TRANSCRIPT OF PROCEEDINGS

THE HON RONALD SACKVILLE AO QC, Chair
MR ALASTAIR McEWIN AM, Commissioner
DR RHONDA GALBALLY AC, Commissioner

THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

PUBLIC HEARING 20

THURSDAY, 28 APRIL 2022 AT 10.01 AM (AEDT)

DAY 7

MR PATRICK GRIFFIN SC, Senior Counsel Assisting
MR BEN FOGARTY, Counsel Assisting

CHAIR: Good morning everyone. Today's hearing follows Public hearing 20 which was held over six days from 7 to 14 December 2021. That six-day hearing examined in particular two case studies involving a registered service provider Life Without Barriers. The purpose of today's hearing is to receive oral submissions from Counsel Assisting the Royal Commission and from any of the parties given leave to appear at the Public hearing who wish to supplement the written submissions they have filed in reply to Counsel Assisting's submissions.

I'm joined today by Commissioner Alastair McEwin AM in the Sydney hearing room and by Commissioner Rhonda Galbally AC. Commissioner Galbally is joining the hearing from Melbourne.

I begin with an acknowledgement of country. We wish to acknowledge the Gadigal People of the Eora Nation, the traditional custodians of the land upon which Commissioner McEwin and I are sitting at this hearing, and we pay our respects to their elders past, present and emerging.

We also acknowledge the Wurundjeri people of the Kulin Nation upon which lands Commissioner Galbally is participating in this hearing. We pay our respects to their elders past, present and emerging. We also pay our respects to all First Nations people who may be following this hearing on the live stream or otherwise.

The two case studies which were the subject of evidence of Public hearing 20 principally related to two houses operated by Life Without Barriers. The first case study focussed on the experiences of two residents of the Lismore house to which we've given the pseudonyms of Sophie and Natalie. Sophie gave evidence herself and her parents, Michelle and Greg, also pseudonyms, gave evidence about Sophie's experiences.

Natalie's mother, Jennifer - that's also a pseudonym, gave evidence in the form of a written statement, which was read at the hearing.

The second case study concerned a group of residents living together in the Melbourne house, or a Melbourne house, operated by Life Without Barriers, specifically Rebecca, Robert, Amanda and Marco are the names we have given to those residents. The Royal Commission heard about the experiences of these residents from Robert's foster parent, Paul, via audiovisual link and from Rebecca's mother Catharine via prerecorded evidence.

At the conclusion of the hearing directions were made for Counsel Assisting the Royal Commission to file written submissions, and for all parties who had been given leave to appear at the hearing to have the opportunity to file written submissions in reply. The directions stated that after receiving all written submissions and responses, the Royal Commission would hold a further short hearing for the purpose of receiving oral submissions. That is the hearing we are holding today, 28 April 2022.

Counsel Assisting the Royal Commission filed extensive written submissions on 18 March 2022. These total about 250 pages. Six parties have filed written submissions in response to Counsel Assisting's submissions. Responses have been received on behalf of Sophie, Greg and Michelle, Paul, LWD - LWB Manager 2, as the relevant person was referred to,

from Life Without Barriers, and from the Australian Government. Life Without Barriers' written submissions, in particular, are also very extensive, comprising about 140 pages. All written submissions are available on the Royal Commission's website.

The Royal Commission so far as published Commissioners' reports of a number of public hearings. As has been explained previously, we do not intend to publish a Commissioners' report for each Public hearing, although, of course, the evidence of all hearings will inform the final report of the Royal Commission. However, we do intend to publish in due course a Commissioners' report for Public hearing 20, and that report will contain findings and recommendations.

What findings and recommendations to make on the basis of the evidence presented at Public hearing 20, we shall, of course, be taking into account the written and oral submissions of Counsel Assisting the Royal Commissions and of the parties who have been given leave to appear at the hearing. I shall now take appearances.

MR P. GRIFFIN SC: Chair, my name is Patrick Griffin SC. I appear along with Ben Fogarty as junior counsel as Counsel Assisting the Royal Commission. Can I also mention the appearance of Ms Anne Healey of counsel who appeared for Michelle and Greg. Ms Healey is in London and the nature of the connection is such she doesn't want to disrupt the inquiry by announcing her own appearance.

CHAIR: Thank you very much for that. Can I take the other appearances, starting with the Commonwealth of Australia.

MS MORGAN: Commissioners, may it please the Royal Commission, my name is Morgan and I appear for the Australian Government.

CHAIR: Thank you, Ms Morgan. An appearance for the State of New South Wales.

MS FURNESS: My name is Gail Furness and I appear with Mr Glover for the State of New South Wales.

CHAIR: Yes, thank you, Ms Furness. Is there an appearance for the State of Victoria.

MS R. BEDFORD: Yes, there is, Commissioner. It is Rebecca Bedford from MinterEllison for the State of Victoria.

CHAIR: Thank you, Ms Bedford. Do we have an appearance on behalf of Sophie?

MS CRAIG: Good morning, Commissioners. My name is Ms Craig, and I appear on behalf of Sophie.

CHAIR: Thank you, Ms Craig. And is there an appearance on behalf of Paul?

MR BRENNAN: Yes. Good morning. If the Commission pleases, my name is Brennan and I appear for Paul.

CHAIR: Thank you, Mr Brennan. Life Without Barriers.

MS CALLAN: Yes. If it please the Commission, my name is Callan. I appear with Ms Ellicott instructed by Corrs Chambers Westgarth for Life Without Barriers. Can I also indicate to the Commission that from Life Without Barriers in attendance remotely, watching all or substantial part of this hearing, are a number of the members of the Board of Life Without Barriers and the whole of the Life Without Barriers Senior Executive Team, plus its General Counsel.

CHAIR: Yes. Thank you very much, Ms Callan. There is, I think, an appearance from REDinc; is that right?

MR O'BRIEN: Yes. Good morning, Commissioners. O'Brien for REDinc.

CHAIR: Thank you, Mr O'Brien. There may be an application later from the Office of the Public Advocate of Victoria, but we will defer that for the moment, I think. Yes, Mr Griffin.

MR GRIFFIN: Can I indicate that, of the written submissions received, they fall into various categories. Firstly, an invitation to the State of New South Wales and New South Wales Ombudsman and also the State of Queensland elicited the response that they didn't wish to make any written submissions.

CHAIR: Thank you.

MR GRIFFIN: Written submissions where there was no request to make oral submissions were received from Sophie, Michelle and Greg, Paul, worker or Manager number 2 and the Araluen Centre. And written submissions with a desire to make oral submissions were received from the Australian Government, Life Without Barriers, and the Public Advocate of Victoria.

In respect of the Public Advocate of Victoria, on 22 April, that office sought leave to file written submissions. You, Chair, determined they could appear today and seek leave to hand up those written submissions. If leave is granted, Ms Fritze, a solicitor from that office, will seek to make some short oral submissions based upon these written submissions. My understanding is that those written submissions have been provided to the other parties.

CHAIR: Mr Griffin, when will be a convenient time to deal with that application?

MR GRIFFIN: Chair, we can either deal with it now, or it's proposed that the application will be made when I've finished my oral submissions.

CHAIR: Yes. Well, I'm content with the latter course so we will deal your oral submissions. Thank you.

MR GRIFFIN: In addition, Life Without Barriers made an application on 12 April 2022 to adduce further evidence. On 21 April 2022, Chair, you accepted the tender of this evidence which, in short compass, is a supplementary statement of Claire Robbs, the CEO of Life Without Barriers dated 12 April 2022, the Life Without Barriers practice government

framework which bears the number LWB.0007.0001.0220, and short biographies of two external members of Life Without Barriers' practice governance committee which bears the reference numbers LWB.0016.0003.0001 for the first biography, and 0002 for the second. So that's the evidence as it currently stands before the Commissioners.

Before I deal in any detail with the proposed findings to be made by the Commission, as you've indicated, Chair, Public hearing 20 was the third 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.

Two case studies were considered. They went under the general title of the Lismore houses and the Melbourne house. The focus of the hearing was to look at the role and responsibility for preventing and responding to violence, abuse, neglect to residents in supported accommodation. There were, as a result of the public hearing, some common themes which emerged.

Firstly, the allegations of violence, abuse, neglect and exploitation experienced by residents living in LWB group homes at the hands of staff, other residents and persons external to those homes. Secondly, the adequacy of measures that LWB took to prevent such violence, abuse, neglect and exploitation. Thirdly, the adequacy of LWB's response to allegations of that nature.

Fourthly, the role played by the National Disability Insurance Scheme Quality and Safeguards Commission in its uncovering or responding to allegations of others of possible violence, abuse, neglect and exploitation of residents. And, finally, the role played by NDIA which is the National Disability Insurance Agency in allocating and funding and planning of supports and services to residents, and how that may have contributed to their vulnerability to violence, abuse, neglect or exploitation.

The submissions prepared by Counsel Assisting are both comprehensive and extensive. They adopt the following structure: After the introductory sections outlining some of the matters I've briefly summarised, we then look in part 2, a summary of the history and structure of Life Without Barriers. Part 3 addresses in some detail the events of the Lismore houses, particularly in respect to Sophie and Natalie's experience, and we take a narrative overview before considering the issues presented by each case study, and analysing the documentary evidence.

Part 4 of Counsel Assisting's submissions address the Melbourne house, and, again, we proceed by way of a narrative of the experiences of the residents of the house before considering the particular issues presented in that case study by way of analysis of the evidence. Part 5 addresses general issues relating to Life Without Barriers, including the evidence provided by the CEO, Ms Claire Robbs. And part 6 provides detailed consideration of external bodies including the NDIS Commission, the NDIA, and the role of community visitors in respect to group homes.

And finally, in part 7, Counsel Assisting outlines the recommendations and findings which we invite the Royal Commission to make on the basis of the evidence presented at the Public hearing.

We circulated to the parties a list of proposed findings which have subsequently been amended, and, as a result of discussions which have occurred right up until this morning, that document has been further amended, and I propose to make it available to the parties during the course of the morning. If it assists those following the proceedings, can I just take the opportunity to go through the document which has been circulated and indicate some recent changes.

CHAIR: Can I just check with you, please. I have a document headed Amended List of Proposed Findings and Recommendations; is that the most recent version?

MR GRIFFIN: As far as I'm aware.

CHAIR: Alright. I assume -

MR GRIFFIN. --

CHAIR: I assume my colleagues have the same document.

MR GRIFFIN: Yes. If one goes to those findings which have been proposed by Counsel Assisting and move to - just to finding number 8, I now understand that that finding is accepted in the amended form by Life Without Barriers. Can I indicate where there are -

CHAIR: I'm sorry to interrupt. Is it possible to bring these paragraphs up on the screen as you're referring to them, or is that a little too difficult?

MR GRIFFIN: I will check. I'm told potentially.

CHAIR: Well, I suggest you continue, and if we're able to accommodate that request, no doubt the relevant paragraph will appear on the screen. You go ahead, please.

MR GRIFFIN: Can I indicate that proposed finding 8 is accepted by Life Without Barriers, and can I indicate, subject to anything that Ms Callan has to say, that I understand that where amendments have been made, which have partly been suggested by Life Without Barriers, if Counsel Assisting has agreed to those amendments, it follows that they then accept that finding.

The next one I wish to go to is proposed finding 13. It comes under heading Notification of Sexual Assault to the Board. With the exception of the word "systematic" being altered to "systemic", that finding is accepted by Life Without Barriers.

CHAIR: So that requires "systemic" to be substituted for "systematic" on the version that we have?

MR GRIFFIN: That's correct.

CHAIR: Thank you.

MR GRIFFIN: In respect to proposed finding 15, that is accepted by Life Without Barriers in the amended form.

CHAIR: Yes.

MR GRIFFIN: If I can take you over to proposed finding 50, Counsel Assisting seeks to amend the last line of that proposed finding to insert the word "some" before the words LW -

CHAIR: Just give us a moment because I think the team is doing an heroic job in bringing up the paragraphs. So if we can bring up paragraph 50, then people following will be able to see what finding 50 says. We're having a difficulty. Perhaps you might just read out the finding.

MR GRIFFIN: Yes. The finding says:

> "LWB house staff, disability support coordinators, team/practice leaders and program managers for the Melbourne house were aware of resident-to-resident violence and conflict in the house between 2013 and 2020, and it was having adverse effects on residents and..."

Insert the word "some":

> "...LWB staff in the house."

And in that formulation, LWB accepts that finding. In respect to - you will note that that is consistent with proposed order 49 which refers to some LWB staff.

CHAIR: Yes.

MR GRIFFIN: In respect to proposed order 52 which states:

> "LWB failed to communicate to residents' families in a consistently and a timely fashion that incidents of resident-to-resident violence have happened in the house."

The word "consistently" is replaced by the word "consistent" and is then accepted by LWB.

Proposed finding 55 dealing with staffing at the house reads:

> "On some occasions, there were not enough staff to adequately support and supervise residents in the house, and on those occasions this had an adverse effects on the residents."

That proposed finding is now accepted by LWB. I can take you to proposed finding 74 under the general heading Failure of LWB to Take Proactive Approach. 74 reads:

"Ms Robbs' views as of the date of giving evidence indicates that, if confronted with identical circumstances to those involved in Sophie's case, she would not regard that as a matter that she would automatically refer to the Board."

That finding is now accepted by LWB. Proposed order 75 under the heading Community Visitors reads:

"It would be open to the Royal Commission to find that LWB failed without reasonable excuse to provide community visitors with the documentation required under section 130(1)(d) of the *Disability Act 2006 (Victoria)*."

That proposed finding is now accepted by LWB.

CHAIR: Do we have a list or can we deduce from the document we have which findings are substantially in dispute?

MR GRIFFIN: Such a document is being prepared, Chair, and we hope to have it shortly.

CHAIR: Thank you.

MR GRIFFIN: The written submissions of the parties are in some cases, as you've mentioned, Chair, comprehensive, and I don't intend in these oral submissions to repeat in any detail what's said in those submissions. In particular, I acknowledge the fact that written submissions were made by Sophie and her parents, Michelle and Greg, and if I can simply observe that both of those submissions were notable for their plain English and for the heartfelt sentiments which are set out in them, and they both support, in general terms, the findings that we've proposed that you consider making.

Paul's submission was also helpful, he being the foster parent of Robert. He has made some suggestions as to findings which we've elected not to adopt, not because we're critical of them, but because we don't think they're appropriate at this stage in this hearing, but we thank him for the time he's put into them.

The written submission from Manager or Worker 2 of Life Without Barriers is, with respect, Chair and Commissioners, a submission which seeks from the Commission an exoneration of his conduct in respect to the case study. Counsel Assisting is of the view that it's not appropriate for the Commission to proceed down that line.

If, during the course of reaching your final view about the proposed orders, and in view of anything you wish to say in the final report about this public hearing, it's a matter for Commissioners at that stage as to whether they want to go down that path, but the primary function of this public hearing is not to conduct an in-depth investigation in relation to each and every staff member, and we're simply not in a position, on the current evidence, to be able to reach any firm conclusions about the -

CHAIR: Is it fair to say that none of the proposed findings specifically identified worker 2 to be regarded as adverse to that worker?

MR GRIFFIN: I think that is a fair summary, Chair. The submission from the Araluen Centre is much more general in nature if I might say so. It's helpful in setting out their point of view as to what a provider should do in certain circumstances. Once again, I invite Commissioners to read that and take it into account in your general considerations, but I don't wish to say anything more about it at this stage.

Can I go to the question of the submissions of Life Without Barriers. Given the nature of the concessions or acceptance of the findings which I've outlined, it's unnecessary for me to go through in any detail the proposed findings that we urge upon you, Commissioners, and the response from Life Without Barriers. Their submission is an extensive one and sets out in some detail why they think a particular finding should or shouldn't be made, but, in particular, makes reference to what I might describe as the context in which certain things occurred, and I wish to make some general observations in respect to those submissions.

The Commission heard from Ms Claire Robbs, the CEO, but we didn't hear from any Board member, and so there is an absence of any evidence, in some respects, as to what the Board knew or thought or did at various times.

CHAIR: Was LWB, if I may refer to it as such, invited to nominate the witnesses they wished to present evidence at the hearing?

MR GRIFFIN: They were, Chair. Yes. Consequently, Counsel Assisting comes from this position: That in a large organisation, the primary person who sets the culture, the attitude and the standards of that organisation must be the CEO. That person is not solely responsible, and, indeed, a board will frequently play a significant role itself. In the absence of particular evidence going to that issue, Counsel Assisting is working on the basis that Ms Robbs was the person in the organisation that set the culture, the attitude and standards. She -

CHAIR: That tends to be supported, subject to what Ms Callan might say, by LWB's written submissions, which emphasise a distinction between the responsibility of the CEO and the responsibility of the Board.

MR GRIFFIN: And particularly in respect to what information went to the Board, when it went to the Board and in what form. It's regrettable to have to submit, but Counsel Assisting's view is that the evidence of Ms Robbs was unsatisfactory in many respects. We deal with this in the written submission in some detail.

CHAIR: Could you give us the reference, please.

MR GRIFFIN: Yes. Well, if not immediately, someone can find it for you.

CHAIR: Well, if not immediately, someone could find it.

MR GRIFFIN: But I want to make some general observations. A person in her position has to have a keen insight into what the organisation is doing and how it does it, and needs to have a curiosity as to what's happening in their various facilities. Now, that can be achieved in a number of ways in traditional line management of reporting up through the chain, but there is a real issue for any CEO to determine how can you assure yourself that

what you're being told, or, more importantly, what you're not being told, is affecting the decision-making that you engage in?

When asked during the public hearing whether Ms Robbs had ever attended the Lismore houses or the Melbourne house, she indicated as of December last year she had not. She was asked questions about how she sought to inform herself of what was happening in the organisation to verify or confirm what she was being told up through the management chain, and her general approach was not one of spending much time on the ground, to use my expression. Certainly talking to other staff members at Head Office and talking to senior managers, yes, but very little evidence of actually talking to frontline workers or employees of the organisation.

Her evidence in respect to what matters were reported to the Board was also deficient. That was most prominent when we were dealing with the case study involving Sophie. I indicate that in Counsel Assisting's submissions, Ms Robbs is dealt with at paragraphs 198, 203 - pages 198 to 203, paragraphs 648 to 657.

If I can come back to Sophie's position, I seek to put in very simple language what the evidence says. Sophie had expressed a desire to have intimate relationships. Not an uncommon desire for a woman of her age and background. She was confronted with house rules and relationship rules which, in effect, prevented her having somebody that she wanted to form a relationship attend the house after 6 pm in the evening.

When she agreed to meet somebody, she did so outside the house with the disastrous consequences, Commissioners, you heard about. Counsel Assisting accepts that when the police became involved, Life Without Barriers had to take into account the role of the police investigation and ensure that they didn't do anything which would cut across that investigation or prejudice it.

But, nonetheless, the support provided to Sophie after the event of the assault was deficient in many respects. Now, whether that occurred because frontline staff members at the house were told not to be involved, for fear of compromising the actions of the police or for some other reason, or whether it's because they weren't sufficiently trained to deal with somebody in Sophie's position, the end result was she didn't receive the support one would have expected in that environment.

During the public hearing, an issue was raised with Ms Robbs about whether or not the events that Sophie was subjected to were brought to the attention of the Board, and the evidence was that they weren't in a timely fashion. But of more significance was the line of questioning, if confronted with Sophie's scenario in December 2021, would you do anything differently? And, in broad terms, the answer was no. Yes, there was discussion about reporting lines and some changes, but that answer was a very stark answer which revealed, in our submission, a lack of understanding, empathy and insight into what should have happened.

I note from Ms Callan's comments this morning that members of the Board are listening to these remarks. Only they can answer the question of whether they would want to know, but it's hard to believe that a conscientious Board member was not want to know that a resident in one of their houses had been subjected to the most serious sexual assault. The line of

argument advanced in part by Ms Robbs was that it wasn't, from a legal point of view, the responsibility of Life Without Barriers because the events didn't occur on the premises where Sophie resided is, with respect, deeply disturbing. Those of us assisting you, Commissioners, are well aware of the legal considerations that apply in these circumstances, and no doubt lawyers advising Life Without Barriers are well aware of all the legal considerations. But where's the care, concern and empathy? Where's the board member who would put up their hand and say, "One of our residents was grossly assaulted, but I wouldn't want to know that"?

The failure to inform the Board in a meaningful fashion and in a timely fashion deprived the Board of the opportunity not only to look at the circumstances of what happened to Sophie, but also look more generally at the organisation's other homes, see whether they wanted to put in place preventative measures, more precise policies, better training, better support for staff if they didn't have the training that was deemed necessary to deal with that sort of situation.

So not only do we say that Ms Robbs made a grave error of judgment in not reporting to the Board, but, as we stand here today, we can have no confidence if something of a similar nature arose again, that she would act in a way that we urge was really the only alternative open to her. By the time she gave evidence, Ms Robbs indicated that she had been following the proceedings in the previous four days; she had been provided with statements; she and her legal advisers knew the documentary material that we were going to consider during the hearing.

The second area of concern which flows out of that is what role does reputational damage or harm to the organisation play in decision-making? Was it weighed up that it was better to confine the reaction to what happened to Sophie for corporate or other reasons? To what extent, when it was eventually made known to the Board, did the Board consider these issues?

The events may be historical, but they're contemporary in the nature of what happened. When one looks at that particular instance, it highlights, as far as Counsel Assisting is concerned, reservations that this Commission might have about the capacity of Ms Robbs to discharge the full range of her duties, and the capacity of the Board to respond appropriately.

Commissioners, let me make it perfectly clear: it is not the role of this Royal Commission to determine whether Ms Robbs is the CEO of Life Without Barriers. That's a matter for the Board. But I raise these matters today to encourage the Board to look into the ramifications of what was uncovered in both the Lismore houses and the Melbourne home.

Another characteristic with respect of the written submissions of Life Without Barriers is what old common lawyers used to call "confess and avoid". That is, you acknowledge some deficiency - in this case you acknowledge the findings to be made - but you then seek to explain it away.

Now, I'm not saying that that happens in all instances by any stretch of the imagination, and it is legitimate on occasions to respond by setting out the context in which something occurred. But when, in setting out the context, it's not accompanied by deep thought about

what happened and why, then it really looks like it's simply making a concession because you've got no alternative but to make it. Let me explain in a little more detail what I'm referring to.

If you accept something happened and the organisation or the staff should have done better, isn't it axiomatic that you must understand why they didn't do better, why staff members didn't do what you would expect them to do, why management wasn't aware of something? You can take each individual finding and start asking those series of questions, and it was the hope of those assisting you that the written submissions of Life Without Barriers would start exploring some of those questions. Yes, something happened which we concede shouldn't have happened, but we've thought about it, and we've come to certain views about why it happened, and we've come to views about how we might prevent or ameliorate the chance of it happening in the future.

Let me give you an analogy from another field. For many years in the medical field of all health professionals, there was a culture of not confronting mistakes or errors or poor judgment or dereliction of duty, primarily because of the fear of the legal consequences. You don't put your hand up because that will be treated as an admission, and we will get sued. That became somewhat intractable in the health area. Then a program of what's called root cause analysis was introduced which, in a nutshell, said if something happens, for example, in a hospital, which shouldn't have happened, let's get everybody concerned in a room and get them to tell it exactly like it was, with no fear of consequence.

Now, that sort of form of root analysis is protected legislatively by not being able to be used in any subsequent proceedings, but it opened up those institutions and developed a culture of acknowledging when things went wrong. In a major teaching hospital, for example, in any capital of Australia, hundreds of thousands of decisions of a clinical nature are made every day. And the vast, vast majority of those decisions are sound, well-founded and appropriate. But when something goes wrong, an open organisation wants to know why, and once they work out some of the reasons why, what we can do about it.

It's not apparent in the written submissions of Life Without Barriers evidence of this exercise being undertaken, even in recent times. It might be that it has, and we simply haven't been told about it, but it is significant because how do you learn? How do you improve? How do you protect those people that have been entrusted into your care, which this is ultimately why you exist in the first place, to provide a service and protect the clients you have.

In view of that line of submission, I invite Commissioners to consider at the conclusion of this hearing whether or not they would invite Life Without Barriers, perhaps in six months time, to report to the Commission, particularly from a Board perspective, as what they've learnt from public hearing 20, what they've done in relation to issues which have emerged, how they've reviewed policies or developed new policies, and the whole myriad of other matters which are in part alluded to in the submissions when they talk about recent developments, and they need to be congratulated for embarking upon some of those programs, but we really don't know enough detail, firstly, about the scope of those initiatives, but, secondly, about what's the timetable for implementing these things?

It is good to have outside advice and expertise come in and look at an organisation, but not if it's at the cost of the Board and the senior management advocating their ultimate responsibility for how the organisation is run and how the clients are provided with services, protected and treated.

I raise that now because it is not part of the proposed findings as such; it's simply something that I raise having considered in some detail the written submissions which have come in, and particularly in light of the fact of the Board's participation today, and if Ms Callan or the Board are in a position to give some response later today in respect to that proposal, it will be warmly accepted. If it's a situation that requires more thought on their part because of the late notice, I would have no difficulty of that, subject to the views of the Commissioners.

We also, when looking at the Lismore houses, dealt with the situation of Natalie, and that's reflected in a number of proposed findings. It raises some of the same issues I've referred to in respect of Sophie. It has to arise from a spirit of openness. It has to arise in circumstances where frontline workers are not only carefully selected and trained, but also supported.

It wasn't clear from the evidence of Ms Robbs in any specific way the extent to which that issue had been addressed. Does the organisation work on a reactive or a proactive approach? If one works in a reactive fashion, you simply wait for concerns or complaints to be raised, and then deal with them in whatever fashion you feel appropriate, but that assumes that people with concerns will complain. That assumes staff members will feel comfortable and confident raising with their managers issues that they feel should be addressed. It assumes that residents will have family members who have the time, the expertise and the wherewithal to step forward and raise issues.

All of that is important, but it can't be the end of the discussion. And what in Counsel Assisting's submission was lacking as a general comment from Ms Robbs' evidence was a proactive mindset. How does she, and subsequently the Board, satisfy themselves that they're meeting the standards they wish to meet?

Many of those listening to these proceedings would be aware of the general notion of an audit. There is a world of difference between having a process of auditing, be it financial or be it as to quality and standards, where everybody in advance knows that the person conducting the audit is going to attend and what they will be looking for, as opposed to a situation where you simply get a knock on the door.

Solicitors are required to keep trust accounts. The fear that resides in the minds of all solicitors is the trust account inspector simply turning up one day and saying, "Show me the books". In a case of a service provider, you're assumed to be well intentioned, you're assumed to have a series of skills and resources, and, in some cases, many years of expertise, but how do you bridge the gap between those assumptions and the reality of your performance?

Life Without Barriers is an organisation which has been around for over two decades. It's an organisation which started as a very small operation in regional New South Wales and now has revenue in excess of $750 million annually. My recollection is it has surplus of

approximately $50 million. That is a testament to the growth of the organisation and, presumably, a testament to a feeling that it does what it does well.

But how do we know that? Is it simply growth for growth's sake? Does somebody in a management position have the skills and the acumen to be able to grow with the organisation? What does it take to manage a three-quarter of a million dollar operation? These are all matters ultimately for the Board, but they're issues that impact upon the delivery of service.

When we came and looked at the Melbourne house, there were a whole series of issues which arose which were slightly different from dealing with the Lismore situation. In Lismore we're dealing primarily with two particular individuals and the events which happened to them and trying to draw thematic conclusions from those. In Melbourne, we're dealing with some of the same issues but different issues, and, in particular, resident-to-resident violence and violence between staff and residents.

It's accepted that in group houses where the residents have quite complex disabilities, that that is a difficult and complex situation to manage, but it shouldn't catch anyone by surprise if you're going to have residents with those disabilities residing in the same location, you have to anticipate how you're going to meet those needs. And during the hearing we dealt in some detail with the question of assessment of residents, compatibility between them and that process, and that's outlined in some of the proposed findings.

But one of the responses from Life Without Barriers is, well, yes, there were 61 incidents of violence in the Melbourne house in a particular period of time, but the inference is that that is intrinsic because of the nature of the house and the characteristic of the residents. There's also a suggestion that where's the evidence that that is of concern? The first response of Counsel Assisting to that is, the information of doing a comparison between the Melbourne house and other houses conducted by Life Without Barriers with a similar mix of residents is entirely within the province of Life Without Barriers. If they want to assert that the events in the Melbourne house were not, to use my words, unusual, and you took all those factors into account, show me the evidence. Show me where you've done a study of other houses looking at that issue. Because in the absence of that, what you're saying is mere speculation. It's an assertion; it's not verified.

We know that there is frequently resistance to the use of the word normalisation, but why shouldn't this Commission seriously look at whether or not the level of violence in the Melbourne house was, over a period of time, normalised? It was inevitable. It was a characteristic which flowed from the nature of the residents and their disabilities.

If you follow that line of argument to its logical conclusion, what are you saying to those residents? I will accept you into the house; I will put you in a situation where there will be violence; I will put you in a situation of harm and risk. Where else would we accept that? In what other circumstances? As an aside, putting prisons to one side, would we be sanguine about those circumstances? Why are we not simply exacerbating the discrimination that confronts many people with disability in their life generally?

There is also a tenor through the submissions, and particularly in Ms Robbs' evidence, that we're well intentioned and we're doing really good work. Counsel Assisting accepts that.

We don't seek to impugn the character of any individual at Life Without Barriers. We assume that they're doing the job to the best of their ability in the circumstances they find themselves in, until there's evidence to the contrary.

They do work, especially on the frontline, which is often difficult. It's very challenging. It can be hard to leave at work when you clock off for the day. And we came across evidence of individuals working for Life Without Barriers that had enormous concern for the particular residents they were dealing with. That's not in doubt, as I said, unless there's clear evidence to the contrary.

But what's the organisation doing to support them? Why is the organisation saying to a frontline worker, "I would like you to work at the Melbourne house, and you should expect there will be a high level of violence which will occur." Who's prepared to stand up and accept that assumption? Why not acknowledge the complexity, be transparent about it and grapple with it? In a case of Victorian house, historically, say to the department, "No, we want to have more say in who comes into our house. We're going to take more seriously the assessment of compatibility." As an antecedent question, we're going to ask ourselves, "Should this individual be in a group home?"

Counsel Assisting recognises that that raises all sorts of policy and other issues about the models of accommodation for people with disability, and it's recognised that there can be enormous pressure to find a place for somebody, but the public interest is not served by not confronting that issue, and if it be that different models of accommodation are required, if it be much more resources are required, higher staffing ratios, the employment of external experts or counsellors to come in and intervene in certain situations, make the case to the funders. Set out what the situation is, all the things you've done, how you've analysed the issues and if, at the end of the day, you think you're not able to do what you think should be done, make the case to the funders.

And on the other side of the equation, talk to the families. Potential residents will probably have a file because of previous interactions with the system, or previous accommodation or previous assessments of their disabilities. Talk to the families. Convert it from a file to an organic situation. And, dare I say, talk to the potential residents. This is their home. The points I'm raising are very strongly made by the families in this public hearing. They're made by Sophie's parents. They're made by Paul. One asks rhetorically: what more could they have done, and were they hampered by a lack of a receptive attitude? Or, in the case of Sophie, were the parents, in effect, invited to come in and do some of the work of LWB?

These are really fundamental questions which we say flow from these case studies, and our assessment of Life Without Barriers' written response is deficient in many of these respects, and we wait with interest for their reply later today. If the assumptions or propositions I've been advancing are not well founded, tell us why. If we've diminished the quality of what you've done, specify it. If you have plans as a result of this public hearing to change and do better, give us details, and consider the invitation to report back to the Commission in due course.

Chair, I note the time.

CHAIR: Yes, well, is it convenient to take a break now?

MR GRIFFIN: Yes.

CHAIR: In that case, it is just after 11.05 Sydney time. If we resume at 11.25. Is that convenient?

MR GRIFFIN: Thank you.

CHAIR: Yes. We will adjourn until 11.25. Thank you.

ADJOURNED 11.06 AM

RESUMED 11.24 AM

CHAIR: Yes, Mr Griffin.

MR GRIFFIN: Thank you, Chair. I want to take the Commission to LWB's submissions about neglect, which appear at paragraphs 208 and onwards in their written submissions. I want to do so in the context of the evidence in relation to Natalie. LWB construes neglect very narrowly, inter alia, by pointing out the possible consequences to them of a finding of neglect. In our submission, this mistakes the purpose of the provision which is to protect vulnerable people. We don't submit that record keeping failures caused Natalie's bowel obstruction, but a finding of causality should not be required to establish a finding of neglect.

In our view, it should be sufficient that the deficiency had the capacity to seriously jeopardise Natalie's health. We say that LWB response fails to take account of the cumulative effect of a failure to record the Movicol dosage over a period that was proximate to the bowel obstruction. They in turn submit the evidence does not permit a finding that Movicol was not administered. The difficulty with that conclusion is, because LWB did not recognise this was potentially a case of neglect, we cannot now know whether Movicol was administered or not. The LWB staff should have identified that in circumstances where Natalie was admitted to hospital with a bowel obstruction and where critical records were not kept in the period prior to this admission, this was potentially a case of neglect. We say they should have at least performed sufficient investigations at the time to conclude that it was not neglect.

If one goes to LWB's own document entitled *Stop It Before It Starts*, SIBIS, that's an initiative which is set out in a booklet which appears at LWB.1001.0001.6007. Their own document adopts a very broad definition of what constitutes neglect, being, and I quote:

> "The failure to provide for a person's basic needs including food, drink, shelter, clothing and medical needs."

CHAIR: There's more than a hint in LWB's submissions of the neglect being somehow equivalent to negligence as defined in the regulator by the *Civil Liability Act*, but I'm not sure that's in the territory that we're in.

MR GRIFFIN: As so often, happens, Chair, you pre-empt where I'm going.

CHAIR: Sorry.

MR GRIFFIN: We understand the legal definitions that are often applied here, but, in this particular setting, LWB sets out in its own publication a much broader, and, we would submit, a much more sensible approach. Under their definition in that booklet, surely Natalie's bowel impaction would have been caught, and it would lead to a more broad definition of neglect.

Chair, as you and the Commission are aware, legislation is often interpreted in a very strict fashion by black letter lawyers, but as a general rule, when you're dealing with a part of human activity that is protective in nature, you should take a much more expansive view than what a black letter lawyer may take, and rather than seeing neglect in terms of negligence, it should be in terms that quite rightly are set out in their definition:

> "The failure to provide for a person's basic needs, including food, drink, shelter, clothing and medical needs."

A much more realistic approach, in our submission. But, in our view, not reflected in the analysis in the LWB submission on the question of what constitutes neglect.

CHAIR: One might have thought that a failure to keep medical records over a period of time in relation to a resident who is at risk of particular medical conditions, it be regarded as neglect if it could increase the risk of that condition materialising, and, presumably, the failure to keep critical records ordinarily must have some impact upon the risk of a condition materialising.

MR GRIFFIN: That's correct, Chair. Our approach is supported by the evidence given by Samantha Taylor, the Acting NDIS Commissioner, who gave evidence, and, in her view, Natalie's bowel incident that I:

"Might raise allegations of neglect."

So clearly in the mind of Ms Taylor that that's the territory we're looking at. So I invite particularly Ms Callan to respond to these propositions in respect to how LWB approaches the definition - the working definition of what constitutes neglect - would be of great interest to you as Commissioners, as you're considering the matter.

There's another aspect of Natalie's position which raises a thematic issue. In respect of findings 26 and 27, LWB reply at paragraph 193 by contending that the evidence is insufficient to find that LWB staff failed to communicate to Jennifer when it became clear that the personal care assurances did not -- in respect to Natalie. You might remember, Commissioners, that the evidence was that Natalie did not want her personal care attended to by other than female staff.

LWB points to notes of a voice message on 17 December 2015 and a conversation on 18 December 2015 where LWB said that there would always be at least one female on night shift. Additional notes of a conversations of 17 and 18 do not alter the fact that after these

conversations, between August and December 2015, there was no further communication between LWB and the mother. And yet male staff members were continuing to perform personal care on Natalie, which was outlined in paragraph 306 of our submission. This is another example of where not only is there a lack of communication, which I referred to earlier between LWB and family members, but this is a situation where the family member raised an issue, received an assurance which one would normally be prepared to take to the bank, only to find that, for various reasons, it hadn't been met.

That raises the fundamental issue of trust. That a relationship with a provider is taking over the care of a resident, there must be implicit trust between the provider and the resident, but also between the provider and the family of the resident who, understandably, have an ongoing concern to make sure that their family member is being well cared for. It's simply not acceptable to give an assurance, breach that assurance and not inform the person who you gave the assurance that you weren't complying with it. So I raise those specific issues because they're matters which I think there is still quite a distance between Counsel Assisting and the position adopted by LWB.

Can I now go to the proposed findings in relation to the Australian Government's submissions, and I understand that the findings which are 76 to 81 can be brought up on the screen to assist those. You will see in the heading NDIS Commission Before Proposed Finding 76, subject to any observations by Ms Morgan on behalf of the Australian Government, it's my understanding that proposed finding 76 is accepted on the basis that it's referred to as a finding, as opposed to an adverse finding. I can come back to discuss that. But the same situation applies to finding 77. I will give people a moment to simply read that proposed finding.

And then when we come to proposed finding 78, you will see in the initial proposal it has five sub-paragraphs, (i) to (v), and the new finding which is proposed by Counsel Assisting is in similar terms, with the exception that it deletes (v). I could indicate, Commissioners, we propose to have a document for you and the parties later, perhaps after lunch, which will set out what I'm now saying to assist you.

In respect to proposed finding 79, once again it is accepted, subject to an amendment. So, 79 you will see currently is in terms of (i) to (v), and the proposed new finding is in (i) to (vi). Could I indicate that if you go to the original findings, which should be on the screen I hope shortly.

CHAIR: We've got 79(i) to (iv) on the screen at the moment. Now we have (v) and (vi) as well.

MR GRIFFIN: The original (iv) was deleted, and then in the reformulation, you take the original (v), but delete the last four lines, "and is required by section 24(2) of the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 (Cwth)", and that's replaced by a provision in the proposed finding in similar terms with that deletion taken into account.

CHAIR: So, finding 79(iv) is retained, but with the last sentence deleted, and there's a new 79(v) which repeats some of the material previously in the last sentence of 79(iv).

MR GRIFFIN: Yes, and I think that will be apparent when we produce the new document.

CHAIR: All right. Thank you.

MR GRIFFIN: Then proposed finding 80 has been agreed, subject to an amendment, and that is when you look at 80(ii) you will see that it says:

> "I hope the NDIS Commission failed at the time to identify this part of Jennifer's June 2020 complaint as an allegation of a reportable incident and also failed to request LWB to notify it."

And the words:

> "Accordingly so it could request and obtained relevant records."

Is deleted. And in the proposed re-formulation of (ii), after "notify it" becomes:

> "Of that reportable incident."

CHAIR: That amendment, as I understand it, is consistent with the submission advanced -

MR GRIFFIN: Yes.

CHAIR: - on behalf of the Australian Government.

MR GRIFFIN: Yes, it is. