| No. | Proposed Finding and CS reference | LWB position |
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| **Issues related to Lismore** | | |
| | ***Support provided to Sophie by LWB* – CS [82]-[106]** | |
| 1. | LWB's care of Sophie was, in certain respects, inadequate [106(a)]. | LWB accepts Proposed Finding 1. |
| 2. | LWB did not provide adequate communication to Sophie or her parents about the level and type of support to be provided [106(b)]. | LWB accepts Proposed Finding 2. |
| 3. | LWB did not properly assess compatibility with existing residents when determining to accept Lucy into the home [130(a)]. | LWB accepts Proposed Finding 3. |
| 4. | LWB did not consult with or notify existing residents/ their families in determining whether to accept Tyler and Lucy in the home [130(b)]. | LWB accepts Proposed Finding 4. |
| 5. | LWB's failure to consult with existing residents and to properly assess resident compatibility constituted a contravention of LWB policy [130(c)]. | LWB accepts Proposed Finding 5. |
| 6. | LWB knew that Sophie wished to have intimate (including sexual) relationships [156(a)]. | LWB accepts Proposed Finding 6. |
| 7. | LWB took inadequate steps to facilitate Sophie's goal of having safe intimate and sexual relationships (for example, allowing Sophie's fiancé to sleep overnight) [156(b)]. | LWB accepts Proposed Finding 7. |

| No. | Proposed Finding and CS reference | LWB position |
|---|---|---|
| 8. | LWB did not provide, or facilitate the provision of, appropriate sex and relationship education that recognised Sophie's goals to experience romantic and intimate relationships, and which reflected the identified gaps in her knowledge and understanding of the risks associated with pursuing these particular goals [171]. | LWB submits that instead of Proposed Finding 8, the following alternative finding is available on the evidence:<br><br>*LWB could have done more to provide and facilitate the provision of appropriate sex and relationship education to Sophie. However, the evidence indicates that staff took Sophie's desire to explore sexuality, intimacy and relationships seriously, and endeavoured to provide and facilitate the provision of support and education to Sophie on these issues.* |
| 9. | LWB's Relationship Rules did not respect Sophie's dignity of risk and privacy and did not appropriately support her right to intimacy [196(a)]. | LWB submits that Proposed Finding 9 ought to be modified as follows:<br><br>*LWB's Relationship Rules did not <u>sufficiently</u> respect Sophie's dignity of risk and privacy and did not <u>sufficiently</u> ~~appropriately~~ support her right to intimacy.* |
| 10. | LWB's Relationship Rules had the real potential of creating unsafe situations for Sophie and undermined her sense of having a real home [196(b)]. | LWB accepts Proposed Finding 10. |
| 11. | After Sophie's sexual assault, LWB staff provided inadequate support to her and did not respond appropriately to her changing needs over the following 18 months [209(a)]. | LWB submits that instead of Proposed Finding 11, the following alternative finding is available on the evidence:<br><br>*Whilst LWB did provide support to Sophie in the aftermath of the sexual assault, LWB should have done better in supporting Sophie and her family. For instance, Sophie should have been provided with a key support worker at LWB who she could go to when needed and it should have been explained to her why certain workers could not engage with her in discussions about the sexual assault.* |
| 12. | LWB did not properly debrief or provide guidance to their staff about how best to support Sophie in the aftermath of the sexual assault [209(b)]. | LWB accepts Proposed Finding 12. |

| No. | Proposed Finding and CS reference | LWB position |
|---|---|---|
| 13. | The sexual assault and its connection to the Relationship Rules should have been reported to the Board, in particular for consideration as to whether there should be any review of systematic issues (such as training or amendment of policies) and/ or whether an apology should be made to Sophie and her family or other remedial action taken [219(a)]. | LWB submits that instead of Proposed Finding 13, the following alternative finding is available on the evidence:<br><br>*The sexual assault on Sophie should have been recorded in LWB's incident management system; an internal investigation conducted; and the incident ought to have been escalated internally to senior executive management, including to the Chief Executive Officer, for consideration of any actions that should be taken in response, including:*<br><br>- *whether the incident reflected the existence of any systemic issues that might need to be addressed through measures such as enhancements to training or amendment of policies;*<br>- *whether to report the sexual assault to the Board of LWB as a case study, to assist the Board in performing its functions of monitoring and oversight; and/or*<br>- *whether an apology should be made to Sophie and her family or other remedial action.* |
| 14. | LWB failed to adequately train Sophie's support workers in respect of her behaviours of concern and behaviour support plans [236(a)]. | LWB submits that instead of Proposed Finding 14, the following alternative finding is available on the evidence:<br><br>*Training of LWB Worker 2 was inadequate in respect of Sophie's behaviour support plans and behaviours of concern. In relation to the incidents with Sophie in March 2019, LWB could have done more to ensure Sophie's behaviour support plans were being adhered to and better promote client and staff welfare.* |
| 15. | LWB Worker 1 responded to Sophie in an inappropriate manner [236(b)]. | LWB accepts Proposed Finding 15. |
| 16. | LWB did not take action in respect of the deficiencies identified in the document entitled 'Operational and systemic issues identified during the investigation' [236(c)]. | LWB accepts Proposed Finding 16. |

| No. | Proposed Finding and CS reference | LWB position |
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| 17. | The Relationship Rules were within the scope of the documents sought by the NSW Ombudsman in his email dated 20 March 2018 [247(a)]. | LWB accepts Proposed Finding 17 (except the date should be 2 February 2018). |
| 18. | LWB failed to provide the Relationship Rules to the NSW Ombudsman pursuant to that email [247(b)]. | LWB accepts Proposed Finding 18. |
| 19. | LWB failed to promptly act to remove LWB Worker 3 from working at the Lismore house and from other work in the community with other LWB clients [296(a)]. | LWB accepts Proposed Finding 19. |
| 20. | LWB failed to immediately report these allegations about LWB Worker 3 to the State Director and executive [296(b)]. | LWB accepts Proposed Finding 20. |
| 21. | LWB failed to apologise to Natalie or her family for the conduct of LWB Worker 3 [296(c)]. | LWB accepts Proposed Finding 21. |
| 22. | LWB failed to consider whether deficiencies in staff training contributed to LWB Worker 3's conduct and/or to the failure of LWB workers to report LWB Worker 3's conduct at an earlier time [296(d)] | LWB accepts Proposed Finding 22. |
| 23. | LWB failed to take timely action to ensure that all staff in the Lismore house were properly trained in preventing and recognising sexual abuse following the conduct of LWB Worker 3 [296(e)]. | LWB accepts Proposed Finding 23. |
| 24. | LWB failed to inform Natalie of her right to obtain legal advice in respect of her possible entitlement to compensation [296(f)]. | LWB accepts Proposed Finding 24. |
| 25. | Following LWB Worker 3's sexual misconduct towards Natalie, LWB repeatedly assured Jennifer that personal care would not be performed by male carers, and repeatedly failed to comply with those assurances [318(a)]. | LWB accepts Proposed Finding 25. |
| 26. | LWB failed to communicate with Jennifer when it became apparent that its assurances that personal care would not be performed by male carers could not or would not be met [318(b)]. | LWB submits that Proposed Finding 26 is not available on the evidence before the Commission. |

| No. | Proposed Finding and CS reference | LWB position |
|---|---|---|
| 27. | LWB's failures to comply with its assurances and to communicate when such assurances could not be met exacerbated the trauma suffered by Natalie and Jennifer as a result of the sexual misconduct of LWB Worker 3 [318(c)]. | LWB submits that Proposed Finding 27 ought to be modified as follows:<br>*LWB's failures to comply with its assurances ~~and to communicate when such assurances could not be met~~ exacerbated the trauma suffered by Natalie and Jennifer as a result of the sexual misconduct of LWB Worker 3.* |
| 28. | LWB failed to keep complete records (in relation to the dose of Movicol) in the lead-up to Natalie's hospitalisation [335(a)]. | LWB accepts Proposed Finding 28. |
| 29. | LWB failed to keep proper records (specifically, bowel charts for Natalie) from 1 December 2019 to 29 February 2020, and from 10 March 2020 to 31 May 2020 [335(b)]. | LWB submits that Proposed Finding 29 ought to be modified as follows:<br>*LWB failed to keep proper records (specifically, bowel charts for Natalie) from 1 December 2019 to 29 February 2020~~ and from 10 March 2020 to 31 May 2020~~.* |
| 30. | LWB failed to respond appropriately after Natalie's hospitalisation. Specifically, LWB did not acknowledge their past failure to complete bowel charts and failed to respond to Jennifer's concerns about this failure [335(c)]. | LWB accepts Proposed Finding 30. |
| 31. | LWB failed to treat the lead up to and hospitalisation of Natalie as a reportable incident that should have been reported as such to the NDIS Commission [335(d)]. | LWB submits that Proposed Finding 31 is not available on the evidence before the Commission. |
| 32. | LWB failed to support Natalie in preparing a budget during the period from 2013 to 2017, when LWB had effective control over Natalie's discretionary spending. As such, LWB failed to support Natalie in pursuing her independence [359(a)]. | LWB submits that Proposed Finding 32 is not available on the evidence before the Commission. |
| 33. | LWB inadequately supported Natalie in preparing a budget during the period from 2017 onwards [359(b)]. | LWB submits that Proposed Finding 33 is not available on the evidence before the Commission. |

| No. | Proposed Finding and CS reference | LWB position |
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| 34. | LWB failed to properly communicate with Jennifer about Natalie's discretionary spending. This failure occurred both before and after 2017, but was particularly acute from 2017 onwards, when Anna and Jennifer became Natalie's joint financial managers [359(c)]. | LWB submits that Proposed Finding 34 is not available on the evidence before the Commission. |
| 35. | The Department alone was responsible for selecting the initial residents of the Melbourne house in 2011 [514(a)]. | LWB accepts Proposed Finding 35. |
| 36. | When selecting the initial residents, the Department did not adequately assess their compatibility with one another [514(b)]. | LWB accepts Proposed Finding 36. |
| 37. | The Department and LWB had joint responsibility in assessing ongoing compatibility of residents, with LWB responsible for the day-to-day monitoring and assessment of resident compatibility [514(c)]. | LWB accepts Proposed Finding 37. |
| 38. | LWB failed to take adequate steps to:<br>i. properly assess the ongoing compatibility of residents in the house<br>ii. notify the Department of ongoing incompatibility of residents in the house<br>iii. submit a reconfiguration request to the Department to respond to the ongoing incompatibility of residents in the house [514(d)]. | LWB submits that instead of Proposed Finding 38, the following alternative finding is available on the evidence:<br>*During the period from early 2015 to 30 October 2020, LWB failed to take adequate steps to:*<br>*(a) properly assess Katie's ongoing compatibility with the other residents of the Melbourne House;*<br>*(b) notify the Department of Katie's ongoing incompatibility; and*<br>*(c) submit a reconfiguration request to the Department to respond to Katie's ongoing incompatibility* |
| 39. | LWB and the Department failed to consult with existing residents and/or their families regarding: i. ongoing compatibility of residents ii. compatibility of new residents proposed for the house, including Katie [514(e)] | LWB accepts Proposed Finding 39(i).<br>LWB submits that instead of Proposed Finding 39(ii), the following alternative finding is available on the evidence:<br>*LWB failed to consult with the existing residents and/or their families regarding the compatibility of Katie before Katie moved into the Melbourne House.* |

| No. | Proposed Finding and CS reference | LWB position |
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| 40. | LWB's failure to consult with existing residents and/or their families about ongoing compatibility of residents and compatibility of proposed new residents for the house, including Katie, did not comply with its own policies [514(f)]. | LWB submits that, instead of Proposed Finding 40, the following alternative finding is available on the evidence:<br>*LWB's failure to consult with the existing residents and/or their families about Katie's compatibility before Katie moved into the Melbourne House and on an ongoing basis, did not comply with its own policies.* |
| 41. | Prior to 2014 when Katie moved into the house:<br>i. She had resided at different supported accommodation in Melbourne that was managed by LWB.<br>ii. ii. LWB was aware that Katie exhibited behaviours of concern, including physically aggressive behaviour [514(g)]. | LWB accepts Proposed Finding 41. |
| 42. | LWB failed to fully complete the Service Reconfiguration Request Form and Vacancy Profile that it submitted in early 2014 to the Department about Katie as a proposed new resident of the house [514(h)]. | LWB accepts Proposed Finding 42. |
| 43. | The Department failed to adequately assess resident compatibility when it:<br>i. reviewed LWB's Service Reconfiguration Request Form and Vacancy Profile about Katie in early 2014<br>ii. approved Katie's placement in the house in early 2014 [514(i)]. | LWB neither accepts nor rejects Proposed Finding 43 but makes short submissions as to context. |
| 44. | Some of the residents in the Melbourne house were incompatible [514(j)]. | LWB accepts Proposed Finding 44. |
| 45. | That incompatibility caused some of the resident-to-resident violence and conflict in the house [514(k)]. | LWB submits that instead of Proposed Finding 45, the following alternative finding is available on the evidence:<br>*The unpredictable behaviours of concern of some residents may have given rise to some of the resident-to-resident violence and conflict in the Melbourne House.* |

