments should consider the need for dedicated legislation to give effect to *OPCAT* in their respective jurisdictions. During its consultations to inform the recommendations, the AHRC heard that legislation is necessary for a number of reasons, including to ensure:[122]

- the roles, structure and mandate of the NPM model are clearly defined
- guaranteed unfettered NPM and SPT access to all places of detention
- inspections are culturally appropriate and rely on relevant expertise
- adequate funding for federal coordination and state/territory NPM bodies
- functional and structural independence of the coordinating NPM body is enshrined

- the NPM model is intended to survive changes of government and has equivalent status to other independent statutory bodies
- the relationship with the SPT is established and provides for the coordinating NPM body directly to access the SPT
- individuals are protected from reprisals as a result of making a complaint or providing information to the NPM bodies.

The AHRC noted that internationally, States which have created the NPM structure without legislation have encountered significant challenges, including no guarantee of independence and no system of accountability that can undermine the NPM's legitimacy nationally and internationally.[123] Submissions to the Royal Commission have similarly emphasised the need for such legislation.[124]

The Australian Government should revisit the AHRC's recommendation and introduce dedicated legislation to give full effect to the key provisions of *OPCAT*, and ensure national coordination of Australia's *OPCAT* response. In addition, as the lack of NPMs with clearly defined functions in the three largest states is the key barrier to achieving compliance with *OPCAT*, we recommend that all states and territories introduce legislation to establish the functions of their NPM and facilitate inspections by the SPT.

Designating and resourcing National Preventive Mechanisms

Speaking at Public hearing 17 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', Carolyn Frohmader, Executive Director of Women with Disabilities Australia, said 'it is very regrettable that we still have some states and territories who are yet to even work out how their National Preventive Mechanism is going to operate'.[125]

The relevant discussions held by Attorneys-General in December 2022 are a positive development but must result in an agreement that facilitates action. Consistent with *OPCAT's* specifications, NPMs in all jurisdictions should be resourced in a way that permits them to effectively fulfil *OPCAT's* core functions, including the 'preventive package'. The governments of New South Wales, Victoria and Queensland should move swiftly to designate NPMs in their jurisdictions and in doing so, consider the views of people with disability and their representative organisations.

Recognising places of detention

The United Nations Committee Against Torture has observed that Australia's adoption of a 'primary versus secondary' approach to places where people are deprived of their liberty inappropriately limits the mandate of NPMs. The Committee argues that Australia's approach is contrary to the requirements of Article 4(2) which states:[126]

> For the purposes of the present Protocol, deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.[127]

In other words, the *OPCAT* treaty 'is intended to apply to the full range of places where people may be deprived of their liberty including prisons, immigration detention, aged and social care and mental health facilities'.[128]

Submissions pointed out that Australia's approach leads to a lack of monitoring many other places in which people with disability are routinely deprived of their liberty. These include disability-specific accommodation settings, mental health settings, residential aged care facilities, hospital emergency departments, schools with 'exclusion' or 'time-out' rooms and rehabilitation facilities.[129] Responses to issues papers commented on the value of *OPCAT* having application to all closed settings affecting people with disability.[130] In particular, respondents told us that disability-specific accommodation settings must be recognised by the Australian Government as falling within the definition of 'places of detention'[131] as they are environments where individuals often need a high level of care,[132] depend on others for the basic necessities of life, and are therefore at risk of having their freedom of choice or movement restricted or removed altogether.[133]

There is a strong expectation from Australian Disabled People's Organisations for an Australian NPM to extend to the many types of disability specific and related institutions where people with disability are over-represented, formally detained or compelled to remain. These include locked psychiatric wards and mental health facilities, compulsory care and aged care facilities, dementia units and nursing homes, closed community-based accommodation and residences for people with disability. They also encompass 'time out' and seclusion rooms and segregated areas in educational settings; rehabilitation facilities; aged care facilities, dementia units and nursing homes; emergency rooms and hospitals; child welfare institutions; out-of-home care arrangements; and boarding schools.[134]

The Law Council of Australia told us Australia should adopt a broader definition of 'places of detention'.[135] 'Secondary' places of detention, including disability specific institutions, must be included within the ambit of the functions of all NPMs.[136] The AHRC said evidence shows rates of violence in these detention settings are unacceptably high. Current levels of oversight are insufficient and people in these settings are less likely to complain or have access to or awareness of complaint mechanisms.[137] The AHRC also suggested that NPMs should consider prioritising 'secondary' places of detention to further efforts to end disability-based detention.[138]

The Queensland Public Advocate also endorsed the need for an enlarged view of what constitutes places of detention. It emphasised the high use of restrictive practices against people with disability in 'secondary' settings such as disability accommodation services. This sits alongside a 'suboptimal' approach to authorising restrictive practices and more limited presence of natural safeguards in these settings.[139] We note that the definition of a place of detention in New Zealand includes places where people with disability reside.[140]

We agree that governments should adopt a wider approach to the interpretation of 'places of detention' that ensures all places of detention where people with disability are deprived of their liberty fall within the scope of NPM monitoring. It should then be a matter for each jurisdiction's NPM to determine which places of detention they prioritise. Although ideally this will occur as part of a broader collaborative approach by the NPM Network to implementing *OPCAT*.

Prioritising inspections

We also endorse the approach proposed by the AHRC whereby NPMs should prioritise visits to particular places of detention, or specific cohorts of detained people, based on where the need is likely to be greatest.[141]

During the AHRC's consultations in 2020 to inform Australia's implementation of *OPCAT*, prisoners with disability were nominated by stakeholders as one such important cohort.[142] The evidence before the Royal Commission, which is not limited to the evidence highlighted in this chapter, certainly lends support to this nomination. More broadly, the evidence about the extent of violence, abuse, neglect and exploitation experienced by people with disability, across a range of settings, amounts to a strong case for NPMs to prioritise inspections of these settings with specific attention to issues affecting people with disability.

There is value in the AHRC's proposal that NPM bodies should use a consistent methodology to determine inspection priorities.[143] We agree that the Commonwealth Ombudsman, as NPM Coordinator, should lead work with NPM bodies and other stakeholders to develop related guidance.[144] Such guidance may best be badged as 'factors to consider' rather than rigid criteria that must be followed. There is also value in the AHRC's suggestion that there should be a coordinated approach to prioritising particular practices or themes across different detention settings.[145] Consideration of this by the NPM Network should be led by the Commonwealth Ombudsman. Evidence suggests that, in relation to people with disability, the experiences of children in places of detention, the use of restrictive practices, medical neglect, and accessibility of facilities may all be worthy of a coordinated approach. A number of submissions have also suggested that NPMs should prioritise monitoring the use of restrictive practices.[146]

A disability inclusive approach to *OPCAT*

A broader definition of places of detention is critical but is only one component of a disability-inclusive approach to implementing *OPCAT*. In 2019, the CRPD Committee remarked on Australia's 'lack of engagement' with people with disability and their representative organisations about the designation and establishment of a National Preventive Mechanism.[147] In September 2022, the AHRC told us there had still been 'little engagement by the federal and state and territory governments with disability rights groups and individuals with disability' in relation to *OPCAT*.[148]

Such engagement should occur on multiple levels:[149]

- NPMs should establish processes to enable people with disability in places of detention to share information and experiences with them in numerous ways and anonymously when preferred.
- NPMs should actively engage people with disability and their representative organisations to inform the way they carry out their functions, such as decisions about visiting places of detention and monitoring criteria and priorities. Formal and informal engagement strategies should be used.
- NPM staff should be trained on the human rights framework within which *OPCAT* sits[150] as well as issues affecting people with disability in places of detention. These issues include accessibility, communication and decision-making supports, non-consensual practices, use of restrictive practices and indefinite detention. Senior-practitioner type roles could be considered to give expert advice to NPMs given their skills in promoting the reduction and elimination of the use of restrictive practices.
- NPMs must have the resources and expertise to engage with people with disability during inspections and report on the issues that affect them. This includes having staff or external consultants with the necessary skills to provide reasonable adjustments, communication supports and supported decision-making during NPM inspections. People with disability should be involved in conducting inspections.
- NPMs should collect and publish quality data about people with disability in places of detention and the issues that affect them. The AHRC indicates data should ideally inform any Outcomes Framework associated with Australia's Disability Strategy 2021–2031 and the National Disability Data Asset.[151]

A positive example of engaging experts with lived experience as part of a monitoring team was provided to the Royal Commission by the Office of the ACT Inspector of Custodial Services (OICS). For a review of a particular centre, OICS engaged a person who works for a disability advocacy organisation and has lived experience with a hearing impairment. She was able to provide expert input not just with respect to her own disability but also with respect to issues affecting a cross-section of those with different types of disability, such as the induction and assessment process for young people who may have a disability. The OICS reflected that having someone with lived experience of disability on the review team was immensely valuable as it allowed issues to be identified that would not otherwise have been detected. OICS said it planned to employ this approach for future reviews.[152]

As NPM Coordinator, the Commonwealth Ombudsman has a critical role to play in working with the NPM Network to promote a broadly consistent approach to meeting the above requirements. We understand that the Commonwealth Ombudsman intends to develop a disability engagement strategy and, in consultation with people with disability and representative organisations, to develop disability standards for inspection.[153] Ideally the NPM Network will adopt common disability standards and commit to reporting related data in a consistent way. We support these initiatives.

Recommendation 11.6 Enshrining key provisions of *OPCAT* in legislation

The Australian Government should revisit the Australian Human Rights Commission's recommendation and introduce legislation enshrining the key provisions of the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*) and facilitate the national coordination of Australia's *OPCAT* response.

Recommendation 11.7 Resourcing and wider definition of places of detention

The Australian Government and state and territory governments should:

a. agree to provide resources to enable National Preventive Mechanism bodies in all jurisdictions to fulfil the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment's* core functions, including the 'preventive package'

b. enact legislation incorporating a broader definition of 'places of detention' to enable all places where people with disability may be deprived of their liberty to be monitored by National Preventive Mechanism bodies.

Recommendation 11.8 Legislating National Preventive Mechanisms

All state and territory governments should introduce legislation to establish the functions of their National Preventive Mechanism bodies and facilitate inspections by the United Nations Subcommittee on the Prevention of Torture.

Recommendation 11.9 Designating National Preventive Mechanism bodies

The governments of New South Wales, Victoria and Queensland should designate National Preventive Mechanism bodies in their jurisdictions.

Recommendation 11.10 Improved consistency and coordination

The Commonwealth Ombudsman should:

a. ensure the OPCAT Advisory Group includes people with disability

b. lead work with the National Preventive Mechanism Network to:

- develop a consistent methodology for determining National Preventive Mechanism inspection priorities
- implement a coordinated approach to prioritising inspections of places of detention that pose a high risk to people with disability, focusing on particular practices affecting people with disability across detention settings
- develop and adopt common disability inspection standards for use in all jurisdictions
- commit to nationally consistent collection and reporting of data about monitoring places of detention.

Recommendation 11.11 Disability inclusive approach to implementing *OPCAT*

National Preventive Mechanism (NPM) bodies in all Australian jurisdictions should implement their functions in a disability-inclusive way by:

- enabling people with disability in places of detention to share information and experiences with the NPM using a variety of communication forms
- ensuring staff participate in ongoing education and training about the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* human rights and issues affecting people with disability in places of detention
- ensuring staff conducting NPM inspections have the skills and experience to provide reasonable adjustments, communication supports and supported decision-making to people with disability when required
- involving people with disability in the inspection of places of detention
- collecting and publishing data about people with disability in places of detention, aligned with disability inspection standards.

Endnotes

1 *The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006).
2 *The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006), arts 3 and 4.
3 *The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006), art 12.
4 Exhibit, 11-012.01, 'Statement of Eileen Baldry', 22 October 2020, at [15]; Transcript, Eileen Baldry, Public hearing 11, 18 February 2021, P-233 [14–33]; Eileen Baldry, 'Rights of persons with disability not to be criminalised' in Elizabeth Stanley (ed), *Human rights and incarceration*, Palgrave Studies in Prisons and Penology, 2018, pp 58–59.
5 Law Council of Australia, Submission in response to *Criminal justice system issues paper*, 17 August 2020, ISS.001.00370, p 71; Australia OPCAT Network, *The implementation of OPCAT in Australia,* January 2020, cited in Australia OPCAT Network, Submission, 16 July 2020, SUB.100.00834, p 80. See also: Penelope Weller, 'OPCAT monitoring and the Convention on the Rights of Persons with Disabilities', (2019), vol 25 (1), *Australian Journal of Human Rights*, p 131.
6 Penelope Weller, 'OPCAT monitoring and the Convention on the Rights of Persons with Disabilities', (2019), vol 25(1), *Australian Journal of Human Rights*, p 131.
7 Public hearing 27, 'Conditions in detention in the criminal justice system'; Public hearing 11, 'The experiences of people with cognitive disability in the criminal justice system'.
8 Public hearing 2, 'Inclusiveness in education in Queensland – preliminary inquiry'; Public hearing 7, 'Barriers experienced by students with disability in accessing and obtaining a safe, quality and inclusive school education and consequent life course impacts – including use of restrictive practices'; Public hearing 24, 'The experience of children and young people with disability in different education settings'.
9 Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern'.
10 Public hearing 13, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)'; Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)'; Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence'; Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)'; Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)'.
11 Transcript, Carolyn Frohmader, Public hearing 17.2, 31 March 2022, P-275 [11–12].
12 Australian Human Rights Commission, Submission in response to *Criminal justice system issues paper*, 20 March 2020, ISS.001.00087, p 9.
13 Human Rights Law Centre, Submission in response to *Criminal justice system issues paper*, 31 March 2020, ISS.001.00098, p 22; People with Disability Australia, *A voice of our own – Safeguards help marginalised people with disability, Submission responding to the Disability Royal Commission's Safeguards and quality issues paper (Nov 2020)*, February 2021, Submission in response to *Safeguards and quality issues paper*, 1 March 2021, ISS.001.00579, p 24.
14 Australian Human Rights Commission, *Implementing OPCAT in Australia*, Final report, June 2020, pp 23–24.
15 Julie Bishop, Minister for Foreign Affairs & George Brandis, Attorney-General, *Improving oversight and conditions in detention,* media release, Canberra, 9 February 2017.
16 Julie Bishop, Minister for Foreign Affairs, *Ratification of OPCAT caps year of significant human rights achievements for Turnbull Government,* media release, Canberra, 15 December 2017.
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4. Community visitor schemes

Key points

- All states and territories except Western Australia and Tasmania have a community visitor scheme (CVS) for people with disability. Community visitors are appointed individuals who visit people with disability. Their role is to independently monitor services and facilities provided to people with disability and assist with resolving issues or complaints.
- The National Disability Insurance Scheme Quality and Safeguarding Framework (NDIS Framework) recognises that community visitors play an important role in promoting and protecting the rights and wellbeing of people with disability. They identify issues that people with disability may not otherwise raise and provide an early warning system to prevent abuse and neglect. CVS also provide an escalation pathway for issues to be addressed by relevant authorities.
- There has been substantial investment in implementing state and territory-based CVS. The evidence we have heard shows that, while there is room for improvement, CVS are highly regarded within the jurisdictions they operate.
- Australia's Disability Strategy 2021–2031 allocates responsibility for the operation of CVS to the states and territories. However, states and territories do not take a consistent approach to prescribing the role and functions of CVS.
- A nationally consistent approach is needed to fill the gaps in coverage of CVS. This includes adopting common monitoring standards informed by the National Disability Insurance Scheme (NDIS) practice standards and quality indicators. In addition, changes are needed to accommodate the different services and regulatory landscape created by the introduction of the NDIS.
- The Australian Government and state and territory governments should enter into a national agreement that establishes how CVS and the National Disability Insurance Scheme Quality and Safeguards Commission (NDIS Commission) will share information to effectively exercise their respective functions. Legislation should be amended to allow CVS to share information with the NDIS Commission and National Disability Insurance Agency (NDIA).
- The *National Disability Insurance Scheme Act 2013* (Cth) and NDIS Framework should be amended to recognise CVS as a critical safeguard.

4.1. Introduction

Article 16 of the *Convention on the Rights of Persons with Disabilities* (*CRPD*) provides that:

> In order to prevent the occurrence of all forms of exploitation, violence and abuse, States parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.[1]

Community visitors (also known as 'Official Community Visitors', 'Official Visitors' or 'Official Visitors Disability', depending on the jurisdiction) are appointed individuals who visit people with disability living in prescribed accommodation to independently monitor the services and facilities provided. They also assist with resolving issues or complaints. All states and territories, apart from Western Australia and Tasmania, administer a community visitors scheme (CVS). Their specific functions and powers differ among jurisdictions but, in general, community visitors can enter and inspect services without notice, inspect documentation relating to the operation of a service and talk privately with residents. They are required to report on their work to relevant ministers and parliaments.

The National Disability Insurance Scheme Quality and Safeguarding Framework (NDIS Framework), agreed to by the Australian Government and all state and territory governments, recognises that:

> Community visitors can play an important role in promoting and protecting the rights and wellbeing of people with disability, identifying issues that people with disability may not otherwise raise, providing an early warning system to prevent abuse and neglect, and providing an escalation pathway for issues to be addressed. The value of the community visitor role arises from their ability to visit services (that are within the scope) without advance notice and enquire into conditions, often on the basis of concerns they have been alerted to by residents' families, friends or workers. Importantly, visitors are able to identify problems that have not been reported by families, friends or workers.[2]

In 2018, a national review of CVS, commissioned by the Department of Social Services (DSS), found that community visitors made over 12,000 planned and unannounced visits to adult disability services across Australia in 2016–17.[3] Community visitors encouraged people with disability to express their views and assert their rights, and linked them with supported decision-making processes and advocates.[4] The review observed that, as well as helping individuals, community visitors are well-placed to identify and flag systemic issues.[5] The disability service providers consulted expressed strong support for CVS, commenting on their value in helping to locally resolve issues and complaints, building service capacity, and identifying and reporting on good practice.[6]

More recently, in November 2021, the Joint Standing Committee on the National Disability Insurance Scheme (Joint Standing Committee) observed that community visitors play an important safeguarding role, acting as 'eyes and ears' to ensure the safety and quality of

supports to people with disability.[7] The Joint Standing Committee said community visitors are particularly vital for people who experience severe barriers in speaking up, complaining or advocating for themselves.[8]

We have been told that CVS are a critical preventative and corrective safeguard that perform a valuable role in the context of disability services.

Australia's Disability Strategy 2021–2031 allocates responsibility for operating CVS to the states and territories.[9] There are strong reasons for this to continue, although states and territories do not take a consistent approach to CVS. We were told changes are needed to accommodate the different service and regulatory system created by the National Disability Insurance Scheme (NDIS). Views differ in key reports, among stakeholders and jurisdictions as to the nature of the changes that should be made.

We consider that state and territory CVS for people with disability should be retained, enhanced where they already operate, and implemented where they do not. To achieve nationally consistent schemes, state and territory governments should agree on the components of CVS that will be implemented. They should also agree on common standards to guide the work of CVS in relation to people with disability whom they visit. Where relevant, these standards should be informed by NDIS practice standards and quality indicators.

At a minimum, the scope of the CVS role should allow them to visit people living in supported accommodation and licensed boarding houses, whether or not delivered by NDIS providers. They should visit frequently and certainly more regularly than currently occurs. Consideration should also be given to providing community visitors with discretion to visit individuals who may be at elevated risk of abuse or harm, based on a consideration of factors broader than just service type.

Lastly, the Australian Government and state and territory governments should enter into a national agreement establishing how CVS and the NDIS Quality and Safeguards Commission (NDIS Commission) will share information to enable effective exercise of their respective functions. The information-sharing agreement should be reflected in state and territory legislation establishing CVS. In developing the agreement, the Australian government and state and territory governments should have regard to the new National Disability Agreement, as recommended in Volume 5, *Governing for inclusion*. Further, the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) and NDIS Framework should also formally recognise CVS as a safeguard for people with disability.

4.2. Current community visitor schemes

New South Wales, Victoria, Queensland, South Australia, the Northern Territory and the Australian Capital Territory all have a CVS under which community visitors visit people living in disability services.[10]

In New South Wales, the CVS is administered by the Ageing and Disability Commission (in consultation with the Office of the Children's Guardian in relation to visiting children in residential out-of-home care, who may or may not have a disability). Community visitors visit supported accommodation services providing full-time care. These services include supported accommodation operated by NDIS providers, assisted boarding houses and residential out-of-home care for children.[11] The CVS is currently under review as part of the statutory reviews of the *Ageing and Disability Commissioner Act 2019* (NSW) and the *Children's Guardian Act 2019* (NSW).[12]

In Victoria, the CVS is administered by the Office of the Public Advocate. Community visitors visit accommodation facilities for people with disability (including people with mental illness). These facilities include group homes, residential treatment facilities, specialist disability accommodation, and supported residential services and cover services operated by NDIS providers.[13]

In Queensland, the Office of the Public Guardian administers the CVS. Community visitors visit authorised mental health services, the Forensic Disability Service, residential services with level 3 accreditation and premises where a NDIS-funded adult lives and receives NDIS services or supports delivered by a registered NDIS provider. They also visit children and young people living in out-of-home care (including foster, kinship care and residential care) or in youth detention centres, and adult correctional centres.[14]

In South Australia, the CVS is administered by the Principal Community Visitor. Community visitors visit people receiving care in a mental health treatment centre, attending a community mental health facility or living in state-run disability accommodation.[15] They can also visit an NDIS participant who is under the guardianship of the Public Advocate.[16]

Community visitors ceased visiting non-government disability accommodation service providers, supported residential facilities and day options programs in South Australia from May 2019.[17] This occurred because the South Australian Government received advice that the *NDIS Act* 'covers the field' regarding quality and safeguards for NDIS service providers and participants. This meant that the *NDIS Act* was inconsistent with state laws authorising community visitors to inspect NDIS providers, rendering those laws invalid to the extent of the inconsistency under section 109 of the *Australian Constitution*.

In the Northern Territory, the Community Visitor Program is administered by the Anti-Discrimination Commission. Community visitors visit mental health inpatient facilities and disability accommodation including secure care facilities, appropriate places (for people on a supervision order) and residential facilities administered by the Department of Health. Services operated by NDIS providers are not within the scope of the Community Visitor Program.[18]

In the Australian Capital Territory, community visitors are administered by the Official Visitors Board. They visit youth and adult detention facilities, residential out-of-home care facilities for children and young people, mental health facilities, accommodation for people with disability (including aged care facilities) and accommodation for people requiring housing assistance. Services operated by NDIS providers are not included in the Official Visitor Scheme.[19]

Western Australia and Tasmania do not have a CVS that enable visits to people in disability accommodation. Tasmania has a CVS, which visits prisons and mental health facilities.[20] Western Australia has a Mental Health Advocacy Service, which visits people on involuntary treatment orders, people referred for psychiatric examination and people who are subject to custody orders and required to undergo treatment.[21]

Similarities and differences between schemes

Under each scheme, the right or obligation of community visitors to visit a service or facility is connected to the nature of the services being delivered at a particular site. All schemes provide community visitors with the following functions and powers:

- right of entry to undertake announced and unannounced visits to premises/facilities
- authority to confer with residents in private and with staff
- authority to view, and to obtain copies/extracts from, documentation relating to services and support within the facilities
- ability to refer matters/complaints to external agencies or to support a person to make a complaint
- provide visit reports as soon as practicable to their coordinating agency or panel
- provide an annual report to the minister responsible for the scheme who tables the report in the relevant parliament.

Key differences between the schemes include:

- who can be appointed as a community visitor
- whether the position is paid or voluntary
- whether community visitors can visit services delivered by NDIS providers
- whether the schemes cover services for other cohorts of people
- how the schemes report data and outcomes.

Schemes determine their own visiting schedules.

4.3. Community visitors in the context of the NDIS

State and territory CVS predate the establishment of the NDIS. They evolved when disability services were either directly provided by state and territory governments, or by non-government organisations that were funded to provide such services.

NDIS Quality and Safeguarding Framework

The NDIS Framework was agreed to by the Australian Government and all state and territory governments in 2016. It recognises that community visitors play an important role in promoting and protecting the rights and wellbeing of people with disability. The NDIS Framework notes that there was 'considerable support' for a community visitor type function to be embedded within the NDIS Framework. However, there were also a range of questions which needed to be resolved about 'how community visitors will fit within the changing disability system, and which of the existing state and territory models are most appropriate'.[22] For example:

> As large residential services become less common and new national quality and safeguarding measures are introduced, there is a need to consider the scope of the community visitor function and how it integrates with other escalation pathways and oversight mechanisms. There is also a need to confirm whether community visitors should be volunteers or paid visitors, what training community visitors need, and the resourcing levels required.[23]

The NDIS Framework agreed that:

> Existing state and territory community visitor schemes will continue during the transition to the NDIS, and an independent evaluation of the schemes will be undertaken during this period. The results of the evaluation will be used by the Disability Reform Council to inform decisions about the role of community visitors in the NDIS.[24]

In late 2018, WestwoodSpice was commissioned by DSS, on behalf of the Disability Reform Council, to review the community visiting role, if any, in the context of the NDIS when fully implemented.[25] The *WestwoodSpice Community Visitor Schemes Review Final Report (WestwoodSpice Review* report*)* is discussed in detail later in section 4.4. Among its recommendations were that CVS should be further reviewed once there had been an adequate opportunity to observe the impact of the NDIS Framework.[26]

An independent review of the NDIS was announced by the Minister for the NDIS in October 2022. The terms of reference for the review do not specifically refer to community visiting but the Australian Government has indicated that it provides an opportunity to consider the role of CVS.[27] The Independent Review Panel is to provide a final report to the Disability Reform Ministers' Meeting by October 2023.

