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

# Public Hearing **Report**

## Public hearing 14

Preventing and responding to violence, abuse, neglect and exploitation in disability services (South Australia)

Adelaide
7 to 11 June and
Virtual, 30 September 2021

**Commissioners**

The Honourable Ronald Sackville AO QC

Ms Barbara Bennet PSM

Mr Alastair McEwin AM

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# Preface

## Acknowledgment of Country

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, seas and waters of Australia, and pay respect to First Nations Elders past, present and emerging. We recognise First Nations peoples' care for people and country, including First Nations men and women whose words and voices led to the establishing of this Royal Commission. We also acknowledge the Traditional Custodians of the lands on which the Royal Commission's offices are based in Brisbane, Canberra and Sydney.

## Content warning

This report contains information that may be distressing to readers.

It includes accounts of violence against, and abuse, neglect and exploitation of, people with disability. If you need support to deal with difficult feelings after reading this report, there are free services available to help you.

Blue Knot Foundation offers specialist counselling support and a referral service for anyone affected by the Disability Royal Commission.

For support please call their national hotline on 1800 421 468 (they are open every day).

In addition to the Blue Knot Foundation, the Australian Government provides support to assist people to engage with the Royal Commission.

Further information about these supports, including how to access them, is available on the counselling and support section of our website.

Contact details for further resources are as follows:

- Lifeline: 13 11 14
- Beyond Blue: 1300 224 636

# Overview and summary

1. The Honourable Ronald Sackville AO QC (Chair), Ms Barbara Bennett PSM and Mr Alastair McEwin AM conducted Public hearing 14 in Adelaide from 7 to 11 June 2021, with an additional hearing day held virtually on 30 September 2021 for oral submissions (Public hearing 14 or the hearing). Public hearing 14 is one of a series of public hearings examining systemic issues concerning the manner in which disability service providers can or should prevent and respond to violence towards and abuse, neglect and exploitation of people with disability.

2. As observed in previous reports, the significance of this hearing and other similar hearings goes beyond investigations of the actions of specific service providers or regulatory bodies in particular situations. The Royal Commission intends its case studies to explore the practices and policies of government and non-government service providers, particularly as the practices and policies affect the health, wellbeing and human rights of participants in the National Disability Insurance Scheme (NDIS) and other clients of service providers.

3. Public hearing 14 was held in two parts. During the first part, the Royal Commission examined the experiences of 'Mitchell'[1] and Mr Daniel Rogers, who received disability accommodation services provided by the South Australian Department of Human Services (DHS) over about five years. The issues examined included:

    - the nature and quality of the services provided to Mitchell and Daniel Rogers
    - the responses of DHS when incidents occurred or complaints were made
    - how DHS communicated with and provided information to Mitchell and Daniel Rogers' families
    - the process of transitioning to different accommodation.

4. We have used 'Victoria' and 'James' as pseudonyms for Mitchell's guardians. The pseudonym 'N-Street' has been used to describe the location and name of Daniel Rogers' place of residence. We refer to Mitchell's home as the 'Residence'.

5. A number of themes concerning the provision of accommodation services emerged during this part of the hearing, including the need for:

    - a person-centred approach to the delivery of services, reflected in the culture of the residence
    - effective communication between service providers and people with disability and their families
    - adequate training, supervision and monitoring of staff
    - effective risk management policies and procedures.

1 A pseudonym.

6. The second part of Public hearing 14 focused on the South Australian and Australian governments' responses to the reports of two independent inquiries held following the death of Ms Ann-Marie Smith on 6 April 2020. Ms Smith was a South Australian resident and NDIS participant. She died in what have been described as 'appalling' circumstances after a substantial period of neglect.[2] Ms Smith's death shocked the community, and prompted reviews into safeguarding of people with a disability.

7. In the years leading up to Ms Smith's death, she lived by herself in her own home, and had a sole carer employed by a registered NDIS service provider.[3] A friend of Ms Smith, to whom we have given the pseudonym 'Brooke', gave evidence about Ms Smith's life before her death.

8. In addition to examining the key issues revealed by the two inquiries, the hearing addressed the responses of the DHS, NDIS Quality and Safeguards Commission (NDIS Commission) and National Disability Insurance Agency (NDIA) to the recommendations made by the inquiries.

2 Exhibit 14-216, DRC.2000.0008.0673, pp 4, 79.

3 Exhibit 14-216, DRC.2000.0008.0673, p 4.

## Findings

9. In this Report, the Commissioners make findings based on the evidence given during the first part of Public hearing 14. That evidence concerned, among other things:

    - The responses of DHS to an anonymous letter received on 3 March 2018 (3 March Letter) threatening harm to Mitchell when he lived at the Residence. These included two investigations:
        - the investigation by DHS commencing in April 2018 (First Investigation)
        - the investigation by DHS commencing in January 2021 (Second Investigation). This followed criticism by the South Australian Ombudsman of the adequacy of the First Investigation.[4]
    - DHS's responses to injuries sustained by Daniel on or about 18 February 2019 while he was a resident at N-Street.

10. We make a series of observations about the responses of agencies to the two reports considered in the second part of Public hearing 14, but we do not make findings based on the evidence concerning the responses. However, we record the key themes emerging from the evidence and identify matters for further investigation by the Royal Commission.

11. The findings are as follows:

### Mitchell's case study

**Finding 1**

- The South Australian Department of Human Services (DHS) did not take the 3 March Letter seriously enough. It failed to instigate a formal investigation into the identity of the author as soon as possible after becoming aware of the Letter. DHS failed to discharge its responsibility to take appropriate measures to find out the source of an apparently serious threat to the safety and wellbeing of a person with disability in its care.
- The failure to instigate a formal investigation in a timely fashion had significant consequences for the manner in which DHS handled the matter afterwards.

4 Exhibit 14-219, SOM.9999.0001.0001, pp 29-30.

**Finding 2**

The First Investigation conducted by DHS was seriously deficient in that:

- it was delayed unjustifiably
- the delay made it less likely that the author of the 3 March Letter would ever be identified
- it did not constitute a thorough investigation focused on identifying the author of the 3 March Letter.

**Finding 3**

The Second Investigation conducted by DHS was deficient in the methodology employed and the scope of the investigation. The investigation was not carried out in a thorough or satisfactory manner.

**Finding 4**

- DHS's failure to undertake thorough and competently conducted inquiries into the identity of the author of the 3 March Letter and the seriousness of the threat to Mitchell's safety and wellbeing caused Victoria and James significant distress and led to them losing trust and confidence in DHS.
- The breakdown of communication between DHS and Victoria and James over a lengthy period demonstrates the importance of open and effective communication in maintaining trust and confidence between the service provider and the family or supporters of the person with disability in the care of a service provider.

**Finding 5**

DHS's inadequate response to the 3 March Letter reflected a failure to adopt a person-centred approach focussing on Mitchell's safety and wellbeing in the Residence.

## Daniel Rogers' case study

**Finding 6**

DHS's response to the injuries sustained by Daniel Rogers and recorded in DHS's electronic incident database (known as Riskman) on 22 February 2019 was deficient in that:

- the information recorded in Riskman was inaccurate and contributed to a delay in DHS appreciating the seriousness of the injuries
- an official investigation into the circumstances in which Daniel Rogers sustained the injuries was not commenced in a timely manner
- DHS failed to seek an urgent medical opinion about the nature and likely cause of Daniel Rogers' injuries
- the investigation conducted by DHS's Incident Management Unit (IMU) was at best cursory and did not constitute a serious attempt to determine the cause of the injuries or the person or persons responsible.

**Finding 7**

Daniel Rogers experienced neglect when he resided at N-Street. His poor personal hygiene and grooming; the lack of care about his clothing and his choices about his purchases; and the unsatisfactory state of cleanliness and maintenance of the home reflected the absence of a person-centred approach by DHS at N-Street.

**Finding 8**

DHS failed to create an environment in the Residence and N-Street in which Mitchell and Daniel Rogers were kept as safe and well-supported as they should have been and as their families were entitled to expect. Too often DHS failed to adopt a person-centred approach at the Residence and N-Street.

**Finding 9**

There has been inadequate institutional accountability on the part of DHS for the failures experienced by Mitchell, Daniel Rogers and their families. This has prevented them from feeling that their concerns have been properly addressed, and that DHS has taken appropriate measures to acknowledge the impact on them of DHS's failures.

# Part 1: Introduction and background

## Public hearing 14

12. Public hearing 14 took place in Adelaide from 7 to 11 June 2021 with an additional hearing day held virtually on 30 September 2021 for oral submissions. Commissioner the Honourable Ronald Sackville AO QC (Chair) and Commissioners Barbara Bennett PSM and Alastair McEwin AM participated in the hearing.

13. Ms Kate Eastman AM SC was the Senior Counsel Assisting the Royal Commission. She appeared with Ms Elizabeth Bennett and Dr Hayley Bennett, instructed by the Office of the Solicitor Assisting the Royal Commission. The parties given leave to appear at Public hearing 14 and their legal representatives are set out at **Appendix A.**

14. Thirteen witnesses provided statements to the Royal Commission for Public hearing 14. Eleven of those witnesses also gave oral evidence. **Appendix B** contains a list of witnesses and the dates on which they gave evidence.

15. At the conclusion of the hearing, the Chair directed Counsel Assisting the Royal Commission to prepare written submissions. These submissions were provided to the parties given leave to appear on 6 August 2021.

16. Submissions in response were received on 10 September 2021 from the South Australian government, the Australian government, the South Australian Public Advocate and Principal Community Visitor, and Victoria and James (Mitchell's guardians). These submissions are available on the Royal Commission's website.[5]

17. On 30 September 2021, the Royal Commission heard oral submissions from Counsel Assisting the Royal Commission and the legal representatives of Victoria and James, the Australian government and the South Australian government. Mrs Karen Rogers, Daniel Rogers' mother, also addressed the Commissioners.

18. The Commissioners have considered the oral and written submissions in making the findings in this Report.

## Preparation of this Report

19. The three Commissioners who participated in Public hearing 14 have prepared this Report. Commissioners Rhonda Galbally AC, Andrea Mason OAM and John Ryan AM have read and commented on a draft of the Report. Their comments have been considered by the Commissioners responsible for the contents of the Report.

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5 'Public hearing 14, Adelaide – Responses to Counsel Assisting submissions', *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, web page. <https://disability.royalcommission.gov.au/publications/public-hearing-14-adelaide-responses-counsel-assisting-submissions>.

## Scope of the Report

20. This Report is organised into five Parts:

- Part 1 provides introductory comments.
- Part 2 addresses Mitchell's case study.
- Part 3 addresses Daniel's case study.
- Part 4 examines the investigative reports produced following the tragic death of Ms Ann-Marie Smith.
- Part 5 identifies key themes that emerged from the investigative reports and the responses of the NDIS Commission, NDIA and DHS to the recommendations in those reports. These themes relate to:
    - the identification of NDIS participants who are at heightened risk of violence, abuse, neglect and exploitation
    - the appropriate response once any NDIS participant is identified as being in a situation of heightened risk of abuse or neglect
    - information sharing arrangements between the state of South Australia, the NDIA, and the NDIS Commission.
- Part 6 identifies a number of areas for further investigation which emerged during Public hearing 14. These relate to:
    - factors used to identify people with disability who are at-risk of violence, abuse, neglect and exploitation
    - the central importance of a person-centred approach to delivery of services and supports for people with disability
    - whether a conflict of interest arises when a person receives support coordination and other support services from the same service provider, and the appropriate response to such a conflict
    - the significance of effective communication between service providers and people with disability in supported disability accommodation and their families
    - the mechanisms that should be used to ensure the provision of high quality services to people living in supported disability accommodation
    - the significance and continued operation of community visitor schemes following transition to the NDIS
    - the significance and continued operation of providers of last resort following transition to the NDIS.

21. A list of the acronyms and abbreviations used at the public hearing and in the submissions is set out in **Appendix C.**

## Factual findings and observations on the evidence

22. Although much of the evidence concerning the case studies of Mitchell and Daniel Rogers was not in dispute, there were certain disagreements or differences of perception among witnesses. We have not attempted to resolve all the conflicts, but we have made findings on some disputed matters. These include certain findings adverse to the interests of parties given leave to appear at the hearing.

23. None of the parties with leave to appear directly challenged the evidence given by Victoria, James or Karen Rogers. No submission was made that their evidence should not be accepted. We accept the evidence given by Victoria, James and Karen Rogers as reliable and credible.

## Approach to recommendations

24. Counsel Assisting submitted that it is premature for this Report to make recommendations about the provision of services for people with disability or about the role and functions of the NDIS Commission and the NDIA. Counsel Assisting pointed out that the Royal Commission proposes to conduct a number of hearings to examine the practices and policies of service providers and the role of the Australian government, state and territory bodies and regulators in monitoring the quality, safety and standards for the delivery of services.[6] We accept the submission.

25. Counsel Assisting identified a number of matters that the Royal Commission should investigate further, all of which are considered in this Report. These include:

- the role of the NDIS Commission and other regulators overseeing disability service providers
- the extent to which the NDIS Commission can or should rely on information from and investigations by those service providers when responding to complaints and/or reportable incidents
- the introduction of a national Community Visitor Scheme
- complaints systems that are more person-centred and trauma informed
- the extent to which people with disability who have high support needs have choice and control over where and with whom they live
- whether there is a conflict of interest where a participant receives support coordination and core NDIS supports from the same NDIS provider.[7]

6 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [320].

7 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [321].

26. Counsel Assisting submitted that the Royal Commission should made six recommendations in relation to two of the case studies examined in Public hearing 14 involving people with disability who received accommodation and support services from DHS.[8] In response to Counsel Assisting's proposed recommendations, South Australia outlined actions it had taken to implement the proposed recommendations.[9] In those circumstances we consider it is neither necessary nor appropriate to make the proposed recommendations in this Report.

## Terminology

27. Several witnesses at Public hearing 14 used the term 'vulnerable' when describing people with disability at heightened risk of neglect or abuse. The term was used in the two reports considered in Parts 4 and 5 of this Report.

28. Many disability advocates prefer not to use the word 'vulnerable' to describe people with disability because it implies a deficit on the part of people with disability. Advocates argue that people with disability are not inherently 'vulnerable', but may experience circumstances placing them at a greater risk of harm.[10] At Public hearing 14, then NDIS Commissioner Graeme Head agreed that the expression 'vulnerable' can imply an inherent deficit on the part of the person with disability. He stated that the NDIS Commission views vulnerability in the context of systems that identify and respond to risk, including risks arising from the nature of supports a person with disability receives.[11] We accept that language characterising a person with disability as vulnerable can wrongly imply that the disability is the cause of the heightened risk, rather than systemic failures or the attitudes or conduct of other people.

29. Accordingly, we use 'at risk' when describing people with disability whose circumstances make them more likely than other people with disability to experience violence, abuse, neglect or exploitation. We use the term 'vulnerable' only when quoting directly from other sources.

8 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [322].

9 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, Annexure A.

10 Transcript, Nicole Lee, Public hearing 5, 18 August 2020, P-13 [16–45]; Transcript, Rosemary Kayess, Public hearing 5, 18 August 2020, P-32 [44–47] – P-33 [2–33]; see also, Exhibit 14-216, DRC.2000.0008.0673, p 38.

11 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-300 [3–44].

## Human rights framework

30. As with all of the Royal Commission's work,[12] Public hearing 14 was informed by the human rights framework and Australia's obligations under the *Convention on the Rights of Persons with Disabilities* (*CRPD*).[13] We have referred at length to articles of the *CRPD* in other reports of Public hearings.[14]

31. While we are mindful of all the articles of the *CRPD*, including the General principles[15] and the General obligations,[16] two articles of the *CRPD* are of particular significance to the subject matter of Public hearing 14.

32. Article 19 of the *CRPD* provides:

> States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:
>
> a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

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12 *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019, 13 May 2021, 24 June 2021, preamble.

13 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

14 See, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 2: Inclusive education in Queensland – preliminary inquiry*, October 2020, [21–29]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 3: The experience of living in a group home for people with disability*, September 2020, [248–259]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 4: Healthcare for people with cognitive disability*, October 2020, [181–182]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 5: Experiences of people with disability during the ongoing COVID-19 pandemic*, November 2020, [32–40]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 6: Psychotropic medication, behaviour support and behaviour of concerns*, June 2021, [14–16]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 7: Barriers to accessing a safe, quality and inclusive school education and life course impacts*, November 2021, [47–71]; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 12: The experiences of people with disability, in the context of the Australia Government's approach to the COVID-19 vaccine rollout*, October 2021, [36–47].

15 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), art 3.

16 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), art 4.

b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

33. Article 28(1) of the *CRPD* provides:

> States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

# Part 2: Mitchell

> … so we're the family who have received the most appalling of letters, death threats to one of our loved ones, and nothing has been said by anybody, which I --- in any context, I consider that the … strangest of circumstances.[17]

34. Mitchell has Autism Spectrum Disorder and lives with an intellectual disability.[18] He has also been diagnosed with anxiety and bipolar disorder.[19] At the time of the hearing, Mitchell was 38 years old.

35. James and Victoria are Mitchell's maternal aunt and uncle. They have been involved in Mitchell's accommodation and support arrangements for many years and were appointed his guardians in June 2018.[20] Victoria grew up in the same family home with Mitchell and has enjoyed a close relationship with Mitchell for all of his life.[21]

36. Mitchell has complex support needs and began to live in supported accommodation as a teenager. By the time he was 18 years old, Mitchell had lived in three different supported accommodation settings.[22] When Mitchell was 21 years old he moved to the Strathmont Centre,[23] a large institution operated by the South Australian government which at one time housed up to 600 people with disability.[24] He lived at the Strathmont Centre until it was decommissioned in 2016.[25]

37. When Mitchell left the Strathmont Centre, James and Victoria had to assemble a new core support team for Mitchell, which was supposed to consist of six to eight workers. Victoria and James were involved in the selection of the support workers and kept in mind Mitchell's preference for female support workers due to his past experiences with male support workers.[26] Victoria, James and the Strathmont Centre's Accommodation Manager concluded that the transition to the new accommodation was not successful and that new supported accommodation should be found for Mitchell.[27]

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17 Transcript, 'Victoria', Public hearing 14, 7 June 2021, P-35 [8–11].

18 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [13].

19 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [14].

20 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [6]; Exhibit 14-28, 'Statement of James', 25 May 2021, at [5].

21 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [7].

22 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [18].

23 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [19].

24 For an overview of the history of state-operated disability services in South Australia including the Strathmont Centre, see Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, [16]; Transcript, Richard Bruggemann, Public hearing 14, 7 June 2021, P-60 [2–7].

25 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [19].

26 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [22].

27 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [23]; Exhibit 14-28, 'Statement of James', 25 May 2021, at [14].

38. In late 2016, Mitchell moved into a one bedroom unit within a newly built cluster of units operated by DHS under 'in-kind' funding arrangements between the South Australian government and the Australian government (Residence).[28] The Residence is bounded by a strip of concrete and there is no garden other than a row of hedges by the fence line.[29]

39. DHS told Victoria and James that it only intended Mitchell to stay at the Residence for six months. During this period, he would participate in up-skilling therapy to allow him to transition to living in the community. Victoria and James supported this as a short-term care model at the time.[30] However, at the time of the hearing, Mitchell was still living at the Residence.

## 2017 to early 2018

40. During Mitchell's first year at the Residence, James and Victoria developed concerns about the quality of supports and services Mitchell was receiving. Victoria was particularly concerned about the way information was communicated by the Residence management to James and her.[31]

41. Victoria and James do not recall being made aware of any DHS policies or procedures setting out how to raise concerns or complaints, except to direct complaints to DHS managers rather than to staff at the Residence.[32] James and Victoria established good relationships with key personnel at DHS who they contacted regularly to raise any concerns or complaints about Mitchell's care.[33]

42. Between January and August 2017, Victoria and James raised a number of concerns with DHS, including:

- not being told about an injury to Mitchell's foot which resulted in him being treated at hospital
- a staff member taking Mitchell to a topless waitress restaurant without consulting them
- being told by an Area Manager that Mitchell had been 'out of control' for months and required urgent intervention.[34]

28 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [23].

29 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [26].

30 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [25].

31 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [32].

32 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [33]; Transcript, James, Public hearing 14, 7 June 2021, P-23 [18–25].

33 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [33]; Transcript, Victoria, Public hearing 14, 7June 2021, P-22 [17–19].