| No. | Proposed Finding and CS reference | LWB position |
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| 46. | The incompatibility of residents had a negative effect on all of the residents of the house, their families and LWB staff working at the house [514(l)]. | LWB accepts Proposed Finding 46. |
| 47. | There was a high frequency of resident-to-resident violence and conflict in the house between 2011 and 2020 [565(a)]. | LWB submits that instead of Proposed Finding 47, the following alternative finding is available on the evidence:<br>*Between 2011 and 2020, there were 61 recorded incidents of resident-to-resident violence and conflict between residents at the Melbourne house.*<br>If, contrary to the above, the Commission is minded to make a finding as proposed by Counsel Assisting, LWB respectfully submits it ought to be limited to a date range of 2013 to 2020. |
| 48. | The resident-to-resident violence and conflict in the house included:<br>i. verbal abuse and threats<br>ii. intimidation and harassment<br>iii. objects being thrown or used as implements to strike others<br>iv. physical assaults that resulted in bruises, cuts and wounds and, at least on one occasion, a fracture [565(b)]. | LWB accepts the evidence supports Proposed Finding 48 in modified form as follows (which employs factual language to avoid characterisation of residents with behaviours of concern as perpetrators of violence):<br>*The resident-to-resident violence and conflict in the house included:*<br>*~~(a) verbal abuse and threats;~~*<br>*~~(b) intimidation and harassment;~~*<br>*(a) yelling, screaming and using language that was likely to have caused the other residents to be fearful, scared and/or intimidated;*<br>*(b) objects being thrown or used as implements to strike others; and*<br>*(c) physical assaults that resulted in bruises, cuts and wounds and, at least on one occasion, a fracture.* |

| No. | Proposed Finding and CS reference | LWB position |
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| 49. | The resident-to-resident violence and conflict in the house had adverse effects on all of the residents and LWB staff in the house [565(c)]. | LWB submits that Proposed Finding 49 ought to be modified as follows:<br><br>*The resident-to-resident violence and conflict in the house had adverse effects on all of the residents and <u>some</u> LWB staff in the house.* |
| 50. | LWB house staff, Disability Support Coordinators, Team/Practice Leaders and Program Managers for the Melbourne house were aware of resident-to-resident violence and conflict in the house between 2011 and 2020 and that it was having adverse effects on residents and LWB staff in the house [565(d)]. | LWB submits that Proposed Finding 50 ought to be modified as follows:<br><br>*LWB house staff, Disability Support Coordinators, Team/Practice Leaders and Program Managers for the Melbourne house were aware of resident-to-resident violence and conflict in the house between ~~2011~~ <u>2013</u> and 2020 and that it was having adverse effects on residents and <u>some</u> LWB staff in the house.* |
| 51. | LWB's Operations Manager and CEO were aware of resident-to-resident violence and conflict in the house and that it was having adverse effects on residents and LWB staff in the house from August 2013 [565(e)]. | LWB accepts Proposed Finding 51. |
| 52. | LWB failed to consistently, and in a timely fashion, communicate to residents' families that incidents of resident-on-resident violence had happened in the house [565(f)]. | LWB accepts the substance of Proposed Finding 52, but submits it ought to be modified as follows:<br><br>*LWB failed to ~~consistently, and in a timely~~ ~~fashion,~~ communicate to residents' families <u>in a consistent and timely fashion</u> that resident-to-resident violence and conflict had happened in the house.* |
| 53. | LWB did not take timely or adequate action to reduce or eliminate resident-to-resident violence and conflict in the house [565(g)]. | LWB submits that Proposed Finding 53 ought to be modified as follows:<br><br>*LWB did not take <u>sufficiently</u> timely or adequate action to reduce ~~or eliminate~~ resident-to-resident violence and conflict in the house.* |
| 54. | LWB did not adequately train or support LWB house staff, who worked directly with the residents, to reduce or eliminate resident-to-resident violence and conflict in the house [565(h)]. | LWB submits that Proposed Finding 54 ought to be modified as follows: |

| No. | Proposed Finding and CS reference | LWB position |
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| | | ~~*LWB did not adequately*~~ *The train<u>ing</u> or support <u>provided to</u> LWB house staff, who worked directly with the residents, to reduce ~~or eliminate~~ resident-to-resident violence and conflict in the house <u>was not always effective in reducing such incidents.</u>* |
| 55. | At times there were not enough staff to adequately support and supervise residents in the house and this had adverse effects on the residents [607(a)]. | LWB submits that Proposed Finding 55 ought to be modified as follows:<br>~~*At times*~~ *<u>On some occasions</u>, there were not enough staff to adequately support and supervise residents in the house ~~and this had adverse effects on the residents.~~* |
| 56. | There was a high turnover of disability support workers at the house [607(b)] | LWB submits that Proposed Finding 56 is not available on the evidence before the Commission. |
| 57. | There was a high turnover of LWB management personnel responsible for the house, particularly, Disability Support Coordinators, Team/Practice Leaders and Program Managers [607(c)]. | LWB submits that Proposed Finding 57 is not available on the evidence before the Commission. |
| 58. | There was inadequate support and leadership from LWB management for disability support workers at the house, particularly in respect of adequate staffing levels, managing residents' behaviours of concern, responding to resident-to-resident violence and giving staff enough time to do critical paperwork during their shifts [607(d)]. | LWB submits that Proposed Finding 58 ought to be modified as follows:<br>*<u>In the period 2013 to 2015</u>, there was <u>at times</u> inadequate support and leadership from LWB management for disability support workers at the house, ~~particularly~~ in respect of ~~adequate staffing levels,~~ managing residents' behaviours of concern~~,~~ <u>and</u> responding to resident-to-resident violence ~~and giving staff enough time to do critical paperwork during their shifts~~.* |

| No. | Proposed Finding and CS reference | LWB position |
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| 59. | Some disability support workers were not adequately trained or qualified to support residents with high support needs and/or with behaviours of concern [607(e)]. | LWB submits that instead of Proposed Finding 59, the following alternative finding is available on the evidence:<br><br>*LWB provided training or support to disability support workers to support residents with high support needs and/or with behaviours of concern.*<br><br>*However, at times in the period 2013 - 2015, some LWB disability support workers were not adequately trained to support residents with high support needs and/or with behaviours of concern.* |
| 60. | The high turnover of disability support workers and the inadequate support and leadership of LWB management had adverse effects on the residents [607(f)]. | LWB submits that instead of Proposed Finding 60, the following modified finding is available on the evidence:<br><br>*At times, the ~~high~~ turnover of disability support workers and the ~~inadequate~~ level of support ~~and leadership~~ of LWB management may have had adverse effects on the residents.* |
| 61. | LWB excessively relied on agency and casual disability support workers at the house, which had an adverse impact on residents [607(g)]. | LWB submits that instead of Proposed Finding 61, the following alternative finding is available on the evidence:<br><br>*At times during the period 2013 to 2020, LWB used agency and casual disability support workers to address contingencies such as: planned and unplanned staff leave, when additional staffing might be required and for staff shortages at the Melbourne house. Where those agency staff were unfamiliar, their presence may have had an adverse impact on residents.* |
| 62. | Agency and casual staff were not always familiar with the residents or their behaviour support plans and needs [607(h)]. | LWB accepts Proposed Finding 62 |
| 63. | Agency staff did not have access to LWB's 'policy centre' containing all LWB policies [607(i)]. | LWB accepts Proposed Finding 63 |
| 64. | LWB's communication to families of residents about the house and its residents was deficient [607(j)]. | LWB accepts Proposed Finding 64. |

| No. | Proposed Finding and CS reference | LWB position |
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| 65. | Families of the residents made a number of requests and complaints to LWB about the upkeep, cleanliness and maintenance of the house, in particular between 2016 and 2019. LWB failed to adequately respond to those requests and complaints, which had an adverse effect on the residents [636(a)]. | LWB submits that Proposed Finding 65 ought to be modified as follows:<br><br>*Families of the residents made a number of requests and complaints to LWB about the upkeep, cleanliness and maintenance of the house, in particular between 2016 and 2019. Aspects of LWB's responses to those requests and complaints were not adequate ~~failed to adequately respond to those requests and complaints~~, which had an adverse effect on the residents.* |
| 66. | From 8 June 2017 to 14 August 2017 the spa bath in the house didn't work and needed repair. For some of the same period, the bathroom could not be used and needed repair [636(b)]. | LWB submits that Proposed Finding 66 ought to be modified as follows:<br><br>*From 8 June 2017 to 14 August 2017 the spa bath in the house didn't work and needed repair. For some of the same period, one of the bathrooms could not be used and needed repair*. |
| 67. | From early October 2017 to 21 November 2017 the oven in the house did not work and needed repair [636(c)]. | LWB accepts Proposed Finding 67. |
| 68. | LWB failed to have in place an adequate system to ensure maintenance, upkeep and cleanliness concerns brought to its attention were responded to in a timely manner [636(d)]. | LWB submits that Proposed Finding 68 ought to be modified as follows:<br><br>*Between 2016 and 2019, LWB failed to have in place an adequate system to ensure maintenance, upkeep and cleanliness concerns brought to its attention were responded to in a timely manner at the Melbourne house*. |

| No. | Proposed Finding and CS reference | LWB position |
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| 69. | LWB's residential statements did not provide adequate information to residents, their families, guardians and/or carers about:<br>i. what specific services LWB was to provide to residents in the house<br>ii. how (if at all) residents' families, guardians and/or carers were to be involved in the care of residents<br>iii. what (if any) processes of communication and/or consultation there were to be between residents' families, guardians and/or carers and LWB [647(a)]. | LWB accepts Proposed Finding 69(i).<br>LWB submits the Commission should not make Proposed Findings 69(ii) and (iii). |
| 70. | LWB's service statements did not provide adequate information to residents, their families, guardians and/or carers:<br>i. what specific services LWB was to provide to residents in the house<br>ii. what (if any) processes of communication and/or consultation there were to be between residents' families, guardians and/or carers and LWB [647(b)] | LWB accepts Proposed Finding 70(i).<br>LWB submits the Commission should not make Proposed Finding 70(ii). |
| 71. | LWB did not keep adequate records of financial expenditure of the residents' money, including the fortnightly 'residential charge' taken out of residents' Disability Support Pensions [647(c)]. | LWB submits that the Commission should consider making a modified form of Proposing Finding 71 in the following terms:<br>*LWB did not keep ~~adequate~~ detailed records of specific financial expenditure of the resident's money, including the fortnightly 'residential charge' taken out of the residents' Disability Support Pensions.* |
| 72. | Ms Robbs was reluctant to accept that there had been any significant deficiency in the operations or services provided by LWB. It was only where evidence was irrefutable and undeniable that she was prepared to concede that there was a systematic failing in LWB's approach [658(a)]. | LWB submits that Proposed Finding 72 is not available on the evidence before the Commission. |
| 73. | Ms Robbs, as CEO of LWB, and LWB more generally, did not take a proactive approach to monitoring, detecting and/or rectifying deficiencies in the operations of LWB, but rather, responded to revelations about deficiencies as those revelations occurred [658(b)]. | LWB submits that Proposed Finding 73 is not available on the evidence before the Commission. |

| No. | Proposed Finding and CS reference | LWB position |
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| 74. | Ms Robbs' views as of the date of giving evidence indicates that, if confronted with identical circumstances to those involving Sophie's case, she would not regard that as a matter that she would automatically refer to the Board [658(c)]. | LWB submits that Proposed Finding 74 ought to be modified as follows<br><br>*Ms Robbs' views as of the date of giving evidence indicates that, if confronted with identical circumstances to those involving Sophie's case, she would not regard that as a matter that she would automatically refer to the Board but that if the same event were to happen today, it would be entered on to the incident system, assessed by the National Safeguarding Unit and would be managed differently.* |
| 75. | It would be open to the Royal Commission to find that LWB failed to provide Community Visitors with documentation required under s 130(1)(d) of the *Disability Act 2006* (Vic) [745]. | LWB submits that instead of Proposed Finding 75, the following alternative finding is available on the evidence:<br><br>*In the period 2011 to 2017 during which Community Visitors made 18 visits to the Melbourne House, on 2 occasions LWB did not provide Community Visitors with critical incident reports which they were entitled to access under s 130(1)(d) of the Disability Act 2006 (Vic). In the period following the introduction of i-Sight from December 2017 and up to 6 March 2020, whilst LWB staff made genuine attempts to facilitate access in critical incident reports throughout the period, there were instances when LWB did not provide Community Visitors with critical incident reports which they were entitled to access.* |
| 76. | In respect of Paul's complaint dated 4 November 2020 which was closed by the NDIS Commission on 1 October 2021, that the NDIS Commission did not subsequently monitor whether or not LWB completed its CHES update as its officer informed Paul it would do [737(a)]. | LWB makes no submissions in respect of Proposed Finding 76. |
| 77. | The NDIS Commission does not currently make available to quality auditors on a systematic basis information about complaints and reportable incidents relating to a registered NDIS provider that they are auditing [737(b)]. | LWB makes no submissions in respect of Proposed Finding 77. |
| 78. | In respect of 'the May 2019 reportable incident' involving Sophie, that: | LWB accepts Proposed Finding 78. |

| No. | Proposed Finding and CS reference | LWB position |
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| | i. One of LWB's key personnel was aware of this reportable incident on 26 March 2019.<br>ii. Pursuant to s 20(2) of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) LWB was required to notify the NDIS Commission of this incident within 24 hours (that is, by 27 March 2019).<br>iii. LWB did not notify the NDIS Commission within 24 hours, but rather, notified it on 13 May 2019 (48 days later).<br>iv. LWB did not comply with s 20(2) of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).<br>v. The NDIS Commission has not taken any compliance or enforcement action or any other action in respect of this delay in notification of 'the May 2019 reportable incident' by LWB [737(c)]. | |
| 79. | In respect of LWB's notification of 'the May 2019 reportable incident' ('Reportable incident 4-BDP29NT'), part of which identified Sophie as the impacted person, that:<br>i. The document entitled 'Operational and Systemic Issues Identified During the Investigation' was prepared by the same LWB officer who authored LWB's Final Investigation Report for reportable incident 4-BDP29NT on or about September 2019.<br>ii. That document was relevant to the NDIS Commission's oversight of reportable incident 4-BDP29NT.<br>iii. That document was not provided to the NDIS Commission by LWB as part of its response to the NDIS Commission's request for information and documents in relation to reportable incident 4-BDP29NT dated 17 July 2019.<br>iv. That document should have been provided to the NDIS Commission by LWB, pursuant to s 24(2) of the *National Disability Insurance* | LWB accepts Proposed Finding 79. |

| No. | Proposed Finding and CS reference | LWB position |
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| | *Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth).<br><br>v. The NDIS Commission relied solely on LWB to provide it with information and documents about reportable incident 4-BDP29NT and did not conduct any subsequent check of LWB's records to confirm whether it had, in fact, provided the NDIS Commission with all relevant information and documents in relation to the investigation and/or assessment reportable incident 4-BDP29NT as it requested and as is required by s 24(2) of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth) [737(d)]. | |
| 80. | In respect of part of Jennifer's June 2020 complaint concerning an allegation that LWB staff failed to seek medical attention sooner for Natalie prior to her becoming hospitalised with a serious bowel obstruction in March 2020, that:<br><br>i. This allegation constituted a reportable incident, being an allegation of 'neglect of a person with disability', as defined in s 73Z(4) of the *National Disability Insurance Scheme Act 2013* (Cth).<br><br>ii. The NDIS Commission failed, at the time, to identify this part of Jennifer's June 2020 complaint as an allegation of a reportable incident and also failed to request LWB to notify it accordingly so it could request and obtain relevant records.<br><br>iii. Despite acknowledging since 17 November 2021 that this part of Jennifer's June 2020 complaint constitutes a reportable incident, at the time of Public hearing 20, the NDIS Commission had not requested LWB to notify it accordingly or requested of LWB any relevant records, or taken any other action in respect of it [737(e)]. | LWB makes no submissions in respect of Proposed Finding 80. |
| 81. | At the time of Public hearing 20 the NDIS Commission (through its Commissioner and Acting Commissioner) had only initiated one inquiry into reportable incidents and/or complaints under its inquiry powers, namely the Supported Accommodation Inquiry, since its commencement [737(f)]. | LWB makes no submissions in respect of Proposed Finding 81. |