Coverage of NDIS services

The transition of disability services from state and territory governments to the NDIS has had implications for the coverage of these services by CVS. Only New South Wales, Queensland and Victoria have given their community visitors legislative power to visit people with disability living in services operated by NDIS providers. No issues seem to have been raised in these jurisdictions concerning possible inconsistency with the *NDIS Act*:

- In New South Wales, community visitors can visit an accommodation service for a person with disability delivered by a person or organisation that provides supports to a participant under their NDIS plan, where the participant is in the full-time care of the service provider.[28]
- In Queensland, community visitors are permitted to visit premises where a funded adult participant lives and receives services or supports paid for wholly or partly from funding under the NDIS; and where each of the following apply:[29]
    - the services or supports are provided under the participant's plan by a registered NDIS provider registered to provide a relevant class of supports
    - the services or supports are within a relevant class of supports (high intensity daily personal activities, assistance with daily life tasks in a group or shared living arrangement, specialist positive behaviour support that involves the use of a restrictive practice, and specialist disability accommodation).
- In Victoria, community visitors can visit specialist disability accommodation operating under a residency agreement without invitation, and specialist disability accommodation (SDA)[30] operating under a standard lease if invited.[31]

In South Australia, the Public Advocate (who is also the Principal Community Visitor) has authority to delegate power to community visitors to visit people under the guardianship of the Public Advocate.[32]

The *NDIS Act* and *NDIS Rules* do not explicitly refer to CVS or address their interface with the NDIS or the NDIS Commission, including in relation to information-sharing.

Site visits by the NDIS Quality and Safeguards Commission

The Operational Protocol for NDIS Participants at Risk states that:

> In order to monitor compliance of providers, the NDIS Commission also has a role in directly engaging with participants, guardians and family members. This includes face to face visits where risk factors have been identified through local or national compliance activities and other regulatory functions. A site visit can also be undertaken as a reactive response to a participant risk issue identified by the NDIS Commission or the NDIA under this Protocol, to monitor provider compliance with the NDIS code of conduct, and where applicable, the practice standards.[33]

The NDIS Commission has access to participant data from the National Disability Insurance Agency (NDIA), which includes the NDIA's 'flags for vulnerability'.[34] The NDIS Commission takes account of these 'flags' when responding to reportable incidents and complaints including in the course of conducting any relevant site visits.[35] This is a relatively new process, which the NDIS Commission has indicated will be reviewed on a six-monthly basis.[36]

The NDIS Commission's draft Site Visit Policy states that site visits with participants may be undertaken by other entities, such as the NDIA, community visitors or advocates, at the NDIS

Commission's request.[37] Where community visitors or advocates are already involved with participants, it may be appropriate to request that they engage with the participant to ensure the participant is aware of and is able to use the NDIS Commission's complaints function.[38]

4.4. Key reports about community visitor schemes

Our terms of reference direct us to have regard to the findings and recommendations of previous relevant reports and inquiries.[39] Since 2018, four key reports have considered CVS and are summarised in chronological order below. The *WestwoodSpice Review* report is discussed in more detail given it focused exclusively on CVS. Each report supported the continuation of community visiting and provides evidence showing that CVS are widely valued as a quality and safeguarding mechanism.

WestwoodSpice Review

In December 2018, WestwoodSpice was engaged by DSS to conduct a national review of CVS for the Disability Reform Council of the then Council of Australian Governments (COAG).[40]

The *WestwoodSpice Review* report considered whether the current CVS should change in light of the introduction of the NDIS. The review identified the 'consistency, potency and coverage' of existing state and territory CVS as problematic. It observed that the NDIS is creating a more diverse disability housing market, complicating the issue of which services community visitors should visit. There were also questions about whether community visitors have sufficient enter and inspect authority under current legislation.[41]

The *WestwoodSpice Review* report considered the advantages and disadvantages of allowing the NDIS Commission to administer a national CVS. Identified advantages included the simplicity offered by a single national scheme and the ability to set a common philosophy of practice, standards and follow-through.[42] Identified disadvantages included significant numbers of people with disability (and other vulnerable people) not being NDIS participants and potentially compromising the independence of the community visitor role.[43]

The *WestwoodSpice Review* report identified several reasons why states and territories should remain responsible for administering CVS.[44] These included the nexus between community visitors for disability services and other state-based service types, and the ability of community visitors to provide assistance relating to other state-based services used by people with disability, such as health and housing. It also noted that adult safeguarding legislation and supporting mechanisms, if introduced, will be state and territory-led.

The *WestwoodSpice Review* report concluded that CVS should be formally recognised and included within the NDIS Framework,[45] community visitors should continue to be provided by state and territory-based schemes,[46] and the Northern Territory, Western Australia and Tasmania may wish to consider the establishment of a CVS.[47] It also made several recommendations to support the interface of CVS with the NDIS Commission,[48] including authorising community visitors to enter the premises of NDIS providers and sharing data and information.

The *WestwoodSpice Review* report recommended that the Australian Government and state and territory governments should work towards achieving national consistency in relation to key aspects of CVS.[49] It observed that, against a background where the NDIS is resulting in much greater diversity of disability accommodation models, in the future:

> schemes will need to move from focusing on a list of visitable places to consideration of the factors that contribute to risk as well as identifying where risk sits as part of strategic and integrated protection.[50]

Report of the South Australian Safeguarding Task Force

A Safeguarding Task Force was appointed in 2020 by the South Australian Minister for Human Services to examine gaps in oversight and safeguarding regimes for South Australians with disability. This followed the April 2020 death of an NDIS participant, Ms Ann-Marie Smith, in circumstances indicating potential neglect.[51]

The Task Force noted that the establishment of the NDIS had limited the scope of the South Australian CVS.[52] Community visitors could no longer visit people with disability receiving NDIS accommodation services unless those people were also under the guardianship of the South Australian Public Advocate. The Task Force reported that, after receiving legal advice from the Crown Solicitor, the South Australian Government formed the view that the *NDIS Act* 'covered the field' in the area of quality and safeguards. This meant that attempts by a state government to pass legislation covering the same area could be struck down on constitutional grounds. The government considered that:[53]

- constitutional issues would arise if South Australia legislated to provide quality and safeguarding powers to the state's CVS in relation to NDIS funded services
- as a consequence, coercive powers to compel the production of information, or require corrective measures by a service provider, could ultimately become invalid.

The Task Force emphasised the merit in having a broadly empowered CVS under which the community visitor can visit potentially vulnerable people in all group homes, all supported residential facilities and day options programs, regardless of the provider. It considered that the 'cleanest and best way to achieve this' would be for the NDIS Commission to operate a national CVS as part of its functions. The Task Force argued that:

> The Commission should be making many more unannounced visits to service sites and needs to improve their responsiveness to notifications of adverse events or participants at risk. The [Community Visitor Scheme] as part of the Commission's range of functions would be a vehicle to achieve these tasks and it is hoped that this will soon be recognised at a national level.[54]

However, the Task Force noted 'the current expressed intention of the Commonwealth not to fund a national CVS, but to accommodate State/Territory CVS programs'. It recommended that the South Australian Government should seek further expert legal advice and:

> work with the Commonwealth to create a [revised] scheme that is compatible with state and federal laws and able to provide well-being checks on potentially vulnerable people and provide intelligence to the Commission for the purpose of its monitoring and investigation functions.[55]

The Task Force recommended that, in the interim, the South Australian Government should affirm its commitment to its CVS and consider enabling community visitors to visit supported residential facilities.[56]

Robertson Review

In May 2020, the Honourable Alan Robertson SC was appointed to review the NDIS Commission's regulation of the provider of NDIS supports and services to Ms Ann-Marie Smith (Robertson Review). This independent review was commissioned by the then NDIS Commissioner, Mr Graeme Head, in the wake of the aforementioned death of Ms Smith.[57]

Mr Robertson observed the *WestwoodSpice Review* report finding that:

> there is a place for a Community Visitor Scheme because it can be that extra pair of eyes of somebody coming in and being able to talk to individuals about how things are going in their lives and having some kind of external input. Then the community visitor can refer any matters of concern to the appropriate investigating authority. In this respect, community visitors are expert 'complainants'.[58]

Mr Robertson considered that Ms Smith's isolation and immobility, together with having a sole carer, contributed to her premature death.[59] Because Ms Smith lived in a private home, the South Australian CVS was not available to her. Mr Robertson believed that:

> if there had been a system of regular visits to persons with the vulnerability of Ms Smith even where such a person was living in her own home, the neglect of her, which led to her death, is unlikely to have occurred.[60]

Mr Robertson recommended that consideration be given to the NDIS Commission establishing its own CVS to provide for individual face-to-face contact with vulnerable NDIS participants.[61] He said that:

> The advantage of the NDIS Commission having this function in relation to NDIS participants is that the result would be national and uniform in circumstances where two of the States and Territories do not have a Community Visitor Scheme, and as between those jurisdictions which do have such a scheme there is some variation.[62]

Mr Robertson envisaged that state and territory CVS would continue to apply to people with disability who are not NDIS participants.[63]

Joint Standing Committee Report

In November 2021 the Joint Standing Committee finalised its report on the NDIS Commission.[64] The Committee noted that a number of submissions and witnesses identified community visitors as key to an effective, proactive monitoring and enforcement model for the NDIS Commission. The Committee heard suggestions for increased coordination with and support from existing state and territory CVS, as well as for the establishment of a national CVS to be administered by the NDIS Commission.[65]

The Committee observed that there are compelling arguments for both a national CVS overseen by the NDIS Commission and for strengthened arrangements between the NDIS Commission and state and territory CVS. It said:

> a national scheme would provide the benefit of nationally consistent arrangements with clear scope to monitor matters that are within the Commission's jurisdiction, and coverage of participants in all states and territories.[66]

The Committee also noted:

> state-based schemes are able to look at a range of services that a person with disability might receive and can therefore give a more holistic picture of a person's experiences.[67]

The Committee recommended that the NDIS Commission should expressly consider the role of CVS in assisting the NDIS Commission with carrying out its functions.[68] It also recommended that the Australian Government should explore amendments to the *NDIS Act* to establish a national CVS to be overseen by the NDIS Commission.[69] The Committee clarified that a national scheme should supplement, rather than replace, existing state and territory-based schemes.[70] It emphasised that:

> Regardless of whether the Commission has its own scheme, or if it continues and strengthens arrangements with state-based schemes, there will need to be different agreements with states and territories regarding areas of interface in the provision of support to people with disabilities.[71]

The Committee acknowledged strong arguments for recognising CVS in the *NDIS Act*, whether these be existing state and territory schemes or a new national scheme administered by the NDIS Commission.[72] The Committee recommended that unless and until a national CVS is established:[73]

- consideration should be given to expanding the NDIS Commission's functions to include coordination and support for state and territory-based CVS to report on matters affecting NDIS participants
- governments should work together to ensure that each jurisdiction has a CVS that can report to the NDIS Commission on risks to NDIS participants

- the NDIS Commission should review agreements with state and territory bodies responsible for CVS to ensure there are clear protocols in place for overseeing the provision of NDIS services and for two-way data and information sharing.

The Australian Government referred the Committee's recommendations about CVS to the independent NDIS Review, which is due to report in October 2023. In doing so it noted 'the scope of CVS functions within relevant jurisdictions is often broader than people with disability who may be participating in the NDIS'.[74]

4.5. What we were told about community visitor schemes

The Royal Commission has received evidence about the essential role played by community visitors in identifying, exposing, preventing and responding to allegations of violence against, and abuse, neglect and exploitation of, people with disability.

How community visitors perform their role

We have heard from a number of witnesses about how community visitors perform their role. During Public hearing 3, 'The experience of living in a group home for people with disability', Victorian community visitors, Mr David Roche and Ms Cindy Masterson, said community visitors approach their visits to services by asking themselves if they would be happy to live there and if they would find the conditions reasonable for themselves.[75]

The Queensland Public Advocate, Ms Shayna Smith, gave evidence at Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern'. Ms Smith told us about how community visitors respond to issues they identify:

> depending on what the issue is, the lower level issues would be provided back to the service provider at the first instance and attempt to resolve it at the local level, and that could be just a request for further information or further documents that may not have been available during the visit, ranging to the more serious incidents where community visitors would report that to the appropriate agencies such as the NDIS Quality and Safeguard Commission or our State Disability Services Department or even the police if it was a significant risk of harm.[76]

At Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', Professor Richard Bruggeman, Professorial Fellow in the Department of Disabilities and Social Inclusion at Flinders University, described the role of community visitors:

> Basically, what community visitors do is they go into houses, they ask questions, they examine documents, they look at what's going on and they can see bad things if they are happening. They also see good things and they report on those increasingly.[77]

The Victorian Public Advocate, Dr Colleen Pearce, gave evidence at Public hearing 26, 'Homelessness, including experience in boarding houses, hostels and other arrangements', about the role of community visitors. It is to 'be there for the individual', 'to listen to them and hear their stories and then to help them tell their stories to anyone who would listen'. She said that community visitors 'often live in the area of the houses they visit', and 'form part of the social capital'.[78]

The value of community visitor schemes

Evidence on the value of CVS has been given across a number of hearings. In Public hearing 6, Ms Smith, the Queensland Public Guardian, described the 'quite extensive powers' of community visitors and their value in relation to people with disability subject to restrictive practices:

> I believe our community visitors play an important role in the safeguarding framework of people who are subject to restrictive practices in Queensland, as they can actually oversight and monitor services provided at those visitable sites. So it allows them to actually enter those sites, either announced or unannounced visits, and speak to the people residing at those sites but it also allows them to be the eyes and ears at looking out at what services are being delivered and how they are being delivered at that site.[79]

At Public hearing 14, we heard evidence about the role and effectiveness of a CVS in providing independent oversight over and advocacy in disability services, particularly in the context of services provided to people with disability in their homes. This included escalating concerns about inadequate investigations by the South Australian Department of Human Services (DHS) regarding threats against 'Mitchell' while he was receiving DHS disability accommodation services.[80] Public hearing 20, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)', examined issues concerning a Melbourne group home operated by Life Without Barriers. We heard about the important role that community visitors played in observing, recording and reporting on the extent and the severity of resident-to-resident violence and resident-to-staff violence, and the high rates of use of agency and casual staff, in the group home.[81]

In Public hearing 26, Dr Colleen Pearce told us the community visitor model does not require a person with disability to make a complaint to elicit a response, whereas:

> to get the Quality and Safeguards Commission to act you need a complaint. And think of the people that have spoken here today. How are they going to – what are they going to say the complaint is? And how are they going to articulate that and without advocacy or Community Visitors, how are they going to have their voices heard?[82]

Dr Pearce described the Victorian CVS as a 'very powerful' model.[83] She explained that community visitors had been raising serious issues concerning the living conditions and treatment of residents at Hambleton House, a large supported residential service (SRS) facility

and other SRSs for a number of years.[84] In 2019 and 2020 community visitors reported on a range of issues at Hambleton House.[85] This led to authorised officers undertaking inspections and compliance monitoring. All residents were subsequently transferred to other facilities and administrators were appointed to Hambleton House.[86]

Responses to our *Safeguards and quality issues paper* also identified CVS as a critical oversight mechanism that warrants expansion. Respondents identified community visitors as particularly important for people with impaired decision-making capacity. Some of those people, without strong advocacy support, may struggle to access complaint-based systems that rely on articulate, assertive and empowered complainants.[87]

The Northern Territory Community Visitors Program described CVS as the 'eyes and ears' in abuse prevention.[88] National Disability Services and the Queensland Office of the Public Guardian supported a well-resourced, nationally coordinated CVS.[89] Other responses supported expanding the functions and reach of CVS.[90]

In response to the *Health care for people with cognitive disability issues paper*, the NSW Ageing and Disability Commission said that Official Community Visitors in New South Wales have uncovered a range of concerns involving people with disability. Those include residents not being involved in decisions about their lives, poor behaviour support practices, and the use of unnecessary or unauthorised restrictive practices.[91]

The Victorian Government told us, 'Community Visitors provide a critical safeguard, independent support and advocacy for often isolated members of the community.'[92] Ms Anne Gale, the South Australian Public Advocate and Principal Community Visitor, also emphasised that CVS play a proactive and reactive role in protecting the wellbeing of vulnerable people.[93]

Gaps and limitations

In Public hearing 26, Dr Pearce said the CVS in Victoria did not have sufficient resources to visit the large number of additional disability group homes – around 250 – that have proliferated since the rollout of the NDIS.[94] She also pointed out that community visitors are not authorised to visit people with disability at risk of abuse or harm residing in unregulated 'pop up' accommodation.[95]

Dr Pearce also gave evidence that service providers sometimes dispute the legal entitlement of community visitors to inspect documents.[96] She said service providers have, at times, told community visitors that they can only view records by using the computer onsite. This limits the time community visitors can spend interacting with residents.[97] In their *Report of Public hearing 20*, the Commissioners found that Life Without Barriers failed, without reasonable excuse, to provide Community Visitors with the documentation required under section 130(1)(d) of the *Disability Act 2006* (Vic).[98]

We have also heard that community visitors may not have sufficient time to perform their role. Ms Susan Rewell, a community visitor in Victoria, told us that community visitors spend as much time as possible speaking with and observing residents at the places they visit. She said it takes longer to interact with residents who have limited verbal communication.[99] Ms Rewell explained that community visitors have less time available to spend with residents if they need to be 'in the office looking at documents or searching for documents'.[100]

At Public hearing 14, witnesses expressed concern about the South Australian Government's withdrawal of community visitors from non-government disability accommodation service providers, supported residential facilities and day programs.[101] Ms Karen Rogers, mother of Daniel Rogers, an adult with disability, told Public hearing 14 that:

> The South Australian Community Visitor Scheme needs to be strengthened and funded appropriately… I think visitors need to do regular scheduled and unscheduled visits to all accommodation services, and not just the government services, the NGOs as well. The program should be expanded to include day options and people living in their own homes, particularly people deemed as vulnerable.[102]

We were also told about the need for CVS in jurisdictions without them. In response to the *Safeguards and quality issues paper*, Advocacy Tasmania highlighted the need for community visitors for people with disability in Tasmania.[103]

Some respondents to the *Safeguards and quality issues paper* raised concerns about 'disconnects' where the NDIS Commission has safeguarding responsibilities. These include closed settings, where community visitors are predominantly relied on and where there is cross-over with the jurisdiction of trustees, guardians and ombudsmen.[104]

Respondents also suggested that community visitors could potentially visit private dwellings, with appropriate consent.[105] We sought further evidence on this issue during Public hearing 14. Professor Bruggeman, Professorial Fellow in the Department of Disability and Social Inclusion at Flinders University, told us that having community visitors visit people in private homes would need to be 'an opt-in model'.[106] When asked if he had a view on an opt-in model, Mr Martin Hoffman, the then CEO of the NDIA, said:

> one could well see how something like that could work. And we have envisaged in our planning processes and conversations, that would be a good vehicle for asking people, 'would you like, would you be prepared, would you like to have someone come and knock on your door from time to time?[107]

Asked the same question, Mr Graeme Head, former NDIS Commissioner, said, 'I think it will be a very critical question to answer in the design of any initiative.' Mr Head suggested that an initial assessment could be made about the extent to which an NDIS participant would be prepared to participate in such a scheme.[108]

Community visitors and the NDIS

Much of the evidence we received concentrated on whether the role of the NDIS Commission regarding CVS should be expanded.

Dr Pearce expressed concern about ongoing uncertainty regarding the future role of CVS with the continued rollout of the NDIS. She said it was 'critical' that the 'fundamental safeguard' provided by community visitors should not be lost going forward and the role should be 'enshrined in legislation'.[109]

Dr Pearce was also critical of the NDIS Framework still not formally recognising CVS despite the *WestwoodSpice Review* report recommending doing so in 2018.[110] Dr Pearce said there was a 'mismatch between State legislation, which is setting up and empowering the community visitors, and a Commonwealth framework that doesn't recognise community visitors and operates on a complaints-based system'.[111]

Dr Pearce reported that when the Public Advocate wants to share information gathered by community visitors with the NDIS Commission, the Public Advocate has to frame the information as a complaint, even though it is not always appropriate to do so.[112] She also expressed frustration with the limitations of the information-sharing arrangements between the Public Advocate and the NDIS Commission. Dr Pearce explained that while the Public Advocate is 'welcome to provide as much information as possible to the Commission' there is 'very little guarantee of receiving a response':

> Currently when a community visitor raises an issue, and it ends up in the Safeguarding Commission and we don't get a response and we don't know what they do, community visitors go back to the house and a participant or resident might say, 'What happened?' We have to say, 'We didn't know'. We did raise the issue, we talked to the service provider, we raised with the Commission but we don't always know what they did other than we are told it was referred to the incident reporting team, or it was referred somewhere else. As I said, that's not the Commission being uncooperative, it is a function of the current information sharing provisions.[113]

During Public hearing 14, Martin Hoffman, former CEO of the NDIA, advised that the merits of a proactive system of identifying and visiting vulnerable NDIS participants (in the form of a CVS) was under consideration.[114] Mr Hoffman indicated that this consideration would form part of the planned review of the NDIS Framework.[115] Ms Lois Boswell, CEO of DHS, told us that the South Australian Government was engaging with the Australian Government and the NDIS Commission on the potential for a national CVS.[116]

In giving her evidence, Ms Ann Gale, the South Australian Public Guardian and Principal Community Visitor, discussed establishing a dedicated national CVS for all NDIS participants. She said that such a CVS, led by the NDIS Commission and potentially in partnership with the states and territories, would assist in protecting the rights of vulnerable people in the community.[117]

In submissions following Public hearing 20, Counsel Assisting submitted that the Royal Commission should consider whether to recommend the development of a national CVS. This would complement the NDIS Commission's oversight of the quality of services provided by NDIS-funded service providers.[118] In response, the Victorian Public Advocate submitted that the *NDIS Act* should be amended to refer to the legislation underpinning the Victorian CVS (and other CVS) as a key component of a national safeguarding framework.[119] During Public hearing 26, Dr Pearce reiterated the need for CVS to be able to operate in the new landscape brought about by the establishment of the NDIS.[120]

In October 2022, the Victorian Government recommended in a submission to the Royal Commission that the Australian Government should consider:[121]

- recognising the role of community visitors in the NDIS Framework including amending the *NDIS Act*, if required
- facilitating the effective interface between the NDIS Commission and existing state and territory community visitors and official visitor schemes
- ensuring community visitors (or other independent visitors) are available to all NDIS participants, as recommended by the Robertson Review
- addressing current barriers to sharing information about at-risk participants between the NDIS and community visitors, including information to ensure community visitors can carry out their powers and functions.

Evidence provided by the NDIS Commission

In Public hearing 14, the former NDIS Commissioner, Mr Graeme Head, indicated his general support 'for a Community Visitor Scheme that is aligned to the NDIS'.[122] He said it was a matter for Australian Government and state and territory disability ministers to determine any changes needed to the community visiting arrangements outlined in the NDIS Framework.[123] Mr Head observed:

> community visiting as it exists now was not actually designed in any jurisdiction for the NDIS and the NDIS itself changes some of the fundamental concepts that have underpinned community visiting, and my view is that in taking the principle of community visiting into an NDIS model, that actually requires rethinking, a redesign of the approach, so that it makes sense in the environment in which NDIS supports are being provided.[124]
>
> …
>
> I think it's the case that if we accept that an NDIS version of community visiting remains a sensible safeguarding measure, then it makes sense to have a nationally consistent set of arrangements around that.[125]

Mr Head stated that the *NDIS Act* 'does provide for the concurrent operation of state and territory laws'[126] but said 'I'm not sure that I think it would be a good idea to have two separate systems operating in respect of NDIS participants, but that's a personal view'.[127]

Mr Head indicated it would make sense for a national CVS to be operated by the NDIS Commission.[128] He said a visiting scheme:

> would provide an important additional vehicle for reaching out to people who may have difficulty in raising concerns themselves, alongside those things that the Commission deals with through its own visits and other forms of outreach that are within the agency's processes.[129]

Mr Head noted he had advised the Ministerial Council for Disability Reform to consider the establishment and operation of a national CVS as part of the review of the NDIS Framework.[130] He said establishing an NDIS CVS within the NDIS Commission would enable the NDIS Commission to:[131]

- draw on an additional quality and safeguarding mechanism to uphold the rights of, and promote the health, safety and wellbeing of, participants, which may be particularly useful where face-to-face interaction with participants and NDIS providers and local resolution of issues would assist
- integrate the community visiting function with the NDIS Commission's other quality and safeguarding mechanisms
- more readily obtain intelligence from community visitors and use that intelligence across the Commission's other functions
- deploy community visitors as an additional means of promoting continuous improvement among NDIS providers.

Mr Head also noted and addressed the arguments in the *WestwoodSpice Review* report in favour of retaining state and territory CVS. He gave reasons why the NDIS Commission could operate an effective scheme.[132]

Mr Head advised that the first step in establishing an NDIS CVS would be reaching agreement among all Australian governments. He suggested that consideration of this issue could form part of the planned review of the NDIS Framework. Should agreement be reached, Mr Head also said the *NDIS Act* required amendment to allow the NDIS Commission to establish and operate a CVS. Detailed provisions about the scheme could be made in new NDIS Rules. The NDIS Commission would want to develop those rules in close consultation with participants, NDIS providers and state and territory community visitor schemes.

Mr Head suggested that initially, an NDIS CVS could visit group homes operated by NDIS providers.[133] He said it would be essential for certain matters to be determined at the outset.[134] They would include clearly delineating the functions and powers of community visitors from the NDIS Commission's compliance and enforcement powers under the *NDIS Act*.[135] A consultation

process could then follow to consider the effectiveness of the NDIS CVS and identify any necessary changes.[136]

In Public hearing 26, the current NDIS Commissioner, Ms Tracy Mackey, was asked if any steps had been taken to develop a national CVS. She advised:

> There's a review of the National Quality and Safeguarding Framework. That review was due at the end of last year but will be undertaken, I understand, as a part of the broader NDIS review that the Government has indicated it will proceed with. And as part of that review because the Framework includes consideration of a Community Visitor Scheme and those arrangements, they will be considered as a part of that process.[137]

In Public hearing 32, 'Service providers revisited', Ms Mackey told us she has expressed her support for the establishment of a CVS aligned with the NDIS Commission's regulatory monitoring functions and operated by the NDIS Commission.[138] Ms Mackey said such a scheme:

> would need to be consistent with upholding the human rights of Participants, recognising that the NDIS is very different to the settings State and Territory community visitor schemes were designed to serve, and in sync with maturing NDIS stewardship arrangements.[139]

Ms Mackey further stated that:

> The NDIS Commission is undertaking some early work to identify and explore options for a community visitor scheme for the NDIS. This work is focusing on identifying a model that would have Participant choice and control at its centre, and that could achieve the safeguarding function identified in the Robertson Review, namely, to provide for individual face-to-face contact with NDIS Participants who are at increased risk in order to assess risks to those Participants. There are many issues that would need to be considered before a model could be proposed.[140]

Ms Mackey identified these issues as including:[141]

- identifying the purpose of the scheme (for example, will its purpose be only to safeguard participants identified as being at risk or will it be to also resolve low-level issues at a local level and/or be a source of regulatory intelligence for the NDIS Commission)
- determining the approach to identifying at-risk participants
- identifying the categories of participants (self-managed, plan-managed or Agency-managed) and the types of settings that would be within the scope of the scheme
- the nature of visits (whether to check on service provision or, more consistently with the rights-based focus of the NDIS, to support participants in exercising their rights)
- determining the legal basis for right of entry, if required, including in relation to participant consent.