34 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [35(a)–(c)].

43. After communicating these concerns to DHS, Victoria became aware that a DHS employee had alleged that she, Victoria, regularly telephoned the Residence up to 15 times a day. The allegation was untrue. James and Victoria were appalled and believed the allegation was made to discredit Victoria in her interactions with DHS.[35] On 14 September 2017, Victoria received a written apology from the then Director of Accommodation Services, who acknowledged that the allegation was untrue.[36]

44. From August 2017 to June 2018, the Director of Accommodation Services was Victoria and James' point of contact at DHS.[37] From September 2017, James regularly attended meetings with the Residence's management, chaired by the Director of Accommodation Services.[38] Victoria attended some but not all of the meetings.[39] James recalled the following matters were discussed at the meetings:

- clarity on roles and responsibilities to ensure consistency in information provided to the family
- staffing updates, rosters and training for staff
- communication with the family
- responses and actions to particular incidents.[40]

45. James said that at the time he and Victoria hoped to receive a timeframe in which Mitchell would be moved to a more stable and permanent environment, as the Residence was only regarded as 'temporary' accommodation.[41]

46. James said the meetings did not assist in developing the kind of open communication that he and Victoria needed with DHS.[42] He explained this by reference to an incident in December 2017, when they became aware that an intercom installed in Mitchell's unit eleven months earlier had video capacity and was being used to observe Mitchell in his home.[43] Victoria and James felt the video had been used without proper consideration for Mitchell's privacy or dignity and without their consent being sought.

35 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [36].

36 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [37]; Exhibit 14-33, IND.0083.0002.0032.

37 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [34].

38 Exhibit 14-28, 'Statement of James', 25 May 2021, at [19].

39 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [39]; Exhibit 14-28, 'Statement of James', 25 May 2021, at [20].

40 Exhibit 14-28, 'Statement of James', 25 May 2021, at [22].

41 Exhibit 14-28, 'Statement of James', 25 May 2021, at [23]. See also Report, [38].

42 Exhibit 14-28, 'Statement of James', 25 May 2021, at [25].

43 Exhibit 14-28, 'Statement of James', 25 May 2021, at [26].

47. In an email, the Director of Accommodation Services acknowledged the inappropriateness of installing a device capable of videoing Mitchell in his unit without informing James and Victoria or seeking their consent. The Director described the failure as a 'breakdown in communication' and apologised that appropriate approvals and safeguards had not been negotiated and documented before the intercom had been installed.[44]

48. As a consequence of the intercom issue and other matters, the site manager was moved from the Residence. It appears that at least one staff member felt aggrieved by this change.

## The 3 March 2018 Letter

49. On 3 March 2018, Victoria and James received a letter at their home address (3 March Letter). The letter read as follows:

> Dear Victoria and James
>
> Thought you needed to know that senior management has seen fit to remove the site manager [redacted] from the [redacted] site. Her coleauges [sic] think this is unfair as she has been a great employee and advocate for DCSI and your nephew (AKA) the piglet for many years.
>
> I would like to point out that due to her professional work ethic and approachable manner, many staff (60) I believe felt the need to support her and have signed a partition [sic], to keep her in the role, not all of them from [redacted]. Management [names redacted] have been active in putting a stop to this partition [sic] bullying and threatening staff with threats of job loss if they don't stop what they are doing. As you would imagine the staff involved are angry and pissed off which now puts your nephew at risk.
>
> *food …poison
>
> *medication…wrong
>
> *shampoo…what's in the bottle acid?
>
> *bruises…how did that happen
>
> *other clients with violent behaviour.. eg dumb bells

44 Exhibit 14-40, IND.0083.0003.0001.

*going out…falling down stairs

*how well does he swim

*locked up

*food withheld

*going through the wind screen …seatbelt unclipped

This little piglet is going to be abused with cruelty violence… regularly and repeatedly.[45]

50. Victoria and James considered that the letter represented a significant threat to Mitchell. They notified the Director of Accommodation Services[46] and the South Australian Principal Community Visitor on the same day they received the letter.[47] The Director of Accommodation Services provided the 3 March Letter to the Executive Director and to the Area Manager responsible for Mitchell.[48]

## Report to South Australian Police

51. On 5 March 2018, James and the Director of Accommodation Services jointly reported the 3 March Letter to the South Australian Police (SA Police).[49] There was no evidence about SA Police's handling of the complaint. It is sufficient for the purpose of this Report to record that DHS understood that SA Police declined to investigate the matter.

52. James recalled that, notwithstanding SA Police's decision not to investigate, he was 'left in no doubt that [DHS] would conduct their own internal investigation'.[50]

## DHS's interim measures

53. Between 3 and 5 March 2018, DHS implemented regular safety checks and overnight supervision of Mitchell, ensured that a shift supervisor was present at the Residence overnight and created a list of support workers approved by Victoria and James to work with Mitchell (interim measures). The interim measures were designed to ensure Mitchell's safety while the 3 March Letter was being investigated.[51]

45 Exhibit 14.1, IND.0083.0001.0050.

46 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [53].

47 Exhibit 14-219, SOM.9999.0001.0001, [113].

48 Exhibit 14-105, SAG.9999.0007.0001, p 3.

49 Exhibit 14-105, SAG.9999.0007.0001, p 3.

50 Transcript, James, Public hearing 14, 7 June 2021, P-29 [19–20], P-32 [3–18].

51 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, [54–56]; Exhibit 14-28, 'Statement of James', 25 May 2021, at [35–36].

54. On 7 March 2018, James and Victoria became aware that a member of staff who they did not know well had been rostered to support Mitchell that day.[52] They emailed the Director of Accommodation Services to seek reassurances that DHS was taking precautions to ensure Mitchell's safety. The Director replied on the same day confirming the interim measures provided for staff outside the approved list to be rostered to work at the Residence only as a last resort. He also stated that as the 3 March Letter was anonymous and police had declined to investigate, it would be hard to identify the source of the letter. Nonetheless, the Director concluded that the author was most likely a member of staff.[53]

55. In response to this email, James stated that his and Victoria's 'paramount concern' was ensuring Mitchell's safety, rather than identifying the author of the 3 March Letter.[54] The Director of Accommodation Services replied that he believed identifying the author of the letter would allow DHS to 'neutralise the threats made to Mitchell'.[55] Victoria believed as a result of this email that an investigation of the incident would take place.[56]

56. Despite this exchange, James and Victoria felt DHS was not taking the 3 March Letter seriously enough. It appeared to them that the issue was being left to the Director of Accommodation Services to deal with at a local level when they considered the issue serious enough to warrant immediate involvement by DHS's senior executives.[57]

## Complaint about Victoria

57. On 11 March 2018, Victoria attended the Residence and discussed the 3 March Letter with two of the support workers. Victoria made a recording of the conversation. Mitchell was present during the conversation and when he heard the word 'piglet' mentioned, he named another support worker who had called him by that name. When Victoria asked if that person had hurt him, he responded 'yes'.[58]

58. While Victoria was at the Residence, the Director of Accommodation Services contacted James to advise that the support workers alleged that Victoria had forced them to read the 3 March Letter aloud to Mitchell. The support workers felt Victoria had accused them of being party to the 3 March Letter.[59] Victoria denied this allegation. She considered the support workers should be investigated for making false allegations about her. She believed that an investigation was underway, but she did not expect that her own actions would become the subject of investigation.[60]

52 Exhibit 14-27, 'Statement of James', 25 May 2021, at [40].

53 Exhibit 14-42, IND.0083.0003.0009, p 3.

54 Exhibit 14-28, 'Statement of James', 25 May 2021, at [42]; Exhibit 14-42, IND.0083.0003.0009, p 2.

55 Exhibit 14-42, IND.0083.0003.0009, p 1.

56 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [64].

57 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [59]; see also Exhibit 14-42, IND.0083.0003.0009.

58 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [66–67].

59 Exhibit 14-28, 'Statement of James', 25 May 2021, at [45].

60 Exhibit 14-27, 'Statement of Victoria', 25 May 2021, at [68].

## Initial attempts to identify the author of the 3 March Letter

59. It appears that DHS considered it likely the author of the 3 March Letter was a DHS employee who had worked with Mitchell at some stage.[61] This appears to have been a plausible hypothesis, given that the author of the letter had access to Victoria and James' home address, which was kept on DHS's system. Moreover, the letter referred to discontent among staff and used the epithet 'piglet' to refer to Mitchell. Victoria and James said that one of Mitchell's support workers had used the epithet for Mitchell many years previously. Not surprisingly, they considered it derogatory and inappropriate.[62]

60. Although DHS believed that the author of the 3 March Letter may have been a member of staff who worked with Mitchell, little was done to find out the author's identity. This is despite the 3 March Letter being referred to DHS's Incident Management Unit (IMU) for investigation on the same day it was received.[63]

61. On about 10 March 2018, the Director of Accommodation Services discussed the 3 March Letter with some of the managers and shift supervisors responsible for the Residence. No records of these discussions were kept and no investigation report was produced as result of these conversations.[64]

62. On 12 March 2018, the day after Victoria's interaction with the two support workers, James emailed the Director of Accommodation Services requesting that:

- DHS remove the support worker identified by Mitchell from the Residence
- the IMU investigate the allegations by the support workers against Victoria
- DHS progress the transfer of Mitchell from the Residence.[65]

63. On 16 March 2018, the Director of the IMU emailed James to seek clarification about his concerns relating to the allegations made by the two support workers against Victoria, to which James responded on 20 March 2018.[66] On 4 April 2018, James met with the then IMU Director to discuss the 3 March Letter and the allegations about Victoria.[67]

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61 Exhibit 14-42, IND.0083.0003.0009, p 3.

62 Transcript, James, Public hearing 14, 7 June 2021, P-54 [47] – P-55 [1–4]; Transcript, James, Public hearing 14, 7 June 2021, P-50 [15–19].

63 Exhibit 14-105, SAG.9999.0007.0001, p 3.

64 Exhibit 14-105, SAG.9999.0007.0001, p 4; Transcript, Antony Allwood, Public hearing 14, 9 June 2021, P-190 [46–47] – P-191 [1–8].

65 Exhibit 14-28, 'Statement of James', 25 May 2021, at [47]; Exhibit 14-43, IND.0083.0003.0006.

66 Exhibit 14-28, 'Statement of James', 25 May 2021, at [49]; Exhibit 14-44, IND.0083.0003.0014.

67 Exhibit 14-28, 'Statement of James', 25 May 2021, at [50–51].

64. Between 4 April and 8 May, the IMU Director, James and Victoria exchanged correspondence about the investigation into the allegations about Victoria's interaction with the support workers.[68] There was no mention of the investigation into the 3 March Letter. Following this correspondence, James and Victoria received no further updates about the investigation into the allegations against Victoria or the 3 March Letter.[69]

## Submissions on response to the 3 March Letter

65. Counsel Assisting's written submissions contend that it is open to the Commissioners to accept James and Victoria's assessment that DHS 'did not take the 3 March Letter seriously enough on 3 March 2018 and in the immediate days that followed'.[70] The submissions note that around 10 March 2018, the Director of Accommodation Services spoke with staff at the Residence to find out whether they suspected anyone of writing the letter. However, no formal, methodical investigation was instituted and no records were kept of these inquiries.[71] Counsel Assisting also submits that 'the failure to treat the 3 March Letter seriously at this point in time had significant consequences for the manner in which the matter was handled by DHS throughout 2018 and 2019'.[72]

66. James and Victoria support the proposed findings.[73]

67. South Australia's written reply submits that in the days following the receipt of the 3 March Letter, it took a number of steps that demonstrated that it took the letter seriously. These included deploying a new supervisor to the Residence, implementing hourly checks from outside Mitchell's accommodation and placing an additional supervisor onsite overnight.[74] DHS submits that these steps demonstrate a genuine concern for Mitchell's welfare and a commitment to taking 'all reasonable steps to ensure Mitchell's safety and reassure his family'.[75] With the exception of the hourly checks, which were discontinued because they were unsettling to Mitchell, the interim measures continued after 7 March 2018.[76] The reply also notes that DHS escalated the matter to the Executive Director and Area Manager responsible for Mitchell and the IMU Director, and jointly reported the letter to SA Police with James.[77]

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68 Exhibit 14-28, 'Statement of James', 25 May 2021, at [52]; Exhibit 14-45, IND.0083.0003.0007.

69 Exhibit 14-28, 'Statement of James', 25 May 2021, at [52].

70 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [69].

71 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [68].

72 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [69], [323(1(a)-(b))].

73 Submissions of 'Victoria' and 'James', Public hearing 14, 17 September 2021, SUBM.0014.0001.0040, [11].

74 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [5–6].

75 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [5], [10].

76 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [7]; Exhibit 14-105, SAG.9999.0007.0001, p 3.

77 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [8–9].

68. South Australia expressly accepts, however, that following the initial disclosure of the 3 March Letter, DHS 'did not undertake a discrete and targeted investigation to determine the author of the anonymous letter'.[78] The State also accepts that, although James made it clear at that stage that he was not concerned about identifying the author, DHS had an obligation to attempt to find out the author's identity regardless of the family's wishes.[79] Counsel Assisting clarified in oral submissions that the proposed finding was 'centred around the primary contention that there was no appropriate investigation at that point in time or in the days immediately after'.[80]

69. We make the following finding:

**Finding 1**

- The South Australian Department of Human Services (DHS) did not take the 3 March Letter seriously enough. It failed to instigate a formal investigation into the identity of the author as soon as possible after becoming aware of the Letter. DHS failed to discharge its responsibility to take appropriate measures to find out the source of an apparently serious threat to the safety and wellbeing of a person with disability in its care.
- The failure to instigate a formal investigation in a timely fashion had significant consequences for the manner in which DHS handled the matter afterwards.

## The First Investigation

70. The IMU did not commence its investigation until 20 April 2018 (First Investigation), some seven weeks after the 3 March Letter was received.[81] The IMU interviewed a total of nine staff between 25 May 2018 and 21 November 2018, mostly by telephone. There are no records indicating that the IMU attempted to locate other staff members identified during the interviews even though several were identified by name and the remaining staff members presumably could have been identified by accessing DHS's incident reporting system.[82] The investigation also did not systematically review or check rosters, incident report registers or other available electronic records for evidence of who might have been involved in the 3 March Letter.[83]

78 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [11].

79 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [11].

80 Transcript, Ms Kate Eastman SC (Counsel Assisting), Public hearing 14, 30 September 2021, P-437 [13–15].

81 Exhibit 14-105, SAG.9999.0007.0001, p 5.

82 Exhibit 14-105, SAG.9999.0007.0001, p 5.

83 Exhibit 14-105, SAG.9999.0007.0001, p 7.

71. A report of the investigation was produced in late November 2018 (First Investigation Report).[84] It included a 'summary' of the following conclusions:

> Police declined to investigate the anonymous letter
>
> All staff interviewed denied having any knowledge of who authored the letter
>
> To date, there have been no known incidents of harm that reflect the threats outlined within the anonymous letter.[85]

72. The First Investigation Report also examined the allegations made by two support workers that Victoria 'made them' read the 3 March Letter aloud in Mitchell's presence.[86] The First Investigation Report stated that the support workers maintained their allegations during their interviews.[87] According to the First Investigation Report, Victoria gave Mitchell a bank statement while the support workers read the 3 March Letter and told him to read it. The First Investigation Report recorded that 'upon reviewing the transcript of the conversation, [the support workers] concluded that they had misunderstood [Victoria] when she was speaking to [Mitchell]'.[88] Accordingly, the allegation against Victoria was not upheld.

## Submissions on the First Investigation

73. Counsel Assisting submits that the First Investigation and First Investigation Report were deficient in a number of respects:

- The First Investigation did not clearly focus on identifying the author of the 3 March Letter. This issue was only one of four addressed in the 20 page report. Much of the First Investigation concentrated on determining whether Victoria had forced staff to read the 3 March Letter aloud in front of Mitchell.[89]
- Despite the length of time required to complete the First Investigation Report, its analysis of the evidence relating to the author of the letter was superficial. The question of authorship of the 3 March Letter was addressed in two and a half pages. The information provided by staff members was summarised in a single paragraph, while no serious attempt was made to determine who might have been aggrieved by the staff changes in February 2018 or who might have gained access to Victoria and James' home address. The superficiality of the report was in part a consequence of the delay in instigating the investigation, as evidenced by the gaps in recollections of some witnesses.[90]

84 Exhibit 14-110, SAG.0002.0020.0013.

85 Exhibit 14-110, SAG.0002.0020.0013, p 7.

86 Exhibit 14-110, SAG.0002.0020.0013, p 8.

87 Exhibit 14-110, SAG.0002.0020.0013, pp 8-9.

88 Exhibit 14-110, SAG.0002.0020.0013, p 11.

89 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [74–76], [79–81].

90 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [77–78], [83–84].

- DHS conducted the First Investigation without interviewing James, Victoria or Mitchell, and without communicating the conclusions in a clear and transparent way.[91]
- Of the three conclusions in the First Investigation Report:
    - the first was known as at 5 March 2018
    - the second recorded the bare denial of staff of any knowledge of the authorship of the 3 March Letter
    - the third simply reported that no incidents of harm reflecting the threats in the 3 March Letter had occurred.[92]

74. Counsel Assisting submits that the following findings should be made:

    The First Investigation was seriously deficient in that:

    a. it was delayed unjustifiably;

    b. the delay made it less likely that the author of the 3 March Letter would ever be identified;

    c. the First Investigation did not constitute a full or thorough investigation aimed at identifying the author of the 3 March Letter.[93]

75. South Australia's written submissions contend no finding should be made about 'perceived omissions' in the First Investigation because the IMU considered making inquiries to find out who might have had access to Victoria and James' home address, but concluded that DHS's records did not contain the relevant information.[94]

76. The fact that DHS considered finding out whether its records would show who might have had access to the address does not answer the other deficiencies of the First Investigation identified by Counsel Assisting. Moreover, South Australia concedes that the First Investigation was deficient in seeking to identify the author of the 3 March Letter.[95] The evidence amply justifies a finding that the First Investigation was neither thorough nor focussed on identifying the author of the 3 March Letter.

91 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [89].

92 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [86].

93 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [90].

94 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [13].

95 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [19].

77. South Australia also contests the proposed finding that the delay in conducting the First Investigation made it less likely that the author of the 3 March Letter would be identified. It argues that there can be no certainty that the author would have been identified had the investigation commenced earlier.[96]

78. It may well be true that an earlier investigation still may not have identified the author of the 3 March Letter. But it can readily be inferred that the unwarranted delay adversely affected the thoroughness of the investigation, thereby reducing the chances of a successful outcome.

79. We make the following finding:

**Finding 2**

The First Investigation conducted by DHS was seriously deficient in that:

- it was delayed unjustifiably
- the delay made it less likely that the author of the 3 March Letter would ever be identified
- it did not constitute a thorough investigation focussed on identifying the author of the 3 March Letter.

80. Victoria and James' written submissions support Finding 2, but contend that two additional findings should be made:

- The direction by the DHS Director to the IMU Investigator not to follow up on the identity of the author of the 3 March Letter represented a grave departure from what should have been the primary focus of the First Investigation.[97]
- DHS was wrong to blame statements made by James about his interest in finding out the identity of the author of the 3 March Letter for its failure to undertake a proper investigation.[98]

81. The first finding proposed by Victoria and James rests on a diary note made by the IMU investigator for the Second Investigation as recorded in DHS's internal audit report. The diary note was to the effect that the Director gave clear instructions to an investigator in the First Investigation not to follow up on the identity of the author of the 3 March Letter.[99]

96 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [18].

97 Submissions of 'Victoria' and 'James', Public hearing 14, 17 September 2021, SUBM.0014.0001.0040, [13–17].

98 Submissions of 'Victoria' and 'James', Public hearing 14, 17 September 2021, SUBM.0014.0001.0040, [18–23].

99 Exhibit 14-105, SAG.9999.0007.0001, p 4.

82. If the diary note recorded a direction that was in fact given and followed, that would be a matter of significant concern, as Mr Allwood of DHS conceded in his evidence.[100] However, the evidence does not identify the author of the diary note or the circumstances in which it was made. For that reason, the evidence is insufficient to make the finding proposed by Victoria and James.

83. The second finding proposed by Victoria and James rests on a statement in the First Investigation Report to the effect that James had indicated that he was not concerned to learn the identity of the author of the 3 March Letter. We have considerable sympathy with James' disappointment about his views being used to justify the narrow focus of the First Investigation. However, Mr Allwood accepted that James' views expressed shortly after the 3 March Letter was received did not detract from DHS's duty to identify the person making threats against Mitchell.[101] In these circumstances we do not consider it necessary or appropriate to make the second finding sought by Victoria and James.

## The Second Investigation

84. The Principal Community Visitor reported on DHS's First Investigation in the 2017-2018 Annual Report on the South Australian Community Visitor Scheme (CVS).[102] This report, along with correspondence from the Principal Community Visitor, came to the attention of the South Australian Ombudsman.[103] On 2 April 2019, the Ombudsman advised the Principal Community Visitor he had decided to undertake an 'own initiative' investigation[104] into DHS's response to the 3 March Letter and related matters.[105]

85. In his provisional report, the Ombudsman expressed a preliminary opinion that the First Investigation had not been adequate.[106] The Ombudsman's final report records that Ms Lois Boswell, the Chief Executive Officer of DHS, responded to the preliminary opinion by asserting that the Director of Accommodation Services and the IMU Director did properly investigate the letter.[107] Ms Boswell appeared to adopt the view of the current and former IMU Directors that 'nothing more could have been done at the time, or now' to investigate the 3 March Letter.[108]

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100 Transcript, Antony Allwood, Public hearing 14, 9 June 2021, P-198 [44–47] – P-199 [2–4].

101 Transcript, Antony Allwood, Public hearing 14, 9 June 2021, P-200 [7–10].

102 Exhibit 14-28, 'Statement of James', 25 May 2021, at [55]; Exhibit 14-219, SOM.9999.0001.0001.

103 Exhibit 14-219, SOM.9999.0001.0001, p 2.

104 *Ombudsman Act 1972* (SA) s 13(2).

105 Exhibit 14-46, IND.0083.0001.0043.

106 Exhibit 14-219, SOM.9999.0001.0001, p 4.

107 Exhibit 14-219, SOM.9999.0001.0001, p 4.

108 Exhibit 14-219, SOM.9999.0001.0001, p 4.

86. DHS resisted conducting a further investigation on the basis that:

> It is now over two years since the original letter was sent and the ability to undertake any further meaningful enquiries is unrealistic. There have been significant staff changes within Accommodation Services and in the department's opinion further enquiries would not identify the author, which would be the only real basis for conducting further enquiries.[109]

87. The Ombudsman's final report concluded that DHS's response had not properly addressed the Ombudsman's preliminary view that the First Investigation was defective. In his final report, the Ombudsman concluded that DHS 'failed to properly investigate the letter, and that this was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act'.[110] The Ombudsman recommended that further investigations be carried out to identify the author of the 3 March Letter.[111]

88. The Ombudsman's final report also recommended that DHS apologise to James and Victoria for the failure to properly investigate the 3 March Letter.[112] DHS sent a letter of apology but it was not received by James and Victoria. Ms Boswell gave evidence that she 'felt terrible about that'.[113] Victoria and James accepted that the letter of apology had gone astray in error.[114]

89. DHS commenced a second investigation in January 2021 (Second Investigation), resulting in a report dated 12 February 2021 (Second Investigation Report).[115]

90. The Second Investigation Report was not provided to Victoria and James or to Ms Boswell.[116] A letter dated 1 March 2021 was sent to Victoria and James that said:

> I refer to the investigation undertaken by the Department of Human Services into an anonymous letter you received on 3 March 2018 threatening the safety of your nephew [Mitchell].
>
> In December 2018 the department concluded the investigation which did not identify the author of the letter.

109 Exhibit 14-219, SOM.9999.0001.0001, p 4.

110 Exhibit 14-219, SOM.9999.0001.0001, pp 29-30.

111 Exhibit 14-219, SOM.9999.0001.0001, p 31.

112 Exhibit 14-219, SOM.9999.0001.0001, p 30.

113 Transcript, Lois Boswell, Public hearing 14, 11 June 2001, P-409 [43].

114 Transcript, Victoria, Public hearing 14, 7 June 2021, P-18 [42–44].

115 Exhibit 14-115, SAG.0002.0020.0034.

116 Transcript, Lois Boswell, Public hearing 14, 11 June 2001, P-407 [14–27].

As you would be aware the SA Ombudsman undertook an investigation into specific incidences in the departments care of [Mitchell]. In the SA Ombudsman report dated 27 January 2021 the SA Ombudsman recommended the department undertake further enquiries to identify the author of the letter.

I wish to advise that the department has acted on the recommendation and an additional eight witness statements have been obtained. The author of the letter was not identified, and I am satisfied that no further enquiries can be made. I now consider this matter closed.

Please feel free to contact me on [phone number] or at [email] should you have any questions regarding the content of this letter.[117]

## Submissions on the Second Investigation

91. Counsel Assisting submits that the Second Investigation, like the First Investigation, was not clearly directed to identifying the author of the 3 March Letter.[118] Counsel Assisting proposes a finding that the Second Investigation was conducted neither competently nor properly because it had deficiencies in methodology, analysis and the scope of the information received.[119]

92. Counsel Assisting points to the investigator's decision to limit interviews to staff who worked at the Residence over the two months preceding receipt of the 3 March Letter as an unduly restrictive interpretation of the Ombudsman's recommendation.[120] In addition, Counsel Assisting is critical of the investigator's failure to create a timeline of events, compare differing accounts by interviewees or review DHS's electronic incident database (known as Riskman) for material information.[121]

93. South Australia's submissions acknowledge that the Second Investigation would have been 'more comprehensive' if the investigator had identified (and presumably interviewed) more potential witnesses.[122] This reflected Mr Allwood's concession in his evidence that the methodology employed in the Second Investigation was deficient.[123]

117 Exhibit 14-51, IND.0083.0001.0058.

118 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [98].

119 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [105].

120 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [98–99].

121 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [100].

122 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [26].

123 Transcript, Antony Allwood, Public hearing 14, 9 June 2021, P-195 [12–21].

94. We make the following finding:

**Finding 3**

The Second Investigation conducted by DHS was deficient in the methodology employed and the scope of the investigation. The investigation was not carried out in a thorough or satisfactory manner.

95. As Counsel Assisting submits, the letter dated 1 March 2021 that DHS belatedly sent to Victoria and James did not acknowledge that they had experienced distress over a prolonged period as a result of the 3 March Letter and DHS's failure to conduct thorough inquiries into the source of the threat. The letter simply asserted that the author could not be identified and provided no more than a cursory explanation of the investigative process.[124]

96. Ms Boswell accepted in her evidence that, considering the contents of the 3 March Letter and the period of time that has elapsed since the receipt of the letter, it was not surprising that Victoria and James have lost complete trust and confidence in DHS. Ms Boswell said that it was her responsibility to restore the lost trust and confidence.[125]

97. South Australia's submissions do not dispute that Victoria and James were significantly distressed by the events following receipt of the 3 March Letter and that they have lost trust and confidence in DHS. The submissions also accept that the breakdown in communication between DHS and Victoria and James exacerbated the concerns they had about the quality of care provided to Mitchell.[126]

124 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [103].

125 Transcript, Lois Boswell, Public hearing 14, 10 June 2021, P-410 [39–47].

126 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [28–29].

98. We make the following finding:

**Finding 4**

- DHS's failure to undertake thorough and competently conducted inquiries into the identity of the author of the 3 March Letter and the seriousness of the threat to Mitchell's safety and wellbeing caused Victoria and James significant distress and led to them losing trust and confidence in DHS.
- The breakdown of communication between DHS and Victoria and James over a lengthy period demonstrates the importance of open and effective communication in maintaining trust and confidence between the service provider and the family or supporters of the person with disability in the care of a service provider.

99. Counsel Assisting's written submissions argue for a finding that Mitchell's case study highlights DHS's failure to maintain a person-centred approach to the safety and wellbeing of people in its accommodation services.[127]

100. South Australia's submissions accept that a person-centred approach to the delivery of services and supports for people with disability is of central importance. South Australia contends, however, that the evidence does not support a finding in the broad terms proposed by Counsel Assisting. It also points to changes that have more recently occurred that are designed to achieve 'cultural change in the delivery of person-centred care'.[128]

101. We accept that the evidence presented at the hearing relates to the particular circumstances of Mitchell's case. The references in South Australia's submissions to the measures taken to change the culture within DHS suggests that Mitchell's case may illustrate systemic deficiencies and a cultural problem at the time across DHS's provision of services to people living in residential disability accommodation.

127 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [272].

128 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [40].

102. Nonetheless we accept South Australia's submission that the proposed finding should be expressed by reference to the particular circumstances of Mitchell's case. We therefore make the following finding:

**Finding 5**

DHS's inadequate response to the 3 March Letter reflected a failure to adopt a person-centred approach focussing on Mitchell's safety and wellbeing in the Residence.

## DHS's response to proposed recommendations

103. Counsel Assisting submits that it is premature for the Royal Commission to make recommendations about the role and responsibilities of service providers generally in preventing and responding to violence, abuse, neglect and exploitation of people living in disability residential accommodation.[129] However, Counsel Assisting proposes the following recommendations directed to DHS:

a. DHS should engage an independent investigator with appropriate forensic skills to conduct an investigation into the 3 March Letter.

b. DHS should consult with Victoria and James about the terms of reference for the investigation and be given the opportunity to participate in the investigation.

c. DHS should commit to publicly releasing any investigation report.

d. DHS should consult with Victoria, James and Mitchell to ascertain their wishes with respect to:

    i. a genuine and meaningful apology that acknowledges the impact of DHS's failures on each of them and their family; and

    ii. discuss what redress and/or additional supports and assistance they require.[130]

129 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [320].

130 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [322(d)].

104. In an Annexure to South Australia's submissions, DHS provides information on its response to each of the proposed recommendations. The Annexure states that:

- DHS has engaged an external investigator to conduct the proposed investigation.
- DHS has given instructions for Victoria and James to be consulted and, if they wish, to be involved in the investigation.
- Any disclosure of information in the report will need to comply with applicable Privacy Principles.
- On 3 June 2021, the Chief Executive Officer resent the formal letter of apology dated 1 March 2021, which Victoria and James had not received. The Chief Executive Officer sent a further letter dated 20 July 2021 apologising to Mitchell and to Victoria and James for the errors identified in the Ombudsman's Final Report.[131]

105. In view of DHS's constructive response to the recommendations proposed by Counsel Assisting, we do not consider it necessary formally to make the recommendations in this Commissioners' Report. However, we propose to obtain further information from DHS within the next six months to ascertain progress of the external investigation and to determine whether Victoria and James are satisfied with the other measures DHS has agreed to implement.

131 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, pp 16-17.

# Part 3: Daniel Rogers

> Daniel lived at N-Street for about 15 years. In that time I learned a lot about how best to advocate for my son. I learned to 'pick my battles' and to raise things only that I thought absolutely had to be addressed.[132]

106. Daniel Rogers was 40 years old at the time of the hearing. He has Autism Spectrum Disorder, an intellectual disability, epilepsy, a movement disorder and limited speech. He also has echolalia, which causes him to repeat words and phrases he hears.[133] His mother, Mrs Karen Rogers, describes Daniel as very gentle and sweet.[134]

107. On 12 July 1992, when Daniel Rogers was 11 years old, he began living in disability supported accommodation. At the time, this required Mrs Rogers and Daniel's father, Mr Graham Rogers, to relinquish him into state care, a decision which caused them considerable distress.[135] Daniel Rogers moved into a house operated by a South Australian government agency with three other boys of a similar age.[136]

108. In 2004, Daniel Rogers and two of the men he lived with moved to a house in Adelaide referred to at the hearing as 'N-Street'.[137] The N-Street house was one of a number of disability accommodation sites operated by DHS in the same area under 'in-kind' funding arrangements between the South Australian government and the Australian government.[138]

109. Daniel Rogers left N-Street in February 2019 and began living with his parents in Adelaide.[139] He continued to live with his parents at the time of the hearing.

110. Throughout the period when Daniel Rogers lived at N-Street, disability support services were provided by various state-run agencies.[140] Daniel Rogers and the other residents of N-Street regularly attended structured activities known as 'day options' during the week. Mrs Rogers organised for her son to attend a different day option to the other three residents. She did this because she 'felt they lived together through circumstance, not by choice, and [she] didn't think they should be together 24 hours a day'.[141]

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132 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [39].

133 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [15].

134 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [11].

135 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [20–23].

136 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [22–23].

137 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [28]; Transcript, Karen Rogers, Public hearing 14, 8 June 2021, 90 [17–20], [38].

138 Exhibit 14-211, 'Statement of Lois Boswell', 19 May 2021, at [51].

139 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [68].

140 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [27].

141 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, 91 [2–5]; Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [30].

111. Staff were rostered at N-Street on a 24-hour basis. One or two support workers were rostered during the day and one at night. A shift supervisor managed the support workers at N-Street, as well as other houses operated by DHS, and reported to a manager at DHS's office.[142]

112. Mrs Rogers said she often felt she had cause to complain about Daniel's care but decided to 'pick her battles'.[143] She based this judgment on her personal experiences, and also on her experience as a disability advocate who understands the systems supporting her son. During the period from late 2016 and onwards, Mrs Rogers felt the quality of services that Daniel received and the level of communication between her and DHS and N-Street staff deteriorated.[144]

113. Mrs Rogers gave evidence about a number of incidents involving the quality of care and services provided to Daniel by the staff at N-Street and the way in which her concerns and complaints were responded to by the staff, managers and DHS. These included unexplained injuries to Daniel; a failure to pack sufficient medication for Daniel when he went on holidays; poor standards of his grooming and personal hygiene; and continuing concerns about how his money was used and accounted for by staff.

## Unexplained bruising

114. Mrs Rogers gave evidence about a series of occasions when Daniel Rogers experienced significant bruising. Although the injuries were recorded on the incident management system for DHS disability accommodation services, known as 'Riskman', the evidence addressed the way the injuries were recorded and responded to, including how information was communicated to Mrs Rogers about Daniel Rogers' injuries.

115. On 28 October 2018, Mrs Rogers collected Daniel Rogers from N-Street to visit the family home over the weekend. When he arrived at the home and removed his jacket, Mrs Rogers observed bruises on his inner arm. The bruises were close together and about the size of a forefinger.[145] She took photographs of the bruising and sent them to Mr Cunningham, the Accommodation Services Manager responsible for N-Street at the time. Mr Cunningham told Mrs Rogers that the matter would be investigated.[146]

142 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [31].

143 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [39].

144 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [40].

145 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [48].

146 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [49].

116. On 29 October 2018, a staff member reported the bruising in Riskman.[147] When completing an incident report, staff members were required to classify the incident according to an 'impact category'. Five options were available: insignificant, minor, moderate, major or catastrophic.[148] Staff only received on the job training in the use of Riskman,[149] but DHS required every Riskman report to be reviewed and responded to, regardless of the severity of the incident reported.[150] Mr Cunningham said that Riskman reports of any severity were sent to him and the Area Manager.[151]

117. In the 29 October 2018 Riskman Report, Daniel Rogers' injuries were classified as 'insignificant'.[152] Mr Cunningham conceded in his oral evidence that bruising should never be recorded as 'insignificant' because it involves an injury to the client.[153]

118. Further incidents of unexplained bruising to Daniel Rogers occurred in February 2019. On 17 February 2019, staff noticed bruising on the left side of his buttocks. This was recorded by staff in their shift notes, but a Riskman report was not completed.[154] On 18 February 2019, different staff noticed the bruising, found the notes from the previous day and made a report in Riskman the same day.[155] The bruising was classified as 'insignificant'.[156]

119. On 18 February 2019, staff at Daniel's day option service provider, Windamere Park, discovered bruising on Daniel Rogers' body. The staff completed an NDIS reportable incident form on 19 February. The form recorded bruising on his 'left lower back' on 18 February and on the 'right side of Daniel's lower back' the following day. The form also stated that, on 18 February, staff had noticed that a paint or dye had been applied to Daniel Rogers' back which obscured the bruising.[157] Although Windamere Park staff determined the bruising had happened outside their premises, they nonetheless considered it appropriate to notify the NDIS Commission.[158]

147 Exhibit 14-136, SAG.0002.0007.0699.

148 Exhibit, 14-152, SAG.0002.0021.0002, p 10.

149 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-142 [33–41].

150 Exhibit 14-151, SAG.0002.0021.0135, pp 6-7.

151 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-136 [23–38].

152 Exhibit 14-136, SAG.0002.0007.0699, p 2.

153 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-148 [9–12].

154 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-138 [35–42].

155 Exhibit 14-132, SAG.0002.0007.2036.

156 Exhibit 14-132, SAG.0002.0007.2036, p 1.

157 Exhibit 14-16, IND.0081.0004.0003, p 5.

158 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [77]; Exhibit 14-16, IND,0081.0004.0003.

120. Windamere Park's incident report was not immediately provided to the staff at N-Street, but the information contained in the report was conveyed to DHS on 26 February 2019.[159] The N-Street staff did not immediately make inquiries of Windamere Park about whether they had noticed any injuries to Daniel Rogers.[160]

121. The Riskman report of 18 February 2019 came to Mr Cunningham's attention by 20 February 2019. On that date, he recorded an instruction 'to follow up on this Riskman Report, explanation for bruising is required'.[161]

122. On 21 February 2019, N-Street staff made another Riskman report, stating that they had noticed a 'medium [size] bruise on the right bottom and the colour of the bruise is pink'.[162] This bruising was again classified as 'insignificant' in the Riskman report.[163]

123. Mr Cunningham was notified by email of the entry in the Riskman report, apparently on 22 February 2019.[164] There is no indication in the Riskman report that Mr Cunningham gave instructions for any further action to be taken as a consequence of the entry. Nor is there any record to suggest that Mr Cunningham's instruction of 20 February 2019 was followed.

124. Mr Cunningham accepted, consistently with his view that bruising should never be categorised as 'insignificant', that the entries in Riskman were incorrect and that the bruising should have been recorded as 'major.'[165]

125. Mr Cunningham also accepted that a pattern of bruising over a short period should have raised alarm bells. He thought he would have spoken to the shift supervisor about the causes of the bruising, but agreed that if he had spoken to the supervisor the conversation would have been recorded in his journal notes.[166] There are no journal notes in the Riskman Report of 21 February 2019 to suggest that the supervisor made inquiries. Nor is there any evidence that the inquiries Mr Cunningham requested in relation to the 18 February Riskman Report were ever made.

159 Exhibit 14-90, SAG.0002.0007.2046, p 2.

160 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [76].

161 Exhibit 14-132, SAG.0002.0007.2036, p 2.

162 Exhibit 14-137, SAG.0002.0007.2038, p 1.

163 Exhibit 14-137, SAG.0002.0007.2038, p 1.

164 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-144 [2–17]. Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-144 [1–9].

165 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-141 [32–42].

166 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-140 [33–43].

126. According to Ms Muriel Kirkby, the Director of Accommodation Services in DHS, if Daniel Rogers' injury had been recorded as 'major' in the Riskman system more senior staff of DHS would have been notified.[167] Mr Cunningham was unable to explain why he did not change the classification recorded in Riskman, but stated that the incident was 'escalated very quickly'.[168]

127. Mrs Rogers received a call from N-Street at 5.54 pm on 22 February and was told that there was a large bruise on Daniel Rogers' back. She gave her permission to call a doctor. A locum attended N-Street that day and recommended that Daniel Rogers be admitted to hospital, where he underwent a CT scan.[169] Mrs Rogers went to the hospital and saw the bruising for the first time. She was shocked by the extent of the bruising, which extended from Daniel's spine to his front.[170] The photographs of the bruising that Mrs Rogers took that night were in evidence.

128. Daniel Rogers found the hospital to be a difficult experience because he is fearful of needles.[171] Since the scans revealed no internal damage or bleeding, he was discharged on the morning of 23 February.[172]

129. Mrs Rogers decided to take Daniel Rogers to the family home so he could rest in quiet and comfort. On the way home, they stopped at N-Street to collect his medication. Mrs Rogers reported that Daniel Rogers became distressed when they came near N-Street, and repeatedly said 'don't want it'.[173] Mrs Rogers went inside N-Street to get the medication. A support worker initially gave her the wrong medication and had to be prompted to provide her with Daniel Rogers' correct medication.[174]

130. Staff completed a further Riskman report on 22 February following the hospital admission. That Riskman report focused on the admission itself and classified it as a 'major' incident.[175] The underlying bruise remained recorded as 'insignificant'.

131. Daniel Rogers returned to N-Street in the afternoon of 23 February 2019.[176] Mrs Rogers said that she brought him back to N-Street because two staff members whom she trusted were on duty and they promised her they would look after Daniel.[177]

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167 Exhibit 14-116, 'Statement of Muriel Kirkby', 5 May 2021, at [28].

168 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-141 [25–30].

169 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [52].

170 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [54].

171 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [56].

172 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [57].

173 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [57].

174 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [58].

175 Exhibit 14-133, SAG.0002.0007.2040.

176 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [60–61].

177 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [59].

132. On 25 February, two days after Daniel Rogers was discharged from hospital, Mrs Rogers met with Mr Cunningham and presented him with photographs of Daniel's injuries from hospital. He was shocked by the photographs.[178] Mr Cunningham, Ms Kirkby, the Area Manager and the Regional Manager met with Daniel and his parents at N-Street later that day.[179]

133. Daniel Rogers was distressed and refused to leave his room at N-Street, and so the group met in his room. Mrs Rogers described the room as filled with very thick dust, with dirty floors and walls.[180] Ms Kirkby acknowledged in her evidence that the house was in a 'disgraceful' state and agreed it had 'an air of neglect'.[181]

134. At the 25 February meeting, DHS representatives acknowledged that issues had risen concerning Daniel Rogers' care and that DHS would investigate the bruising he had sustained. The meeting also discussed how to find alternative accommodation for him.[182] The incident was referred to DHS's triage panel on 25 February 2019 for the purpose of referring it to the IMU.[183]

135. Mrs Rogers took Daniel Rogers home after the meeting. When he left N-Street, his family was provided with a box of personal items that included many clothes that belonged to other residents of N-Street. A number of personal items, including shoes, clothing and newly purchased bedding, were never returned to Daniel Rogers and his family.[184] Mrs Rogers returned clothing that did not belong to Daniel. Ultimately DHS paid Mrs Rogers $500 as a reimbursement for Daniel's missing personal items.[185]

136. On 26 February 2019, Mr Cunningham called and asked Mrs Rogers to report the bruising to SA Police. She did so.[186]

137. On 27 February 2019, two SA Police detectives attended N-Street and spoke to staff on duty. The officers also spoke with Mr Cunningham.[187]

138. On 28 February 2019, Mr Dodd declared Daniel Rogers' injuries referred to in two February Riskman reports as a 'Critical Client Incident' in accordance with the relevant DHS Policy. This declaration triggered a requirement for DHS to appoint an Incident Manager. The Director of Accommodation Services, Ms Kirkby, was appointed to this role.[188]

178 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [62].

179 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [65].

180 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [63].

181 Transcript, Muriel Kirkby, Public hearing 14, 8 June 2021, P-172 [33–41].

182 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [65–66].

183 Exhibit 14-64, 'Statement of Wayne Cunningham', 14 May 2021, at [14(g)].

184 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [81–82].

185 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [85].

186 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [69]; Exhibit 14-64, 'Statement of Wayne Cunningham', 14 May 2021, at [14(m)].

187 Exhibit 14-90, SAG.0002.0007.2046, pp 2-3.

188 Exhibit 14-109, 'Statement of Stewart Dodd', 13 May 2021, at [57].

139. According to Mr Cunningham, he began around this time to 'gather information to inform any investigation into the incident, including statements from relevant staff members'.[189]

140. Mr Cunningham gave evidence that he and a colleague from Human Resources interviewed every member of staff that worked at N-Street in the week commencing 18 February 2019 and documented their responses to a series of questions.[190] A timeline of events prepared by Mr Cunningham records that the interviews took place on 28 February and identifies staff who were asked to provide statements. The timeline does not identify the questions staff were asked to answer.[191] The contents of those interviews and the statements provided in response to Mr Cunningham's requests were not in evidence.

141. Mr Cunningham said that DHS interviewed Daniel Rogers as part of this investigation, but this claim does not appear to be supported by any contemporaneous records.[192] Mrs Rogers denied that anyone from DHS ever interviewed Daniel in their investigations.[193]

142. Based on the information obtained in the interviews, Mr Cunningham concluded that the cause of the injuries could not be determined: 'Staff believed [the injuries] occurred outside the home, but no one could come to a determination'.[194] The only tangible outcome of these interviews appears to have been that staff were required to undertake a code of ethics training module.[195]

143. According to his notes, Mr Cunningham was notified by email on 4 March 2019 that the incident had been referred to the IMU for investigation.[196]

144. On 7 March 2019, Mrs Rogers and Mr Rogers met with Ms Kirkby, Mr Stewart Dodd (the then IMU Director) and other DHS representatives. Mrs Rogers recalled she was advised that the IMU was 'not going to start investigating until the police investigation had been completed'.[197] Mr Dodd said in his statement that the 'IMU did not commence an investigation until [SA Police] had finalised theirs'.[198]

145. The inference we draw from this evidence is that, although Mr Cunningham arranged for some staff to be interviewed before 7 March 2019, by that date the IMU's investigation into the circumstances of Daniel's injury had not commenced.

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189 Exhibit 14-64, 'Statement of Wayne Cunningham', 14 May 2021, at [14(h)].

190 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-148 [21–24].

191 Exhibit 14-90, SAG.0002.0007.2046, pp 2-4,

192 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-148 [34–36].

193 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-104 [1].

194 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-148 [31–32].

195 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-148 [24–25].

196 Exhibit 14-90, SAG.0002.0007.2046, p 5.

197 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-111 [42–43].

198 Exhibit 14-109, 'Statement of Stewart Dodd', 13 May 2021, at [59].

146. On 30 March 2019, SA Police advised the IMU that it would be taking no further action in its investigation.[199] Mrs Rogers said that SA Police had kept her up to date with the investigation and informed her of the decision to close the investigation.[200]

147. Mrs Rogers expected that DHS's investigation would commence once SA Police decided to close their investigation.[201] However, she was not involved in or consulted about any investigation that took place.[202] No-one asked her for any photographs of the bruising and no-one ever came and talked with Daniel Rogers.[203]

148. Nothing significant appears to have occurred between 30 March 2019 and 8 May 2019. On the latter date, the IMU's Investigation Team reviewed the SA Police files and 'all former Disability SA documents' and drafted an investigation report.[204] Mr Dodd received and approved the report on the same day, including a recommendation in the report that the file be closed.[205]

149. The IMU report is four pages long. It provides a chronology of events between 17 February 2019 and 22 February 2019. It states that the radiologist at the hospital was unable to speculate about the nature or cause of Daniel Rogers' injury, noting only that the injury was 'uncommon'.[206] The IMU report concludes that:

> Whilst the injury is uncommon it is unable to be determined the likelihood [sic] that the injury has resulted from an assault or an accident.[207]

150. The IMU report has a number of curious features.

151. First, SA Police concluded that the bruising was likely to have been caused between 6:00 am on Monday 18 February 2019 and 9:00 am on Tuesday 29 February 2019. Yet the IMU report asserts, without any supporting evidence, that it was 'possible' the bruising had been sustained during Daniel Rogers' visit to the family home on Sunday 17 February 2019.[208]

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199 Exhibit 14-113, SAG.0002.0007.1159, p 1.

200 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-106 [22–27].

201 Exhibit 14-5, 'Statement of Karen Rogers', 5 May 2021, at [72]; Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-103 [31–33].

202 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-103 [40–43].

203 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-103 [45–47] – P-104 [1].

204 Exhibit 14-109, 'Statement of Stewart Dodd', 13 May 2021, at [61].

205 Exhibit 14-109, 'Statement of Stewart Dodd', 13 May 2021, at [62].

206 Exhibit 14-113, SAG.0002.0007.1559, p 3.

207 Exhibit 14-113, SAG.0002.0007.1559, p 4.

208 Exhibit 14-113, SAG.0002.0007.1559, p 3.

152. Secondly, the IMU investigation report concludes that Daniel Rogers initially appeared to have a 'bruise, red marks to the left side of his hip on Monday 19 February 2019', but states that 'upon closer inspection it appeared to be dye or paint and part of it was removed with a wet wipe by a [Windamere] support worker'.[209] This conclusion contradicts the reportable incident form prepared by Windamere Park that recorded that Daniel Rogers was discovered to have bruising on his body which was obscured by paint or dye.[210]

153. Thirdly, the IMU investigation report states that on 18 February 2019 Daniel Rogers' day option provider, Windamere Park, documented the 'paint/dye coloured mark' on Daniel Rogers' right hip but did not report this to Disability Services'.[211] The same comment is made about Windamere and its staff on 19 February 2019. The IMU investigation report fails to record that Windamere Park, a registered NDIS service provider, reported both the paint and the bruising it obscured in a reportable incident form sent to the NDIS Commission.[212]

154. Fourthly, the IMU investigation report observes that, according to one DHS support worker and Daniel Rogers' support plan, Daniel 'can become aggressive and slap himself in the chest and thighs, bite other clients and kick and hit walls. [Support worker] also stated that Daniel jumps and throws himself on to the bed suddenly and can injure himself'.[213] This comment appears to imply, without direct evidence, that Daniel Rogers' injuries may have been self-inflicted.

155. It is notable that Mr Cunningham, who gave evidence that he knew Daniel Rogers 'very well',[214] recorded in his contemporaneous notes that on 25 February 2019 he was asked by a senior colleague whether Daniel had 'any history of self abuse'.[215] According to his notes, Mr Cunningham responded 'nothing to this level', causing the colleague to recommend that an 'investigation commence'.[216]

156. Fifthly, the IMU investigation report claims that, if Windamere Park had reported the bruising to DHS as soon as it was detected, 'the injury sustained would have been found three days earlier'.[217] Given the opportunities staff at N-Street had to observe the bruising and record its severity, the report's comment reads as an attempt to shift blame to Windamere Park.

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209 Exhibit 14-113, SAG.0002.0007.1559, p 3.

210 Exhibit 14-16, IND.0081.0004.0003, p 5.

211 Exhibit 14-113, SAG.0002.0007.1559, p 3.

212 Exhibit 14-16, IND.0081.0004.0003,

213 Exhibit 14-113, SAG.0002.0007.1559, p 4.

214 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-132 [13].

215 Exhibit 14-90, SAG.0002.0007.2046, p 2.

216 Exhibit 14-90, SAG.0002.0007.2046, p 2.

217 Exhibit 14-113, SAG.0002.0007.1559, p 4.

157. Neither the IMU nor any other DHS staff notified Mr and Mrs Rogers of the outcome of the investigation. Many months later, Mrs Rogers requested DHS provide an update on the investigation. As a result of the request, Mr and Mrs Rogers met with Ms Boswell and Mr Dodd on 8 July 2020.

158. At this meeting, Ms Boswell and Mr Dodd apologised to Mr and Mrs Rogers for failing to notify them about the conclusion of the investigation.[218] Mr Dodd advised them that DHS's investigation was inconclusive.[219] When Mrs Rogers requested a copy of the investigation report, she was told she would need to make a Freedom of Information request to obtain a copy.[220]

159. Mrs Rogers considered it to be too onerous for her to be required to make a Freedom of Information request.[221] She saw the IMU investigation report for the first time during preparations for Public hearing 14.[222]

## Submissions on DHS's response to Daniel's bruising

160. Counsel Assisting submits that DHS's response to Daniel's bruising was inadequate because:

- DHS did not immediately investigate the cause of the bruising identified on 22 February 2019 with the DHS staff who supported Daniel Rogers
- the investigators did not seek expert medical opinion about the likely or possible timing or cause of the bruising
- it is not clear what effect this delay in investigation and escalation had on the prospects of identifying the cause of the bruising of Daniel Rogers.[223]

161. South Australia resists this finding and contends that the Royal Commission should find that DHS investigated the cause of the bruising at the appropriate time, making use of the earlier investigation conducted by SA Police.[224]

162. In our view, the evidence demonstrates that DHS's response to the injuries sustained by Daniel Rogers was not as timely, robust or systematic as it should have been.

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218 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-104 [47] – P-105 [1–4].

219 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-102 [29–33].

220 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-105 [16–25].

221 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-102 [33–35].

222 Transcript, Karen Rogers, Public hearing 14, 8 June 2021, P-105 [27–33].

223 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [150].

224 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [44].

163. First, the Riskman reports described the bruising as 'insignificant'.[225] South Australia seeks to justify this description on the ground that bruising often worsens following an initial trauma and the early presentation did not suggest a serious injury.[226] But Mr Cunningham conceded in his evidence that bruising should never be recorded in Riskman as insignificant.[227] Moreover, the same description was used in the recording in Riskman on 21 February when the bruising had become more pronounced and discoloured.[228]

164. Secondly, although Mr Cunningham apparently interviewed some staff, there is no evidence indicating that this was a systematic inquiry or that it was conducted in a manner likely to produce worthwhile results.

165. The IMU investigation report summarises events from the perspective of DHS staff between 17 February and 22 February.[229] However, the report sheds no light on whether this account was drawn from statements provided to police, statements provided by staff at Mr Cunningham's requests, or information provided during the course of the 'formal interviews' conducted by Mr Cunningham, or a combination of these sources. The report also fails to consider apparent inconsistencies in the accounts given by staff.

166. Thirdly, DHS did not seek an independent medical opinion addressing the nature and possible causes of Daniel Rogers' injuries.[230] The hospital radiologist expressed the view that the injuries were 'uncommon' but was unable to provide information about the cause of the injury.[231] DHS did not take any steps following Daniel Rogers' discharge from the hospital to seek another medical opinion. A doctor asked to express such an opinion could have been provided with material not available to the radiologist, such as detailed information about Daniel Rogers' movements and activities during the relevant period.

167. Fourthly, the IMU investigation was carried out in a single day, five weeks after the SA Police investigation concluded.[232] The report shows that the investigation was at best cursory, and at worst conducted with an eye to casting responsibility for Daniel Rogers' injuries on actors other than DHS.

225 Exhibit 14-132, SAG.0002.0007.2036, p 1.

226 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [45].

227 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-146 [9–12].

228 Exhibit 14-137, SAG.0002.0007.2038, p 1.

229 Exhibit 14-113, SAG.0002.0007.1559, pp 1-3.

230 Transcript, Wayne Cunningham, Public hearing 14, 8 June 2021, P-150 [13–25].

231 Exhibit 14-113, SAG.0002.0007.1559, p 3.

232 Exhibit 14-109, 'Statement of Stewart Dodd', 13 May 2021, at [61–62].

168. Rather than characterise DHS's response to Daniel Rogers' injuries as 'inadequate', it accords more precisely with the evidence to conclude that DHS's response was deficient in several specific respects. We make the following finding:

**Finding 6**

DHS's response to the injuries sustained by Daniel Rogers and recorded in Riskman on 22 February 2019 was deficient in that:

- the information recorded in Riskman was inaccurate and contributed to a delay in DHS appreciating the seriousness of the injuries
- an official investigation into the circumstances in which Daniel Rogers sustained the injuries was not commenced in a timely manner
- DHS failed to seek an urgent medical opinion about the nature and likely cause of Daniel Rogers' injuries
- the investigation conducted by DHS's Incident Management Unit (IMU) was at best cursory, and did not constitute a serious attempt to determine the cause of the injuries or the person or persons responsible.

169. It follows that we are not prepared to make the finding proposed by South Australia.

## Neglect

170. Counsel Assisting submits that a finding should be made that Daniel Rogers experienced neglect during his residence at N-Street. Counsel points to evidence of numerous failures by DHS, such as his poor state of hygiene and grooming; not dressing him appropriately; failing to ensure he had the correct medication (a failure that potentially could have very serious consequences); and failing to keep the house clean, tidy and properly maintained.[233]

171. Witnesses giving evidence on behalf of DHS recognised that the standard of service provided to Daniel Rogers (and other residents) was often unacceptable. For example, Ms Kirkby attended the house after hearing of Mrs Rogers' longstanding concerns about the conditions in which Daniel Rogers was living. The following exchange took place on the second day of the hearing:

233 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [273].

Dr Bennett: You attended the house that day and you observed the house to be dirty; is that right?

Ms Kirkby: Absolutely, yes. It was disgraceful.

Dr Bennett: Was Commissioner Bennett's characterisation that it had an air of neglect, is that a fair characterisation for you that day?

Ms Kirkby: Absolutely.

Dr Bennett: Is it acceptable that a house that is the home of these people was presenting in that way?

Ms Kirkby: Absolutely not. Absolutely not.[234]

## Submissions on neglect

172. South Australia's written submissions acknowledge that the standard of Daniel Rogers' personal hygiene and grooming and the cleanliness of N-Street was at times unacceptable.[235] Mr Simpson, who presented South Australia's oral submissions, frankly accepted the accuracy of the facts relied on by Counsel Assisting. He also did not dispute that the treatment of both Daniel Rogers and Mitchell was 'unacceptable and substandard'.[236]

173. Despite these concessions, Mr Simpson contended that a finding of neglect should not be made because Daniel Rogers had not been deprived of the necessities of life such as food and shelter.[237] According to Mr Simpson, a finding of neglect involves a legal conclusion that the facts satisfy a definition of neglect adopted by the Royal Commission.[238]

174. The following exchange explains why we reject South Australia's contention:

Mr Simpson: Well, the facts are not in dispute here, Chair. The State accepts what occurs [sic].

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234 Transcript, Muriel Kirkby, Public hearing 14, 8 June 2021, P-172 [33–46].

235 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, [59].

236 Transcript, Mr Tom Simpson, Public hearing 14, 30 September 2021, P-487 [8–9], [21–30].

237 Transcript, Mr Tom Simpson, Public hearing 14, 30 September 2021, P-487 [34–37].

238 That definition is: 'neglect includes physical or emotional neglect, passive neglect or wilful deprivation. Neglect can be a single significant incident or a systemic issue that involves depriving a person with disability of the basic necessities of life such as food, drink, shelter, access, mobility, clothing, education, medical care and treatment'; see Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability, 'Key terms', webpage. <https://disability.royalcommission.gov.au/about-royal-commission/key-terms>.

Chair: I understand that. But there are facts and facts. There are primary facts and there are inferences that you draw from primary facts … We are not applying a statute here. We are applying a definition employed by the Royal Commission to explain the concept of neglect. It may or may not be a comprehensive definition but the question of whether the uncontested primary facts fit the definition is just a question of judgment as to a matter of a fact, isn't it?

Mr Simpson: I accept that, Chair. I accept that.

Chair: What we've got essentially is a different characterisation of the same factual substratum.

Mr Simpson: That is correct, Chair. In effect, that is the issue that the State's submissions are directed at. And the State and the Department accepts that what occurred for Daniel and Mitchell was unacceptable and it was substandard and that it's treatment that people with disabilities should not be subjected to and the consequences for Mitchell and Daniel and their families are very real and we don't shy away from the fact that the Department strives to do better than what was the subject of evidence at the public hearing.

Chair: A pretty good description of neglect, isn't it, what you've just said?[239]

175. We make a finding in the terms proposed by Counsel Assisting:

**Finding 7**

Daniel Rogers experienced neglect when he resided at N-Street. His poor personal hygiene and grooming; the lack of care about his clothing and his choices about his purchases; and the unsatisfactory state of cleanliness and maintenance of the home reflected the absence of a person-centred approach by DHS at N-Street.

239 Transcript, Mr Tom Simpson, Public hearing 14, 30 September 2021, P-487 [8–32].

## Proposed recommendation

176. Counsel Assisting submits that the Royal Commission should make a recommendation to the following effect:

DHS should:

- apologise to Daniel Rogers and his family for its failure to prevent abuse and neglect when Mr Rogers resided at N-Street
- discuss with Daniel Rogers and his family additional supports they require arising from the events at N-Street, including redress for Daniel's experiences.[240]

177. The Annexure to South Australia's submission records that the CEO of DHS wrote to Mr and Mrs Rogers on 22 June 2021:

> … apologising to them and to Daniel Rogers for the hurt and pain experienced in the provision of support to Daniel. The apology recognised that the investigation failed to identify the cause of the severe bruising and for the unsatisfactory way in which the investigation outcome was communicated to them. Ms Rogers' views were also sought in relation to apologising directly to Daniel and whether an apology would be helpful and appropriate if conducted in a trauma-informed manner.[241]

178. The Annexure also records that DHS accepts the recommendation concerning additional supports and redress.[242]

179. In view of these responses, it is not necessary to make the recommendation proposed by Counsel Assisting. The Royal Commission will, however, make inquiries later in the year to find out whether there have been any further developments concerning an apology and additional supports for Daniel Rogers.

## Additional findings

180. Counsel Assisting proposes a finding that DHS failed to create an environment in which Mitchell and Daniel Rogers were safe and well-supported.[243] Counsel Assisting's submissions rely on the evidence referred to earlier in Parts 2[244] and 3 of this Report.[245]

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240 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [322(e)].

241 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, p 17.

242 Submissions of South Australia, Public hearing 14, 10 September 2021, SUBM.0014.0001.0023, p 17.

243 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [319], [323].

244 See Report, [49] ff.

245 See Report, [114] ff.

181. The findings set out earlier in this Report justify making the following finding:

**Finding 8**

DHS failed to create an environment in the Residence and N-Street in which Mitchell and Daniel Rogers were kept as safe and well-supported as they should have been and as their families were entitled to expect. Too often DHS failed to adopt a person-centred approach at the Residence and N-Street.

182. Counsel Assisting proposed an additional finding which South Australia did not resist. We make a finding to similar effect as that proposed by Counsel Assisting:

**Finding 9**

There has been inadequate institutional accountability on the part of DHS for the failures experienced by Mitchell, Daniel Rogers and their families. This has prevented them from feeling that their concerns have been properly addressed, and that DHS has taken appropriate measures to acknowledge the impact on them of DHS's failures.

# Part 4: Ann-Marie Smith

183. As we have noted, the second part of Public hearing 14 considered the responses of the South Australian and Australian governments to the reports of inquiries conducted following the death of Ms Ann-Marie Smith. The measures taken by each government in response to the investigations are a matter of public record.

184. As Counsel Assisting pointed out in her opening statement at Public hearing 14, the Royal Commission did not investigate the cause of Ms Smith's death or the conduct of any individual or organisation involved in providing care to Ms Smith.[246] This is because the Royal Commission's terms of reference require us to ensure that evidence identifying particular individuals as having been subject to violence, abuse, neglect or exploitation 'does not prejudice current or future criminal or civil proceedings or other contemporaneous inquires'.[247]

185. On 3 March 2021, the South Australian Coroner announced that SA Police were conducting an investigation into Ms Smith's death on behalf of the coroner. The South Australian Coroner will determine whether to hold an inquest once that investigation is complete.[248]

186. Counsel Assisting's submissions record that on 6 August 2020 Ms Smith's support worker was charged with manslaughter, that criminal proceedings were in progress and that the Royal Commission would not examine matters that are the subject of criminal proceedings.[249]

187. It is a matter of public record that the support worker, Rosa Maria Maione, pleaded guilty to the charge of manslaughter in the Supreme Court of South Australia. She was convicted of the offence and on 18 March 2022 sentenced to a term of imprisonment of six years and seven months, including a non-parole period of five years and three months.[250]

## Ms Smith

188. Ms Smith was a South Australian resident and NDIS participant. She died on 6 April 2020 in what have been described as 'appalling' circumstances, after a substantial period of neglect.[251]

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246 Transcript, Kate Eastman SC (Counsel Assisting), Public hearing 14, 7 June 2021, P-14 [29–31].

247 *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019, 13 May 2021, 24 June 2021, (n).

248 Courts Administration Authority of South Australia, *A statement from the State Coroner*, media release, South Australia, 3 March 2021.

249 Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [156–157].

250 *R v Rosa Maria Maione* (Supreme Court of South Australia, Bampton J, 18 March 2022).

251 Exhibit 14-216 DRC,.2000.0008.0673, p 79.

189. In the years leading up to Ms Smith's death, she lived by herself in her own home, and received support services from a sole support worker, who was employed by a registered NDIS service provider.[252] Ms Smith preferred to live as independently as possible.[253]

190. The Royal Commission heard evidence about Ms Smith's life from Brooke, a friend of over 40 years.[254] Brooke prepared a statement about her friend, known to her as 'Annie', which described Ms Smith's life as a young woman, her family life and their journey into adulthood. She remembered Ms Smith as a caring person, who was given a lot of love by her family and enjoyed many good years. Brooke said she will always cherish their friendship.[255]

## Independent reviews

191. Ms Smith's death shocked the Australian community. Soon after, a number of inquiries and reviews relating to the circumstances of Ms Smith's death were established. These include investigations by SA Police (leading to the charge of manslaughter against Ms Smith's support worker) and by Safe Work SA.

192. However, the two inquiries of most significance for the purposes of Public hearing 14 were set up by the South Australian government and the NDIS Commission:

- the South Australian government established the South Australian Safeguarding Task Force (Safeguarding Task Force) which produced Interim, Final and Supplementary Reports
- the NDIS Commission commissioned an 'Independent review of the adequacy of the regulation of supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020' (Robertson Report).

193. We refer to the Interim, Final and Supplementary Reports of the Safeguarding Task Force and the Robertson Report collectively as 'the Two Reports'.

252 Exhibit 14-216 DRC,.2000.0008.0673, p 4.

253 Exhibit 14-4, 'Statement of Brooke', 26 May 2021, at [16]. See also, *R v Rosa Maria Maione* (Supreme Court of South Australia, Bampton J, 18 March 2022).

254 A detailed summary of Brooke's evidence is found at Submissions of Counsel Assisting, Public hearing 14, 6 August 2021, SUBM.0018.0001.0001, [163–174].

255 Exhibit 14-4, 'Statement of Brooke', 26 May 2021, at [17].

## The Safeguarding Report

194. On 21 May 2020, the Minister for Human Services in South Australia established the Safeguarding Task Force, comprising twelve members, to 'examine the current gaps in oversight and safeguarding for people living with disability living in South Australia'.[256] In establishing the Safeguarding Task Force the Minister explained:

> It is clear we have some gaps in our system for our most vulnerable people with disabilities. The case of Ann Marie Smith has just shocked everyone. There have been many failings and we want to correct them.[257]

195. It will be seen that the role of the Safeguarding Task Force was not confined to considering the measures that might have protected Ms Smith from the neglect that led to her death.

196. The Safeguarding Task Force published its Interim Report on 5 June 2020,[258] its Final Report on 31 July 2020[259] and a Supplementary Report on 28 September 2020.[260] The Supplementary Report contained the entire Final Report, together with supplementary material. We refer to the Supplementary Report in this form as the 'Safeguarding Report'.

197. The Safeguarding Report identified fourteen 'Safeguarding Gaps' and made seven recommendations to address those gaps. The Safeguarding Gaps related to the functions of the NDIA, the NDIS Commission and the South Australian government, but the recommendations were directed solely to the South Australian government.

198. The Safeguarding Gaps identified by the Safeguarding Task Force include:[261]

- Potentially vulnerable participants are not routinely identified and assigned ongoing support coordination in their NDIS Plan (Safeguarding Gap 1).

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256 Exhibit 14-217, SAG.0002.0023.0114, p 30. The members of the Safeguarding Task Force are: Co-Chair David Caudrey, Disability Advocate; Co-Chair Kelly Vincent, Disability Advocate; Trevor Harrison, Disability Advocate; Jacky Chant, Disability Advocate; Sam Paior, Founder and Director, The Growing Space; Karen Rogers, Project Lead, Our Voice; Marj Ellis, Chief Executive Officer, Lighthouse Disability; Richard Bruggemann, Authorising Officer, Attorney General's Department; Anne Gale, Public Advocate, Office of the Public Advocate; Adam Kilvert, Executive Director, Attorney General's Department; Cassie Mason, Director, Office for Ageing Well, SA Health; and Lois Boswell, Acting Chief Executive, Department of Human Services.

257 Exhibit 14-217, SAG.0002.0023.0114, p 3.

258 Exhibit 14-214, SAG.0002.0023.0092.

259 Exhibit 14-215, CTD.7200.0004.4115.

260 Exhibit 14-217, SAG.0002.0023.0114.

261 Exhibit 14-217, SAG.0002.0023.0114, pp 22-23.

- The support coordinator, when assigned, can be from the same agency that provides other core services for the individual, thus creating a conflict of interest (Safeguarding Gap 2).
- The NDIS Commission does not routinely undertake proactive inspections to vet the performance of service providers (Safeguarding Gap 6).
- The NDIS Commission does not explicitly require of all providers of personal support that there be at least two support workers for that individual (not necessarily at the same time) and that workers in participants' homes have regular supervision (Safeguarding Gap 8).
- The commencement of the NDIS Commission on 1 July 2018 in South Australia created issues with the scope of the Community Visitor Scheme (CVS) (Safeguarding Gap 12).

199. The Safeguarding Gaps formed the basis of the Task Force's recommendations, which are:

> The State Government communicate the matters raised in this report to the Commonwealth Government with special reference to safeguarding Gaps 1 to 9, seeking a response on how these gaps must be addressed as soon as possible (Recommendation 1).[262]
>
> The State Government address the need for vulnerable NDIS participants to have regular health checks including communicating to the Commonwealth Department of Health (Recommendation 2).[263]
>
> The State Government extend the scope of the Adult Safeguarding Unit[264] to include younger adults at risk of abuse prior to 2022, commencing with people with disabilities (Recommendation 3).[265]
>
> DHS revisit the information sharing guidelines as they impact on screening of workers and, in particular, the availability of relevant information from the Commonwealth (Recommendation 4).[266]

262 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 43-47.

263 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 47.

264 The Adult Safeguarding Unit is a body established under the *Ageing and Adult Safeguarding Act 1995* (SA). The Adult Safeguarding Unit responds to reports of actual or suspected abuse of adults who may be vulnerable and at the time of the Safeguarding Report, had jurisdiction over all persons aged 65 years and older and Aboriginal and Torres Strait Islander people aged 50 years and older. The *Ageing and Adult Safeguarding Act 1995* (SA) has since been amended to expand the Adult Safeguarding Unit's jurisdiction to people over the age of 18 years. For an overview of the Adult Safeguarding Unit's functions see, Exhibit 14-217, SAG.0002.0023.0114, p 15.

265 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 47.

266 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 47-48.

The State Government reaffirm the value of a community visitor scheme as an additional safeguard for potentially vulnerable participants and work with the Commonwealth to establish a complementary system (Recommendation 5).[267]

The State and Local Government agencies provide for better access and inclusion so that people with disabilities can fully participate in society (Recommendation 6).[268]

The State Government invest in individual advocacy to assist individuals with accessing what they need from the NDIS and from the community (Recommendation 7).[269]

200. We address questions raised by these recommendations in Part 5 of this Report.

## The Robertson Report

201. On 26 May 2020, the NDIS Commission engaged the Honourable Alan Robertson SC,[270] a retired judge of the Federal Court of Australia (Independent Reviewer), to conduct an independent review of the adequacy of the regulation of the NDIS supports and services provided to Ms Smith (Robertson Report).[271]

202. The terms of reference for the Robertson Report required the Independent Reviewer, among other things, to identify and describe:

- the nature and level of the supports and services provided to Ms Smith
- the extent to which 'mechanisms that might have guarded against the vulnerability of Ms Smith … were available and were accessed by or on behalf of Ms Smith'
- the points, if any, at which concerns about Ms Smith's safety could have been identified and responded to by service providers, government agencies or regulators, recognising that Ms Smith had been living in relative isolation since around 2009
- consider how the NDIS Commission carried out its functions in response to the notification of Ms Smith's death
- identify any failings in how the NDIS Commission carried out its functions.[272]

267 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 48-49.

268 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 49.

269 Exhibit 14-217, SAG.0002.0023.0114, pp 24, 49-50.

270 Exhibit 14-217, SAG.0002.0023.0114, p 4; Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [12].

271 Exhibit 14-216, DRC.2000.0008.0673, p 79.

272 Exhibit 14-216, DRC.2000.0008.0673, pp 79-80.

203. The Summary in the Robertson Report stated that:

> … the main concern of this Review has been to identify what the [NDIS Commission] did or should have done and whether there were any failings in how it carried out its functions.[273]

204. The terms of reference also required the Independent Reviewer to conduct his investigation in a manner that avoided prejudice to any pending or current criminal or civil proceedings. The terms of reference also foreshadowed that the NDIS Commissioner would only publish any resulting report subject to redactions that would avoid prejudicing any criminal, regulatory or civil proceedings, or to protect the privacy of any individuals.[274]

205. In accordance with these terms of reference, the Independent Reviewer provided the NDIS Commission with two versions of the report on 21 August 2020: one unredacted and the other to be made public.[275] The unredacted version of the Robertson Report remains unpublished at the time of this Commissioners' Report.

## The nature and level of supports

206. The Independent Reviewer noted that:

> … being vulnerable, or being at risk of harm or neglect, is not static: a person with a disability may become vulnerable or may be vulnerable at one point but cease to be vulnerable. It is also worth saying that being a person with a disability does not by any means make you vulnerable. I am concerned in this case with a cluster of circumstances which made Ms Smith vulnerable.[276]

207. The Independent Reviewer considered various mechanisms that might have protected Ms Smith. They included:

- guardianship arrangements, noting Ms Smith did not have a guardian appointed[277]
- a CVS, noting that, even though a CVS operated in South Australia at the time, the service was not available to Ms Smith as she lived in her own home[278]
- the complaints system, which was of no assistance since no complaint was made by Ms Smith or on her behalf[279]

273 Exhibit 14-216, DRC.2000.0008.0673, p 4.
274 Exhibit 14-216, DRC.2000.0008.0673, pp 80-81.
275 Exhibit 14-216, DRC.2000.0008.0673, p 2.
276 Exhibit 14-216, DRC.2000.0008.0673, p 38.
277 Exhibit 14-216, DRC.2000.0008.0673, pp 38-39.
278 Exhibit 14-216, DRC.2000.0008.0673, p 40.
279 Exhibit 14-216, DRC.2000.0008.0673, pp 41-42.

- practice standards, but these did not require specifically that a person at risk, such as Ms Smith, should have more than a single carer[280]
- the Code of Conduct applying to all NDIS providers and people employed by them, noting the Code is not self-enforcing and depends on compliance by those to whom the code applies.[281]

208. The Independent Reviewer observed that:

> One 'mechanism' which may have guarded against the particular vulnerability of Ms Smith, arising from her immobility, isolation and a sole carer providing at-home services, would have been the interest of neighbours or other members of the community or of friends and relations.
>
> …
>
> Another mechanism would have been a rule, and the enforcement of a rule, that a person with the vulnerability of Ms Smith should not have been provided with a sole carer.[282]

209. As part of the review process on these and related issues, the Independent Reviewer identified a number of issues of concern:

- Ms Smith's NDIS plans were put together without the benefit of seeing Ms Smith in person or at the home where the services were to be provided[283]
- no clear mechanism existed to identify that Ms Smith was at risk of harm[284]
- although Ms Smith's NDIS plan was agency managed, she did not receive support coordination and there had been no assessment of her 'unique needs and circumstances' for the purposes of determining whether she needed support coordination in her plan[285]
- had such an assessment been done, concerns about her safety could have been identified.[286]

280 Exhibit 14-216, DRC.2000.0008.0673, p 40.
281 Exhibit 14-216, DRC.2000.0008.0673, p 41.
282 Exhibit 14-216, DRC.2000.0008.0673, p 42.
283 Exhibit 14-216, DRC.2000.0008.0673, p 43.
284 Exhibit 14-216, DRC.2000.0008.0673, p 43.
285 Exhibit 14-216, DRC.2000.0008.0673, p 49.
286 Exhibit 14-216, DRC.2000.0008.0673, p 49.

210. The Independent Reviewer concluded that the NDIS Commission could not have identified any of the concerns in the absence of a complaint or a reportable incident being reported, neither of which occurred.[287] He noted, however, that if the NDIS Commission had implemented a proactive system of identifying and visiting participants at risk of harm it might have identified those concerns, but it had no such system.[288]

## The role of regulators

211. The Independent Reviewer recounted the actions taken by the NDIS Commission in response to being notified of Ms Smith's death, although much of this section of the Robertson Report has not been disclosed publicly. The NDIS Commission's investigations culminated on 12 August 2020 in a decision to revoke the registration of Integrity Care (SA) Ltd, the provider of supports to Ms Smith.[289]

212. The Independent Reviewer made some criticisms of the way in which the NDIS Commission exercised its registration functions, notably that the registration process of Integrity Care was 'too weighted towards not jeopardising the service provider's extant registration status'.[290] But the Independent Reviewer did not regard any deficiencies in the NDIS Commission's exercise of its registration function as causative of the neglect and subsequent death of Ms Smith.[291]

213. The Independent Reviewer also considered that there had been no failing in the regulatory actions taken by the NDIS Commission following notification of Ms Smith's death. He also found that the NDIS Commission could not have screened workers to prevent the harm caused to Ms Smith, since the NDIS Commission had no such screening role.[292]

214. The Independent Reviewer considered that the model of regulation under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act) has flaws:

287 Exhibit 14-216, DRC.2000.0008.0673, p 49.

288 Exhibit 14-216, DRC.2000.0008.0673, p 49.

289 Exhibit 14-216, DRC.2000.0008.0673, p 51. The revocation was effected under s 73P of the *National Disability Insurance Scheme Act 2013* (Cth). Integrity Care (SA) Ltd was also subjected to a banning order made under s 73ZN(1)(a) of the *National Disability Insurance Scheme Act 2013* (Cth).

290 Exhibit 14-216, DRC.2000.0008.0673, pp 49-50.

291 Exhibit 14-216, DRC.2000.0008.0673, p 55.

292 Exhibit 14-216, DRC.2000.0008.0673, p 64.

> [T]he NDIS Commission has no role in regulating the NDIA or the planning process but rather regulates and supervises those providing services to the participants in the NDIS. The problem with that model of regulation which has been exposed by Ms Smith's case is that the Commission, as regulator of providers, is too dependent on those providers providing it with accurate and timely information. The Commission does not have real-time access to participant data, including participants' plans which would allow it to know immediately what supports a participant is receiving without asking the provider or the NDIA.[293]

## NDIS processes

215. The terms of reference required the Independent Reviewer to recommend any changes to the NDIS Commission's processes or systems, or the legal framework governing the NDIS Commission's functions, that he considered appropriate.[294] The Robertson Report contains ten recommendations. They include:

> (1) The Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect … The Commission and the NDIS should have a freer and two-way flow of information for this purpose.
>
> (2) No vulnerable NDIS participant should have a sole carer providing services in the participant's own home …
>
> (3) For each vulnerable NDIS participant, there should be a specific person with overall responsibility for that participant's safety and wellbeing …
>
> (4) Consideration should be given to the Commission establishing its own equivalent to State and Territory based Community Visitor Schemes to provide for individual face-to-face contact with vulnerable NDIS participants …
>
> (5) Because of the inherent limitations in record based systems in preventing harm or the risk of harm to vulnerable participants, the Commission should conduct occasional visits to assess the safety and wellbeing of selected individual NDIS participants, whether or not a complaint has been made or a 'reportable incident' notified …[295]

293 Exhibit 14-216, DRC.2000.0008.0673, p 62.

294 Exhibit 14-216, DRC.2000.0008.0673, p 80.

295 Exhibit 14-216, DRC.2000.0008.0673, pp 7-8.

# Part 5: Key issues

216. The Safeguarding Report and Robertson Report (Two Reports) were published on 28 September 2020 and 31 August 2020 respectively. The evidence shows that South Australia, the NDIS Commission and the NDIA has each taken steps to give effect to the recommendations directed to it.

217. Counsel Assisting submits that three distinct key issues rise from the recommendations in the Two Reports:

- the need to identify circumstances placing a person with disability who receives supports or services at heightened risk and the process by which the circumstances should be identified
- the appropriate safeguards that should be put in place once a person at heightened risk of abuse or neglect has been identified
- the importance of information sharing between state government entities (including DHS), the NDIA and the NDIS Commission.[296]

## Key issue 1: Identification of heightened risk

218. The Safeguarding Report stated that having a process to identify NDIS participants potentially at risk is critical, and suggested that the process should involve personal contact.[297] The Safeguarding Report also said that the NDIA should develop a methodology to assess whether participants are at risk of violence, abuse, neglect or exploitation as part of the planning process and put supports in place according to the participant's level of risk.[298]

219. Recommendation 1 in the Robertson Report was:

> The [NDIS] Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect. Every stage of decision-making, including corrective regulation, should be alive to factors indicating that a participant may be vulnerable to harm or neglect … The [NDIS] Commission and the NDIA should have a freer and two-way flow of information for this purpose.[299]

220. The Independent Reviewer also stated that, while recommendations directed to the NDIA were not within its terms of reference, the NDIA should act in the same way in its planning process.[300] Ms Anne Gale, the South Australian Public Advocate agreed that procedures to identify NDIS participants at risk should be in place at all stages of the planning process, but particularly at the beginning with a risk assessment.[301]

296 Submissions of Counsel Assisting, Public hearing 14, SUBM.0018.0001.0001, [198–261].

297 Exhibit 14-217, SAG.0002.0023.0114, p 9.

298 Exhibit 14-217, SAG.0002.0023.0114, p 21.

299 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 68.

300 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 68.

301 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [77].

221. Mr Richard Bruggemann, a Professorial Fellow in the Department of Disabilities and Social Inclusion at Flinders University, said the planning session should be conducted face-to-face, preferably in the individual's home, noting that this would be more likely to establish trust between the NDIS participant and the planner. In his view, one of the most significant factors influencing a person's level of risk is social isolation.[302]

222. Mr Bruggemann said that the planning process for people with intellectual disability, particularly those at risk of harm, should:

- involve face-to-face meetings, preferably in the person's home
- be held over multiple occasions to build necessary trust and understanding
- involve highly skilled and trained professionals from the NDIA who have experience in disability or allied health
- identify both natural and formal safeguards that already exist
- identify safeguarding gaps requiring strengthening
- involve a case manager if risk factors have been identified.[303]

223. Mr Graeme Head, the then Commissioner of the NDIS Commission, said that, following receipt of the Robertson Report, the NDIS Commission and the NDIA agreed to formalise a joint program to consider the recommendations in the report.[304] This resulted in the development of a 'vulnerable participants framework'.[305]

224. The vulnerable participants framework identifies potentially at risk participants on the basis of the types of supports received and certain risk factors.[306] For example, NDIS participants identified under the framework were contacted by NDIA staff and 'partners in the community … to check in with them' during the course of the COVID-19 pandemic.[307] Mr Martin Hoffman, the Chief Executive Officer of the NDIA said that the framework criteria were subsequently refined.[308]

302 Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [63], [65–66]; Transcript, Richard Bruggemann, Public hearing 14, 7 June 2021, P-72 [5–6].

303 Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [67].

304 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [39].

305 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [40]; see also, Exhibit 5-48, 'Statement of Samantha Taylor', 13 August 2020, at [64(b)], [89].

306 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [41]; Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [56–57].

307 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [55].

308 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [57].

225. At the time of the hearing, the risk factors associated with the types of supports received included: living in residential aged care or supported independent living/ specialist disability accommodation; receiving core daily activities supports; participating in Australian Disability Enterprises; and participating in group programs.[309] Mr Hoffman also listed living alone as a criterion to be used in the framework.[310] He appears to have incorporated this criterion as a consequence of a suggestion in the Safeguarding Report.[311]

226. Other risk factors included a participant:

- being over the age of 55 or over the age of 40 and living with parents
- being an Indigenous person
- receiving community nursing, disability-related health or behavioural supports
- requiring assistive products for personal care and safety
- self-managing the NDIS package
- living in short-term crisis accommodation or in a boarding house or shelter or experiencing homelessness.[312]

227. Mr Head estimated that the vulnerable participants framework would identify between 25,000 to 30,000 participants as needing check-ins.[313] Mr Hoffman gave evidence that the NDIA contacted over 70,000 NDIS participants through this program by May 2021.[314] Mr Hoffman explained the difference between these figures was due to the NDIA's evolving understanding of vulnerability and risk and the changing circumstances of NDIS participants which could identify them as being at risk.[315]

228. Mr Head stated that the issues for the NDIS Commission in ensuring it is fully implementing Recommendation 1 of the Robertson Report[316] were:

- to identify deficiencies in the NDIS Commission's approach to risk at the system level
- to work with the NDIA to identify how individual participants at risk can be identified
- to ensure the risks identified for individual participants are responded to appropriately whether by the NDIS Commission, the NDIA or other agencies.[317]

309 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [41(a)].

310 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [56(a)].

311 Exhibit 14-217, SAG.0002.0023.0114, p 8.

312 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [41(b)].

313 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021 at [47]; Exhibit 14-223, CTD.9999.0024.0001, pp 4-5.

314 Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-262 [31–44]; Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [55].

315 Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-262 [39–44].

316 See Report, [219].

317 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [69].

229. Mr Hoffman said the NDIA continued to work with the NDIS Commission, the Australian government Department of Social Services (DSS) and the states and territories to formulate a definition of 'vulnerability' for the purposes of the 'vulnerable participants framework'.[318] Mr Hoffman said in practice the NDIA assesses vulnerability in the context of planning conversations, either in person or over the phone.[319] During planning conversations, planners or Local Area Coordinators (LACs) gather detailed information about a participant's situation, including mainstream, informal and community supports and the impact of their disability on their daily life.[320] As part of these conversations, planners or LACs complete risk assessments that enable them to identify risks and safeguards in participants' lives. They also identify strategies to mitigate risks to the participants and build their capacity to choose and manage the supports in their plans.[321]

230. The starting point for the NDIA is a risk streaming method for all participants as they enter or interact with the NDIS. Streaming refers to the predicted level of assistance or support a participant may need to navigate the NDIS pathway.[322] The factors considered when determining a participant's stream include participants having minimal or no known informal or community supports; currently living in or will be moving into shared supported accommodation; or having a history of abuse or neglect.[323]

231. Mr Hoffman said the NDIA process is intended to identify informal supports or the lack thereof, and to mitigate identified risks.[324] However, Mr Head expressed concerns about the practical operation of the process:

> The NDIA vulnerable participants framework recognises that having a limited informal support network can contribute to vulnerability. However, it is not yet clear to me how completely the NDIA's current data would enable the presence or absence of strong natural supports to be reliably identified.[325]

232. Mr Hoffman noted that the NDIS Quality and Safeguarding Framework (NDIS Framework), like the NDIS, operates on the presumption that all people with disability have the capacity to make decisions and exercise choice and control. Strategies for reducing harm therefore need to consider the likelihood of harm occurring and its severity, and the impact the strategies will have on the participant's choice and control.[326]

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318 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [54–57]. See Report, [27–29] concerning the use of the term 'vulnerable'.

319 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [62].

320 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [63].

321 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [64].

322 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [31].

323 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [33].

324 It is relevant to note that the terms of reference require the Royal Commission to have regard to the Framework; *Letters Patent* (Cth), 4 April 2019 amended 13 September 2019, 13 May 2021, 24 June 2021, (f).

325 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [83].

326 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [27]; see also, Exhibit 14-216, DRC.2000.0008.0673, pp 42, 70.

233. The evidence at Public hearing 14 supported the recommendations in the Two Reports that the NDIA should include in its planning process systems to identify NDIS participants at risk of neglect or abuse. However, the evidence also made it clear that implementing the recommendations requires careful thought and planning.

## Key issue 2: Risk management

234. The second key issue relates to the appropriate response once any NDIS participant is identified as being in a situation of heightened risk of abuse or neglect. The Two Reports considered a number of safeguarding responses for NDIS participants identified as being at heightened risk.

### Designating responsibility for NDIS participants at heightened risk of harm

235. A major theme in the Two Reports related to the lack of continued oversight over NDIS participants within the NDIS system. This was said to arise from the structural complexity of the NDIS and the lack of co-ordination between various sections of the NDIS. The Independent Reviewer described this as 'the piecemeal provision of care to those who wanted it'.[327] He observed that:

> the NDIS has many moving parts, with many roles. This complexity may lead to an end point where there is nobody that has a locus of responsibility to make sure that things are going well overall for the individual. Because there are so many different players, there is no natural person to contact when things are not going so well.[328]

236. The Safeguarding Report made a similar observation when discussing the relationship between the NDIA's LAC, NDIA Planner, Plan Manager, and Support Coordinator roles:

> As well as this cast of players there is an array of functions they perform - from local area coordination, support connection, support coordination, specialist support coordination, plan management and planning. If that sounds confusing and unnecessarily complex it is because it is.[329]

237. This theme from the Two Reports informed the Independent Reviewer's Recommendation 3, which reads in full as follows:

> [f]or each vulnerable NDIS participant, there should be a specific person with overall responsibility for that participant's safety and wellbeing. That individual should be clearly identified by name and, ideally, introduced in person, to the vulnerable NDIS participant. (Although not within my terms of reference, that individual should be identified in a participant's plan.)[330]

327 Exhibit 14-216, DRC.2000.0008.0673, p 70.

328 Exhibit 14-216, DRC.2000.0008.0673, p 70.

329 Exhibit 14-217, SAG.0002.0023.0114, p 8.

330 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 70.

238. Ms Gale described the state-operated system in place before the introduction of the NDIS, where a person with disability had a Service Coordinator or 'case manager' through Disability SA.[331] Ms Boswell confirmed that DHS Disability Community Services previously provided case management services and coordinated supports for adults living with disability, but noted that under the NDIS these services are now delivered by external providers. Accordingly, all DHS Disability Community Services offices had closed by 22 May 2020.[332]

239. Ms Gale gave evidence that under the state-based system, a person with disability knew their case manager and could contact them during business hours. She said that the case manager worked holistically with the person to assist them to connect to both paid disability supports as well as mainstream community supports.[333]

240. According to Ms Gale, there are currently multiple contact points for NDIS participants but no single person or position has overall responsibility for connecting the participant to supports or services.[334] This means that:

    a. There is a lack of support for vulnerable people during the access process. LAC staff are often not experienced enough to engage the clients of OPA [Office of the Public Advocate], many of whom will not readily engage or do not identify as needing service or having a disability.

    b. The lack of a consistent, trusted person in the life of a person with disability has put pressure on OPA staff to fill the gaps by undertaking tasks that fall outside of their traditional remit.

    c. There is no obvious person to work through crises and coordinate responses to homelessness, social hospital admissions, hospital discharge or correctional release.[335]

241. Ms Gale expressed the view that specialist support coordinators are the 'logical' candidates to fulfil such a role in the NDIS system.[336] She acknowledged that in practice, the role of specialist support coordinators is restricted by funding limitations within NDIS plans, both for supports generally and the services of the support coordinator themselves.[337] Accordingly, she recommended that funding for specialist support coordination be uncapped[338] and that support coordination be included in the NDIS planning process.[339]

331 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [78].

332 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [77].

333 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [78].

334 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [79].

335 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [82].

336 Transcript, Anne Gale, Public hearing 14, 9 June 2021, P-226 [45–46].

337 Transcript, Anne Gale, Public hearing 14, 9 June 2021, P-227 [1–12].

338 Transcript, Anne Gale, Public hearing 14, 9 June 2021, P-227 [33–38].

339 Transcript, Anne Gale, Public hearing 14, 9 June 2021, P-228 [6–10].

242. Mr Bruggemann expressed the view that a case manager should be designated as the person with ultimate responsibility for monitoring the safety, health and wellbeing of a participant identified as being at risk.[340] He did not identify who should fulfil this case manager role but thought that some functions should be carried out by LACs. He also observed that the responsibilities of case managers under the former state-based system are now divided between '[NDIA] planners, LACs, support coordinators and others'.[341]

243. Mr Head suggested that, where a person within the 'NDIS apparatus' is identified as being at heightened risk, it may be appropriate to have a single focus point or locus of responsibility for that person.[342] However, he agreed that such a focus point would more appropriately sit within the functions of the NDIA, suggesting that there is little the NDIS Commission can do to formally adopt the recommendation.[343] Mr Hoffman stated that, consistent with the NDIS Framework, the NDIA's view is that different bodies and individuals, starting with the NDIS participant themselves, share responsibility for promoting the safety and wellbeing of a participant and working to reduce risk of abuse, violence, neglect and exploitation.[344] The Robertson Report also acknowledged that 'the structure of the [NDIS] Framework … emphasises the responsibility for safeguarding does not lie with a single government agency or service provider'.[345]

244. Mr Hoffman's view that NDIS participants are presumed to have capacity to make decisions that affect their own lives does not respond to the concern at the heart of the Two Reports: that some people with disability are in a position of heightened risk and that the bodies concerned with the services and supports they receive should take additional steps to safeguard them.[346]

245. We agree that the NDIS Framework envisions that multiple stakeholders will be jointly responsible for safeguarding NDIS participants. However, this shared responsibility for participants' ongoing safety can be distinguished from the function identified in Recommendation 3 of the Robertson Report.

246. Notwithstanding his views about the shared responsibility for safeguarding participants, Mr Hoffman acknowledged that the NDIA plays a significant role in assessing participants at risk, particularly through the role played by LACs and planners during planning process.[347] This is consistent with the evidence concerning

340 Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [73].

341 Exhibit 14-53, 'Statement of Richard Bruggemann', 24 May 2021, at [72].

342 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-318 [5–20].

343 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-318 [34–39].

344 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [75].

345 Exhibit 14-216, DRC.2000.0008.0673, p 44.

346 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [76].

347 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [61–64].

the NDIA's 'streaming process'.[348] It is also consistent with the NDIS Framework's recognition that holistic risk assessments should be conducted during the plan development process, and its identification of the NDIA planner as the person responsible for 'work[ing] with the participant to discuss ways of managing risk and build[ing] strategies to reduce risk into plan implementation'.[349]

247. The Independent Reviewer did not identify a particular office within the NDIA that he considered an appropriate locus for identifying at risk NDIS participants. However, he observed that neither of the delegates who approved Ms Smith's first and second NDIS plan had a face-to-face, or any, meeting with her. This was despite the express advice recorded on her transition to the NDIS that '[d]ue to deteriorating condition person experiences difficulties with understanding complex matters and wishes to have her friend present to assist, face to face contact required'.[350]

248. The Independent Reviewer also observed that the LACs who collected information from Ms Smith to assist the planning delegate only spoke to Ms Smith by telephone with her sole support worker present on the call.[351] While the LACs' conduct was consistent with the NDIA's standard operating procedures at the time, he concluded that 'the process adopted in Ms Smith's case did not fully utilise the planning process as a safeguarding and risk detection measure, consistent with the [*NDIS Act*] and the [NDIS] Framework'.[352]

249. Since the NDIA planning process and the NDIS Framework are currently under review, the NDIA and NDIS Commission have an opportunity to improve the measures required at the planning stage to identify NDIS participants who are at risk of harm, consistently with Recommendation 3 of the Robertson Report.

## NDIS participants living alone and sole carers

250. The Safeguarding Report recognised that the best safeguard for people with disability living alone is to have relatives and friends who can readily provide support if a risk of harm threatens to materialise.[353] Another layer of protection would be in place if the participant's service provider engaged more than one worker to support a participant living alone.[354] The extra pair of eyes would reduce the risk of violence, abuse, neglect or exploitation by a worker who is the exclusive source of support for the participant, even if the participant trusts and respects that worker.[355]

348 See Report, [230].

349 Australian Government Department of Social Services, NDIS Quality and Safeguarding Framework, December 2016, p 31.

350 Exhibit 14-216, DRC.2000.0008.0673, p 44.

351 Exhibit 14-216, DRC.2000.0008.0673, p 44.

352 Exhibit 14-216, DRC.2000.0008.0673, p 45.

353 Exhibit 14-217, SAG.0002.0023.0114, p 21.

354 Exhibit 14-217, SAG.0002.0023.0114, p 21.

355 Exhibit 14-217, SAG.0002.0023.0114, p 21; Exhibit 14-216, DRC.2000.0008.0673, pp 69-70.

251. The Robertson Report recommended that '[n]o vulnerable NDIS participant should have a sole carer providing services in the participants own home',[356] but the Independent Reviewer acknowledged that strategies for avoiding or mitigating harm need to be balanced against the participant's right to exercise choice and control.[357] These observations should be considered in the light of article 19 of the *CRPD*.

252. Article 19(b) provides that people with disability have the right to access a range of in-home, residential and other community support services. It also provides that the purpose of those services is to 'support living and inclusion in the community, and to prevent isolation or segregation from the community'.[358] A recommendation that persons who live alone and have no other connections to the broader community should have more than one support worker is based on the need to mitigate the increased risk of violence, abuse, neglect and exploitation by a sole support worker. In our view, the recommendation in the Robertson Report is consistent with article 19(b).

253. Mr Head provided a detailed response about the steps the NDIS Commission had taken in relation to the issue of NDIS participants living alone. Mr Head summarised the actions of the NDIS Commission:[359]

- In May and June 2020, the NDIS Commission requested information from 2,466 registered NDIS providers who were registered to provide assistance with daily personal activities.
- Between July and October 2020, the NDIS Commission requested information from the 495 registered NDIS providers whose responses to the initial request for information prompted further inquiries about their compliance with their obligations under the NDIS Practice Standards and the NDIS Code of Conduct.[360]
- On 20 November 2020, the NDIS Commission imposed an additional condition of registration on registered NDIS providers that are registered to provide assistance with daily personal activities.
- From 1 February 2021, the NDIS Commission commenced monitoring registered NDIS providers' compliance with the additional condition of registration imposed on 20 November 2020.
- The NDIS Commission has undertaken a number of compliance actions arising from these compliance activities.

356 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 69 (Recommendation 2).

357 Exhibit 14-216, DRC.2000.0008.0673, p 70.

358 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 19(b).

359 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [125].

360 The first two actions predated the Robertson Report.

- The NDIS Commission has engaged an external consultant to undertake consultation with stakeholders about a possible change to the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) to make more permanent the requirements currently implemented through the imposition of the additional condition of registration. This consultation process is due to conclude by the end of May 2021, after which the NDIS Commission will consider amending the NDIS Rules.

254. The NDIS Commission Registrar communicated the additional condition of registration to NDIS registered service providers on 4 November 2020.[361] The notification explained that the NDIS Commissioner had chosen to exercise his power under section 73L(2) of the *NDIS Act* to vary registration requirements by imposing an additional registration condition on providers of personal supports to NDIS participants who live alone.[362] Clause 4 of the condition states that providers must not allow personal support to be provided by a sole support worker to a participant unless the provider:

    a. Firstly, has assessed whether any of the risk factors exist in relation to the participant; and

    b. Secondly:

        i. has entered into a written service agreement with the participant; or

        ii. has prepared a proposed written service agreement to enter into with the participant, made all reasonable efforts to enter it with the participant and provided a copy of it to the participant.[363]

255. Under the condition, 'risk factors' are defined as 'factors that may have a significant impact on a participant's capacity to engage in the community'. Clause 7 of the condition lists the factors:

    a. The participant is not receiving, from any other NDIS provider, supports or services that involve regular, face-to-face contact with the participant.

    b. One or more of the following applies:

        i. The participant or the participant's plan indicates that the participant has limited or no regular, face-to-face contact with relatives, friends or other people with whom the participant is well-acquainted.

361 Exhibit 14-192, CTD.7200.0016.0481.

362 Exhibit 14-192, CTD.7200.0016.0481.

363 Exhibit 14-192, CTD.7200.0016.0481, 3; see also, NDIS Quality and Safeguards Commission, 'Providers of assistance with daily personal activities (personal supports): Additional condition of registration', web page. <https://www.ndiscommission.gov.au/providers/providers-assistance-daily>.

ii. Without the assistance of another person the participant has limited or no physical mobility.

iii. The participant uses equipment to enable them to be physically mobile or to facilitate their physical mobility.

iv. Without the assistance of another person the participant has limited or no ability to communicate with others.

v. The participant uses equipment to enable or facilitate communication with others, including to enable or facilitate the use of a phone or other device.[364]

256. Clause 9 of the condition also imposes particular requirements on the contents of the service agreement required under clause 4(b)(ii), which must consider the participant's risk factors and specify:

e. the rights and obligations of the participant and the provider, respectively, under the agreement;

f. the means by which the participant's support worker will be selected, including the participant's role in the selection;

g. a procedure that will be used to review implementation of the agreement, which must include someone other than the support worker checking directly with the participant, and with appropriate frequency, the participant's level of satisfaction with the type, quality and frequency of personal support being provided;

h. the means by which the provider will supervise and monitor the performance of the support worker to ensure the performance is consistent with the agreement and the participant's safety and well-being, which must include (as far as practicable) visits by a supervisor to the participant's home, at a specified and appropriate frequency, to undertake in-person supervision of the support worker;

i. the means by which the provider will communicate with the participant, which must include (as far as practicable) face-to-face communication with the participant in the participant's home at an appropriate frequency;

j. the means by which the provider will engage with other providers who may be involved in providing supports or services to the participant in the participant's home or in supporting the participant to access community based activities.[365]

364 Exhibit 14-192, CTD.7200.0016.0481, 4; see also, NDIS Quality and Safeguards Commission, 'Providers of assistance with daily personal activities (personal supports): Additional condition of registration', web page. <https://www.ndiscommission.gov.au/providers/providers-assistance-daily>.

365 Exhibit 14-192, CTD.7200.0016.0481, 4; see also, NDIS Quality and Safeguards Commission, 'Providers of assistance with daily personal activities (personal supports): Additional condition of registration', web page. <https://www.ndiscommission.gov.au/providers/providers-assistance-daily>.

257. The additional condition would have provided protection for Ms Smith had the NDIS Commission adopted it during her life. Of particular note are clauses 9(g) and (h), which are to the effect that a person other than the sole support worker must have direct contact with a participant who lives alone. Clause 9(i) requires this contact to be face-to-face with the participant and in their home, as far as practicable.[366]

258. Mr Head explained that the condition does not prevent the NDIS participants choosing a sole carer arrangement, but requires appropriate arrangements to be in place to guard against risks to the participant.[367] The Safeguarding Task Force considered that the NDIS Commission's failure to expressly require recipients of personal supports to have at least two support workers created a safeguarding gap.[368] The new condition goes some way towards addressing the Safeguarding Task Force's concerns.

259. While the notification to service providers on 4 November 2020 indicated that the condition was an interim one,[369] the condition remains in force on the NDIS Commission's website.[370] The NDIS Commission appears to have concluded its consultations on the efficacy and appropriateness of the additional condition in September 2021, after the conclusion of Public hearing 14. A report recording the outcomes of that consultation[371] summarises stakeholder views about the additional condition:

> There was no consensus among stakeholders that the literal interpretation of the Robertson Review's recommendation 2 was either practical, desirable, or necessary. There was, however, general support among the stakeholders for the NDIS Commission's initial response to the Robertson recommendation, being the additional condition attached to service providers' registration. None of the stakeholders interviewed expressed any concern that the NDIS Commission's response was other than appropriate given its statutory and regulatory obligations.[372]

366 Information for providers has also been published on the NDIS Commission's website. See, NDIS Quality and Safeguards Commission, 'Providers of assistance with daily personal activities (personal supports): Additional condition of registration', web page. <https://www.ndiscommission.gov.au/providers/providers-assistance-daily>.

367 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [156].

368 Exhibit 14-217, SAG.0002.0023.0114, p 13 (Safeguarding Gap 8).

369 Exhibit 14-192, CTD.7200.0016.0481, p 1.

370 Information for providers has also been published on the NDIS Commission's website. See, NDIS Quality and Safeguards Commission, 'Providers of assistance with daily personal activities (personal supports): Additional condition of registration', web page. <https://www.ndiscommission.gov.au/providers/providers-assistance-daily>.

371 NDIS Quality and Safeguards Commission, 'Final stakeholder consultation report for Regulatory Recommendation 2 in the Robertson Review into circumstances relating to the death of Ann-Marie Smith', web page. <https://www.ndiscommission.gov.au/document/3301>; see also, Exhibit 14-195, CTD.7200.0016.0388.

372 NDIS Quality and Safeguards Commission, 'Final stakeholder consultation report for Regulatory Recommendation 2 in the Robertson Review into circumstances relating to the death of Ann-Marie Smith', web page. <https://www.ndiscommission.gov.au/document/3301>; Exhibit 14-195, CTD.7200.0016.0388, p 14.

260. In light of this feedback we consider it is appropriate that the NDIS Commission retain the condition while reviews of the NDIA planning process and the NDIS Framework continue.

## A conflict of interest?

261. The Safeguarding Report found that a support coordinator employed by an agency that provides other services for the same NDIS participant is not truly independent. The report concluded that not separating the roles invites conflicts of interest and 'participant capture'.[373]

262. Ms Gale expressed the view that NDIS participants whose supports and services are provided by a single service provider are at greater risk of harm because of the potential for a conflict of interest. She said that OPA staff often receive proposals from Supported Independent Living (SIL) providers to also provide accommodation to an NDIS participant in receipt of SIL from that provider. Ms Gale thought that a potential conflict of interest also occurs when the same agency provides support coordination (or specialist support coordination) and SIL services.[374]

263. On 15 April 2021, Ms Gale wrote to Mr Hoffmann to express her concerns about the potential for conflict of interest to arise when the support provider and the accommodation provider are the same entity.[375] Mr Hoffman responded on 10 May 2021,[376] indicating his willingness to work together on the issues that she raised in her correspondence.[377]

264. In the meantime, Ms Gale said that where support services are linked to accommodation, she believed that people with disability are at increased risk of abuse and neglect. In Ms Gale's experience, service providers who provide support and accommodation to the same participant will either provide those services under a single agreement, or will require the participant to agree to exclusive arrangements that bind them to the single agency.[378] If the service provider is no longer willing or able to provide SIL services, the NDIS participant will lose both the SIL service and their accommodation.[379]

265. Mr Head said that the NDIS Commission's regulation of providers requires them to address and manage any conflicts of interest.[380] For example, all NDIS providers, including unregistered providers, must comply with the NDIS Code of Conduct. One of the obligations for all NDIS providers and workers under the NDIS Code of Conduct is that they act with integrity, honesty and transparency.[381]

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373 Exhibit 14-217, SAG.0002.0023.0114, pp 9-10.

374 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [57].

375 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [59]; Exhibit 14-60, SOA.9999.0002.0001.

376 Exhibit 14-61, SOA.9999.0002.0004.

377 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [61].

378 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [62].

379 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [62].

380 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [191–204].

381 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [191].

266. At the time of Public hearing 14, the NDIS Commission had not formed a view that there was an inherent conflict of interest where a participant receives support coordination from an NDIS provider that also provides core NDIS supports to the participant.[382]

267. Mr Head argued that, if limitations are placed on support coordinators also providing core supports, it would be important to consider the maturity of the NDIS market and the availability of NDIS providers, particularly in rural and remote settings. It would also be important to consider whether limitations could be subject to maintaining the participant's choice and control so that a participant could choose to have a support coordinator that also provides core supports to the participant if they wished to do so.[383] Mr Hoffman generally agreed with Mr Head's position.[384]

## Key issue 3: Information sharing

268. The third key issue relates to information sharing between the State of South Australia, the NDIA, and the NDIS Commission. The Robertson Report recommended greater levels of information sharing between the various entities at a number of levels.[385] The Safeguarding Report also referred to gaps in information sharing.[386]

### Information sharing arrangements and infrastructure

269. Ms Boswell said that work on information sharing arrangements between various agencies within the South Australian government and the NDIS Commission was continuing in response to the gaps in information sharing between state agencies, the NDIA and the NDIS Commission that were identified in the Safeguarding Report.[387]

270. Public hearing 14 also received evidence about developments in information sharing arrangements between the NDIS Commission and NDIA. In the context of identifying vulnerable NDIS participants, Mr Head reported that the NDIA intended to provide its 'vulnerability flags' to the NDIS Commission for officers to view through the NDIS Commission's Operating System.[388] The so-called 'participant view' gives NDIS Commission officers information about reportable incidents, complaints and behaviour support issues. It also provides access to demographic information about the participant, including their culturally and linguistically diverse status; whether they are an Aboriginal or Torres Strait Islander person; the participant's disability and secondary disabilities; and key details about their NDIS plan.[389]

382 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [187].

383 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [190].

384 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [93].

385 Exhibit 14-216, DRC.2000.0008.0673, pp 8, 77 (Recommendations 1, 7, 8 and 9).

386 Exhibit 14-217, SAG.0002.0023.0114, pp 23-24; see, Safeguarding Gap 11 and Recommendation 4 of the Safeguarding Report.

387 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at pp 23-24.

388 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [48].

389 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [49].

271. Mr Head said the NDIS Commission would contribute data to the NDIA under the NDIA's vulnerable participants framework for the provider issues theme. This would likely include data about any providers identified by the NDIS Commission as being subject to investigation in circumstances where it was known or seemed likely that the NDIS Commission would seek to take significant enforcement action against the provider.[390] Mr Head reported that the NDIS Commission has access to information held by the NDIA under the Data Access and Transfer Operational Protocol (Data Protocol) agreed between the NDIA and the NDIS Commission in July 2020.[391] The Data Protocol provides for data sharing using 'authorised datasets'.

272. The Data Protocol specifies the authorised datasets each agency provides to the other. These include a range of demographic and other information about each participant, including disability types and some indicators relevant to risk (for example, being in shared supported accommodation or residential aged care); plan dates and plan activity indicators; and support categories and classes and the funded budget amount.[392] Data is provided to the NDIS Commission on a fortnightly basis, although the NDIA also provides additional, up-to-date information to the NDIS Commission on request.[393]

273. Mr Head stated that negotiations were underway to provide the NDIS Commission with direct access to the NDIA's information system 'PANDA' to allow access to more up-to-date data 'where access to the data that is updated fortnightly is not considered sufficient'.[394]

274. The Data Protocol also provides that information can be shared under an 'exceptional data request process'. This process relates to sharing data outside the authorised datasets; for external release of data included in the datasets; and for purposes not approved under the Data Protocol.[395] The Data Protocol also states that sharing of identified data between the NDIA and the NDIS Commission is authorised under the *NDIS Act* 'where there is a serious threat to the life, health or safety of an individual … for the purpose of identifying and contacting individuals at risk'.[396] More recent amendments to this legislative scheme for sharing information are discussed below.

390 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [45].

391 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [90].

392 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [92].

393 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [275–276].

394 Exhibit 14-183, 'Statement of Graeme Head', 14 May 2021, at [276].

395 Exhibit 14-211, CTD.8000.0013.0365, pp 7-8, Appendix C, Appendix D.

396 Exhibit 14-211, CTD.8000.0013.0365, p 8.

## Amendments to legislation

275. In October 2021, the Australian Parliament passed legislation amending the *NDIS Act* in response to recommendations in the Robertson Report.[397] The *National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Act 2021* (Cth) (*NDIS Amendment Act*) expands the powers of the NDIA to record, disclose or use information in circumstances where it is reasonably believed that it is for the purpose of, or in relation to, preventing or lessening a threat to an individual's life, health or safety.[398] This replaces the previous standard of 'serious threat', which was criticised by the Robertson Report as imposing too high a threshold on the NDIA and NDIS Commission in the performance of their functions.[399] According to the Explanatory Memorandum:

> This amendment will enable the [NDIA] and the [NDIS] Commission to provide a proactive individualised approach to identifying a participant that may be at risk of harm so that appropriate actions can be taken to reduce and better protect the participant.[400]

276. *The NDIS Amendment Act* confers a new power on the NDIS Commission to disclose information to state and territory agencies for the purposes of NDIS worker screening.[401] Similar to changes affecting the NDIA, the *NDIS Amendment Act* also lowers the threshold for the NDIS Commission for information recording, disclosure or use from being necessary to prevent or lessen a 'serious' threat to an individual's life, health or safety, to 'a threat', current or future.[402]

397 *National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Act 2021* (Cth).

398 *National Disability Insurance Scheme Act 2013* (Cth) s 60(2)(e).

399 Explanatory Memorandum, National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Bill 2021 (Cth), p 5; see also, Recommendations 1, 7, 9 of the Robertson Report, Exhibit 14-216, DRC.2000.0008.0673, pp 68-69, 77-78.

400 Explanatory Memorandum, National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Bill 2021 (Cth), p 5.

401 *National Disability Insurance Scheme Act 2013* (Cth) s 67A(1)(da).

402 *National Disability Insurance Scheme Act 2013* (Cth) s 67A(1)(e); Explanatory Memorandum, *National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Bill 2021*, p 7.

# Part 6: Areas for further investigation

## Risk factors

277. As we have explained, each of the Two Reports into the circumstances of Ms Smith's death concluded that it was important for the regulatory framework governing disability services to identify and take account of the factors that can increase the risk that a recipient of services will experience violence, abuse, neglect or exploitation.[403]

278. The Royal Commission intends to investigate further the mechanisms for the identification and protection of people with disability at heightened risk. We will consider the measures that have been introduced for NDIS participants and assess whether:

- they are adequate
- they should be extended to include other people with disability who are not NDIS participants, and, if so, how.

## Person-centred approach to service delivery

279. The experiences of Mitchell, Daniel Rogers and Ms Smith demonstrate the importance of a person-centred approach to the delivery of services and supports for people with a disability.

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

281. In the Robertson Report, the Independent Reviewer observed that the NDIS Framework and the legislative scheme underpinning the NDIS emphasise that the system is supposed to be 'person-centred'. However, he considered a number of steps in Ms Ann-Marie Smith's interactions with the NDIS would be more appropriately described as 'transactional' and 'form driven'.[404] These included occasions involving automated decision-making; the absence of face-to-face meetings; and a failure to observe the setting where Ms Smith received the services delivered under her plan – in her home.[405] The Independent Reviewer concluded that in Ms Smith's circumstances a person-centred approach to the preparation and approval of her plan would have provided a 'fundamental quality and safeguarding measure' that would operate as a complement to the corrective and regulatory powers available under the *NDIS Act*.[406]

403 See Report, at [218] ff.

404 Exhibit 14-216, DRC.2000.0008.0673, pp 46-47.

405 Exhibit 14-216, DRC.2000.0008.0673, p 46.

406 Exhibit 14-216, DRC.2000.0008.0673, p 47.

282. It is not enough for a policy to claim to be person-centred. Person-centred approaches must be embedded in day-to-day practice and cultures of all those responsible for the delivery of services.

283. The Royal Commission intends to continue investigating how service providers and their regulators can be encouraged or, if necessary, required to implement person-centred practices. The Royal Commission's Final Report will address this issue.

## Conflicts of interest

284. As noted in relation to the first key issue above, the Royal Commission received evidence that a conflict of interest may arise in circumstances where a person with disability receives support coordination and other support services from the same service provider.[407] The Royal Commission received similar evidence at Public hearing 13.[408]

285. The Royal Commission intends to examine further whether a conflict of interest arises where an NDIS participant receives support coordination and other services from the same service provider, and the appropriate response to such a conflict.

## Communication

286. The importance of effective and appropriate communication is a key theme emerging from all of the case studies. It has two components: communication with individuals with disability, and communication with their families, supporters and advocates.

287. Effective communication with the person receiving supports and services is perhaps the most important means of ensuring the person exercises choice and control over the delivery of services. Effective communication is also essential to determine in a timely fashion that supports and services are not working well or that a person with disability is at risk of harm. This is a lesson to be learnt from Mitchell and Daniel's case studies. Ms Smith's case illustrates the disastrous consequence that can result from the absence of face-to-face meetings between people with disability living alone and agencies responsible for providing or funding supports.

407 See Report, [261–267].

408 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Report of Public hearing 13: Preventing and responding to violence, abuse, neglect and exploitation in disability services (a case study)*, April 2022, [300].

288. The ability to raise concerns and complaints without fear of recrimination is part of good and effective communication. The experiences of Victoria, James, Mitchell, and Karen and Daniel Rogers demonstrate the consequences for a person in residential disability accommodation if communications between the service provider, the resident and the resident's family break down.

289. The Royal Commission intends to continue its inquiries into the ways that communication between people with disability and their supporters and disability services and regulators can be supported and encouraged.

## Quality of services

290. Providing high quality services and supports is necessary to ensure that people living in supported disability accommodation feel safe in their home environment and are protected against violence, abuse, neglect and exploitation. Daniel Rogers feared going into his own home and leaving his bedroom. Mitchell's home was the place where he had to live with the threat of violence contained in the 3 March Letter. Neither of the families who gave evidence at Public hearing 14 described their sons' supported disability accommodation as having the sense of a home. Both families spoke of the importance of Daniel Rogers and Mitchell feeling that they live in a safe and comfortable home.

291. Quality of services is also a fundamental concern underpinning a number of the recommendations flowing from the Two Reports. In particular, the Robertson Report's recommendation that 'no vulnerable NDIS participant should have a sole carer providing services in the participant's own home'[409] was founded on the basis that a second (or further) carers or support workers can increase the oversight over service delivery and the quality of services provided.[410] The Two Reports highlighted the potential for a reduction in the quality of services when there is not a second set of eyes evaluating the quality of provision of those services.

## Community Visitor Schemes

292. Public hearing 14 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. In Mitchell's case, the then Principal Community Visitor played a significant role in monitoring the First Investigation and alerting the South Australian Ombudsman of his concerns about the way the 3 March Letter was managed by DHS. This ultimately led to the Ombudsman initiating an investigation, which recommended that DHS conduct the Second Investigation.

409 Exhibit 14-216, DRC.2000.0008.0673, pp 7, 69 (Recommendation 2).

410 Exhibit 14-216, DRC.2000.0008.0673, pp 69-70.

## Community Visitor Schemes by jurisdiction

293. The South Australian CVS is established under the *Mental Health Act 2009* (SA).[411] The Principal Community Visitor and community visitors are independent statutory appointments.[412] Similar state government funded bodies operate to visit people with disability in most other states and territories,[413] except Western Australia and Tasmania.[414]

294. Community visitors are empowered by legislation to visit and inspect facilities or services where people with disability live identified under legislation. In South Australia these include mental health treatment centres, community mental health facilities and state government-operated disability accommodation.[415] They also provide advocacy and support to the people with disability living in or using these facilities.

295. From May 2019, the South Australian CVS ceased visiting non-government disability accommodation service providers, supported residential facilities and day options programs.[416] In September 2019, Ms Ann Gale, who is both the South Australian Principal Community Visitor and the South Australian Public Advocate, used her statutory authority as the Public Advocate to delegate the power to visit people subject to guardianship orders with the Public Advocate to the South Australian CVS.[417] Ms Gale said that community visitors complemented the work of the Public Advocate as they can visit people under guardianship orders (including NDIS participants) on a more regular basis than the staff of the Public Advocate. Community visitors are also able to monitor the needs of people who are visited but who do not necessarily require active decisions to be made on their behalf.[418]

296. For NDIS participants who are not under the guardianship of the Public Advocate and are clients of NDIS provider-operated disability services, the NDIS Commission is the primary body with responsibility for providing oversight of disability services.[419]

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411 *Mental Health Act 2009* (SA) div 2.

412 *Mental Health Act 2009* (SA) s 50.

413 *Ageing and Disability Commissioner Act 2019* (NSW) pt 4; *Children's Guardian Act 2019* (NSW) pt 9; *Disability Act 2006* (Vic) pt 3 div 6, pt 6 div 7; *Public Guardian Act 2014* (Qld) pt 6; *Official Visitor Act 2012* (Act); *Mental Health and Related Services Act 1998* (NT) pt 14; *Disability Services Act 1993* (NT) pt 6.

414 In Western Australia, a number of community visitor schemes are operated by non-government organisations, although these are not established under legislation and do not visit people with disability. In Tasmania, the state government's official visitor scheme is empowered to visit only prisons and mental health facilities under the *Mental Health Act 2013* (Tas) and the *Corrections Act 1997* (Tas).

415 *Mental Health Act 2009* (SA) ss 52, 52A; *Disability Services (Community Visitor Scheme) Regulations 2013* (SA) reg 4.

416 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [152].

417 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [28].

418 Transcript, Anne Gale, Public hearing 14, 9 June 2021, P-216 [5–40].

419 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [150].

297. As noted in earlier parts of this Report, Daniel Rogers and Mitchell lived in supported disability accommodation that was operated by DHS under in-kind arrangements. The arrangements are governed by a bilateral agreement between the South Australian government and the Australian government governing the transition to the NDIS.[420] The bilateral agreement provides that between 1 July 2018 and 30 June 2023 the NDIS will operate under transitional arrangements in South Australia.[421] Under the agreement, South Australia is entitled to offset a portion of the funds it is obliged to contribute to the NDIS through in-kind arrangements, by which it funds supported disability accommodation for NDIS participants in that state.[422] The government bodies which operate those services – namely DHS and its agencies – are not registered NDIS providers for the purpose of regulating those services.[423] The South Australian CVS continues to operate within these settings because community visitors have jurisdiction to visit 'state government-operated disability accommodation' in South Australia.[424]

298. When the NDIS becomes fully operational in South Australia, DHS-operated disability accommodation will be operated by a government-owned trading entity registered as an NDIS registered provider.[425] This will result in sites and services which currently operate under in-kind arrangements (and therefore under state jurisdiction) falling under the NDIS Commission's regulatory jurisdiction. The transition in regulatory arrangements over these accommodation settings will mean that under current legislation in South Australia the CVS will also lose the authority to visit these sites.

## Community Visitor Schemes following the transition to the NDIS

299. During Public hearing 14, the Royal Commission received evidence about recent measures taken by the NDIA and the NDIS Commission to engage actively with NDIS participants deemed 'at risk', including under the vulnerable participants framework.[426] Mr Hoffman gave evidence that by May 2021 the NDIA had contacted over 70,000 NDIS participants through this program.[427] Mr Head also gave evidence about the NDIS Commission's exercise of its visitation powers in South Australia between 1 July 2018 and the date of the hearing.[428]

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420 See Report, at [38], [108].

421 Exhibit 14-222, DRC.2000.0008.0828, cl 6-7.

422 Exhibit 14-222, DRC.2000.0008.0828, cl 56, Schedule B.

423 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [76]; Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-235 [16–30].

424 *Disability Services (Community Visitor Scheme) Regulations 2013* (SA) reg 3 (definition of 'disability accommodation premises').

425 Exhibit 14-122, 'Statement of Lois Boswell', 19 May 2021, at [76]; Transcript, Martin Hoffman, 9 June 2021, P-235 [16–30].

426 See Report, [223] ff.

427 Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-262 [31–44]; Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [55]. See also Report, [227].

428 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-325 – P-326 [3–20].

300. While the check-in program employed by the NDIA during the COVID-19 pandemic and the NDIS Commission's visitations appear to have been well received, both differ significantly from CVS programs.

301. First, the programs differ in their scope and operations. The NDIA check-in program does not require a complaint to be made and is only available to NDIS participants identified as 'vulnerable' by the NDIA.[429] Visits are generally prompted by the NDIS Commission identifying compliance concerns on the part of a registered NDIS service provider and are targeted at providers, rather than participants.[430] By contrast, community visitors routinely visit sites and services independently of compliance concerns, as authorised by legislation. Community visitors are entitled to visit, speak to and observe support workers and people with disability, including people who are not NDIS participants and those who may not fall within the NDIA's definition of 'vulnerable'.[431]

302. Second, the purpose of the NDIA's check-in program and of the NDIS Commission's visits differ from the objective of CVS programs. The purpose of the check-in program is 'to reassure participants that they are well supported and connected with the NDIA, and that the NDIA and partners are responsive to their needs'.[432] The check-in program 'also aims to help the NDIA identify any risk or potential safety concerns for the participants'.[433] However, Mr Hoffman accepted that the program is not intended to be a mechanism for NDIS participants to raise concerns about crisis situations unrelated to their disability or the services they receive.[434]

303. The NDIS Commission's site visits have a broader range of purposes, including discussing complaints, conducting welfare checks, educating providers on behaviour support, conducting investigations and responding to reportable incidents.[435] However, the most common purposes for NDIS Commission visits in South Australia between 2018 and May 2021 were to engage with providers and monitor compliance.[436]

304. The purpose of the South Australian CVS is to 'monitor, report and advocate for individuals and on systemic issues for people using state run disability services and mental health services'.[437] Ms Gale explained that the CVS has a broad role which allows it to respond to and refer complaints; engage with individuals and service providers about issues affecting the wellbeing of persons visited; identify non-compliant activity; comment on quality of life issues; and assist individuals to access services.[438]

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429 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [56].

430 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-325 [31–46] – P-326 [9–13].

431 See Report, [292].

432 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [59].

433 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [59].

434 Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-267 [20–47].

435 Exhibit 14-183, Statement of Graeme Head, 14 May 2021, at [217(a)–(f)].

436 Exhibit 14-183, Statement of Graeme Head, 14 May 2021, at [219].

437 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [17].

438 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [91].

305. Third, neither the NDIA nor the NDIS Commission's programs appear to have powers of inspection similar to those available to CVS programs. The NDIA's check-in program is focused on direct contact between the NDIA and the NDIS participant. Mr Head said that when conducting a visit NDIS Commission officers could require a service provider to produce certain records, but inspection of documents would generally be left to the Commission's auditing processes.[439]

306. The Safeguarding Report noted that the South Australian government has received advice from the South Australian Crown Solicitor's Office that the *NDIS Act* has 'covered the field' of quality and safeguards for NDIS service providers and participants.[440] Ms Boswell agreed this was still South Australia's position at the time of Public hearing 14.[441] If correct, this advice means that, except as permitted by Commonwealth legislation, a state cannot authorise a CVS to assess and report on the quality of facilities and services provided by an NDIS service provider to NDIS participants using NDIS funding.[442]

307. In contrast, Queensland, New South Wales and Victoria have introduced reforms expressly empowering their CVS to visit NDIS service provider operated sites and services. In Queensland, community visitors are empowered to 'regularly visit' adult NDIS participants in 'visitable sites', including authorised mental health services, forensic disability services and premises where NDIS participants live and receive supports or services other than private dwellings.[443] In New South Wales, community visitors are entitled to visit 'visitable services', which include accommodation services where any adult with disability is in the full-time care of the service provider, an assisted boarding house or any other service prescribed as a visitable service.[444] In Victoria, community visitors are empowered to visit supported disability accommodation settings and other NDIS provider operated sites.[445] The continued operation of CVS programs in the NDIS sector in these three states suggests that South Australia is unique in its interpretation of the *NDIS Act*.

308. We express no view on the correctness of the legal advice received by South Australia. It is sufficient to note that South Australia has acted on this advice by limiting the types of services and sites that its CVS can visit. In consequence, a significant group of NDIS participants who used to receive visits no longer have the benefit of this oversight mechanism. The number of South Australian NDIS participants who do not receive community visitors in South Australia will grow when in-kind arrangements end on 31 June 2023.

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439 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-329 [25–47] – 330 [6–16].

440 Exhibit 14-217, SAG.0002.0023.0114, p 18.

441 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-420 [10–14].

442 *Australian Constitution* s 109; *Clyde Engineering v Cowburn* (1926) 37 CLR 466; *Ex parte McLean* (1930) 43 CLR 472; *R v Credit Tribunal; Ex parte General Motors Acceptance Corporation (Australia)* (1977) 137 CLR 545, 563-4.

443 *Public Guardian Act 2014* (Qld) ss 39 (definition of 'visitable site'), 41-42.

444 *Ageing and Disability Commissioner Act 2019* (NSW) s 20 (definition of 'visitable services').

445 *Disability (National Disability Insurance Scheme Transition) Amendment Act 2019* (Vic) item 54; *Disability Act 2006* (Vic) s 130(2).

309. Ms Gale said the absence of regular, routine inspections by a regulator or other independent body leaves vulnerable people at risk if service providers are inexperienced or under-resourced.[446] She said that establishing a dedicated national CVS for all NDIS participants, led by the NDIS Commission potentially in partnership with the States and Territories, would assist in protecting the rights of people with disability at risk of harm.[447]

## A national Community Visitor Scheme?

310. The Robertson Report recommended that the NDIS Commission consider establishing its own equivalent to state and territory based CVSs.[448] The Independent Reviewer also recommended that the NDIS Commission should conduct occasional visits to assess the safety and wellbeing of selected individual NDIS participants, whether or not a complaint has been made.[449] This recommendation appears to contemplate a more active role for the NDIS Commission than it has adopted to date.

311. The Independent Reviewer cited a review of CVS programs nationally conducted in 2018 by WestWood Spice and chaired by DSS (WestWood Spice review). The WestWood Spice review recorded that 'CVS achieve important outcomes for people with disability in services, encouraging them to express their views, listening, building capacity in asserting rights or linking with supported decision-making processes and advocates'.[450] The WestWood Spice review concluded that the CVS programs have a broader scope than the NDIS but have a 'contribution to make to the NDIS Quality and Safeguarding Framework and … should be formally recognised within the NDIS Framework'.[451] The review also recommended that the role of community visitors should continue to be provided by state and territory-based CVSs,[452] and that all jurisdictions should work towards national consistency in key aspects of the CVS.[453]

312. The WestWood Spice review considered the establishment of a national CVS under the helm of the NDIS Commission to be consistent with the NDIS Commission's oversight role.[454] The review identified a number of benefits from the introduction of a national CVS under the NDIS Commission. These included providing a single point for complaints; national consistency in practices and standards; links between 'key areas of risk' including restrictive practices; and direct flow of information between community visitors and the NDIS Commission.[455]

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446 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [90].

447 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [93].

448 Exhibit 14-216, DRC.2000.0008.0673, p 71 (Recommendation 4).

449 Exhibit 14-216, DRC.2000.0008.0673, p 75 (Recommendation 5).

450 Exhibit 14-218, CTD.7200.0016.0406, p 8.

451 Exhibit 14-218, CTD.7200.0016.0406, p 51 (Recommendation 1).

452 Exhibit 14-218, CTD.7200.0016.0406, p 51 (Recommendation 2).

453 Exhibit 14-218, CTD.7200.0016.0406, p 51 (Recommendation 5).

454 Exhibit 14-218, CTD.7200.0016.0406, p 43.

455 Exhibit 14-218, CTD.7200.0016.0406, p 43.

313. The review also identified several disadvantages to a national CVS which, in its view, outweighed the advantages. These included:

- A national CVS under the NDIS Commission would not have the same independent status and impartiality held by state and territory CVS programs.[456]
- A national CVS under the NDIS Commission would only have jurisdiction over services and sites within the NDIS Commission's jurisdiction and over NDIS participants. By contrast, CVS programs around Australia have jurisdiction over a range of sites and settings and over people with disability who are not NDIS participants.[457]
- CVS programs typically take a broad view of the lives of the people they visit, rather than seeing them as consumers of services. A national CVS under the NDIS Commission would be more limited in its approach to visitation because it would be restricted by the NDIS Commission's jurisdiction and priorities.[458]

314. Mr Head was supportive of CVS programs generally, but he agreed with the WestWood Spice review that the CVS has not been designed with the NDIS system in mind. He said that the NDIS changed some of the 'fundamental concepts' underpinning CVS programs.[459] Mr Head acknowledged that there is some overlap between the NDIS Commission's site visits and the work of CVS but he considered that the former was not intended to replace the latter.[460]

315. In a letter to the Deputy Secretary, DSS on 1 April 2021,[461] Mr Head suggested that an NDIS community visitor scheme could be established modelled on existing state and territory schemes with any necessary adaptations. The NDIS Commission could be required to report on its operation after a certain period of time and then lead a consultation process to determine the future scope and functions of the scheme.[462]

316. Mr Head also suggested that any national CVS established under or in connection to the NDIS Commission should align with existing information gathering mechanisms. He noted he had advised the Ministerial Council for Disability Reform to give consideration to the establishment and operation of a national CVS as part of the review of the NDIS Framework.[463] In Mr Head's view, the NDIA's planning processes, which are meant to be used to identify the presence of risk factors and the absence of supports, could be used to direct the efforts of a national CVS.[464]

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456 Exhibit 14-218, CTD.7200.0016.0406, p 44.

457 Exhibit 14-218, CTD.7200.0016.0406, p 44.

458 Exhibit 14-218, CTD.7200.0016.0406, p 44.

459 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-321 [20–25].

460 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-237 [4–8].

461 Exhibit 14-183, 'Statement of Graeme Head AO', 14 May 2021, at [249].

462 Exhibit 14-183, 'Statement of Graeme Head AO', 14 May 2021, at [253].

463 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-323 [3–11].

464 Transcript, Graeme Head, Public hearing 14, 10 June 2021, P-323 [33–44].

317. Mr Head was of the view that the NDIS Commission did not have the power to establish its own CVS. He considered this to be a decision for government, particularly DSS.[465] Mr Hoffman considered this to be a matter for the Ministerial Council for Disability Reform to determine,[466] although he said the merits of such a scheme were under consideration by the NDIA.[467]

318. The evidence examined at Public hearing 14 shows that there are conflicting views among stakeholders and between jurisdictions about the need for a national CVS operating under the NDIS Commission. While all witnesses generally expressed the view that community visitors perform a valuable role in the context of disability services, there is a lack of consistency in the approaches taken by states in prescribing their jurisdiction, particularly following the introduction of the NDIS. The Royal Commission intends to examine further the interactions between CVSs and the NDIS in its later work.

## Community visits to private homes

319. The Safeguarding Report recognises the value of community visits into the person's own home but acknowledges that the South Australia CVS does not have statutory power to enter the private home of a person with a disability, except by invitation.[468] In the other jurisdictions with CVS programs examined in this Report, none expressly empowers community visitors to enter a person's private home.[469]

320. The Safeguarding Report points out that conferring power on a CVS to enter private homes without an invitation presents significant human rights issues.[470] Ms Gale raised similar concerns, recording that 'many people with disability do not consider it appropriate' for a CVS to have such powers.[471]

321. Accordingly, if a proposal to confer such power is to be seriously considered, people with disabilities should first be consulted. The Royal Commission will consider this issue further.

465 Exhibit 14-183, Statement of Graeme Head, 14 May 2021, at [242]; Transcript, Graeme Head, Public hearing 6, 25 September 2020, P-362 [9–15].

466 Transcript, Martin Hoffman, Public hearing 14, 9 June 2021, P-271 [3–5].

467 Exhibit 14-202, 'Statement of Martin Hoffman', 20 May 2021, at [82].

468 Exhibit 14-217, SAG.0002.0023.0114, p 18.

469 See Report, [305].

470 Exhibit 14-217, SAG.0002.0023.0114, p 17.

471 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [27].

## Provider of last resort

322. Public hearing 14 heard evidence about the need for 'providers of last resort' when a person with disability, including an NDIS participant, is at risk of becoming homeless. This can happen when the participant does not have private accommodation and there is no provider willing and able to provide accommodation for the participant.[472]

323. Prior to the introduction of the NDIS in South Australia, DHS was the provider of last resort.[473] This role was apparently not created by legislation or regulations and the evidence did not address closely how DHS performed that role. However, DHS has continued to act as a provider of last resort during the transition to the NDIS.[474]

324. During the hearing, Ms Gale explained the need for a provider of last resort 'that can step in when the market fails to provide the required services'.[475] This is particularly significant following the introduction of the NDIS, which is a market-based system.

325. Ms Boswell also gave evidence that DHS will likely continue to undertake the provider of last role, even after full transition to the NDIS in that state.[476] However, she was unsure whether this would continue permanently.[477]

326. The Joint Standing Committee on the NDIS recommended in its report *Transitional Arrangements for the NDIS* that the Australian, state and territory governments and the NDIS collaborate to include crisis housing and provider of last resort arrangements in their bilateral agreements governing the transition to the NDIS in each jurisdiction.[478] The recommendation does not appear to have been followed in South Australia, as the bilateral agreement between the Australian government and South Australia makes no reference to a provider of last resort.

327. In our view there should be a 'provider of last resort' in each Australian jurisdiction. There will always be people with disability who require care and support outside the NDIS or other programs established by legislation and specifically funded by governments. There will also be circumstances where the market is unable to meet the needs of particular NDIS participants for one reason or another. South Australia correctly recognises that it cannot completely 'vacate the field' in providing disability services.[479]

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472 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [40].

473 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [3–10].

474 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [3–10].

475 Exhibit 14-58, 'Statement of Anne Gale', 28 May 2021, at [44].

476 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [3–10].

477 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [13–16].

478 Joint Standing Committee on the National Disability Insurance Scheme, *Transitional arrangements for the NDIS* (15 February 2018), p xii (Recommendation 9).

479 Transcript, Lois Boswell, Public hearing 14, 11 June 2021, P-359 [1–16].

328. The Royal Commission is concerned to ensure that provision is made for providers of last resort in all Australian jurisdictions. This is an issue which the Royal Commission will investigate further.

329. Accordingly, the Royal Commission identifies the following areas for further investigation:

- the adequacy of mechanisms to identify and respond to NDIS participants at heightened risk of violence, abuse, neglect and exploitation, and whether those mechanisms should be extended to people with disability who are not NDIS participants
- how disability service providers and their regulators can be encouraged or, if necessary, required to implement person-centred practices
- whether a conflict of interest arises when a person receives support coordination and other support services from the same service provider, and the appropriate response to such a conflict
- how communication between people with disability and their supporters and disability services and regulators can be supported and encouraged
- the quality of disability support services
- the interaction between CVS programs and the NDIS
- the continued operation of providers of last resort following the transition to the NDIS in all Australian jurisdiction.

# Appendices

## Appendix A: Leave to appear and legal representatives

| Party | Legal representatives |
|---|---|
| Australian Government,<br>National Disability Insurance Scheme Quality and Safeguards Commission, and<br>National Disability Insurance Agency | K Downes QC with B Deighton, instructed by Gilbert +Tobin |
| State of South Australia,<br>South Australian Public Advocate, and<br>South Australian Principal Community Visitor | T Simpson, instructed by the Crown Solicitor's Office |
| Victoria and James | O'Brien Lawyers |

# Appendix B: List of witnesses

| Witness | Date of appearance |
|---|---|
| Victoria (a pseudonym) | 7 June 2021 |
| James (a pseudonym) | 7 June 2021 |
| Richard Bruggemann | 7 June 2021 |
| Karen Rogers | 8 June 2021 |
| Wayne Cunningham, Department of Human Services | 8 June 2021 |
| Muriel Kirkby, Department of Human Services | 8 June 2021 |
| Antony Allwood, Department of Human Services | 9 June 2021 |
| Anne Gale, Public Advocate and Acting Principal Community Visitor | 9 June 2021 |
| Martin Hoffman, National Disability Insurance Agency | 9 June 2021 |
| Graeme Head AO, National Disability Insurance Scheme Quality and Safeguards Commission | 10 June 2021 |
| Lois Boswell, Department of Human Services | 10 June 2021 |
| Stewart Dodd | No appearance (provided written statement only) |

## Appendix C: Acronyms and abbreviations

| Acronym/Abbreviation | Definition |
|---|---|
| **3 March Letter** | Anonymous letter received by Victoria and James at their home address on 3 March 2018 |
| **CRPD** | *Convention on the Rights of Persons with Disabilities* |
| **COS** | Commission Operating System |
| **CVS** | Community Visitor Scheme |
| **Data Protocol** | Data Access and Transfer Operational Protocol agreed between the NDIA and the NDIS Commission in July 2020 |
| **DHS** | South Australian Department of Human Services |
| **DS Act** | *Disability Services Act 1993* (SA) |
| **DSS** | Commonwealth Department of Social Security |
| **First Investigation** | South Australian Department of Human Services' Incident Management Unit investigation commencing 20 April 2018 |
| **First Investigation Report** | South Australian Department of Human Services' Incident Management Unit investigation report dated November 2018 |
| **IMU** | South Australian Department of Human Services' Incident Management Unit |

| Acronym/Abbreviation | Definition |
|---|---|
| **interim measures** | Measures implemented between 3 and 5 March 2018 by DHS in response to the 3 March Letter, including regular safety checks and overnight supervision of Mitchell, and ensured that a shift supervisor was present at the Residence overnight and created a list of support workers approved by Victoria and James to work with Mitchell |
| **LAC** | Local Area Coordinator |
| **NDIA** | National Disability Insurance Agency |
| **NDIS** | National Disability Insurance Scheme |
| **NDIS Act** | *National Disability Insurance Scheme Act 2013* (Cth) |
| **NDIS Amendment Act** | *National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Act 2021* (Cth) |
| **NDIS Commission** | National Disability Insurance Scheme Quality and Safeguard Commission |
| **NDIS Framework** | National Disability Insurance Scheme Quality and Safeguarding Framework |
| **N-Street** | A supported accommodation site operated by DHS subject to in-kind funding arrangements; Daniel Rogers' place of residence |
| **OPA** | South Australian Office of the Public Advocate |
| **Robertson Report** | *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 |

| Acronym/Abbreviation | Definition |
|---|---|
| **Royal Commission** | Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability |
| **SA** | South Australia |
| **SA Police** | South Australian Police |
| **Safeguarding Report** | Supplementary Report of the Safeguarding Taskforce dated 28 September 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 |
| **Second Investigation** | South Australian Department of Human Services' Incident Management Unit investigation commencing January 2021 |
| **Second Investigation Report** | South Australian Department of Human Services' Incident Management Unit investigation report dated 12 February 2021 |
| **SIL** | Supported Independent Living |
| **Two Reports** | The Safeguarding Report and the Robertson Report |
| **WestWood Spice review** | Community Visitor Schemes Review, Department of Social Services for the Disability Reform Council, Council of Australian Governments, dated December 2018 |


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