Ms Mackey stressed the importance of 'ensuring that outreach options for the NDIS as a whole, including any community visitor scheme, are contemporary and proportionate to participant risk'.[142]

Ms Mackey also said the NDIS Commission's ability to monitor NDIS providers is not as strong as the monitoring ability of regulators in comparable regulatory systems.[143] The NDIS Commission monitors NDIS providers using complaints and reportable incidents as a proxy for compliance, rather than through a formal program of monitoring.[144] In her view, a CVS (or outreach program) could play a role in the NDIS Commission's monitoring functions.

The NDIS Commission will continue to contribute to policy work in this area through DSS, Disability Reform Ministers' Meetings, and the independent review of the NDIS. Ms Mackey observed that if governments agreed to establish a national CVS operated by the NDIS Commission, it will also need to be appropriately resourced.[145]

4.6. The future role of community visitors

In submissions following Public hearing 32, Counsel Assisting observed that the evidence clearly demonstrates community visitors play a 'crucial role' and that existing CVS should continue.[146] Counsel Assisting submitted 'there is benefit in looking at ways to achieve consistency across the existing state and territory schemes and/or to integrate those schemes' into the NDIS Framework.[147] Counsel Assisting noted that existing CVS have limitations or are under-resourced, or both, and more is required than just enhancing those schemes.[148] Counsel Assisting also noted the lack of existing CVS in Western Australia and Tasmania.[149]

Counsel Assisting observed (as did the *WestwoodSpice Review* report) there was a need to consider the emergence of new models of service delivery which enable people with disability greater choice about where and with whom they live. This also applies to residing in private or single-person homes. Counsel Assisting commented that, in their current configuration, state and territory CVS may not adapt well to such a new environment.[150] In view of this, Counsel Assisting observed:

> A properly resourced program of monitoring visits conducted by the NDIS Commission, which is informed by intelligence about 'at risk' participants, could therefore play an increasingly significant role in the future.[151]

In response, the Australian Government recognised that CVS are not consistent and 'are likely to face issues and limitations noting the principles of choice and control'.[152] The NDIS Commission agreed that a nationally consistent approach regarding CVS would be helpful for participants, and said it is 'undertaking work to identify and explore options for a community visitor scheme for the NDIS'.[153] As outlined in the previous section, the NDIS Commissioner described in her evidence how the model could provide a safeguarding role for at-risk NDIS participants.

We have focused on the future role of community visitors from the perspective of how they will operate as a safeguard for all people with disability – not just those who are NDIS participants. It is also necessary to consider the state and territory CVS that do not operate solely for people with disability. As noted in section 4.2, in some jurisdictions CVS also visit people with mental illness, children in out-of-home care and people in detention facilities.

How should schemes be administered?

It is necessary to decide how CVS should be administered going forward. There would appear to be two distinct options:

1. A national CVS, operated by the NDIS Commission, for people with disability participating in the NDIS. It will sit alongside state and territory CVS covering people with disability who are not NDIS participants.
2. State and territory-based CVS for people with disability where community visitors have authority to visit NDIS participants.

The advantages and disadvantages of both options have been comprehensively discussed throughout the chapter. Regardless of which model is adopted, there will be challenges. The question is therefore how these challenges can best be accommodated.

We consider the analysis and recommendations contained in the *WestwoodSpice Review* report, summarised in section 4.4, to be compelling.[154] It is appropriate for a state or territory CVS to monitor the conduct of service providers operating in that jurisdiction. Doing so supports a 'person-centred' perspective because community visitors monitor service providers in the jurisdiction where people with disability live and receive the services rather than whether they are funded to receive NDIS services.

We are particularly cognisant that:

- Many people with disability are not NDIS participants and would not benefit from the coverage of a national CVS operated by the NDIS Commission. For example, people with disability in licensed boarding house accommodation, many of whom are not NDIS participants, told the Royal Commission about being at significant risk of abuse and harm.[155]
- State and territory-based CVS may lose their economy of scale, expertise and local community knowledge if their disability component is excised. This could weaken the level of safeguarding presently offered by these schemes.
- Establishing a CVS within the NDIS Commission – the agency responsible for regulating NDIS providers – would potentially compromise the independence of community visitors.[156] The Ageing and Disability Commission (ADC), which administers the CVS in New South Wales, has explained that the independence of community visitors in that state is important 'to avoid actual or perceived conflicts of interest'.[157]

- To date, the Northern Territory and South Australia have nominated their respective CVS as bodies performing the functions of the National Preventive Mechanism, responsible for independently monitoring places of detention, required under the *Optional Protocol to the Convention Against Torture* (*OPCAT*) - see Chapter 3, 'Optional Protocol to the Convention Against Torture'.

Finally, we take the view that, notwithstanding the advent of the NDIS, states and territories continue to have an important responsibility to prevent, identify and respond to concerns about violence against and abuse of people with disability living in their respective jurisdictions. This is reflected in our recommendation that the states and territories should introduce adult safeguarding laws (Chapter 1, 'Adult safeguarding functions'). It is also recognised by our recommendation that states and territories establish disability death review schemes (Chapter 5, 'Disability death review schemes') to identify systemic trends in deaths of people with disability and ways to prevent similar deaths from occurring in future.

There is clear potential for states and territories to co-locate some or all disability functions – including CVS – within the same body. In New South Wales, for example, the ADC administers both adult safeguarding functions and the CVS.

Nationally consistent CVS operated by states and territories should be maintained and strengthened

Against the above background, we consider the states and territories should continue to operate and support CVS to monitor service provision to people with disability. The state and territory schemes should seek national consistency and establish a clear and strong connection with the NDIS Commission. For this proposal to be achieved, several things need to occur.

Firstly, Western Australia and Tasmania will need to commit to establishing a CVS for people with disability in those states. South Australia will need to adopt a different position in relation to the appropriateness of CVS visiting NDIS providers and to align with the position adopted for some time in New South Wales, Victoria and Queensland.

Secondly, all states and territories must commit to adequately resourcing their CVS. The Royal Commission notes that, in the largest state, New South Wales, the ADC believes the existing recurrent budget of the Official Community Visitor (OCV) scheme is 'insufficient to meet current and increasing demand'. The ADC considers that this presents 'ongoing sustainability issues and significant risks to the ability of [the OCV scheme] to meet their legislated functions'.[158]

Thirdly, key components of the schemes should be nationally consistent to ensure equity and efficiency. CVS should have consistent:

- responsibilities for visiting people with disability and should include people who receive NDIS services
- inspection powers, including to inspect relevant records

- powers to provide information to other relevant bodies, including (but not limited to) the NDIS Commission[159]
- standards for monitoring service provision which, where relevant, reflect NDIS practice standards and quality indicators
- data collection and reporting requirements.

Fourthly, a national agreement is needed between the Australian Government and state and territory governments establishing how CVS and the NDIS Commission will share information to effectively exercise their respective functions. The national agreement should be consistently reflected in state and territory legislation establishing CVS.[160]

We recommend in Volume 5, the development of a new National Disability Agreement which should clearly set out roles and responsibilities of parties to the Agreement (Recommendation 5.1).

Finally, it will be necessary to amend the *NDIS Act* (and the NDIS Framework) and the *National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cth) to recognise state and territory CVS as a formal safeguard for people with disability. To facilitate that safeguarding role, those laws should provide the authorising environment for information-sharing between the NDIS Commission and CVS. State and territory legislation establishing CVS will need to be amended to allow CVS to share information with the NDIS Commission and NDIA. Rules establishing the relationship between CVS and the NDIS Commission may also be required. The Australian Government should take the lead on the national agreement and introducing necessary amendments to Commonwealth legislation.

State and territory governments should actively attempt to achieve national consistency in CVS. They should consult the Australian Government on issues involving the NDIS Commission, for example, developing monitoring standards for CVS which appropriately reflect NDIS practice standards and quality indicators.

Who should community visitors visit?

The jurisdiction of CVS has historically been defined by reference to 'visitable places'. This allows community visitors to enter certain services where people with disability may be at elevated risk of having their rights denied. For people with disability, those services have generally been supported accommodation (group homes) and, in some jurisdictions, licensed boarding houses/SRS.

In our view, it makes sense for CVS to continue to visit these services as long as they continue to exist. CVS should visit these services frequently and certainly more often than currently occurs. As the NDIS Commission has explained, supported accommodation services:

> involve continuous, intimate and fundamental daily life support to people with disability. People living in supported accommodation generally have high support needs, depend

> on others for most aspects of their daily living needs, and may have few protective mechanisms available to them, both to identify risks to them and act on those risks to avoid harm.[161]

We have heard evidence across several public hearings, particularly in Public hearing 26, about ongoing risks to the safety and wellbeing of people with disability living in supported accommodation.[162]

We also acknowledge the observation in the *WestwoodSpice Review* report, echoed by Counsel Assisting, about the need for the future of CVS to account for the more diverse disability accommodation market created by the NDIS. CVS should shift their focus from 'visitable places' towards a more nuanced approach based on 'consideration of the factors that contribute to risk'.[163] In this regard, it is notable that the current statutory review of the *Children's Guardian Act 2019* (NSW) is also examining the scope of the New South Wales CVS in light of recent reforms to the out-of-home care system in that state. The review is considering whether the child-focused component of the CVS 'should be recast' to allocate community visitors to visit specific cohorts of children in out-of-home care, rather than visits based on the accommodation service provided to the child.[164]

However, we maintain our view that supported accommodation and boarding houses/SRS should continue to be prioritised as 'visitable places' given the evidence about the elevated risks posed to residents of these services.

Identifying risk

If the scope of CVS's jurisdiction is not to be determined solely by reference to 'visitable places' but has a broader focus on considering factors contributing to risk, what should these factors be? Further, what are the mechanisms for considering those factors?

The former NDIS Commissioner, Mr Graeme Head, said 'we must avoid a suggestion that vulnerability is in some way innate rather than a function of the way a person interacts with the world that they are living in'.[165] Mr Head spoke about the need to assess 'the extent to which people have either no natural supports or natural supports that might be somewhat fragile or where people become disengaged at certain points'.[166]

We have received evidence about work undertaken by the NDIA and NDIS Commission to identify and use information about potential risks to NDIS participants. The former CEO of the NDIA, Mr Martin Hoffman, provided evidence detailing the systems and processes used by the NDIA to assess the potential vulnerability of participants. These systems and processes have been part of the NDIS pathway for all participants since the commencement of the NDIS.[167]

During Public hearing 14, Mr Hoffman also gave evidence on the NDIA's work to identify people at risk through the Vulnerable Participant Framework.[168] In late 2022 the Royal Commission sought advice about the status of this work. The NDIS Commission informed us that, together with the NDIS, it had entered into the Operational Protocol for NDIS Participants at Risk in July 2022.[169]

The Operational Protocol addresses how and when the agencies will share information and adopt joint operational responses to NDIS participants who are at risk.[170] The intention is that the NDIS and the NDIS Commission will share data 'to support an integrated view of participant circumstances and the presence of any risk indicators'.[171] The Operational Protocol provides for a tiered response, with a number of different escalation levels. Those escalation levels depend on the level of risk for the participant and the possible role of NDIS supports in reducing or contributing to the reduction of that risk.[172] Ms Tracy Mackey, the NDIS Commissioner, advised she anticipates 'how best to proactively identify Participants who may be at greater risk of violence, abuse, neglect or exploitation will continue to be considered in the context of the review of the NDIS'.[173]

The Operational Protocol for NDIS Participants at Risk may be one mechanism for potentially identifying people with disability at greater risk of violence, abuse, neglect or exploitation and to 'triage' those people for visits by community visitors.

Under the Operational Protocol, the NDIA currently conducts routine outbound 'Participant Check-ins' and these can occur more frequently when specific risk indicators are present. During these check-ins the NDIA could seek a participant's consent to CVS visits. The NDIS Commission, which has access to NDIA data about participants flagged as being at greater risk, could also share that information with CVS. As noted earlier in section 4.3 of this chapter, the NDIS Commission's draft Site Visit Policy already enables the NDIS Commission to request engagement with an NDIS participant by a community visitor. Under any arrangement of this type, it will be important to maintain a demarcation between the purpose of site visits conducted by the regulator and the purpose of visits by an independent community visitor. CVS should not be used 'by proxy' to fulfil the proper role of the regulator.

More difficulties arise in relation to people with disability who are not NDIS participants and who do not reside in supported accommodation or a licensed boarding house/SRS. It is difficult to envisage any straightforward means by which CVS could systematically identify individuals who are at greater risk of violence, abuse, neglect or exploitation. One possibility is that CVS could be given power to visit a person with disability if the CVS has grounds for reasonably believing that the person's rights are being or may be breached by a service provider. Those sources might include a neighbour, family member, medical practitioner, police or a body such as the Ageing and Disability Commissioner (New South Wales), Adult Safeguarding Unit (South Australia) or Disability Services Commissioner (Victoria). Any such discretionary power should only be exercised with the consent of the individual concerned and with respect for the individual's choice, control and dignity of risk.

Should community visitors be able to visit private homes?

A key question that has arisen since the death of Ms Ann-Marie Smith in 2020 is whether community visitors should be able to visit private homes. As noted in section 4.4, the Robertson Review suggested that Ms Smith's death would have been unlikely 'if there had been a system of regular visits to persons with [her] vulnerability'.[174] The Robertson Review also made it clear that any such system would need to operate on the basis of consent.[175] Witnesses who provided evidence during Public hearing 14, including the former heads of the NDIA and NDIS Commission, agreed that any such system would need to operate as an 'opt-in model'.[176]

Since Ms Smith's death, the NDIA and NDIS Commission, in response to the Robertson Review's recommendations, have made changes to improve the identification of and response to NDIS participants who may be at greater risk of poor outcomes, including harm. These changes include the introduction of the Operational Protocol for NDIS Participants at Risk. Other changes include placing additional obligations on registered NDIS providers who support people with disability in their own home. This was accompanied by giving the NDIS Commission associated compliance oversight of those obligations.[177]

In addition, as discussed in Chapter 1, South Australia and New South Wales now have adult safeguarding laws which provide the Adult Safeguarding Unit (South Australia) and the ADC (New South Wales) with a range of functions to receive and respond to reports about abuse of an adult with disability or an older person (and in South Australia, abuse of any 'vulnerable adult'). We have recommended that all states and territories establish similar adult safeguarding mechanisms.

The evidence does not justify a recommendation to be satisfied that it is appropriate at this time that CVS should have a general power to visit people with disability living in private homes. However, we consider it may be appropriate for CVS to have the capacity to visit a person with disability living in a private home, with the person's consent, in certain circumstances, such as where the CVS obtains information giving it grounds to reasonably believe that the person's rights are being breached. That information can be obtained via another body such as the NDIS Commission, NDIA or ADC.

Recommendation 11.12 Nationally consistent community visitor schemes

States and territories should:

a. urgently implement community visitor schemes (CVS) for people with disability, if they have not done so already

b. ensure CVS are resourced to conduct frequent visits to individuals who may be at elevated risk of abuse or harm

c. agree to make CVS nationally consistent regarding people with disability, including in relation to:

   - the scope of schemes (who community visitors should visit)
   - powers to visit people with disability, inspect records and provide information to other relevant bodies
   - common monitoring standards
   - the type of data that CVS should capture and report on

d. as a priority, define the scope of CVS with reference to:
    - 'visitable services'
    - mechanisms for identifying factors that may place a person with disability at increased risk of violence, abuse, neglect or exploitation

e. ensure CVS legislation enables relevant information to be shared between CVS, the NDIS Quality and Safeguards Commission and the National Disability Insurance Agency.

Recommendation 11.13 Integration of community visitor schemes with the NDIS

a. The Commonwealth should amend the *National Disability Insurance Scheme Act 2013* (Cth) to formally recognise community visitor schemes (CVS) as a safeguard for people with disability and provide the authorising environment for information sharing between the NDIS Quality and Safeguards Commission (NDIS Commission) and CVS.

b. The Australian Government should:
    - enter into a national agreement with states and territories that commits CVS and the NDIS Commission to:
        - sharing relevant information to effectively exercise their respective functions
        - developing common standards for guiding the work of CVS relating to people with disability.
    - update the NDIS Quality and Safeguarding Framework to formally recognise the important safeguarding role played by CVS.

Endnotes

1 *Convention on the Rights of Persons with Disabilities,* opened for signature 30 March 2007*,* 2515 UNTS 3 (entered into force 3 May 2008), art 16(3).
2 Department of Social Services, Australian Government, NDIS Quality and Safeguarding Framework, December 2016, p 53.
3 Exhibit 14-218, CTD.7200.0016.0406, p 8.
4 Exhibit 14-218, CTD.7200.0016.0406, p 8.
5 Exhibit 14-218, CTD.7200.0016.0406, p 30.
6 Exhibit 14-218, CTD.7200.0016.0406, p 8.
7 Joint Standing Committee on the National Disability Insurance Scheme, *NDIS Quality and Safeguards Commission Review*, November 2021, p 79.
8 Joint Standing Committee on the National Disability Insurance Scheme, *NDIS Quality and Safeguards Commission,* November 2021, p 79.
9 Department of Social Services, Australian Government, Australia's Disability Strategy 2021–2031, December 2021, p 55.
10 *Ageing and Disability Commissioner Act 2019* (NSW), pt 4; *Disability Act 2006* (Vic), pt 3, div 6; *Supported Residential Services (Private Proprietors) Act* 2010 (VIC), pt 9; *Public Guardian Act 2014* (Qld), ch 3, pt 6; *Disability Services Act 1993* (SA), Disability Services (CV Scheme) Regulation 2013 (SA); *Disability Services Act 1993* (NT), pt 6; *Official Visitor Act 2012* (ACT).
11 NSW Ageing and Disability Commission, 'About us – Official community visitors', *Ageing & Disability Commission,* 20 December 2020, web page. <https://www.ageingdisabilitycommission.nsw.gov.au/about-us/official-community-visitors.html>
12 NSW Department of Communities and Justice, *Independent review of the Ageing and Disability Commissioner Act 2019*, Discussion paper, November 2022, pp 11–14; NSW Office of the Children's Guardian, *Statutory review of the Children's Act 2019*, Discussion paper, July 2022, pp 46–52.
13 *Disability Act 2006* (Vic) pt 3 div 6, pt 6 div 7.
14 *Public Guardian Act 2014* (Qld) ch 3 pt 6, ch 4 pt 2.
15 *Mental Health Act 2009* (SA) ss 52, 52A; Disability Services (Community Visitor Scheme) Regulations 2013 (SA) reg 4.
16 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [28].
17 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [150].
18 *Mental Health and Related Services Act 1998* (NT) pt 14; *Disability Services Act 1993* (NT) pt 6.
19 *Official Visitor Act 2012* (ACT); *Disability Services Act 1991* (ACT) pt 3.
20 *Mental Health Act 2013* (Tas) ch 3 pt 2; *Corrections Act 1997* (Tas) s 10.
21 *Mental Health Act 2014* (WA) pt 20.
22 Department of Social Services, Australian Government, NDIS Quality and Safeguarding Framework, December 2016, p 54.
23 Department of Social Services, Australian Government, NDIS Quality and Safeguarding Framework, December 2016, p 53.
24 Department of Social Services, Australian Government, NDIS Quality and Safeguarding Framework, December 2016, p 54.
25 Exhibit 14-218, CTD.7200.0016.0406.
26 Exhibit 14-218, CTD.7200.0016.0406, Westwood Spice, *Community visitor schemes review, Department of Social Services for the Disability Reform Council, Council of Australian Governments*, Final report, December 2018, p 49.
27 Australian Government, Response to the Joint Standing Committee report on the National Disability Insurance Scheme: *NDIS Quality and Safeguards Commission*, April 2023, p 4.
28 Ageing and Disability Commissioner Regulation 2019 (NSW) s 6; *Ageing and Disability Commissioner Act 2019* (NSW) s 20.
29 *Public Guardian Act 2014* (Qld) s 39.
30 Specialist disability accommodation (SDA) is housing designed for people with very high support needs. SDA accommodation may have accessible features to help residents live more independently and allow supports to be delivered safely.
31 *Disability Act 2006* (Vic) s 129(1A).

32 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [28].
33 Exhibit 32-195, CTD.7200.0040.1250, p 8.
34 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [196].
35 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [196].
36 Exhibit 32-007, 'Statement of Tracy Mackey', 15 November 2022, at [195].
37 Exhibit 14-196, CTD.7200.0016.0371, p 3.
38 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [224–225].
39 *Letters Patent* (Cth), 4 April 2019 (as amended), (j).
40 Exhibit 14-218, CTD.7200.0016.0406, Westwood Spice, *Community visitor schemes review, Department of Social Services for the Disability Reform Council, Council of Australian Governments*, Final report, December 2018.
41 Exhibit 14-218, CTD.7200.0016.0406, p 8.
42 Exhibit 14-218, CTD.7200.0016.0406, p 43.
43 Exhibit 14-218, CTD.7200.0016.0406, p 44.
44 Exhibit 14-218, CTD.7200.0016.0406, p 46.
45 Exhibit 14-218, CTD.7200.0016.0406, recommendation 1.
46 Exhibit 14-218, CTD.7200.0016.0406, recommendation 2.
47 Exhibit 14-218, CTD.7200.0016.0406, recommendation 3.
48 Exhibit 14-218, CTD.7200.0016.0406, recommendation 4.
49 Exhibit 14-218, CTD.7200.0016.0406, recommendation 5.
50 Exhibit 14-218, CTD.7200.0016.0406, p 49.
51 Exhibit 14-215, CTD.7200.0004.4115.
52 Exhibit 14-215, CTD.7200.0004.4115, pp 18–19.
53 Exhibit 14-215, CTD.7200.0004.4115, p 18.
54 Exhibit 14-215, CTD.7200.0004.4115, p 18.
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159 We note that at the time of writing, this issue is being examined by the independent review of the *Ageing and Disability Commissioner Act 2019* (NSW) in NSW.

160 In this regard, we note that a joint submission was made to the NDIS Review by state and territory public advocates and public guardians in March 2023 endorsing a national approach to community visiting as part of the NDIS Framework. It also recommended that the Australian Government should urgently remove information-sharing barriers that currently prevent the NDIA and NDIS Commission from sharing relevant information with CVS: Australia's Public Advocates and Public Guardians, Submission to NDIS Review, March 2023, pp 16–18.
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5. Disability death review schemes

Key points

- Article 25 of the *Convention on the Rights of Persons with Disabilities* recognises that people with disability have the right to enjoy the highest attainable standard of health.[1]
- Compared with the general population, Australians using disability services are 4.7 times as likely to die before the age of 65.[2] Their rate of having a 'potentially avoidable death'[3] is 3.6 times higher than the general population.[4] The highest death rates are among people with disability receiving residential accommodation or other accommodation support.[5]
- Evidence indicates that systemic reviews of the deaths of people with disability are critical to understanding and addressing the factors that contribute to these disproportionate outcomes.
- The NSW Ombudsman's longstanding function to review the deaths of people with disability living in supported accommodation and assisted boarding houses was removed in 2022. In Victoria, the Disability Service Commissioner's role to review the deaths of people using disability services has substantially diminished since the introduction of the National Disability Insurance Scheme (NDIS). No other state or territory has a disability death review scheme although there have been calls for their establishment.
- There should be disability death review schemes in each state and territory, operated by an appropriate independent body. A national agreement between the Australian Government and state and territory governments should set out nationally consistent components of death review schemes. The agreement should establish a clear connection between the functions of those schemes and the NDIS Quality and Safeguards Commission's reportable incident function in relation to the deaths of NDIS participants.

5.1. Introduction

An Outcome Area of Australia's Disability Strategy 2021–2031 is ensuring that people with disability experience the best possible health and wellbeing throughout their lives. This is consistent with article 25 of the *Convention on the Rights of Persons with Disabilities* (*CRPD*) which recognises that people with disability have the right to enjoy the highest attainable standard of health. The National Agreement on Closing the Gap also aims to ensure that First Nations peoples, who are almost twice as likely to have a disability compared with non-Indigenous Australians,[6] enjoy long and healthy lives.

Research shows that we are a long way from achieving these ambitious goals. Compared with the general population, Australians using disability services are 4.7 times more likely to die before the age of 65[7] and have a 'potentially avoidable death'[8] rate 3.6 times as high.[9]

Additionally, Australians with intellectual disability have a reduced life expectancy and an elevated comparative mortality rate that exceeds that of other groups with health disadvantage.[10] In one recent Australian study, 38 per cent of deaths of people with intellectual disability were found to be to be from potentially avoidable causes, a figure more than double that of the general population.[11] The median age of death for people with intellectual disability was found to be 27 years lower than that of the general population (54 years compared with 81 years).[12] A research report commissioned by the Royal Commission – *The economic cost of violence, abuse, neglect and exploitation for people with disability* – considered potentially avoidable deaths among people with disability.[13] The research estimated the total annual cost of these deaths to be $2 billion.[14]

Systemic reviews of the deaths of people with disability offer a way to understand the reasons for and, where possible, prevent potentially avoidable deaths.

Systemic reviews of deaths are aimed at identifying trends in factors contributing to the deaths of a group of people and recommending actions to prevent or reduce future deaths. To do this, they review information from relevant sources about individuals who have died. Systemic death reviews do not replace or duplicate processes for investigating individual deaths (for example, internal agency investigations and criminal or coronial investigations). They are conducted so as not to jeopardise those other proceedings in any way. There are child death review mechanisms[15] and mechanisms for reviewing domestic violence homicides[16] across Australia.

Until July 2022, the NSW Ombudsman was required by law to review the deaths of people with disability living in residential care, including in supported group accommodation and assisted boarding houses.[17] That function was removed (without public consultation) in July 2022.[18] In Victoria, the Disability Services Commissioner (DSC) reviews the deaths of people receiving disability services. However, this ministerially conferred function has been substantially reduced since the introduction of the National Disability Insurance Scheme (NDIS) because the Victorian Government no longer delivers most disability services.[19] No other state or territory has, or has ever had, a system for reviewing the deaths of people with disability, although ongoing disability death review schemes have been recommended in Queensland[20] and the Australian Capital Territory.[21]

The NDIS Quality and Safeguards Commission (NDIS Commission) has an oversight role in relation to certain deaths through its reportable incidents function.[22] However, it does not systemically review the deaths of people with disability. The focus of the NDIS Commission's reportable incident function is to oversee how registered NDIS providers respond to reportable incidents,[23] which includes certain deaths. This very important focus is nonetheless quite different to that of a systemic death review.

In our view, each state and territory should have a disability death review scheme and these schemes should be nationally consistent. There should be a national agreement between the Australian Government and state and territory governments which:

- defines the respective roles of state and territory death review schemes and the NDIS Commission in relation to the deaths of people with disability
- establishes a clear connection between the functions of the death review schemes and the relevant functions of the NDIS Commission, and supports the development of appropriate operational processes to facilitate this connection
- mandates mutual information sharing between the death review schemes and the NDIS Commission
- commits to nationally consistent disability mortality data collection and reporting requirements.

We acknowledge the risk that any new disability death review schemes may be compromised by being overwhelmed with an unmanageable volume of death notifications. However, research indicates the deaths of people using disability services are highest among those receiving residential accommodation support (large or small residential/institutions with 24-hour care, hostels, group homes, and centre-based respite/respite homes) and other accommodation support (including attendant care/personal care, in-home accommodation support, alternative family placement).[24] We therefore propose it should be mandatory for new schemes to be notified of and to review the death of a person with disability receiving residential accommodation support or other accommodation support.

After the new schemes have operated for a period, consideration should be given to extending their scope to reviewing the deaths of people with disability in custody and in acute healthcare facilities. Rather than mandating the notification of these deaths, a person or body with legitimate interest should be able to request a review. The scheme operator should then have discretion to review the death where they determine it is in the public interest and the scheme has sufficient capacity to do so. Schemes should also be empowered to conduct reviews of a particular cohort of deaths and to make referrals to the coroner for an inquest.

The death review scheme in each jurisdiction should be operated by a body with existing responsibilities for and expertise in the disability sector. The relevant body should be determined by each state and territory.

5.2. Systemic disability death reviews

Only New South Wales and Victoria have had ongoing arrangements for conducting systemic reviews of the deaths of adults with disability. There have been two separate reviews in Queensland which both recommended that an ongoing review function be established.[25] In the Australian Capital Territory, Official Visitors Disability Services recommended that consideration be given to establishing a disability death review function to monitor deaths and identify systemic concerns.[26]

New South Wales

In 1998, the former Community Services Commission (CSC) established a Disability Deaths Review Team to review the deaths of people with a disability in residential care. The CSC's existing monitoring and review powers were engaged to monitor and review those deaths. By 2001, all disability accommodation services funded under the *Disability Services Act 1993* (NSW) were required to notify the CSC of residents' deaths. Between 2000 and 2002, the CSC published three reports about its death reviews.[27]

In December 2002, the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) was amended and the CSC was amalgamated with the NSW Ombudsman. Under Part 6 of the Act, the Ombudsman was required to review the causes and patterns of 'reviewable deaths'. A 'reviewable death' was defined to include the deaths of people with disability in residential care in New South Wales.[28] This statutory death review function was described as 'a first in the world'[29] requiring the NSW Ombudsman to:[30]

- monitor and review reviewable deaths
- recommend policies and practices to be implemented by the NSW Government and service providers to prevent or reduce reviewable deaths
- keep a register of reviewable deaths (classifying the deaths by cause, demographic criteria or other factors prescribed by the regulations)
- undertake (alone or with others) research or other projects for the purpose of formulating strategies to reduce or remove risk factors associated with preventable reviewable deaths.

The Act required relevant bodies to notify the NSW Ombudsman of reviewable deaths and allowed the Ombudsman to obtain information and assistance from, as well as to share information with, a range of individuals and bodies.[31]

For the purpose of exercising the death review function, the NSW Ombudsman could:[32]

- keep under scrutiny systems for reporting reviewable deaths
- undertake detailed reviews of information relating to reviewable deaths
- analyse data relating to the causes of reviewable deaths to identify patterns and trends
- consult with and obtain advice from any person or body with appropriate expertise.

The NSW Ombudsman could establish advisory committees to assist with exercising their death review functions and was required to publicly report on the exercise of those functions.[33]

Removal of the NSW Ombudsman's disability death review function

The NSW Ombudsman's last report about its reviews of the deaths of people with disability was published in August 2018. With the implementation of the NDIS in New South Wales, disability funding and service delivery transitioned from the NSW Government to the Australian

Government. Providers of disability accommodation services became funded by the NDIS and the NDIS Commission began overseeing reportable incidents involving NDIS supports and services. The NSW Ombudsman observed:

> This report is being released at a time of change in the safeguarding arrangements for the NDIS in NSW. With the start of the NDIS Quality and Safeguards Commission on 1 July 2018, some of our functions related to NDIS providers and people with disability have transferred to the NDIS Commission. In relation to the deaths of people with disability in residential care in NSW, we are working with the NDIS Commission on a joint approach that should enhance the work in this critical area. This will include the NDIS Commission examining the involvement of NDIS providers, while my office will maintain our ongoing review of the health and other service systems in NSW. We welcome the opportunity afforded by the joint arrangements to continue this vital work, with a view to potentially informing a national approach to reviewing the deaths of people with disability.[34]

The NSW Ombudsman continued to have jurisdiction over NDIS providers in 2018 and 2019 under an arrangement between the Australian Government and the NSW Government. In September 2018, the NSW Ombudsman finalised operational arrangements with the NDIS Commission and the State Coroner to guide the joint approach.[35]

At the time, the Ombudsman stated, '[T]he arrangements in NSW during 2018/19 may also provide a template for other jurisdictions to consider, and potentially lead to a national approach to reviewing the deaths of people with disability and to identifying strategies for reducing deaths.'[36]

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) was amended in June 2019. This amendment clarified that a 'reviewable death' included the death of any person who, at the time of the person's death, was living in, or was temporarily absent from, supported group accommodation or an assisted boarding house, including supported group accommodation provided by a registered NDIS provider.[37]

As part of the NSW Ombudsman's strategic initiatives for 2021 and 2022, it planned to:

> Review and refresh our approach to reviewing the deaths of persons with disability in residential care, to ensure consistency with the work of recently established agencies including the NDIS and the Ageing and Disability Commission, and to better focus our preventive recommendations on those, such as NSW Health, that we oversight.[38]

The Ombudsman indicated that it had commissioned an external review of its disability death review function and had subsequently provided a report and related legal advice to the NSW Government. It did not disclose further details of the report or legal advice.[39]

On 1 July 2022, the *Disability Inclusion Amendment Act 2022* (NSW) removed the NSW Ombudsman's function to review the deaths of people with disability.

The NDIS Commission now has jurisdiction in relation to the deaths of people with disability in connection with the provision of NDIS supports or services. Prior to the NDIS rollout in New South Wales, the NSW Ombudsman systemically reviewed the deaths of people with disability living in supported group accommodation or assisted boarding houses.

The second reading speech of the Disability Inclusion Amendment Bill 2022 (NSW) in the Legislative Council explained:

> This function of the Ombudsman was largely terminated by the full implementation of the NDIS because New South Wales no longer directly funds or provides disability services and supports. The legislation needs to be updated to reflect these changed roles and responsibilities. The NDIS Quality and Safeguards Commission now oversees the deaths of people with disability in connection with the provision of NDIS supports or services.[40]

There was no comment in the Bill's Explanatory Notes or the second reading speech about the differences between the NDIS Commission's jurisdiction, via its reportable incident function, and that of the NSW Ombudsman.

The NSW Ombudsman indicated that it would table its final disability death review report in late 2022.[41] As at the time of writing, this report has not been published.

Issues identified by the NSW Ombudsman's death reviews

The NSW Ombudsman published nine reports from 2003 to 2022 about its reviews of the deaths of people with disability.[42] A 2019 *Scoping Review of causes and contributors to deaths of people with disability in Australia* (Scoping Review) conducted by Professor Julian Trollor and Dr Carmela Salomon (discussed in sections 5.3 and 5.4) praised the NSW Ombudsman's approach to systematically and quantifiably accounting for contributing and direct causes of death, in addition to underlying causes.[43] It also commended the Ombudsman's stratified analysis of demographics, health status, and causes of and contributors to death based on a person's accommodation type. This allowed for a more nuanced picture of different types of deaths.[44]

A recurrent theme in the NSW Ombudsman's reports was the critical importance of people with disability having equitable access to appropriate health services and the coordination of support between mainstream health services and specialist disability services in providing appropriate care. The Ombudsman made recommendations about the need for:

- improved health data identifiers for people with disability
- equitable access to mainstream community-based health programs, including programs for chronic disease management and preventative health
- improved quality of care and support for people with disability in hospitals
- better coordination between, and collaboration by, health services and disability services.

Another constant theme was the substantial health and other risks faced by assisted boarding house residents and the need for significantly enhanced safeguards and supports to address these risks.[45]

Several of the NSW Ombudsman's recommendations resulted in significant policy changes over the past two decades. For example:

- In response to recommendations for changes to disability service procedures regarding nutrition and swallowing,[46] minimum requirements were implemented for government operated and funded accommodation services to address swallowing risks. This included the development of competencies related to nutrition, swallowing and mealtime management.[47]
- NSW Health responded to the Ombudsman's recommendations about service provision to people with disability during hospitalisation[48] by developing a service framework to improve the health care of people with intellectual disabilities. Multidisciplinary health teams, including nurse specialist positions, were created. Initiatives to support local specialist services to better train health workers about the needs of people with intellectual disabilities were implemented.[49] A network for Intellectual Disability was included in NSW Health's Agency for Clinical Innovation.[50] This resulted in various projects aimed at improving the hospital experience for people with disability.[51]
- The Ombudsman recommended that all funded disability services and licensed boarding houses have at least one person on each shift who was trained in first aid.[52] As a result, this became mandatory for all government operated and funded disability services[53] and licensed boarding houses.[54]
- Other Ombudsman recommendations resulted in improvements to medication administration and record keeping, and a screening tool for assessing the suitability of boarding house accommodation for people with disability.[55] The Primary and Secondary Health Care service model was revised to deliver a consistent approach to improving the health outcomes for people living in licensed boarding houses.[56]

The NSW Ombudsman's reports detailed its work with stakeholders to progress solutions to local and systemic issues identified by death reviews and the progress made by agencies to implement its recommendations. The Ombudsman also published fact sheets for support staff and managers in disability accommodation services, staff working with boarding house residents and for general practitioners. The fact sheet topics included key risk factors for people with disability, how to support individuals to improve their health and how to reduce preventable deaths.[57]

Victoria

The *Disability Act 2006* (Vic) enables the DSC to provide advice, inquire into or investigate matters referred to the DSC by the relevant Minister or the Secretary.[58] Matters can relate to the provision of disability services by a disability service provider or regulated service provider, or complaints about disability services.[59]

On 26 July 2017, a ministerial referral was made requesting the DSC to review deaths occurring in disability services.[60] A new ministerial referral was made on 21 September 2017. It requested, among other things, that the DSC inquire into and, at its discretion, investigate any matter relating to the provision of services by disability service providers identified in:[61]

- incident reports received from the Department of Health and Human Services, including all deaths (where the deceased was a person with disability receiving services at the time of their death) and major impact incidents relating to assault, injury or poor quality of care
- deaths referred by the State Coroner where the deceased was a person with disability receiving services at the time of the person's death
- matters involving abuse and neglect referred by the Community Visitors Board.

In undertaking an investigation under this referral, the DSC could consider actions the service provider should take to improve services and provide the service provider with a Notice to Take Action.[62] The Minister requested that the DSC's annual report include: a comprehensive annual review of deaths that occur in services; the number, type and outcomes of investigations conducted; and an overview of any practice or systemic issues identified.[63]

The ministerial referral has been extended twice. The current referral, issued on 2 May 2022 and valid until 30 June 2023, requests the DSC to inquire into and, at the DSC's discretion, investigate any matter within DSC's jurisdiction relating to the provision of services, including the abuse, neglect or death of a person with disability.[64]

Many disability service providers in Victoria formerly registered under the *Disability Services Act 2006* (Vic) are no longer registered under this Act because they have transitioned to being funded under the NDIS. Those service providers are now subject to the oversight of the NDIS Commission as registered NDIS providers. As a result, over the past few years, there has been a gradual reduction in the DSC's disability death review jurisdiction. It is now limited to the deaths of people who are provided residual disability services by the Victorian Government outside of the NDIS.[65]

Issues identified by the Disability Services Commission's death reviews

The DSC has published two reports about its death reviews.[66] In October 2021, it also published an Occasional Paper, *Learning from reviews of Victorian disability service provision to people who have died 2017 to 2021 – A reflection for future safeguarding*.[67]

The DSC's reports have highlighted the potentially avoidable nature of some deaths, including examples of where poor quality of care, disrespect for fundamental human rights, and unsafe and inconsistent practices by service staff have been involved. Those reports have made suggestions about preventing falls, responding better to changes in health and better mealtime supports for people with disability in supported accommodation.[68] They have also emphasised the importance of positive behaviour supports, person-centred care and good communication supports when supporting people with disability.[69]

The DSC has developed related advice for providers. The Victorian Department of Health and Human Services has also developed practice guidance on specific topics for use in disability group homes.[70]

Queensland

In March 2016, the Queensland Office of the Public Advocate (OPA) published a report about its review of the deaths of people with disability in care in Queensland between 2009 and 2014. The report used a similar methodology to that adopted by the NSW Ombudsman.[71] It also conducted a detailed analysis of where and when deaths occurred and attempted to define and quantify the number of potentially avoidable deaths in the sample (the deaths of 73 people were included in the sample).[72]

The OPA report recommended that an appropriate agency should be resourced and tasked to carry out regular systemic reviews of deaths of people with disability who die in care. It recommended that outcomes of these reviews should be reported to Parliament at least biennially.[73]

In late 2016, the State Coroner agreed to trial an expert panel review process to examine the health care management of persons whose deaths were reported to the State Coroner as a 'death in care (disability)'. These are deaths of a person with disability who was living in certain types of supported accommodation services and/or who was receiving high level support as an NDIS participant in a supported living arrangement. In 2019, the State Coroner published a report, *Deaths in Care (Disability) Expert Review Panel Final Report* (*Expert Review Panel Final Report*). The report summarised the expert panel's reviews of deaths of 11 people who had lived in supported residential accommodation and potential concerns were identified about the adequacy of their health care management prior to death. It directed a number of recommendations to the State Coroner. The report highlighted the need for a continued systemic focus on these types of deaths.[74]

Issues identified by the Queensland death reviews

The OPA report identified that a high proportion of the people with disability in care who died were being administered psychotropic medication in cases where, based on available information, few seemed to have a diagnosis of mental illness. There was also a large presence of undetected ill health, with many people not diagnosed with the condition that led to their death until either just before their death or until the autopsy. Many of the most common 'causes of death' involved conditions that were amenable to therapeutic treatments or evidence-based preventative measures, such as vaccinations. The report made a range of recommendations to address a number of systemic issues relevant to people with disability in care, including for:[75]

- improvements in health services practice and standards, including improvements in education and training of providers and a focus on building capability in delivering health services to people with disability
- improvements in disability services practice and standards that should form part of the accreditation scheme for disability services regardless of whether this occurs at the state or national (NDIS) level

- identification and management of respiratory disease, epilepsy, constipation and circulatory system diseases, choking/food asphyxia, and neoplasms/cancer
- administration of psychotropic medications
- access to healthcare, coordination of healthcare and disability services, and improved health care and support
- identifying serious health conditions and responding to critical incidents
- end-of-life care and decision-making.

The *Expert Review Panel Final Report* published by the State Coroner commented on several common themes and trends arising from its review of deaths of people who had lived in supported residential accommodation. These included:[76]

- limited indication of coordinated care, despite deceased persons having had contact with a wide range of service providers, as a result of their complex health conditions, comorbidities and functional difficulties
- non-compliance with treatment, or reluctance to engage with treatment, by people living in supported residential accommodation
- the care needs of people with complex health and psychiatric conditions exceeding the support which could reasonably be expected to be provided by their accommodation settings
- practice issues concerning the management of hygiene and medication, record keeping and decision making
- adequacy of staff qualifications and training
- limitations on eligibility screening and assessment.

The *Expert Review Panel Final Report* also made related recommendations in those areas.

5.3. The NDIS Commission's role relating to deaths of people with disability

The NDIS Commission's role in relation to the deaths of people with disability arises from its reportable incidents function.

Reportable incidents

Under the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) (*Incident Management and Reportable Incidents Rules*), registered NDIS providers are required to notify the NDIS Commission of 'reportable incidents'.[77] As explained in Volume 10, *Disability services*, six types of 'reportable incidents' must be notified to the NDIS Commission, including the death of a person with disability.[78] The requirement applies only to 'registered NDIS providers'. Providers must be registered if they deliver services and

supports to NDIS participants who have their plan managed by the National Disability Insurance Agency (NDIA), deliver specialist disability accommodation, or they use restrictive practices or develop behaviour support plans.[79]

Deaths 'in connection with' NDIS services or supports

To be a 'reportable incident', the death of a person with disability must be assessed by a registered provider as having occurred 'in connection with' NDIS services or supports.[80] The NDIS Commission provides guidance to providers to assist them to interpret 'in connection with', a phrase which it describes as being intentionally broad.[81] The guidance emphasises that once the connection between the NDIS supports or service and the person's death is established, it is a 'reportable incident'. The cause of the death, location of the death or whether the death was expected or not does not change whether the death is a reportable incident.[82]

More recently, in its *Own Motion Inquiry into Aspects of Supported Accommodation report*, the NDIS Commission stated:

> There are a number of bases on which there could be a connection between a death and the provision of NDIS supports or services. For example, the death could occur while the supports or services are being provided; or while supports or services should have been being provided but were not provided; or the death could occur in the course of implementing a plan (e.g., a mealtime management plan) developed by a registered NDIS provider (e.g. a speech pathologist).[83]

In 2021–22, the NDIS Commission received 1,921 notifications of deaths out of a total of 16,636 reportable incident notifications[84] (excluding the 1,422,295 notifications received about the use of unauthorised restrictive practices).[85] These notifications may include multiple notifications by different registered providers about the same incident or death.[86]

How the NDIS Commission oversees reportable incidents

When the NDIS Commission receives a reportable incident notification, it reviews the information supplied by the registered NDIS provider and oversees their management and resolution of the incident.

The NDIS Commission can also require the service provider to carry out an internal investigation or engage an independent expert to investigate and report on the incident.[87] It can also require the provider to undertake specified remedial steps. If a reportable incident raises a serious compliance issue, the NDIS Commission can take regulatory action. It can conduct its own investigation and take appropriate enforcement or compliance action such as issuing an infringement notice, a compliance notice or asking a court to impose a civil penalty for a breach of the the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*).[88]

By April 2023, the NDIS Commission had commenced civil penalty proceedings against three NDIS providers in relation to the deaths of NDIS participants. The providers concerned were: the Australian Foundation for Disability (Afford) in relation to the death of Ms Merna Aprem in

2019,[89] Integrity Care (SA) Ltd (Integrity Care) in relation to the death of Ms Ann-Marie Smith in 2020[90] and LiveBetter Services Limited (LiveBetter) in relation to the death of Ms Kyah Lucas in 2022.[91]

Ms Aprem's death was the subject of a reportable incident notification to the NDIS Commission. This triggered an investigation which led to the NDIS Commission commencing civil penalty proceedings against Afford on 6 December 2021. The proceedings were before the Federal Court of Australia at the time of Public hearing 23, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)'. Accordingly, neither the circumstances of Ms Aprem's death nor the NDIS Commission's investigation were the subject of evidence at the hearing. However, information received as part of that investigation resulted in the NDIS Commission commencing additional investigations into Afford, which the Registrar for the NDIS Commission, Ms Samantha Taylor, described in her evidence.[92] In April 2023, Afford took responsibility for Ms Aprem's death having occurred in their care.[93]

Ms Smith's death led to the NDIS Commission initiating an independent review of its regulation of the NDIS services provided to Ms Smith by the service provider, Integrity Care.[94] The NDIS Commission's civil proceedings against Integrity Care, were launched in March 2022. The proceedings have been stayed pending criminal proceedings that were subsequently initiated.[95] Public hearing 14, 'Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)', heard evidence about the response of relevant agencies, including the NDIS Commission, to Ms Smith's death.[96]

Ms Lucas's death triggered an 'extensive investigation' by the NDIS Commission, following which the Commission commenced civil penalty proceedings against LiveBetter in April 2023.[97]

The NDIS Commission published its *Own motion inquiry into aspects of supported accommodation report* in January 2023.[98] It covered a sample of deaths notified to it in connection with services provided by seven Supported Independent Living (SIL) providers between 1 July 2018 and 30 September 2022. It contained limited observations. The inquiry report stated that the NDIS Commission intends to undertake, at a time not specified, a 'comprehensive inquiry' into deaths that have been notified to it.[99]

According to the NDIS Commission, it is 'important that both the NDIS Commission in its regulatory role, and NDIS providers, address the causes of and contributors to deaths of people with disability, to prevent avoidable deaths'.[100]

In 2019, the NDIS Commission commissioned[101] two research projects to obtain an Australia-wide perspective on the prevalence of, and factors contributing to, the deaths of people with disability (Scoping Review)[102] and about the rates of death among people with disability and the causes of those deaths.[103] The NDIS Commission has widely disseminated the findings and recommendations of the Scoping Review. It has also published a number of Provider Practice Alerts informed by the Scoping Review.[104] The Scoping Review is discussed further in section 5.4 ('Prevalence of and factors contributing to potentially avoidable deaths').

5.4. What we were told about the deaths of people with disability and death reviews

Stories of people who have died

During Public hearing 4, 'Health care and services for people with cognitive disability', Ms Kim Creevey gave evidence about her son, Harrison (Harri), who had an acquired brain injury, was non-verbal and used a wheelchair.[105] Harri lived at home with his family and died in 2015 as a hospital inpatient. Ms Creevey believes that on the majority of occasions when Harri was hospitalised, unconscious bias by health staff compromised his medical care.[106] She and her husband feel strongly that, when Harri went into hospital for the final time before his death, the quality of his care was influenced by his disability and assumptions made about the value and quality of his life.[107] Ms Creevey also spoke of her frustration that, while Harri had been treated for pneumonia, his death was attributed to an acquired brain injury and this was not reportable to the Coroner.[108]

We also heard evidence from Ms Jayne Lehmann about the death of her daughter, Sarah, who had an intellectual disability and was diagnosed with Dravet syndrome.[109] Sarah also had verbal dyspraxia and echolalia which significantly impacted her capacity to communicate verbally.[110] Ms Lehmann said the health care and services delivered to Sarah were, at times, hindered by health professionals who were not willing to listen to or value the information provided by Sarah and other family members.[111] Sarah resided in disability supported accommodation at the time of her death. Ms Lehmann was disappointed that, although Sarah's death was reported to the NDIS Commission, she was not contacted about the care and support provided to Sarah or the circumstances of her death. She questioned how the NDIS Commission could review Sarah's death while only considering information supplied by the service provider:

> if a disability organisation is providing the notification of what's happened, how does anyone know that it's accurate? We're not safeguarding them at all. And death is actually one of the biggest triggers for looking into what's happening around that person.[112]

Ms Rachel Browne spoke about the life and death of her son Finlay (Fin), a young man with Down syndrome and autism who died in hospital at the age of 16.[113] Ms Browne said she believed 'internal bias in the health system' had led to Fin's death.[114] Ms Browne described the impact of Fin's death on his family and her efforts to understand what happened to him and achieve accountability regarding Fin's death.[115] Ms Browne recommended a system for recording the causes of death for people with intellectual disability 'so that that information can be analysed and we can get a better understanding of why people are dying in circumstances that might have been prevented'.[116]

We also heard about the life and death of Grant Barnett, who died in 2015. Mr Barnett had a genetic condition that is known to cause intellectual disability, developmental delays and physical differences in males.[117] Ms Karen Barnett was Mr Barnett's sister and Ms Tracy Nash was his full-time support worker in the final six months of his life. Ms Barnett and Ms Nash

described some of their experiences with Mr Barnett's health care in the last months of his life, primarily in hospital.[118] Ms Barnett said that she was 'quite shocked' by some of the care Mr Barnett received in the hospital.[119] Ms Barnett and Ms Nash spoke of the medical staff's lack of direct engagement with Mr Barnett.[120] Ms Barnett said during his long stays in hospital she felt 'Grant was treated like an unintelligent piece of meat that was a burden on the health system.'[121] Following a routine hospital procedure, Mr Barnett required surgery to repair his stomach. He subsequently developed pneumonia and was transferred to the Intensive Care Unit.[122] Mr Barnett was eventually discharged under palliative care and died at home.[123]

At Public hearing 26, 'Homelessness, including experience in boarding houses, hostels and other arrangements', we heard from Ms Georgia Wilson about the death of her mother, Kaye. Kaye was an NDIS participant living in a Victorian supported residential service (SRS) at the time of her death. Kaye's death was not notified to the NDIS Commission as a reportable incident because there was no connection (or alleged connection) between her death and the provision of NDIS support.[124] Ms Wilson spoke about her efforts to obtain accurate information about the circumstances of her mother's death. She also described her concerns about her mother's physical condition at the time of death, which indicated possible neglect. She also spoke of the lack of dignity and respect afforded to her mother's body.[125] While the Human Services Regulator, which is responsible for regulating SRS, substantiated several issues that Ms Wilson complained about, they advised it was not within their jurisdiction to investigate the cause of Kaye's death or whether it was preventable.[126]

Public hearing 27, 'Conditions in detention in the criminal justice system', referred to a report by Human Rights Watch which suggested that 60 per cent of people who died in Western Australian prisons between 2010 and 2020 had disability.[127] Mr George Newhouse, Adjunct Professor of Law at Macquarie University and the University of Technology Sydney and Director and CEO of the National Justice Project, told the us that the 'standard of healthcare' in Western Australia's prisons is 'abysmal'. Mr Newhouse said he was 'involved in six deaths in custody at the moment and, in my view, a lack of appropriate care is a major contributor to those deaths'.[128] He also said, 'We see suicide after suicide' and referred to the death of a 19-year-old man with rheumatic heart disease who had been waiting to see a cardiologist.[129] Mr Newhouse expressed dissatisfaction with the extent to which coroners 'look at the systemic problems within prisons' when there has been a death.[130]

The mother of JC gave evidence during the Public hearing 27 about her daughter's death. JC was shot by police after she called 000 due to concerns about her mental health.[131] JC had had a traumatic childhood,[132] and mental health issues.[133] She had previously had periods of incarceration in Western Australian prisons. While JC died after release into the community, her mother believed:

> If the support JC received in prison was at an appropriate standard and she was linked with appropriate services when released, I strongly believe that her experience out of prison would have been different.[134]

JC's mother concluded:

> There is a clear link between the failures of the prison in providing any ongoing care and JC's mental health worsening which ultimately led to her death. Recovery was not possible for JC because those systems failed her time and time again.[135]

Ms Cheryl Ellis also gave evidence in Public hearing 27 about the death of her son, Mr Gavin Ellis, at the Metropolitan Remand and Reception Centre in Sydney. Mr Ellis had been diagnosed with ADHD, Tourette's syndrome, Obsessive Compulsive Disorder and schizophrenia.[136] He ended his own life. A coronial inquest found that the care and treatment Mr Ellis received prior to his death was inadequate.[137]

Prevalence of and factors contributing to potentially avoidable deaths

Professor Julian Trollor, Chair in Intellectual Disability Mental Health and Head of the Department of Developmental Disability Neuropsychiatry at the University of NSW, gave evidence during Public hearing 4. Professor Trollor identified a link between the higher death rates and the poor management of multiple health conditions of people with cognitive disability and autistic people.[138] He also noted the prevalence of mental and physical health co-morbidities, including sensory abnormalities, epilepsy, problematic feeding behaviours, respiratory and gastrointestinal diseases, mobility restrictions, frailty and premature ageing.[139] Professor Trollor presented evidence suggesting healthcare systems are failing to meet the needs of people with intellectual disability and autistic people in areas such as preventative health care.[140]

Research by Professor Trollor's team suggested potentially avoidable deaths of people with intellectual disability represented 38 per cent of all deaths during a six and a half year period in New South Wales. This proportion was more than double that of the general population.[141] He also drew attention to research which showed that the median age of death in New South Wales for an adult cohort with intellectual disability is 27 years lower than that of the general population (54 years compared with 81 years).[142]

Former NDIS Commissioner, Mr Graeme Head, provided the Royal Commission with a copy of the Scoping Review[143] commissioned by the NDIS Commission in 2019. The aim of the Scoping Review was to review the causes of and contributors to deaths of people with disability. It also aimed to identify population mortality trends and risks concerning the deaths of people with disability.[144]

The Scoping Review aggregated data from death reviews conducted in New South Wales, Victoria and Queensland.[145] In total, it examined the deaths of 901 people with disability, most of which (733) were in New South Wales.[146] The overwhelming majority of deaths were of people with intellectual disability.[147] Among its conclusions was that the vast majority of people with disability who had died had multiple health problems. For a number of the people who died, it was not known when they had had their last comprehensive health assessment.[148] The majority of deaths were 'unexpected' and attributed to 'natural causes'.[149]

The Scoping Review identified four overarching issues emerging from its review of deaths, and types of deaths, from across jurisdictions:[150]

- a lack of proactive support for preventative health care measures
- limited use of communication plans and other communication accommodations[151] which may have curtailed some clients' ability to express emerging health concerns to staff
- concerns about service providers failing to proactively manage emerging and chronic health risks
- staff not always being confident or aware of best practice standards for responding to medical emergencies.

The Scoping Review made the important observation that '[d]espite documented risk of premature mortality, including from preventable causes, mortality data for people with disabilities are not tracked or integrated in a consistent manner'.[152] Efforts to track causes and contributors to deaths are hindered by definitional and methodological inconsistencies between jurisdictions.[153] For example, each state and territory has its own Coroners Act and the definitions of what is considered a reportable death vary. This has implications for which deaths of people with disability are subject to state-based death reviews across jurisdictions. Further, because of inconsistent legislation, not all deaths reportable to a coroner have been in the scope of the state-based death reviews conducted in New South Wales, Victoria and Queensland.[154]

Data about the deaths of people with disability

Professor Trollor described existing gaps in tracking and publishing mortality data, including through the National Australian Coronial Information System,[155] various state regimes,[156] and the reportable deaths function of the NDIS Commission.[157] He discussed the need for wide-ranging state and national mortality data to inform targeted preventative and public health initiatives for people with disability, particularly people with intellectual disability. He noted that analysis of mortality data will help to identify gaps 'in care and care pathways, and direct future health care and social service spending, and research initiatives towards areas of high need'.[158]

Professor Trollor and Mr Jim Simpson, Senior Advocate at the Council for Intellectual Disability, separately submitted that the National Disability Data Asset (NDDA) should provide linked data sources which would allow routine collation, analysis and reporting of deaths. Professor Troller and Mr Simpson said: 'We strongly recommend that premature deaths and avoidable mortality is [sic] a major and early priority for analyses arising from the NDDA.'[159]

Reportable incident data

We asked the NDIS Commission to provide data for years ending 30 June 2019, 30 June 2020 and 30 June 2021 about the number of times the NDIS Commissioner required an NDIS service provider to:[160]

- undertake an internal investigation
- supply a report of an internal investigation
- obtain an independent expert investigation
- supply a report of an independent external investigation
- undertake remedial action.

The NDIS Commissioner advised us that the requested data was available only for certain reportable incident notifications. These were notifications for which an assessment had been completed since relevant enhancements to the NDIS Commission's Operating System database that commenced in July 2020.[161] Data was not available for any reportable incident notifications that had not been concluded at the time of providing the advice.[162]

The NDIS Commissioner also advised that the investigations data provided includes investigations required by the Commissioner under section 26(1) of the *Incident Management and Reportable Incidents Rules*[163] and those undertaken or commissioned by providers without being required to do so by the Commissioner.[164]

The NDIS Commissioner advised that when the Commissioner exercises the section 26(1) power to require an internal or independent external investigation, the power encompasses requiring the provider to supply a copy of the investigation report.[165] However, if the investigation and resulting report has occurred without the NDIS Commission exercising its section 26(1) powers, these reports were not included in the data provided:

> Where registered NDIS providers have carried out investigations of reportable incidents, NDIS Commission reportable incidents officers typically require them to provide a copy of the report of the investigation when the investigation is finalised. I understand that this is required as a matter of course and is generally done without the relevant provider requiring the NDIS Commission to exercise its powers under section 26(1). It is likely that all, or substantially all, of the investigations carried out by providers without the NDIS Commission having to exercise its powers under section 26(1) will have resulted in the NDIS Commission being provided with a report of the relevant investigation, again without the NDIS Commission having to exercise its powers under section 26(1). These reports, and the NDIS Commission's requests for them, are not captured in the data [provided].[166]

The NDIS Commissioner explained that data about remedial action undertaken by a provider:

> is likely to record only those occasions where the particular remedial action does not fall within a more specific category in the 'List of Values Dictionary: Reportable Incidents - Standard Concluding Assessment'. A record of 'remedial action' would therefore not include, for example: changes to staff support and arrangements; reviewing and/or changing rosters; facilitating specific additional training and education for staff; seeking a funding review for the Participant; reviewing specific policies or procedures; or updating specific policies or procedures.[167]

For the 12-month period ending June 2019, data was available for 64 reportable incidents including three incidents involving the death of a person with disability. In relation to incidents involving the death of a person with disability:[168]

- Registered NDIS providers did not undertake any internal investigations.
- Registered NDIS providers voluntarily undertook an external investigation on one occasion.
- There was one occasion of the NDIS Commission exercising its section 26(1) power requiring a registered NDIS provider to provide a final report about an incident involving the death of a person with disability.
- There was one occasion where voluntary remedial action was taken by a registered NDIS provider.

For the 12-month period ending June 2020, data was available for 3,852 reportable incidents including 88 incidents involving the death of a person with disability for which:[169]

- Registered NDIS providers voluntarily conducted internal investigations on 13 occasions and a voluntary external investigation on one occasion.
- There was one occasion of the NDIS Commissioner requiring a provider to provide a final report.
- There was one occasion of the NDIS Commissioner directing a registered NDIS provider to take remedial action.
- Voluntary remedial action was taken by a registered NDIS provider on five occasions.

For the 12-month period ending June 2021, data was available for 12,029 reportable incidents including 120 incidents involving the death of a person with disability. The data for those incidents involving the death of a person with disability indicated that:[170]

- The NDIS Commissioner required registered NDIS providers to conduct an internal investigation on three occasions.
- Registered NDIS providers also conducted voluntary internal investigations on seven occasions and voluntary external investigations on three occasions.
- There was one occasion of the NDIS Commissioner requiring a registered NDIS provider to provide a final report.
- There were three occasions of the NDIS Commissioner directing a registered NDIS provider to take remedial action.
- Voluntary remedial action was taken on 16 occasions.

The value of death reviews

> [A] death review is a window into the life of the person and how well that person lived. There is much to be learned about the qualitative aspects of a person's life through undertaking a death review and how services can achieve higher standards of care, dignity, and participation.[171]

The Scoping Review commissioned by the NDIS Commission, mentioned earlier, reported that:

> Mortality data can provide crucial insight into population specific patterns and support the development of targeted preventative and public health initiatives. Mortality data are helpful in identifying gaps in care pathways, directing future health care and social service spending, and providing focus to research initiatives. Changes in mortality data over-time can support governments to assess the impact of policy shifts and other changes in the health and social care landscape on populations and specific sub-groups. Effective monitoring of mortality data is particularly critical for vulnerable populations that have experienced persistently negative health outcomes.[172] [Citations omitted.]

The former Victorian DSC, Mr Arthur Rogers, gave evidence in Public hearing 3, 'The experience of living in a group home for people with disability', that issues relating to the use of restraints have often been identified through the DSC's death reviews whereas the unauthorised use of restraint does not often feature in complaints or incidents reviewed by the DSC.[173] He said death reviews look broadly at the provision of services and not just factors relating to the person's death.[174] In response to our *Health care for people with cognitive disability issues paper*, Inclusion Australia expressed support for the DSC's death review function.[175]

In Public hearing 4, Mr Jim Simpson, Senior Advocate at the Council for Intellectual Disability, referred to the NSW Ombudsman's former disability death review function and stated that:

> The Ombudsman's reviews have provided invaluable intelligence on the causes of deaths and broader gaps in good practice in the health and disability support systems. The Ombudsman has called on the relevant agencies to account for failures and for systemic action to address failures. With Professor Trollor's research showing 38% potentially avoidable deaths, clearly there is an ongoing need for an independent deaths review system.[176]

Witnesses at Public hearing 6, 'Psychotropic medication, behaviour support and behaviours of concern', also suggested reviews of the deaths of people with disability can highlight practice issues. For example, they might show the administration of antipsychotic medication to people with disability who have no diagnosis of mental illness, which can potentially lead to long term health impacts.[177]

Role of the NDIS Commission

In Public hearing 4, former NDIS Commissioner, Mr Graeme Head, gave evidence on the NDIS Commission's data collection in relation to the deaths of people with disability. This data was collected primarily through its reportable incidents function.[178] Mr Head acknowledged the limitations of the reportable incidents function in relation to gathering comprehensive data about the causes of and contributors to deaths of people with disability. This was particularly where there is no causal relationship between a death occurring and the provision of NDIS supports.[179] Mr Head explained that:

> The NDIS Commission does not have a death review function that obliges the NDIS Commissioner to review and report on all notified deaths in the way that, for example, the NSW Ombudsman produces biennial reports on the deaths of people with disability in residential care to the NSW Parliament.[180]

He explained that the NDIS Commissioner's functions and powers enable the NDIS Commission to investigate individual deaths, or a series of deaths, 'but choosing to exercise these powers in some or all cases is at the discretion of the NDIS Commissioner'.[181]

Mr Head pointed out that the important difference the NDIS Commission could make was not in waiting to receive reports of deaths and then building its own evidence base by reviewing them. Rather, the important difference the NDIS Commission can make is through using its regulatory powers to ensure that the existing research and knowledge is acted on so that real improvements occur for people with disability.[182]

Mr Head provided a comprehensive explanation of how the NDIS Commission was responding to the findings and recommendations of the Scoping Review.[183] He also explained the further actions the NDIS Commission planned to take to assist in preventing avoidable deaths and reducing the risk of serious injury to people with disability.[184]

In November 2022, the current NDIS Commissioner, Ms Tracy Mackey, provided updated information about the actions taken by the NDIS Commission following the Scoping Review. Its work included the publication and distribution of a large number of Practice Alerts about issues placing people with disability at increased risk of death.[185] Ms Mackey also reported:

> work is currently underway to review the NDIS Commission's reportable incidents data in relation to deaths. I anticipate that this work, once completed, will enable the NDIS Commission to test the baseline data established in the Scoping Review against the NDIS Commission's first national collection of reportable incidents involving deaths of Participants, provide a preliminary assessment of the NDIS Commission's actions in response to the Scoping Review, and identify the next priorities and actions to address the causes of and contributors to deaths of people with disability.[186]

Views about the NDIS Commission's role relating to deaths

Submissions to the Royal Commission have queried whether the NDIS Commission's reportable incidents function enables a death to be examined in the same depth as a systemic death review.[187] Professor Trollor said the requirements for when a death becomes reportable 'poses significant limitations in the collation and analysis and understanding of deaths in people with disabilities'.[188] He further said that unless the approach is modified, this system will not represent a comprehensive way of reporting, analysing and understanding the deaths of many people with disability.[189] The deaths of people with disability not receiving NDIS funding or supports from registered NDIS providers, and deaths that are deemed not to occur in connection with the provision of NDIS supports or services, are not examined under the current arrangement.[190]

Inclusion Australia contrasted the NDIS Commission's reportable incidents function with the NSW Ombudsman's former 'clear and comprehensive deaths review system' function.[191] It noted that, unlike the NSW Ombudsman, the NDIS Commission does not have jurisdiction over health services.[192] Mr Jim Simpson of the Council for Intellectual Disability also noted that the NDIS Commission has no jurisdiction over health services. He observed that, while the NDIS Commission has the authority to review 'whether failures in disability support contributed to deaths…we have been concerned whether it will do this as rigorously as the Ombudsman did'.[193]

The Victorian DSC expressed concern:

> that at best there will be a gap in the time it will take the NDIS Commission to achieve the current in-depth standard of reviewing and investigating deaths currently delivered by the DSC, albeit via a different approach to that taken by the DSC. At worst the NDIS Commission's process for reviewing deaths will only ever take a regulatory approach and will rely more on reactive rather than preventative approaches to drive better practice and achieve ongoing quality service improvement.[194]

The Northcott Society also suggested that, 'the [NDIS] Commission should produce thematic findings from their work, similar to the various state Ombudsman reports'.[195]

Why disability death review schemes are needed

Professor Trollor told the Royal Commission:

> It is critical to collect and report data on deaths of people with disability, and to undertake detailed reviews of deaths to see if they could have been avoided. Doing so will inform service system improvements that can promote good health and minimise avoidable deaths. Failure to do so will perpetuate the cycle of early mortality from potentially avoidable causes.[196]

The Victorian DSC recommended the development of 'a nationally consistent arrangement for reviewing and investigating the deaths of people with disability, not only those who are NDIS participants but also those who are not receiving NDIS funding'.[197] The Disability Services Commission provided the Royal Commission with a copy of its 2021 report, *Learning from reviews of Victorian disability service provision to people who have died 2017 to 2021 – A reflection for future safeguarding*.[198] The report states:

> It is the DSC's view that critical insights, evidence and data regarding the quality of service would not have otherwise surfaced without the opportunity afforded to the DSC to inquire into, and investigate, the deaths of people with disability. In considering the future for reviewing disability service provision to Victorians who have died, it is hoped that the reflections and recommendations made in this paper can inform ongoing decisions regarding disability safeguarding and quality monitoring considered by both the Victorian and Federal governments.[199]

The DSC noted that its death review role arose from 'past evidence that neglectful practices within disability services can, and have, led to the deaths of people with disability in Victoria'. It expressed concern about its death review role having been diminished since the introduction of the NDIS and suggested that the maturity of its death review process 'provides a solid foundational base on which future state and federal models of quality and safeguarding may consider building upon in order to achieve real improvement of services for people with disability'.[200]

The Victorian Disability Services Board told us that death reviews should continue in Victoria or be expanded to a national scheme.[201]

Key attributes of a death review scheme

Mr Simpson and Professor Trollor provided a comprehensive joint submission outlining their views about how a death review scheme should operate. They proposed a number of 'key attributes of an optimal approach to reviewing disability deaths':[202]

- consistent collection, routine analysis and public reporting of national data relating to the deaths of people with disability via analysis of data within the proposed NDDA
- meaningful input into the operation of the system from people with intellectual and other disabilities and their families
- a statutory body with power and responsibility to review deaths including power to compel provision of relevant information
- compulsory reporting of deaths of people in high risk groups
- holistic reviews that cover the interplay of roles of the health, disability support and other relevant service systems
- links to relevant functions of state and territory coroners

- links to bodies that have responsibility for standard setting and corrective action in the health, disability support and other relevant service systems.

Mr Simpson and Professor Trollor told the Royal Commission that one body should have the responsibility to carry out holistic death reviews:

> Actions and inactions that lead up to a death do not follow service system boundaries, and a compartmentalised approach may obscure relevant service interactions that contribute to death. Reviews need to focus on both the actions of individual services and the interaction of actions between different service systems.[203]

Their preferred option was for the most appropriate independent statutory body in each state and territory to conduct death reviews.[204] Mr Simpson and Professor Trollor cautioned against locating the role in coroners' offices, saying 'there is a serious risk of disability death reviews being approached in an unduly legalistic framework, and in a way that does not reflect the complexity required for a disability informed approach'.[205]

Mr Simpson and Professor Trollor suggested 'it should be open to anyone to notify the review body of a death of a person with disability so that the body can at least consider conducting a review'. The review body should also have an 'own motion' power to review a concerning death it becomes aware of in some other way.[206]

Mr Simpson and Professor Trollor proposed disability death review schemes should be notified of all deaths required to be notified to the NDIS Commission as a reportable incident, and the deaths of people with disability in particular high risk situations.[207] They suggested this second group should include the deaths of people who live in disability group accommodation (including assisted boarding houses and aged care facilities), people held in custody and people who die in an acute health care facility.

Mr Simpson and Professor Trollor suggested that the review body should follow a triage process to determine whether to conduct a review of a notified death and the intensity of the review. At a minimum, a review would involve obtaining and reviewing relevant information from health, disability and other relevant agencies or service providers and consulting the family, guardian or advocate of the person who has died. The review body and other relevant bodies should have the capacity to share information to inform death reviews.[208]

Mr Simpson and Professor Trollor suggested that each review should generate a report that would be shared with relevant providers, including any recommendations, and the person's family, guardian or advocate.[209] The review body should also communicate its review findings and recommendations to the relevant body that has responsibility for oversight of standards, and the power to undertake disciplinary/corrective action, concerning the provider in question (for example, the NDIS Commission).[210] In addition, the review body should be required to report annually on deaths and reviews, themes from reviews and recommendations made, and also have capacity to publish a special report to parliament.[211]

5.5. A national approach to reviewing deaths

Systemic death reviews have been shown to be an important tool for identifying and understanding the factors that contribute to the deaths of people with disability at the highest risk of poor outcomes. They are also regarded as useful for informing effective policy and practice interventions. We consider systemic death reviews to be a fundamental safeguarding and oversight instrument and critical to preventing violence against, and abuse, neglect and exploitation of, people with disability.

Which body should perform death reviews?

An appropriate independent body in each state and territory with the most relevant functions, powers and expertise should operate a scheme for reviewing the deaths of people with disability. The most appropriate body is likely to differ among jurisdictions. Possibilities include health or community services oversight bodies (for example, the Queensland Family and Child Commission), public guardians/public advocates, disability oversight bodies (for example, the DSC in Victoria and the Ageing and Disability Commissioner in New South Wales) and ombudsman offices.

We have considered a range of factors in recommending that states and territories should operate disability death review schemes. This is preferred to a scheme operated by a national body, such as the NDIS Commission. Each death review scheme should be appropriately aligned to where the individual person with disability who has died was living. It is also appropriate for the independent state or territory body undertaking a death review to be able to examine the related conduct of service providers in their geographic location. We note that this is how jurisdiction over deaths is determined by criminal justice and coronial systems, as well as schemes for reviewing the deaths of children and domestic violence related homicide.

There are other important practical reasons for disability death review schemes being operated by the states and territories. As noted previously, unmet health needs are a recurrent theme of death reviews previously conducted by the NSW Ombudsman, and currently by the Victorian DSC and Queensland Office of the Public Advocate. In 2015, the then NSW Acting Ombudsman, Professor John McMillan AO, reported:

> Our reviewable death work over the past 12 years has highlighted significant problems in the mainstream health system (and the interface between disability and health services) that adversely affect the health outcomes of people with disability. For example, we have found substantial gaps in health care coordination, poor transfer of care from hospital to home, and poor access to community-based health care and programs.[212]

And in 2018, the then NSW Ombudsman, Mr Michael Barnes, stated:

> The issues identified in this report underscore the importance of continuing to examine the involvement of both disability supports and health services. Our reviews consistently

> demonstrate that improving health and other outcomes for many people with disability is heavily reliant on effective and cooperative work between the person with disability, disability providers, and health services. There are multiple, powerful examples of the need for effective interagency work in this report. These include individuals who did not receive the crucial support they needed to minimise their resistance to medical treatment, did not obtain timely and appropriate access to assessments and community-based support to identify and manage swallowing, falls, respiratory and obesity risks, and did not receive the assistance they required in hospital.[213]

Further, the Victorian DSC noted that this Royal Commission's *Interim report* and our *Report of Public hearing 4* both identified key themes similar to those identified by the DSC's death reviews. Those include health system challenges, issues concerning the integration of the health and disability service sectors, and concerns about training and education of health professionals.[214]

To perform their role effectively, death review schemes need to be able to require health services to share relevant information and to direct appropriate recommendations at these services. Health services are operated by the states and territories. As a national body, the NDIS Commission does not have jurisdiction over state and territory health services. Additionally, state and territory police and coroners often hold critical information about deaths. It is our view that state and territory death review bodies will be better placed to develop and maintain effective working relationships with these entities.

Finally, we consider that broadening the NDIS Commission's remit to include a systemic disability death review function would place an unnecessary burden on an organisation that already has considerable responsibilities and is facing challenges in responding to the volume of matters under its oversight. The discussion in section 5.3 about the compliance action taken by the NDIS Commission against service providers in relation to the deaths of Ms Aprem, Ms Smith and Ms Lucas demonstrates the vital role the NDIS Commission has in relation to reportable incidents involving the deaths of NDIS participants. Rather than taking on a systemic review function, the NDIS Commission should be free to focus on executing its unique regulatory, compliance, and investigative functions.

We propose arrangements for an effective relationship between state and territory disability death review schemes and the NDIS Commission. This nexus has the potential to be mutually beneficial. It could enhance the NDIS Commission's capacity to pursue issues arising from death reviews conducted under state and territory schemes that relate to individual NDIS providers and to providers more generally.

How should disability death review schemes operate?

We make the following observations about how disability death schemes could operate.

Designated organisations should be required by law to notify the death review scheme operator of any 'reviewable death'. Scheme operators should record core information in a deaths register and conduct a preliminary assessment of every death notified. This assessment should determine whether to review the death and, if so, the extent of the review required.

Scheme operators should have the power to:

- treat a relevant death as a 'reviewable death' if they become aware of it by means other than mandatory notification, and if it is in the public interest to do so
- undertake cohort or issues-based death reviews, direct investigations into particular individual deaths where necessary or make referrals to the coroner to conduct an inquest
- require relevant organisations and individuals to provide information relevant to the review. This information should include records about services provided to the individual who has died as well as internal root cause analyses or critical incident reviews of the death. For deaths notified to the NDIS Commission as a reportable incident, it would also include the Commission's assessment of the notification and other relevant information holdings (see 'Relationship between scheme operators and the NDIS Commission', below, for further discussion)
- make a report to the relevant state or territory parliament at any time (in addition to being required to make a public annual report).

Scheme operators should have agreements with police and the coroner in their jurisdiction and conduct death reviews in a way that does not interfere with police and/or coronial investigations. State and territory legislation establishing the schemes should include provisions for a two-way information exchange between the scheme and the police, the coroner and the NDIS Commission.

Scheme operators should make appropriate recommendations, following death reviews, to designated organisations. They should refer any conduct-related concerns to the appropriate regulatory or complaint handling body for action, such as the relevant health care complaints body or the NDIS Commission.

Scheme operators should also be required to periodically publish reports recording findings and recommendations. This reporting would be informed by all notified deaths, not just those subject to an individual review.

States and territories should consider the benefits of providing for scheme operators to be advised by a panel of expert advisors. The disability death review function previously operated by the NSW Ombudsman was advised by such a panel which included general practitioners, an obstetrician, gastroenterologist, geriatrician/endocrinologist, a rehabilitation specialist and an epilepsy specialist.[215]

Relationship between scheme operators and the NDIS Commission

We envisage that the NDIS Commission would continue to receive and assess notifications of deaths that are 'reportable incidents'. The NDIS provider making the notification would still be required to advise the NDIS Commission of the action taken to manage the reportable incident. For all reportable incidents, the NDIS Commission's immediate focus would be to ensure the provider has identified and addressed any risks arising from the incident (including risks to the broader service environment). The NDIS Commission would still be able to require the provider to investigate or take other remedial action.

Under our death review scheme proposal, the NDIS service provider would submit a simultaneous notification (ideally via an electronic alert) of the death to the scheme operator in the relevant state or territory where the service is delivered. The NDIS Commission could then provide the scheme operator with relevant information about deaths notified to it as reportable incidents. This would include the provider's notification to the NDIS Commission; any information obtained by the NDIS Commission during its assessment of the 24 hour (and subsequent five-day notification) and the provider's response; any information subsequently given to the NDIS Commission by the provider (for example, an internal or external investigation report) and relevant systemic information held about a provider.

Scheme operators would receive mandatory notifications about a broader group of deaths than those notified to the NDIS Commission as reportable incidents. Accordingly, they may identify certain deaths that should have been notified as a reportable incident but were not. In such instances, the scheme operator would alert the NDIS Commission of the relevant death. The scheme operator would also liaise with the NDIS Commission about its findings from its review of the death regarding any concerns about individual NDIS providers or workers (including potential breaches of the *NDIS Act*). It would also communicate the need for broader sector education and awareness raising. As the NDIS Commission is well placed to amplify such messages through its provider networks, this would complement any educative work done by death review scheme operators.

The NDIS Commission would retain regulatory jurisdiction over NDIS providers in relation to deaths notified as reportable incidents and determining whether compliance or enforcement action against a provider is warranted.

To facilitate effective linkages between the NDIS Commission and scheme operators, there is value in the NDIS Commission establishing a separate deaths team to provide a single interface. We encourage the NDIS Commission to consider establishing such a team.

Information sharing

Mandated information sharing between scheme operators and the NDIS Commission must be established to enable state and territory scheme operators to obtain information from the NDIS Commission (and, possibly, the NDIA). The NDIS Worker Screening scheme provides a precedent for similar inter-jurisdictional cooperation on information sharing which facilitates the exercise of functions by the state and territory-based worker screening units and the NDIS Commission.

Information sharing could be specifically mandated in the *NDIS Act* and in the legislation establishing the scheme operators. Consideration may also need to be given to amending existing prohibitions the *National Disability Insurance Scheme (Protection and Disclosure of Information) Rules 2013* (Cth) on the NDIS Commission sharing certain information covered by those Rules.

Family participation

Voluntary participation in death reviews by the family, guardian or advocate of the person who has died is a feature of LeDeR, the national intellectual disability mortality review program in England.[216] The 2019 Scoping Review of causes and contributors to deaths of people with disability in Australia recommended that consideration be given to routinely eliciting family perspectives as part of the death review process. This would allow a more comprehensive understanding of causes and contributors to deaths.[217] We support this recommendation.

Which deaths should be reviewed?

It is not practical for death review schemes to review the deaths of all people with disability. According to the Australian Bureau of Statistics, in 2018 there were 2.4 million Australians under age 65 with disability.[218] If the deaths of all people with disability were reviewable, the sheer volume of cases would overwhelm the schemes and dilute their effectiveness. However, the schemes should review a broader cohort of deaths than those that are notifiable to the NDIS Commission as 'reportable incidents'. The deaths examined should include the deaths of people with disability other than NDIS participants. The question is then how to limit the scope of 'reviewable deaths'.

People with disability living in supported accommodation and licensed boarding houses

In section 5.4 we summarised evidence heard by the Royal Commission about the deaths of Sarah Lehmann, a young woman who lived in supported accommodation at the time of her death, and Kaye, who lived in an SRS when she died.

The NDIS Commission commissioned the Australian Institute of Health and Welfare (AIHW) to examine the deaths of 526,515 people with disability who were under 65 years and who used disability support services funded under the National Disability Agreement for the five years between 1 July 2013 to 30 June 2018.[219]

The AIHW study, *Mortality patterns among people using disability support services*, found that those people who received 'other accommodation services' had the highest rate of death (1,500 per 100,000).[220] These 'other accommodation services' include attendant care, personal care, in-home accommodation support, alternative family placement, and accommodation support services that provide short-term, one-off instances of accommodation.[221] People with disability receiving 'residential accommodation services' also had a high rate of death (1,300 deaths per 100,000 people).[222] 'Residential accommodation services' include large residential/institutions, small residential/institutions, hostels, group homes and centre-based respite/respite homes.[223]

The NSW Ombudsman's former disability death review function involved reviewing the deaths of people with disability living in supported accommodation and licensed boarding houses. Licensed boarding houses are privately operated businesses that house people with disability who need assistance. They may be, but are not necessarily required to be, registered NDIS providers and the people who live in them may or may not be NDIS participants.

The NSW Ombudsman's disability death reviews (and work in connection with other functions)[224] consistently identified concerns about people with disability who live in assisted boarding houses.[225] The NSW Ageing and Disability Commission also provided evidence about significant concerns raised by Official Community Visitors about residents of assisted boarding houses not being supported to access appropriate health and medical services and treatment.[226]

During Public hearing 26, we were advised that data held by the NDIS Commission indicates that 30 per cent of people residing in Victorian SRS (the equivalent of licensed boarding houses in New South Wales) are NDIS participants and are disproportionately more likely to have psychosocial disability or cognitive disability.[227] The DSC in Victoria does not have jurisdiction to review the deaths of people living in SRS because they are not defined as 'disability services' under section 3 of the *Disability Act 2006* (Vic). However, Community Visitors in Victoria have extensively reported on concerns about violence, abuse and neglect experienced by people with disability living in SRS and called for greater regulation and independent oversight of the sector.[228] In Public hearing 26, we heard evidence from the Victorian Public Advocate about these concerns.[229] Several witnesses, including individuals with experience of residing in boarding house accommodation, also gave evidence about conditions in those boarding houses. They spoke about unsafe and unsanitary living conditions, poor nutrition, exposure to violence and abuse, intimidation, financial exploitation and a lack of dignity and respect.[230]

In January 2023, the NDIS Commission published the findings of its *Own motion inquiry into aspects of supported accommodation* report[231] It reported that '[t]he interface with health and the supported accommodation system is not effective for many people living in these settings'[232] and that '[t]he responsiveness of the health system to the needs of people with disability living in group homes, particularly those with intellectual disability, appears to have been not always positive…'.[233]

There is a strong case for the deaths of people with disability living in supported accommodation and licensed boarding houses/SRS to be 'reviewable deaths' for the purpose of the proposed death review schemes. Providers of these services should be required to notify these deaths to the scheme operator in their jurisdiction.

Although the rates of death are also high among people with disability in other forms of accommodation, services mandating notification of these deaths may create practical difficulties. For example, if a person is receiving personal care or other in-home accommodation support from more than one service provider, a question arises as to which provider should be required to notify the death. The number of deaths falling into this category is also likely to be quite large.

People with disability in custody and acute healthcare settings

We have heard that people with disability are grossly over-represented in custodial settings.[234] It has been estimated that at least half of the adults imprisoned in Australia have a diagnosable mental or cognitive disability, or both.[235]

In all states and territories, deaths in custody must be reported to the coroner. In certain circumstances, deaths in acute healthcare settings may also need to be reported to the coroner. Deaths in custody and in acute healthcare settings may also be subject to internal investigations.

Nonetheless, we consider state and territory disability death review schemes should have power to review deaths of people with disability in custody (prisons and police watch houses)[236] and in acute healthcare settings.

Any person with legitimate interest – including a family member, guardian or advocate and bodies such as the Ageing and Disability Commissioner (New South Wales), DSC (Victoria) or the Adult Safeguarding Unit (South Australia) – should be able to request a review. Scheme operators should decide whether to conduct a review based on the public interest and operators having sufficient capacity.

Death review schemes should, however, begin with focusing on reviewable deaths in supported accommodation and licensed boarding houses/SRS. This should continue for a reasonable period of time before their scope is extended to reviewing the deaths of people with disability in custody and acute healthcare settings. A staged approach of this nature will give these schemes opportunity to bed down their operation, refine their methods and processes and test their capacity.

Achieving national consistency

It is desirable for state and territory disability death review schemes to operate with national consistency, particularly in relation to the NDIS Commission and the collection and reporting of data. There should be a national agreement between the Australian Government and state and territory governments that:

- defines the respective roles of state and territory death review schemes and the NDIS Commission in relation to the deaths of people with disability
- establishes a clear nexus between the functions of the death review schemes and the relevant functions of the NDIS Commission and supports the development of appropriate operational processes to facilitate this
- mandates information sharing between the death review schemes and the NDIS Commission
- commits to nationally consistent disability death data collection and reporting requirements.

State and territory legislation establishing death review schemes should have regard to the new National Disability Agreement, as recommended in Volume 5, *Governing for inclusion.*

The Australian Government should ensure that states and territories are able to obtain information from the NDIS Commission (and, if appropriate, the NDIA). This may require amending the *NDIS Act* and the information-sharing prohibitions in the *National Disability Insurance Scheme (Protection and Disclosure of Information – Commissioner) Rules 2018* (Cth).[237]

Data and reporting

A nationally consistent disability data mortality agenda is essential to ensure that state and territory death review schemes produce comparable data. We note that the 2019 Scoping Review made a several observations that should be considered in the development of a shared disability data mortality agenda. For example, the Scoping Review noted the benefits of:

- systematically and quantifiably accounting for contributing and direct causes of death, in addition to underlying causes[238]
- a stratified analysis of demographics, health status, and causes of and contributors to death based on the person's accommodation type[239]
- detailed analysis of where and when deaths took place[240]
- defining and quantifying the number of potentially avoidable deaths in a sample.[241]

The Scoping Review also noted the importance of deciding how to determine the cause of death in cases where no coroner's report is available.[242]

The data captured by scheme operators should form part of the proposed NDDA. An appropriate body, such as the AIHW (which already reports on maternal mortality)[243] could analyse the collective data to identify disability death trends across the country. There is a precedent for this type of arrangement in the role played by Australia's National Research Organisation for Women's Safety (ANROWS). Among other things, ANROWS has worked with the Australian Domestic and Family Violence Death Review Network to report national data about domestic violence homicides.[244]

An issue requiring further consideration, whether or not disability death review schemes are established, is improving the national consistency and quality of the coding and reporting of deaths of people with disability. Professor Trollor's evidence indicated there are currently a number of gaps and inconsistencies in the way that mortality data is collected making comparative analysis difficult. The Scoping Review suggested that an explicit code for disability status should be developed within the National Coronial Information System database.[245]

The Australian Government should lead further consideration of these issues to determine what changes are necessary.

Community of practice

If states and territories agree to establish disability death review schemes, there is merit in jointly establishing a 'community of practice' to promote the development of shared good practice in relation to methodological issues, reporting matters and other relevant issues. There is a precedent for this in the Australian and New Zealand Child Death Review and Prevention Group, a collaboration of all state and territory child death review teams across Australia and New Zealand.

Recommendation 11.14 Establishing disability death review schemes

States and territories should establish and appropriately resource disability death review schemes. These schemes should include:

a. functions to:

- receive, assess and record 'reviewable deaths' of people with disability, as defined in recommendation 11.15
- monitor and review reviewable deaths
- formulate recommendations about policies and practices to prevent or reduce reviewable deaths
- maintain a register of reviewable deaths
- formulate strategies to reduce or remove potentially avoidable risk factors for reviewable deaths
- establish and support the work of an expert advisory committee

b. powers to:

- scrutinise systems for reporting reviewable deaths
- undertake detailed reviews of information relating to reviewable deaths
- conduct own motion investigations into individual or groups of deaths
- analyse data on the causes of reviewable deaths to identify patterns and trends
- consult with, and obtain information from, any person or body with relevant information or appropriate expertise
- invite and consider information from the deceased person's family or guardian or advocate when reviewing and/or investigating a death
- notify the NDIS Quality and Safeguards Commission of matters relevant to the exercise of its functions
- refer identified concerns about conduct or service provision to relevant regulatory bodies for their consideration and appropriate action
- publish reports periodically on systemic findings and recommendations arising from all reviewable deaths
- make a special report to the relevant state or territory parliament about any matter that the scheme operator considers to be in the public interest.

Recommendation 11.15 Disability death review scheme requirements

States and territories should ensure legislation establishing disability death review schemes:

a. defines 'reviewable deaths' to include:
   - deaths subject to mandatory notification
   - deaths that a person or body with a legitimate interest requests a scheme to review

b. requires deaths that are subject to a mandatory notification requirement include the death of a person with disability:
   - living in supported accommodation at the time of their death
   - residing in a licensed boarding house (or equivalent) at the time of their death
   - residing in custody or in an acute health facility at the time of their death (after the disability death review scheme has operated for a period).

Recommendation 11.16 National agreement on disability death reviews

The Australian Government and state and territory governments should enter into a national agreement that:

a. reflects the functions, powers and definitions outlined in recommendations 11.14 and 11.15

b. defines the respective roles of state and territory death review schemes and the NDIS Quality and Safeguards Commission (NDIS Commission) in relation to the deaths of people with disability

c. articulates the relationship between the functions of the disability death review schemes and the NDIS Commission and ensures the appropriate operational processes are in place to facilitate this

d. provides for information-sharing between the death review schemes and the NDIS Commission

e. commits to nationally consistent disability death data collection and reporting requirements, and the inclusion of disability death data within the proposed National Disability Data Asset.

Endnotes

1 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), art 16(3.)
2 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 4.
3 'Potentially avoidable deaths' are deaths that are potentially preventable through individualised care and/or treatable through existing primary or hospital care. Australian Institute of Health and Welfare, National Healthcare Agreement: PI 16–Potentially avoidable deaths, 2022, Metadata Online Registry (METEOR). <https://meteor.aihw.gov.au/content/740864>
4 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 4.
5 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, Supplementary Table S3.7.
6 In 2018, 'when taking differences in the age structure of the two populations into account, Indigenous Australians experienced disability at 1.9 times the rate of non-Indigenous Australians'. Australian Institute of Health and Welfare, 'Disability support for Indigenous Australians' in *Australia's welfare 2021*, Biennial report, September 2021.
7 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 4.
8 'Potentially avoidable deaths' are classified using nationally agreed definitions. They include deaths from conditions that are potentially preventable through individualised care and/or treatable through existing primary or hospital care. They are not deaths that have been individually assessed as avoidable. Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 18.
9 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, p 7. This report used linked data to examine deaths among people with disability who used disability support services funded under the National Disability Agreement during the five years from 1 July 2013 to 30 June 2018. The study included 526,515 people aged under 65 who accessed disability support services, or about 23 per cent of the 2.4 million Australians under age 65 with disability in 2018. The rates and causes of death varied by type of disability, age and sex.
10 Exhibit 4-054, DRC.1000.0003.7065, p 1.
11 Exhibit 4-054, DRC.1000.0003.7065, pp 1, 5–6.
12 Exhibit 4-054, DRC.1000.0003.7065, p 4.
13 James Vincent, Hugh Miller, Kirsten Armstrong, Grant Lian, David Qi, Nansi Richards, Taylor Fry, Dennis McCarthy, Sarina Lacey & Tomas Berry, Centre for International Economics, *The economic cost of violence, abuse, neglect and exploitation for people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, February 2023, pp 80, 112–113, 263–267, 285.
14 James Vincent, Hugh Miller, Kirsten Armstrong, Grant Lian, David Qi, Nansi Richards, Taylor Fry, Dennis McCarthy, Sarina Lacey & Tomas Berry, Centre for International Economics, *The economic cost of violence, abuse, neglect and exploitation for people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, February 2023, p 75, Table 4.1: 550 people with disability experience Potentially Avoidable Deaths per year. Based on 16,000 Potential Years of Life Lost (PYYL) multiplied by $130,000 per PYLL.
15 Queensland Family and Child Commission, *Australian Child Death Statistics 2020*, February 2023, p 10.
16 Australia's National Research Organisation for Women's Safety, *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010–2018*, Second edition, 2022, p iv.
17 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), s 36(1).
18 *Disability Inclusion Amendment Act 2022* (NSW), Schedule 2, 2.1(3).
19 Victoria Disability Services Commissioner, *Occasional Paper No. 3 Learning from reviews of Victorian disability service provision to people who have died 2017 to 2021 – A reflection for*

future safeguarding Occasional paper, May 2021, p 2, incorporated in Victorian Commissioner of Disability Services, Submission, 10 June 2023. SUB.100.01395_01_0001.

20 Office of the Public Advocate (Qld), *Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland*, Systemic advocacy report, February 2016, pp xii, 79; Coroners Court of Queensland, *Deaths in Care (Disability) Expert Review Panel Final Report*, Final report, July 2019, p 61.

21 ACT Official Visitor Scheme, *Annual Report 2020–21*, p 26.

22 *National Disability Insurance Scheme Act 2013* (Cth) s 73Z(4)(a).

23 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018*, part 3, s 14.

24 Australian Institute of Health and Welfare, *Mortality patterns among people using disability support services: 1 July 2013 to 30 June 2018*, September 2020, pp 12, 17.

25 Office of the Public Advocate (Qld), *Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland*, Systemic advocacy report, February 2016, pp xii, 79; Coroners Court of Queensland, *Deaths in Care (Disability) Expert Review Panel Final Report*, Final report, July 2019, p 61.

26 ACT Official Visitor Scheme, *Annual Report 2020–21*, p 26.

27 NSW Ombudsman, *Reviewable Deaths Annual Report 2004*, December 2004.

28 The function also provided for reviewing the deaths of persons with disability receiving assistance from another service provider (of a kind prescribed by regulations) to enable the person to live independently in the community; however, no other service providers were ever prescribed. It also provided for the deaths of certain children to be reviewed.

29 NSW Ombudsman, *Reviewable Deaths Annual Report 2004*, December 2004, p 5.

30 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 36(1).

31 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) ss 37–39.

32 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 36(2).

33 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) ss 41, 43.

34 NSW Ombudsman, *Report of reviewable deaths in: 2014 and 2015, 2016 and 2017 – Deaths of people with disability in residential care*, August 2018.

35 NSW Ombudsman, *Annual Report 2018-19*, October 2019, p 49.

36 NSW Ombudsman, *Report of Reviewable Deaths in: 2014 and 2015, 2016 and 2017 – Deaths of people with disability in residential care*, August 2018, p vi.

37 NSW Ombudsman, *Report of Reviewable Deaths in: 2014 and 2015, 2016 and 2017 – Deaths of people with disability in residential care*, August 2018, p vi.

38 NSW Ombudsman, Strategic Plan 2020-25, July 2020. <www.theioi.org/ioi-members/australasia-pazifik/australia/new-south-wales-ombudsman>

39 NSW Ombudsman, *Annual Report 2021–22*, October 2022, p 43, Strategic initiative 2.5.

40 New South Wales, *Parliamentary debates*, Legislative Council, 19 May 2022 (Taylor Martin).

41 NSW Ombudsman, *Annual Report 2021–22*, October 2022, p 13.

42 NSW Ombudsman, 'Reviewable deaths of people with disability – Annual Reports (2003 – 2022)', web page. <https://www.ombo.nsw.gov.au/Find-a-publication/publications/annual-reports-relating-to-former-functions/reviewable-deaths-of-people-with-disability-annual-reports-2003-2022>

43 Exhibit 4-059, CTD.7200.0001.0060, pp 12, 49.

44 Exhibit 4-059, CTD.7200.0001.0060, p 25.

45 NSW Ombudsman, *Report of Reviewable Deaths in 2008 and 2009 – Volume 2: Deaths of people with disabilities in care*, September 2011, Section 1; *NSW Ombudsman, Report of Reviewable Deaths in 2010 and 2011 – Volume 2: Deaths of people with disabilities in care*, May 2013, pp iii, 60–63.; NSW Ombudsman, *Report of Reviewable Deaths in 2012 and 2013 – Volume 2: Deaths of people with disability in residential care*, June 2015, pp 53–54.

46 NSW Ombudsman, *Report of Reviewable Deaths in 2006 – Volume 1: Deaths of people with disabilities in care*, November 2007, p V.

47 NSW Ombudsman, *Report of Reviewable Deaths in 2010 and 2011 – Volume 2: Deaths of people with disabilities in care*, May 2013, p 66.

48 NSW Ombudsman, *Report of Reviewable Deaths in 2006 – Volume 1: Deaths of people with disabilities in care*, November 2007, pp 72–87.

49 NSW Ombudsman, *Report of Reviewable Deaths in 2007 – Volume 1: Deaths of people with disabilities in care*, December 2008, pp 56–59.

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This data is largely consistent with the Institute's more recent report: 'While the prevalence of intellectual disability in people in prison varies across studies, several studies have found that 25%–30% of people in prison have borderline intellectual disability, and 10% have a mild intellectual disability' [footnote omitted] (Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2018*, p 77).

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6. Reportable conduct schemes

Key points

- The Royal Commission into Institutional Responses to Child Sexual Abuse found that reportable conduct schemes are a best practice model for oversighting how institutions handle allegations of child abuse against their employees. It recommended that nationally consistent reportable conduct schemes be established based on the approach in New South Wales.
- Reportable conduct schemes have still not been established in Queensland, South Australia or the Northern Territory. There are also inconsistencies between the schemes in New South Wales, Victoria, the Australian Capital Territory, and Western Australia (and the scheme yet to commence in Tasmania), including different definitions of reportable conduct.
- Nationally consistent reportable conduct schemes should operate in all states and territories to help prevent and respond to abuse against all children, including children with disability.
- All schemes should include disability service providers that deliver supports or services to children with disability, including National Disability Insurance Scheme (NDIS) providers.
- Reportable conduct schemes should provide appropriate guidance to organisations about responding to allegations of reportable conduct that involve children with disability. Schemes should collect and publicly report consistent data about reportable conduct notifications and outcomes relating to children with disability.
- To reduce duplication and improve the effectiveness of independent oversight, reportable conduct scheme operators and the NDIS Quality and Safeguards Commission should work together to streamline processes for handling matters that fall under the jurisdiction of both the state and commonwealth schemes.

6.1. Introduction

There is limited data on the nature and extent of violence experienced by children and young people with disability in Australia.[1] However, research commissioned by the Royal Commission shows that across 10 studies examining child maltreatment, children with disabilities were reported as being at an increased risk of:[2]

- experiencing sexual and physical abuse before and during care
- being victims of substantiated reports of abuse including physical, sexual and emotional

abuse and neglect

- being at a higher risk of placement instability and entering out-of-home care
- experiencing multiple maltreatment incidents
- being abused by more than one perpetrator compared with children without disability facing abuse.

The Royal Commission into Institutional Responses to Child Sexual Abuse (Child Abuse Royal Commission) found that a large number of First Nations children[3] and children with disability[4] live in out-of-home care (OOHC). As discussed in this chapter, this Royal Commission has heard evidence about children and young people with disability experiencing violence and abuse in a range of institutional settings, including OOHC, schools and juvenile detention centres.

The Child Abuse Royal Commission found, as part of a comprehensive approach to safeguarding children from abuse and harm, reportable conduct schemes are 'a best practice model for cross-sector oversight of institutional handling of employee-related child protection matters'.[5]

Reportable conduct schemes provide independent oversight of the way various government and non-government organisations handle allegations of child abuse or harm made against their employees. Those organisations may include government and non-government schools, out-of-home care providers, health services, juvenile justice, disability services and religious bodies. There are currently reportable conduct schemes in New South Wales, Victoria, the Australian Capital Territory and Western Australia. Tasmania also passed legislation to establish a reportable conduct scheme (administered by a yet to be appointed independent body), which commenced on 1 July 2023.

Reportable conduct schemes require the heads of relevant organisations to notify an independent oversight body of allegations of reportable conduct involving their employees, to investigate the allegation and report the outcome to the body. The schemes are allegation-based, meaning that allegations must be reported regardless of whether there is proof the conduct occurred when the organisation first becomes aware of it. Reportable conduct scheme operators monitor the way organisations handle and investigate allegations. They also monitor their systems for preventing, detecting and responding to reportable conduct. The scheme operators can directly monitor and investigate reportable allegations, and report to parliament if it is in the public interest to do so.

We did not set out to specifically examine reportable conduct schemes given the coverage given to them by the Child Abuse Royal Commission.[6] However, those schemes are relevant to issues on which we received evidence, including:

- the use of restrictive practices in educational and other settings
- frustration and dissatisfaction with processes for making and responding to allegations and complaints of violence against, and abuse, neglect and exploitation of, people with disability
- the importance of capturing better data about people with disability and their experiences.

Reportable conduct schemes can play an important role in addressing these issues. However, there is significant scope to strengthen the responsiveness of such schemes to reportable conduct involving a person with disability and to do so in a way that is nationally consistent.

In particular, schemes should operate with consistent definitions of what constitutes reportable conduct. Also, scheme operators should provide appropriate guidance to organisations about handling and investigating allegations of reportable conduct that involve children with disability. Schemes should also agree to collect and publicly report consistent annual data about disability and adopt a common definition of disability for this purpose. To reduce duplication and improve the effectiveness of overall oversight, reportable conduct scheme operators and the NDIS Quality and Safeguards Commission (NDIS Commission) should work together. They need to streamline processes for handling matters involving children with disability that constitute both 'reportable conduct' under the reportable conduct schemes and 'reportable incidents' handled by the NDIS Commission.

Queensland, South Australia and the Northern Territory should join the other five states and territories in establishing reportable conduct schemes given it is now more than five years since the Child Abuse Royal Commission handed down its final report.

6.2. The history and landscape of reportable conduct schemes

The first reportable conduct scheme was established in New South Wales in 1999.[7] This was aimed at overcoming shortcomings and possible conflicts of interest when agencies investigate child abuse allegations made against their own staff. Until 2017, the reportable conduct scheme in New South Wales was the only such scheme operating in Australia.

In April 2016, the Council of Australian Governments agreed in principle to 'harmonise reportable conduct schemes to improve oversight of responses to allegations of child abuse and neglect'.[8] On 1 July 2017, reportable conduct schemes commenced in the Australian Capital Territory and Victoria.[9]

The Child Abuse Royal Commission examined reportable conduct schemes in Volume 7 of its *Final report* released in 2017. It reported that:

> Case studies, research and consultations on the New South Wales reportable conduct scheme have identified it as an effective mechanism for independent oversight of complaint handling by institutions – encouraging thorough complaint handling and timely and consistent procedures for reporting child sexual abuse.[10]

The Child Abuse Royal Commission found there was consistent broad support for the New South Wales scheme from both government and non-government stakeholders, as well as from state and territory ombudsmen and commissioners of other oversight and regulatory bodies.[11] The Child Abuse Royal Commission recommended:

> State and territory governments should establish nationally consistent legislative schemes (reportable conduct schemes), based on the approach adopted in New South Wales, which oblige heads of institutions to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution's employees.[12]

The Child Abuse Royal Commission observed that 'the potential benefits of nationally consistent implementation of reportable conduct schemes are significant'.[13] It also noted:

> Independent oversight can help institutions better identify and manage risks to children. It can improve institutions' competency, transparency, and accountability in complaint handling, and help create a consistent standard of practice across sectors. Further, independent oversight can assure the public that the institutions entrusted to care for children cannot minimise or ignore complaints, and that the leaders and employees of these institutions cannot operate with impunity.[14]

In March 2020, the reportable conduct scheme in New South Wales was transferred from the NSW Ombudsman to the Office of the Children's Guardian (OCG). This followed the Child Abuse Royal Commission identifying the value of locating reportable conduct schemes within the same oversight agency responsible for the Working with Children Check and monitoring and enforcing the Child Safe Standards.

Since that time, Western Australia has established a reportable conduct scheme which commenced in January 2023. Tasmania also passed legislation to establish a reportable conduct scheme (administered by a yet to be appointed independent body), which commences on 1 July 2023. The reportable conduct scheme will come into effect from 2024.[15]

This leaves Queensland, South Australia and the Northern Territory as the only jurisdictions that have not implemented the Child Abuse Royal Commission's recommendation that reportable conduct schemes should be established in every state and territory.

The governments of South Australia and the Northern Territory agreed to consider the recommendation but have not publicly reported further.[16] The Queensland Government has stated that it is committed to establishing a reportable conduct scheme. It released an issues paper in March 2017[17] and reported in December 2021 that it had:

> consulted government and non-government stakeholders to assess sector readiness, and the potential cost and resource implications of a reportable conduct scheme. This work may inform further consideration by government on options for a reportable conduct scheme.[18]

Similarities and differences between schemes

Despite the Child Abuse Royal Commission recommending nationally harmonised schemes, there are still inconsistencies among the schemes in New South Wales, Victoria, the Australian Capital Territory, Western Australia and Tasmania. Some of the main similarities and differences are noted below.

Organisations and employees within jurisdiction

- Though variously defined, all the schemes cover state or territory government agencies, schools, childcare, out-of-school-hours services, out-of-home care (OOHC) agencies, health services and religious bodies.
- The schemes in Victoria, Western Australia and Tasmania expressly include disability services. In New South Wales and the Australian Capital Territory, the schemes cover disability services delivered by government agencies.[19] They only include non-government disability services if they fall into another category. For example, a specialist substitute residential care provider[20] or an OOHC agency.[21]
- The schemes in Victoria, Western Australia and Tasmania expressly cover organisations that provide overnight camps to children as part of their primary activity. This overcomes a lack of clarity in the New South Wales legislation highlighted by the NSW Ombudsman in 2016[22] and noted by the Child Abuse Royal Commission.
- Apart from the New South Wales scheme, all schemes require operators to be notified of allegations regardless of whether the alleged conduct occurred during the employee's work. In New South Wales, allegations against employees of certain organisations (defined as 'public authorities') need only be reported if the alleged conduct occurred during the employee's work, unless the employee is required to hold a Working with Children Check for their job.
- All schemes cover employees, volunteers, contractors, foster carers and religious ministers although there are some differences in the breadth of coverage.[23]

Definitions of reportable conduct

- Approaches differ across the schemes regarding whether categories of reportable conduct are defined in the legislation or in guidance material.[24]
- All schemes include sexual assault and sexual misconduct as reportable conduct.[25] The Tasmanian scheme also includes 'grooming' as a type of reportable conduct.[26]
- Most schemes include either 'physical assault' (New South Wales and Western Australia) or 'physical violence' (Victoria and Tasmania) as reportable conduct.[27] In the Australian Capital Territory, the scheme covers 'offences against the person' (which include physical assault).[28]
- The New South Wales scheme includes 'ill-treatment' and 'neglect' as reportable conduct.[29] The Victorian, Western Australian,[30] and Tasmanian schemes include 'significant neglect' (but not ill-treatment) and the Australian Capital Territory scheme includes 'ill-treatment or neglect'.[31]
- Only the New South Wales scheme includes statutory definitions of 'ill-treatment' and 'neglect' as reportable conduct.[32] The legislation includes 'using inappropriate forms of behaviour management towards a child' as an example of 'ill-treatment'.[33] This category of reportable conduct is often used to notify concerns involving the use of unauthorised restrictive practices in schools and OOHC settings involving children with disability.

- The Australian Capital Territory scheme does not include legislated definitions of 'ill-treatment' or 'neglect'. The scheme legislation in Victoria and Tasmania refer to 'significant' in relation to harm or neglect,[34] but do not provide examples of what is included. The Tasmanian scheme provides a definition of 'neglect' as reportable conduct where there is 'deliberate or reckless failure to meet the basic needs of the child'.[35] The Western Australian legislation does not include a definition or examples of 'significant neglect'.
- All schemes, apart from the Australian Capital Territory, include 'behaviour causing significant emotional or psychological harm' as reportable conduct.[36] The Australian Capital Territory includes 'behaviour, or a circumstance, that psychologically harms the child'.[37]
- Only the New South Wales scheme includes as reportable conduct criminal offences which relate to failure to report or failure to protect child abuse as reportable conduct.[38]
- The scheme legislation in New South Wales and the Australian Capital Territory expressly provide for conduct that is *not* reportable conduct and give examples.[39]
- There are differences in the guidance material content published by reportable conduct scheme operators to support organisations to meet their obligations. Only the Australian Capital Territory provides guidance about how the use of 'restrictive intervention' may constitute ill-treatment.[40] Only Victoria provides guidance about interviewing children in relation a reportable conduct allegation.[41]

Functions and powers of reportable conduct scheme operators

- Though variously described, the bodies administering reportable conduct schemes in New South Wales, Victoria, the Australian Capital Territory, Western Australia and Tasmania have:
    - a function to monitor relevant entities' reportable conduct systems and compliance with their obligations[42]
    - an educative function to build the capacity of organisations within the scheme to deal with reportable conduct[43]
    - a function to oversee/monitor investigations of reportable allegations[44]
    - the power to compel entities within the scheme to provide certain information[45]
    - the power to directly investigate an allegation of reportable conduct and/or an organisations' response to such.[46]
- Under all the schemes, except for the Tasmanian scheme, the scheme operator has power to exempt certain conduct from being reportable conduct.[47] This is intended to facilitate 'class or kind' agreements with entities.[48] In Victoria and Western Australia, the scheme operator can also exempt certain entities from the reportable conduct scheme.[49]
- All schemes are subject to different annual reporting requirements.[50]

Notification timeframes

The timeframe within which entities must notify reportable allegations varies among the schemes. It can range from within three business days of the day the head of the entity becomes aware of the allegation (Victoria and Tasmania) to within 30 days of the day the head of the entity becomes aware (Australian Capital Territory).[51] The schemes in New South Wales and Western Australia require notification within seven business days of the day the head of entity becomes aware of the allegation.[52]

6.3. Data about children and young people with disability

There is limited published data about the extent to which children with disability are the alleged victims of reportable conduct. The type of data that each reportable conduct scheme operator must publicly report varies.

In New South Wales, the OCG's most recent annual report indicated that 344 (around one-fifth) of the alleged victims were reported to have disability. Of those, 46 per cent (159) were the alleged victims in notifications of assault.[53]

The NSW Ombudsman's 2017 report, *Inquiry into behaviour management in schools: Special report to Parliament*,[54] included the following data arising from a review of reportable conduct matters handled in 2016 to inform its inquiry:[55]

- In 2016, the Ombudsman finalised 1,132 reportable conduct matters. Of these, 26 per cent involved a child with disability or additional support needs.
- Of the finalised reportable conduct matters involving all schools, 12 per cent (41 out of 388 notifications) involved a child with disability or with additional support needs.
- The overall sustained rate for notifications relating to the schools sector is 23 per cent. The overall sustained rate for notifications involving children with disability or with additional support needs relating to the schools sector is 10 per cent.
- Of 1,527 open reportable conduct matters, 10 per cent involve criminal charges. Of these, 12 per cent involve a child with disability or with additional support needs.
- 49 per cent of the matters involving criminal charges involve employees from the schools sector. Of these, 5 per cent involve a child with disability or with additional needs.

The NSW Ombudsman's 2017 report, *The JIRT Partnership: 20 years on*, reported that 29 per cent of all notifications of reportable conduct which were closed in 2013–2014 and 2014–2015 involved a child with disability or child with additional support needs.[56]

The annual reports of the Commissioner for Children and Young People (CCYP), the reportable conduct scheme operator in Victoria, include data about the number and percentage of alleged victims of reportable conduct with disability (except in 2019–2020). It includes allegations notified by disability services since 2017–2018, together with the allegation type

and numbers of allegations substantiated. The CCYP's most recent annual report includes the following data:

- Since the scheme started in 2017, the disability services sector has been responsible for 3 per cent of notifications of reportable allegations.[57] Most (59 per cent) reportable allegations in the disability services sector have involved physical violence, followed by sexual misconduct (13 per cent), significant neglect of a child (10 per cent), sexual offences (9 per cent) and behaviour causing significant emotional/psychological harm to a child (8 per cent).[58]
- In 2021–2022, organisations subject to the scheme identified 14 per cent[59] of the 1,309 alleged victims[60] as having disability.
- The rate of sustained allegations for the disability services sector since the start of the scheme is 20 per cent, compared with the overall substantiation rate of 29 per cent for all sectors.[61]

The annual reports of the ACT Ombudsman, the reportable conduct scheme operator in the Australian Capital Territory, do not include any reportable conduct data in relation to disability. The scheme in Western Australia has not operated for enough time to be the subject of annual reporting and the Tasmanian scheme is yet to commence.

Reportable conduct data provided directly to the Royal Commission by the OCG and the CCYP are presented in section 6.4.

6.4. What we heard about reportable conduct

Reportable conduct scheme operators

The Commonwealth Ombudsman administers the reportable conduct scheme in the Australian Capital Territory in its role as ACT Ombudsman. The Ombudsman said reportable conduct schemes are an example of a successful safeguarding model. This was 'particularly in an environment where multiple service providers are operating, to set high standards and reporting obligations on those providers, in turn overseen by a regulatory body'.[62]

The Ombudsman suggested an effective reportable conduct scheme depends on independent oversight, a clear description of jurisdiction, information sharing and collaboration with other oversight bodies and regulators. It also requires building capacity of designated entities, flexibility of engagement with designated entities, raising public awareness through education and data-based publications and reporting. In a submission, the Ombudsman stated:

> The [Reportable Conduct Scheme] is an important safeguard because it places an obligation on, and supports, designated entities to develop and implement practices and procedures to identify, investigate, respond to and prevent allegations of reportable conduct and reportable convictions.[63]

In response to our *Violence and abuse of people with disability at home issues paper*, the OCG provided reportable conduct data about 'in-home' abuse by employees against children with disability.[64] Of a total 2,420 matters reported, one-third (807) of the primary alleged victims were known to have disability. Of those 807 matters, almost 70 per cent (561) of allegations related to out-of-home care (OOHC), followed by residential care (182) and voluntary OOHC (27). Alleged victims with disability in care were most likely to be the subject of physical assault (332), followed by neglect (185), sexual misconduct (108), ill-treatment (108), sexual offence (55) and psychological harm (14). In 40 per cent of matters involving alleged victims with disability, there were known to have been multiple alleged incidents prior to the alleged abuse being reported. Additionally, 276 of the alleged victims with disability identified as First Nations people and 60 as culturally and linguistically diverse.[65]

The Children's Guardian in New South Wales, Mr Steve Kinmond, told us that 'there is scope for reportable conduct schemes to better respond to disability' by pursuing national consistency in relation to key aspects of the scheme.[66] These include:

- definitions for each form of reportable conduct, either in legislation or by policy
- best practice guidance for organisations within the schemes that address issues relevant to allegations against children with disability
- the collection, reporting and comparison of good quality data using a consistent definition of disability, on the number and percentage of:
    - alleged victims with disability, broken down by sector and allegation type
    - substantiated allegations involving victims with disability, broken down by sector and allegation type
    - criminally investigated allegations involving alleged victims with disability, broken down by sector and allegation type, and noting where convictions are recorded.

The Children's Guardian noted that 'ill-treatment' is a form of conduct that is particularly relevant to the treatment of children and young people with disability. The Guardian said, 'it would be beneficial for this form of conduct to be included in the definition of reportable conduct in all schemes'.[67] He observed:

> There would be considerable value generally in reportable conduct scheme regulators establishing an inter-jurisdictional community of practice, but with a specific focus on how we can work with agencies under our jurisdiction to identify and drive initiatives focused on effectively preventing and responding to allegations of violence, abuse, neglect and exploitation of children and young people with disability.[68]

The Children's Guardian said he intended to raise these issues of national consistency in overseeing reportable conduct matters with his counterparts in other jurisdictions.

We received submissions about lived experiences of the reportable conduct scheme in New South Wales. One woman told us her young child was subjected to serious abuse by staff at

the early intervention unit of a public school and has post-traumatic stress as a result. She said a formal complaint to the Department of Education was not classified as reportable conduct. She was critical of the 'class or kind' determination allowing the department to not notify certain matters that would otherwise be reportable conduct, to the NSW Ombudsman.[69] In her submission she also expressed 'deep concerns as to the NSW Department of Education's investigative processes and accountability of their Employee Performance and Conduct Directorate (EPAC)'.[70] In another submission, an individual who supports a person with disability was similarly critical about public schools being able to 'self-report' incidents of abuse in a way that excludes them from being categorised and scrutinised as reportable conduct.[71]

The CCYP provided us with data about reportable allegations and substantiations involving children and young people with disability. The CCYP reported between 1 July 2017 and 30 June 2019:

- nine per cent of all reportable allegations were recorded as involving a child with disability. Of the matters completed at 30 June 2019, 25 per cent of these allegations involving a child with disability were substantiated compared to 31 per cent of reportable allegations involving all children.[72]
- almost 60 per cent of allegations involving a child with disability involved physical violence compared to 49 per cent of all allegations.[73] Of the physical violence allegations involving a child with disability finalised by 30 June 2019, almost one third were found to be substantiated, slightly lower than the 35 per cent substantiation rate for all physical violence allegations.[74]
- the OOHC sector had the highest proportion of allegations involving children recorded as having a disability (47 per cent). Of the matters completed by 30 June 2019, 17 per cent of allegations in the OOHC sector were substantiated, almost half the substantiation rate for matters involving all children for the same period (31 per cent). Most of the substantiated matters related to physical violence.[75]

The CCYP has received numerous instances of substantiated reportable conduct against students with disability in Victorian schools:[76]

- From 1 July 2017 to 30 June 2019, six per cent of the allegations of reportable conduct received from the education sector involved a child or young person recorded as having a disability. Of these allegations, 55 per cent related to physical violence.[77]
- In this period, nearly half (47 per cent) of all completed reportable conduct matters involving children with disability in the education sector were substantiated. This was considerably higher than the overall substantiation rate for the scheme during the same period (31 per cent).[78]
- For matters finalised by 30 June 2019, half of the allegations of physical violence involving children with disability were substantiated – considerably higher than the substantiation rate for physical violence allegations across the whole scheme to 30 June 2019 (35 per cent).[79]

The CCYP said it was concerned by the 'serious nature' of the substantiated physical violence.[80]

Experiences of reportable conduct

At Public hearing 16, 'First Nations children with disability in out-of-home care', 'IL' described being abused by his carer, leading him to have suicidal thoughts.[81] Kobie Hicks gave evidence at Public hearing 17, 'The experience of women and girls with disability with a particular focus on family, domestic and sexual violence', about being sexually assaulted as a child while living in foster care placements.[82] Elizabeth (Libby) Crawford spoke about being sexually assaulted at the age of 12 while attending a school for children with disability.[83]

At Public hearing 24, 'The experience of children and young people with disability in different education settings', Brittney Wilson spoke about her brother, James, being subjected to ill-treatment by school staff.[84] Alexa told us about her daughter, Bridget, being pushed down by two staff members, causing her head to hit the floor.[85]

At Public hearing 27, 'Conditions in detention in the criminal justice system', we heard about the mistreatment of young people at Banksia Hill Detention Centre, including the use of solitary confinement, physical and emotional abuse, and medical and educational neglect.[86] The stories of Nathan and Maison are included in Chapter 3, 'Optional Protocol to the Convention Against Torture'. We also heard from young people and their parents about the use of restrictive practices in school settings during Public hearing 7, 'Barriers experienced by students with disability in accessing and obtaining a safe, quality and inclusive school education and consequent life course impacts'. In a submission, Sharon and Michael Carmac, the parents of a person with disability, told the Royal Commission of their support for the implementation of a reportable conduct scheme in Queensland.[87]

Restrictive practices

The use of restrictive practices for people with disability is discussed in detail in Volume 6, *Enabling autonomy and access.* Definitions of restrictive practice vary by jurisdiction and sector. The definition adopted by the National Disability Insurance Scheme (NDIS) is 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability'.[88] For the purposes of this *Final report*, we have also used this definition of restrictive practices.

There are gaps and inconsistencies in the authorisation of restrictive practices across different sectors and jurisdictions (including OOHC, schools and juvenile detention centres).

The unauthorised use of a restrictive practice for a child is not included in any scheme's definition of reportable conduct. However, depending on the nature of the restrictive practice (and other factors such as whether use of the restrictive practice is authorised), it may fall within different categories of reportable conduct in each jurisdiction. Those categories are:

- 'ill-treatment' in New South Wales
- 'ill-treatment or neglect' in the Australian Capital Territory

- ‘significant neglect’ in Victoria, Western Australia and Tasmania, and
- ‘behaviour causing significant emotional or psychological harm’ in all schemes except in the Australian Capital Territory, where the potentially relevant category is ‘behaviour causing significant psychological harm’.

The ACT Ombudsman is the only reportable conduct scheme operator whose reportable conduct guidelines for organisations explicitly advises that ‘inappropriate restrictive intervention’ may be a type of ‘ill-treatment’.

We heard concerns about the use of restrictive practices for children during our public hearings on education. Public hearing 7 highlighted a lack of oversight and regulation around the use of restrictive practices against children with disability in educational settings.[89] Several witnesses spoke about their experiences of restrictive practices in education settings.[90] We heard that the school attended by ‘Sam’ classified restraint as a reasonable adjustment for Sam’s disability.[91] Advocates also discussed instances of restrictive practices they knew of.[92] Cecile Elder of Family Advocacy described an incident where a child was pinned to the ground in ‘a prone position by multiple staff members at school’.[93]

Following Public hearing 7, we found that there has been insufficient progress towards addressing the lack of regulation of restrictive practices in education settings in Australia. Coupled with the absence of a clear, agreed definition of what constitutes a ‘restrictive practice’, this placed children with disability at significant risk of harm.[94] We also reached a finding that ‘Sam’s’ school had inappropriately identified restraint of Sam and other students as a reasonable adjustment.[95]

We heard further evidence about the use of restrictive practices at schools during Public hearing 24. Edward Croft described the use of a protective isolation room for his son, Ryan.[96] Ryan’s parents felt they had ‘no choice’ but to accept this practice.[97]

In its submission, the CCYP noted that the use of restraint and seclusion in schools may constitute reportable conduct and that school policy documents should be clear about their obligations under the reportable conduct scheme.[98] The CCYP said it has previously expressed concern about a lack of reference in the Department of Education’s restraint and seclusion policy, guidelines and principles, to the potential interaction between the use of restraint and seclusion and the reportable conduct scheme.[99] Emma Hall, the parent of a child with disability in Victoria, told us that her child was physically restrained and locked in a room at school by two staff members. She said the incident was reported to the CCYP as reportable conduct but the allegations were not substantiated. Ms Hall was critical of the reportable conduct process, stating that the CCYP ‘allowed the school to investigate themselves and obviously the school came back with findings that suited their own agenda’.[100]

The OCG told the Royal Commission that there should be consistent consideration by all reportable conduct schemes as to when unauthorised uses of restrictive practices involving a child with disability should be deemed to be ‘ill-treatment’.[101]

In response to our *Education and learning issues paper*, Family Advocacy expressed support for Proposal 28 in the NSW Ombudsman's 2017 report, *Inquiry into behaviour management in schools: Special report to Parliament*.[102] The report observed that 'significant concerns exist in relation to the actual and/or potential ill-treatment of students with disability in schools'.[103] Proposal 28 stated that the Department of Education:

> should focus on ways in which it can enhance its complaint and reportable conduct practices to better identify and track the use of restrictive practices; consistently examine complaints and reportable conduct matters relating to the use of these practices in the context of the national agenda aimed at reducing their use; and where restrictive practices are used, ensuring that their use is consistently and competently reviewed against 'best practice' policies and procedures.[104]

The NSW Ombudsman also noted that 'there is no specific legislative framework regulating the use of restrictive practices, such as physical restraint or seclusion, in schools in NSW'.[105] It observed examples of the use of restrictive practices occurring in a highly unregulated manner.[106] It also identified the need for clear guidance to staff and school communities about the use of seclusion and restraint and called for 'greater rigour' in how critical events involving restrictive practices are responded to, reported and monitored.[107]

6.5. Nationally consistent reportable conduct schemes that are responsive to disability

Ensuring national coverage of schemes

We note the evidence we heard about violence, abuse, neglect and exploitation experienced by children with disability and the research about their increased risk of abuse and harm, particularly in institutional settings. We also note the Child Abuse Royal Commission observation about the benefits of reportable conduct schemes and its recommended nationally consistent reportable conduct schemes should be established. Against this background, we recommend that the governments of Queensland, South Australia and the Northern Territory join other states and territories in establishing reportable conduct schemes to better safeguard children with disability and all other children.

Explicit inclusion of disability services in all schemes

The Child Abuse Royal Commission specifically recommended that disability services and supports for children with disability should be included in reportable conduct schemes.[108] It stated that this should include NDIS service providers.[109]

It might be argued that reportable conduct against children with disability that occurs in disability organisations is captured by the reportable incident scheme operated by the NDIS Commission. Registered NDIS providers must notify 'reportable incidents' that occur in connection with the provision of supports or services to a person (including a child) with disability. Reportable

incidents include serious injury, abuse or neglect of a person with disability, as well as unlawful sexual or physical contact with a person with disability, sexual misconduct against or in the presence of a person with disability, and the unauthorised use of a restrictive practice in relation to a person with disability. These incidents may also be 'reportable conduct' if the notifying organisation falls within the jurisdiction of a reportable conduct scheme.

Notwithstanding that the NDIS Commission provides external oversight of registered NDIS providers, the reportable incident scheme is not equivalent to a reportable conduct scheme. While NDIS providers must appropriately respond to reportable incidents, they are not necessarily required to investigate an incident or reach a finding as to whether conduct occurred (as reportable conduct schemes require). An NDIS provider is not required to provide the NDIS Commission with a copy of any investigation report or the findings of the investigation. These are both standard requirements under reportable conduct schemes.

In our view, requiring reportable conduct schemes to explicitly include organisations that provide disability services to children, including NDIS providers, avoids any potential doubt or gaps. It would also achieve the outcome intended by the Child Abuse Royal Commission. We recommend that the governments of New South Wales and the Australian Capital Territory amend their reportable conduct legislation accordingly. Having recommended that Queensland, South Australia and the Northern Territory establish reportable conduct schemes as a priority, we further recommend the inclusion of disability services that provide services or supports to children with disability in these schemes.

Including 'ill-treatment' in the definition of reportable conduct

The Child Abuse Royal Commission said that nationally consistent reportable conduct schemes should be based on the approach adopted in New South Wales.

Section 23 of the *Children's Guardian Act 2019* (NSW)[110] defines 'ill-treatment' as 'conduct towards a child that is unreasonable and seriously inappropriate, improper, inhumane or cruel'. It lists the examples of making excessive or degrading demands of a child, a pattern of hostile or degrading comments or behaviour towards a child, and using inappropriate forms of behaviour management towards a child.[111]

We agree with the view expressed by the OCG that serious ill-treatment of a child 'is particularly relevant to the treatment of children and young people with disability' and that 'it would be beneficial for this form of conduct to be included in the definition of reportable conduct in all schemes'.[112] We consider ill-treatment to be the category of conduct that is most likely to capture the unauthorised use of restrictive practices against children with disability – particularly if explicit guidance about this is provided to organisations. Including ill-treatment in the definition of reportable conduct (in legislation or policy) would also faithfully implement the Child Abuse Royal Commission's recommendation that schemes should be based on the approach in New South Wales.

Guidance on issues relevant to children with disability

Reportable conduct legislation is authoritative. However, in practice, organisations rely heavily on guidance resources published by scheme operators to help them meet their reportable conduct obligations. While all reportable conduct scheme operators provide a range of guidance resources, there is scope to enhance guidance about issues relevant to children with disability, including:

- the rights of children with disability to live free of violence, abuse, neglect and exploitation
- examples of conduct towards children with disability that may amount to reportable allegations, including when the unauthorised use of restrictive practices should be treated as an allegation of reportable conduct
- securing the safety of the child with disability, providing related support and other risk management considerations
- identifying and notifying the disability status of children who are the alleged victims of reportable conduct
- facilitating children with disability's participation in the reportable conduct investigation process. That includes identifying and meeting support needs and obtaining evidence from children with cognitive impairment and/or communication needs
- providing reportable conduct information to children with disability in a way that meets their particular needs and circumstances
- handling allegations of reportable conduct that are also 'reportable incidents' notifiable to the NDIS Commission.

Reportable conduct scheme operators should agree to develop broadly consistent guidance resources that address these areas. More broadly, we agree with the OCG's suggestion that it would be beneficial for reportable conduct scheme operators to establish a 'community of practice' to work with organisations to prevent and respond to violence against, and abuse, neglect, and exploitation of, children with disability.[113]

Improving advice about the use of restrictive practices

Prior to this Royal Commission, disability advocates expressed the view that reportable conduct schemes do not provide adequate oversight over the use of restrictive practices.[114] In section 6.3 we observed that the unauthorised use of a restrictive practice is not included in any scheme's definition of reportable conduct but that it may potentially be notified as reportable conduct under various other categories. Despite this, the ACT Ombudsman would appear to be the only reportable conduct scheme operator that explicitly advises organisations in its guidance material that 'inappropriate restrictive intervention' may be a type of 'ill-treatment'.[115]

Against this background, organisations are required to exercise professional judgment to determine if the unauthorised use of a restrictive practice is a reportable allegation. This process

is considerably complicated by the gaps and inconsistencies that apply to the authorisation of restrictive practices across different sectors and jurisdictions. Public hearing 7 in particular highlighted a lack of oversight and regulation around the use of restrictive practices against children with disability in educational settings.

In New South Wales the legislation does define 'using inappropriate forms of behaviour management towards a child' as an example of 'ill-treatment'.[116] However, there is considerable room for organisations to subjectively interpret what constitutes 'inappropriate behaviour management'. This is because the legislation also states that reportable conduct does not include 'conduct that is reasonable for the purposes of discipline, management or care of a child, having regard to the age, maturity, health or other characteristics of the child, and any relevant code of conduct or professional standard'. In this regard, some disability advocates have suggested that 'disability is frequently interpreted as one of these "other characteristics of the child"':[117]

> A child with autism, for example, might become overstimulated and react violently, with a teacher then responding violently in turn. The use of what is euphemistically called 'physical restraint' often involves behaviour that would count as physical violence if a child without disability were subject to it. However, because this conduct is interpreted as 'reasonable for the purposes of discipline, management or care of children,' it may not be reported.[118]

Dr Lisa Bridle gave evidence at Public hearing 2, 'Inclusive education in Queensland – preliminary inquiry', that school staff sometimes construe the use of restrictive practices as 'reasonable management' of a student's behaviour.[119] Dr Bridle reported instances of school staff physically restraining students with disability, including children being tied to chairs or locked in their wheelchairs.[120]

As noted in the previous section, the OCG has proposed that it would be beneficial for 'serious ill-treatment of a child' to be included in the definition of reportable conduct for all schemes. It also proposed schemes in all jurisdictions should consistently consider when unauthorised uses of restrictive practices involving a child with disability should be deemed to be 'ill-treatment'.[121] We further note the NSW Ombudsman's previous recommendation about the need for staff and school communities to receive clear guidance about the use of seclusion and restraint,[122] and the CCYP's view that school policy documents should clearly identify the potential interaction between the use of restraint and seclusion and the reportable conduct scheme.

We consider it essential that, at a minimum, reportable conduct scheme operators provide guidance resources for organisations to support them to have a practical understanding of the intersection between the use of restrictive practices and reportable conduct. Guidance must cover the authorisation, use and oversight of restrictive practices in relevant sectors in each jurisdiction. It should clarify the 'trigger' for notifying use of a restrictive practice as an allegation of reportable conduct in these different contexts. In developing the guidance, reportable conduct scheme operators should ideally partner with relevant bodies and experts, including the NDIS Commission and senior practitioner roles, and organisations representing children with disability.

Collecting and reporting better data about children with disability

Despite the capacity for reportable conduct schemes to be a rich source of data, there is poor visibility of the extent to which children with disability are alleged victims of reportable conduct and how institutions respond to allegations that involve them.[123]

Research commissioned by the Child Abuse Royal Commission highlighted the need for 'routine and reliable identification of disability in administrative data sets'.[124] Our own commissioned research about the nature and extent of violence against, and abuse, neglect and exploitation of, people with disability emphasised there is 'an urgent need' to consider its prevalence and type in relation to children and young people.[125] During Public hearing 7, academic witnesses commented on the paucity of publicly available data about students with disability in particular. They noted the lack of an evidence base presents challenges in addressing barriers to safe, quality and inclusive education for students with disability.[126]

Presently, the reportable conduct scheme in New South Wales publishes limited annual data about trends in relation to children with disability and the scheme in the Australian Capital Territory publishes none. In contrast, the CCYP in Victoria routinely publishes certain data about disability and reportable conduct in their annual report. This includes the number and percentage of alleged victims with a disability, and the number and percentage of allegations notified by disability services, together with the allegation type and numbers of allegations substantiated. However, the CCYP does not publish data about the allegations involving children with disability across sectors, such as schools, with similar breakdowns.

There are several important reasons why scheme operators should collect and publish comprehensive and consistent data about disability and reportable conduct. These include:

- contributing to building the evidence base about the nature and extent of abuse and harm experienced by children with disability, particularly within different institutional settings
- publicly holding sectors to account for the volume and type of allegations involving children with disability they generate and the quality of the responses
- helping reportable conduct scheme operators to identify, from the outset, when an organisation may require additional guidance or support to provide appropriate support to a child with disability through the investigation process
- assisting reportable conduct scheme operators (and sectors) to identify where further capacity building may be needed to strengthen the prevention and response to reportable conduct involving children with disability – and to target their resources accordingly
- allowing comparisons to be made across different jurisdictions with a view to identifying and promoting best practice nationally.

The Royal Commission agrees with the OCG's view about the need to improve the quality and consistency of data that reportable conduct schemes capture about disability. The OCG said this data should be disaggregated by allegation type and sector and include children with disability alleged to be victims of reportable conduct, and substantiated and criminally investigated reportable allegations involving children with disability.[127]

Adopting a common definition of 'disability'

The OCG noted that it requires organisations to provide data about disability using the definition of disability applied by the Nationally Consistent Collection of Data on School Students with Disability (NCCD), when notifying an allegation.[128] The NCCD breaks disability into four categories – physical, cognitive, sensory, and social/emotional. Schools, which account for a significant proportion of all allegations of reportable conduct, are familiar with the NCCD definition but consultations identified it would be appropriate for use by other sectors.[129]

To facilitate the collection of comparable, quality data, we believe reportable conduct scheme operators should agree to a common definition of 'disability', having regard to the discussion in Volume 12, *Beyond the Royal Commission* about the importance of a nationally consistent approach to collecting and reporting disability information and related considerations.

Dual oversight of reportable conduct and incidents

In section 6.4 we noted that reportable incidents notifiable to the NDIS Commission may also be 'reportable conduct' if the NDIS provider falls within the jurisdiction of a reportable conduct scheme. Where this is the case, providers are required to notify the reportable incident or reportable conduct allegation in a way that meets two sets of legislative requirements governed by two different bodies.

In its submission, the OCG observed that:

> With the transition to the NDIS, [voluntary out-of-home care] agencies registered with the NDIS have new reporting requirements to the NDIS Quality and Safeguards Commission. This is additional to the reporting requirements for Reportable Conduct matters (those involving employee to child matters). There is confusion among organisations about these different reporting requirements and what to do when something happens. The OCG has received several calls for support in navigating reporting requirements. The OCG has been working with organisations to understand the changes in the sector in terms of reporting requirements and increasing awareness for the Child Safe Standards.[130]

It is desirable for reportable conduct scheme operators to work cooperatively with other regulators of entities that fall under the reportable conduct scheme, including the NDIS Commission.

The legislation governing reportable conduct schemes in Victoria and Tasmania has provisions that specifically address cooperation with other regulators to avoid unnecessary duplication of oversight. Applicable 'regulators' must be legislatively prescribed in Victoria. The NDIS Commission is not a prescribed regulator in Victoria. In Tasmania, where the scheme has yet to commence, the reportable conduct 'regulator' is responsible for determining who the prescribed entity regulators are.

The NDIS Commission has information sharing agreements with a number of state and territory government agencies and oversight bodies, including the ACT Ombudsman,[131] and the NSW Ombudsman.[132] However, these information agreements do not go further than stating that each agency may request certain specified information of the other in relation to reportable conduct or reportable incidents. In other words, they do not address how the agencies will work together to avoid unnecessary duplication of oversight and enhance intelligence gathering about NDIS providers. We were not provided with agreements between the NDIS Commission and other reportable conduct scheme operators outlining similar provisions.[133]

Without an authoritative 'lever' encouraging reportable conduct scheme operators and the NDIS Commission to take a cooperative approach to exercising their respective functions, it is less likely they will share relevant information. The potential to create inefficiencies that burden all organisations involved (including organisations with notifying obligations) will also be greater.

The NDIS Commission and reportable conduct scheme operators should work together to jointly develop guiding principles that support the efficient and effective handling of reportable incidents that are also allegations of reportable conduct. The guiding principles should address:

- communication at key stages of respective oversight processes and the nature of information that should be shared (for example at the point of notification and final reporting stage, including to inform NDIS compliance functions)
- decision-making in relation to when it may be appropriate for one agency to take the 'lead role' in liaising with a disability service provider about a matter that is both a reportable incident and reportable conduct, and/or to provide them with coordinated directions or feedback
- processes for streamlining 'dual reporting' requirements and otherwise reducing the administrative burden on disability service providers.

In jointly developing the guiding principles, the NDIS Commission and reportable conduct scheme operators should identify and take steps to address any limitations in their scheme's governing legislation (including rules and regulations), impacting their ability to exchange information for the purpose of exercising their respective functions and promoting a coordinated approach to oversight.

Recommendation 11.17 Nationally consistent reportable conduct schemes

States and territories should:

a. establish reportable conduct schemes, where not already in place, in accordance with Recommendation 7.9 of the Royal Commission into Institutional Responses to Child Sexual Abuse and make public their intended timeframe for doing so

b. take action to harmonise their reportable conduct schemes

c. introduce or amend existing legislation to:

- ensure disability service providers that deliver supports or services to children with disability, including NDIS providers, are included in their reportable conduct scheme
- include 'ill-treatment' in the definition of reportable conduct
- enable reportable conduct scheme operators to adopt a common definition of disability
- require reportable conduct scheme operators to collect and publicly report consistent data about reportable conduct notifications and outcomes relating to children with disability.

Recommendation 11.18 Dual oversight of reportable conduct and incidents

State and territory reportable conduct scheme operators and the NDIS Quality and Safeguards Commission should:

a. jointly develop guiding principles to support the efficient and effective handling of reportable incidents that are also allegations of reportable conduct

b. develop broadly consistent guidance material to assist organisations to better understand key issues relevant to notifying, managing and investigating allegations of reportable conduct and incidents involving children with disability.

Endnotes

1 Centre of Research Excellence in Disability and Health, *Research Report: Nature and extent of violence, abuse, neglect and exploitation against people with disability in Australia,* Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, March, 2021, p 20.

2 Joel Koh, Gayatri Kemhavi-Tam & Vanessa Rose, Centre for Evidence and Implementation, and Rebecca Featherson & Aron Shlonsky, Monash University, *Rapid Evidence Review – Violence, abuse, neglect and exploitation of people with disability*, Report prepared for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, August 2021, pp 16–17.

3 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper: Institutional Responses to Child Sexual Abuse in Out-of-Home Care*, March 2016, p 17.

4 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation Paper: Institutional Responses to Child Sexual Abuse in Out-of-Home Care*, March 2016, p 18.

5 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, p 27.

6 It is important to note that the Child Abuse Royal Commission focused on issues relating to child sexual abuse rather than issues of particular relevance to the maltreatment of children with disability.

7 Since March 2020, the NSW Reportable Conduct Scheme has been administered by the Office of the Children's Guardian on commencement of the *Children's Guardian Act 2019* (NSW). Prior to this, the NSW Ombudsman administered the scheme.

8 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, p 259.

9 *Ombudsman Act 1989* (ACT) Pt 2, Div 2.2A; *Child Wellbeing and Safety Act 2005* (Vic) Pt 5A.

10 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, p 263.

11 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, pp 261–62.

12 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, Recommendation 7.9, p 24.

13 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, p 282.

14 Royal Commission into Institutional Responses to Child Sexual Abuse, *Improving institutional responding and reporting*, Final report, Volume 7, December 2017, p 242.

15 *Child and Youth Safe Organisations Act 2023* (Tas) Pt 4, s 32.

16 SA Government Department for Child Protection, *Royal Commission into Institutional Responses to Child Sexual Abuse 2022 recommendation status*, 2022, p 7; NT Government, *Initial response to the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse*, June 2018.

17 Queensland Government, *Queensland Government response to the Royal Commission into Institutional Responses to Child Sexual Abuse*, June 2018, p 29.

18 Queensland Government, *Queensland Government fourth annual progress report – Royal Commission into Institutional Responses to Child Sexual Abuse*, December 2021, p 26.

19 Reportable conduct schemes involve conduct engaged in by an employee of a relevant or designated entity. In New South Wales, the *Children's Guardian Act 2019* (NSW) provides that a 'relevant entity' for the purposes of the reportable conduct scheme includes a public authority or religious body, or an entity listed in Schedule 1: *Children's Guardian Act 2019* (NSW) s 12. An entity in Schedule 1 of *Children's Guardian Act 2019* (NSW) includes 'that part of the Department of Communities and Justice comprising the group of staff who are principally involved in the administration of an Act administered by the Minister for Families, Communities and Disability Services'. In the Australian Capital Territory, the *Ombudsman Act 1989* (ACT) provides that a 'designated entity' for the purposes of the reportable conduct scheme includes an 'administrative unit' (Directorate) of the ACT Government: *Ombudsman Act 1989* (ACT) s 17EA. Since the establishment of the NDIS, the majority of disability services are no longer funded or delivered by state governments.

20 Previously known as voluntary out-of-home care in New South Wales.
21 *Children's Guardian Act 2019* (NSW) Schedule 1; *Ombudsman Act 1989* (ACT) s 17EA.
22 NSW Ombudsman, *Strengthening the oversight of workplace child abuse allegations: A Special Report to Parliament under s.31 of the* Ombudsman Act 1974, February 2016, Chapter 4.
23 In Victoria, volunteers and contractors are covered regardless of whether they are engaged to provide services to children. In New South Wales, allegations against volunteers and contractors only need to be notified if the volunteer or contractor holds a WWCC or is required to hold a WWCC for the purpose of their work with the entity. Similarly, in the Australian Capital Territory and Western Australia, allegations against volunteers only need to be notified if the volunteer or contractor is engaged to provide services to children.
24 *Children's Guardian Act 2019* (NSW) s 20; *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Ombudsman Act 1989* (ACT) s 17E; *Parliamentary Commissioner Act 1971* (WA) s 19G.
25 *Children's Guardian Act 2019* (NSW) s 20(a)–(b); *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Ombudsman Act 1989* (ACT) s 17E(1)(b)(ii)(B)–(iii)(B); *Parliamentary Commissioner Act 1971* (WA) s 19G(1)(a)–(b); *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(a)–(b).
26 *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(d).
27 *Children's Guardian Act 2019* (NSW) ss 20(e), 25; *Parliamentary Commissioner Act 1971* (WA) s 19G(1)(c); *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(c).
28 *Ombudsman Act 1989* (ACT) s 17E(1)(b)(iii)(A).
29 *Children's Guardian Act 2019* (NSW) s 20(c)–(d).
30 The scheme in Western Australia is subject to a staged rollout. 'Significant neglect' will be included in the definition of reportable conduct from 1 January 2024.
31 *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Parliamentary Commissioner Amendment (Reportable Conduct) Act 2022* (WA) s 26; *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(f); *Ombudsman Act 1989* (ACT) s 17E(1)(b)(i).
32 *Children's Guardian Act 2019* (NSW) ss 23, 24.
33 *Children's Guardian Act 2019* (NSW) s 23.
34 *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(e)–(f). Section 3(1) of the *Child Wellbeing and Safety Act 2005* (Vic) defines 'significant', 'in relation to emotional or psychological harm or neglect', as meaning 'that the harm or neglect is more than trivial or insignificant, but need not be as high as serious and need not have a lasting permanent effect'. Section 7(1) of the *Child and Youth Safe Organisations Act 2023* (Tas) defines 'significant', 'in relation to emotional or psychological harm or neglect', as meaning 'that the harm or neglect is more than trivial or insignificant, but is not required to be deemed serious or deemed to have a lasting permanent effect'.
35 *Child and Youth Safe Organisations Act 2023* (Tas) s 7(1).
36 *Children's Guardian Act 2019* (NSW) s 20(g); *Parliamentary Commissioner Amendment (Reportable Conduct) Act 2022* (WA) s 26; *Child Wellbeing and Safety Act 2005* (Vic) s 3(1), definition of 'reportable conduct'; *Child and Youth Safe Organisations Act 2023* (Tas) s 7(2)(e).
37 *Ombudsman Act 1989* (ACT) s 17E(1)(b)(ii)(A).
38 *Children's Guardian Act 2019* (NSW) s 20(f).
39 *Children's Guardian Act 2019* (NSW) s 41; *Ombudsman Act 1989* (ACT) s 17E(2).
40 ACT Ombudsman, *ACT Ombudsman Practice Guide No.2: Identifying Reportable Conduct*, version 2.1, June 2022, pp 4–6.
41 *Child Wellbeing and Safety Act 2005* (Vic) s 16R.
42 *Children's Guardian Act 2019* (NSW) Part 4 s 54, Part 3A Child Safe Scheme, Div 5 Monitoring; *Child Wellbeing and Safety Act 2005* (Vic) Part 5A, s 16G(h); *Ombudsman Act 1989* (ACT) s 17F(1); *Parliamentary Commissioner Act 1971* (WA) s 19M(1)(a), (h)–(i); *Child and Youth Safe Organisations Act 2023* (Tas) s 22(a), (g).
43 *Child Wellbeing and Safety Act 2005* (Vic) s 16G(a)–(b); *Parliamentary Commissioner Act 1971* (WA) s 19M(1)(b); *Child and Youth Safe Organisations Act 2023* (Tas) s 22(b)–(c).
44 *Children's Guardian Act 2019* (NSW) s 43; *Child Wellbeing and Safety Act 2005* (Vic) ss 16G(c), 16W; *Ombudsman Act 1989* (ACT) s 17I; *Parliamentary Commissioner Act 1971* (WA) s 19M(1)(d); *Child and Youth Safe Organisations Act 2023* (Tas) ss 22(d), 30.

45 *Children's Guardian Act 2019* (NSW) ss 42, 45; *Child Wellbeing and Safety Act 2005* (Vic) s 16V; *Ombudsman Act 1989* (ACT) s 17F(2); *Parliamentary Commissioner Act 1971* (WA) s 19S(1)–(2); *Child and Youth Safe Organisations Act 2023* (Tas) ss 23(a), 29(1).

46 *Children's Guardian Act 2019* (NSW) ss 46–48; *Child Wellbeing and Safety Act 2005* (Vic) ss 16G(d)–(e), 16O; *Ombudsman Act 1989* (ACT) s 17K; *Parliamentary Commissioner Act 1971* (WA) ss 19M(1)(e)–(f), 19ZB–19ZE; *Child and Youth Safe Organisations Act 2023* (Tas) ss 22(e)–(f), 24.

47 *Children's Guardian Act 2019* (NSW) s 30; *Child Wellbeing and Safety Act 2005* (Vic) s 16I; *Ombudsman Act 1989* (ACT) s 17G(3); *Parliamentary Commissioner Act 1971* (WA) s 19N(1).

48 'Class or kind' determinations enable regulators to exempt certain entities from notifying reportable allegations, while requiring them to still take action to respond to the allegations.

49 *Child Wellbeing and Safety Act 2005* (Vic) s 16J; *Parliamentary Commissioner Act 1971* (WA) s 19O(1).

50 *Children's Guardian Act 2019* (NSW) ss 136, 138, 139; *Child Wellbeing and Safety Act 2005* (Vic) s 16ZL; *Parliamentary Commissioner Act 1971* (WA) ss 27–28; *Child and Youth Safe Organisations Act 2023* (Tas) ss 22(j), 60.

51 *Child Wellbeing and Safety Act 2005* (Vic) s 16M(1)(a); *Child and Youth Safe Organisations Act 2023* (Tas) s 34(1)(a); *Ombudsman Act 1989* (ACT) s 17G(2).

52 *Children's Guardian Act 2019* (NSW) s 29(4); *Parliamentary Commissioner Act 1971* (WA) s 19U(2).

53 NSW Office of the Children's Guardian, *Annual Report 2021-22,* October 2022, p 35.

54 NSW Ombudsman, *NSW Ombudsman inquiry into behaviour management in schools: A Special Report to Parliament under s 31 of the* Ombudsman Act 1974, August 2017.

55 NSW Ombudsman, *NSW Ombudsman inquiry into behaviour management in schools: A Special Report to Parliament under s 31 of the* Ombudsman Act 1974, August 2017, p 66.

56 NSW Ombudsman, *The JIRT Partnership - 20 years on*, Report to Parliament, August 2017, p 248.

57 Commission for Children and Young People (Victoria), *Annual Report 2021–22*, September 2022, pp 83–84 (Table 14. Notifications of reportable allegations received by sector 2017–22).

58 Commission for Children and Young People (Victoria), *Annual Report 2021–22*, September 2022, pp 87–88 (Table 16. Reportable allegations by sector and type of reportable conduct 2017–22).

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60 Commission for Children and Young People (Victoria), *Annual Report 2021–22*, September 2022, p 95.

61 Commission for Children and Young People (Victoria), *Annual Report 2021–22*, September 2022, p 105 (Table 25. Substantiation rate of reportable conduct incidents by sector 2017–22).

62 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 9.

63 Commonwealth Ombudsman, Submission in response to *Safeguards and quality issues paper*, 15 February 2021, ISS.001.00561, p 10.

64 NSW Office of the Children's Guardian, Submission in response to *Violence and abuse of people with disability at home issues paper*, 18 March 2021, ISS.001.00590, p 5. Data finalised over a five-year period from 1 July 2015 to 30 June 2020, filtered to consider only those in which the primary alleged victim is known to have disability. This data is high-level and is only as accurate as the information provided by relevant entities. Also impacting the data are designated agencies' Class or Kind Agreements, which means the OCG does not receive all assault allegations from these relevant entities – it only receives those above a certain threshold. Furthermore, it is not compulsory for relevant entities to provide information regarding alleged victims (AVs) having disability, identifying as First Nations peoples or being culturally or linguistically diverse. The numbers are therefore not indicative of the total number of AVs with these characteristics but is instead indicative of the number of AVs about whom these characteristics are known.

65 NSW Office of the Children's Guardian, Submission in response to *Violence and abuse of people with disability at home issues paper*, 18 March 2021, ISS.001.00590, p 5.

66 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, pp 10–11.

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76 Victorian Commission for Children and Young People, Submission in response to *Education and learning issues paper*, 18 March 2020, ISS.001.00066_01, p 4.
77 Victorian Commission for Children and Young People, Submission in response to *Education and learning issues paper*, 18 March 2020, ISS.001.00066_01, p 4.
78 Victorian Commission for Children and Young People, Submission in response to *Education and learning issues paper*, 18 March 2020, ISS.001.00066_01, p 5.
79 Victorian Commission for Children and Young People, Submission in response to *Education and learning issues paper*, 18 March 2020, ISS.001.00066_01, p 5.
80 This reportable conduct included incidents of staff: pulling and pushing children, often while yelling at them; placing a child in a headlock; slapping a child on the head or wrist; pulling a child to the ground and forcefully holding them there; dragging a child along the ground; kicking a child; yelling abuse at a child and punching furniture; pinching a child, leaving scratches and bruising; and deliberately throwing a ball to hit a child multiple times. Victorian Commission for Children and Young People, Submission in response to *Education and learning issues paper*, 18 March 2020, ISS.001.00066_01, p 17.
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83 Transcript, Elizabeth (Libby) Crawford, Public hearing 17.2, 31 March 2022, P-222 [7–18]; P-225 [16–28].
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88 *National Disability Insurance Scheme Act 2013* (Cth) s 9.
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Acronyms and abbreviations

ADC – Ageing and Disability Commission (NSW)

ADEs – Australian Disability Enterprises

Afford – Australian Foundation for Disability

AHPRA – Australian Health Practitioners Regulatory Agency

AHRC – Australian Human Rights Commission

AIHW – Australian Institute of Health and Welfare

ALRC – Australian Law Reform Commission

ANROWS – Australia's National Research Organisation for Women's Safety

ASU – Adult Safeguarding Unit (SA)

CCYP – Commissioner for Children and Young People (Vic)

Child Abuse Royal Commission – Royal Commission into Institutional Responses to Child Sexual Abuse

COAG – Council of Australian Governments

COVID-19 – Coronavirus disease 2019

CRPD – Convention on the Rights of Persons with Disabilities

CRPD Committee – United Nations Committee on the Rights of Persons with Disabilities

CSC – (former) Community Services Commission (NSW)

CVS – Community visitor schemes

DHS – South Australian Department of Human Services

DSC – Disability Services Commissioner (Vic)

DSS – Commonwealth Department of Social Services

EPAC – NSW Department of Education Employee Performance and Conduct Directorate

Incident Management and Reportable Incidents Rules – National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 (Cth)

Joint Standing Committee – Joint Standing Committee on the NDIS

LiveBetter – LiveBetter Services Limited

LWB – Life Without Barriers

NCCD – Nationally Consistent Collection of Data on School Students with Disability

NDDA – National Disability Data Asset

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 – Commissioner of the NDIS Commission

NDIS Framework – National Disability Insurance Scheme Quality and Safeguarding Framework

NGOs – Non-governmental organisations

NPMs – National Preventive Mechanisms

OAG – OPCAT Advisory Group

OCG – Office of the Children's Guardian (NSW)

OCV – Official Community Visitor scheme (NSW)

OICS – Office of the ACT Inspector of Custodial Services

OOHC – Out-of-home care

OPA – Office of the Public Advocate

OPCAT – Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Own Motion Inquiry – NDIS Quality and Safeguards Commission, Own Motion Inquiry into Aspects of Supported Accommodation in the National Disability Insurance Scheme, dated January 2023

Robertson Review – 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, dated 31 August 2020

Safeguarding Task Force – The Safeguarding Task Force established on 21 May 2020 by the SA Minister for Human Services with responsibility to examine and report quickly on gaps and areas that need strengthening in safeguarding arrangements for people with disabilities living in the State.

Scoping Review - Carmela Salomon & Julian Trollor, A scoping review of causes and contributors to deaths of people with disability in Australia: Findings, Report of the Department of Developmental Disability Neuropsychiatry, Faculty of Medicine, University of New South Wales, dated August 2019

SDA – Specialist Disability Accommodation

SIL – Supported Independent Living

SPT – United Nations Subcommittee on the Prevention of Torture

SRS – Supported residential services

The hotline – The National Disability Abuse and Neglect Hotline

WestWoodSpice Review report – Community Visitor Schemes Review, Department of Social Services for the Disability Reform Council, Council of Australian Governments, dated December 2018

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Exploitation of People with Disability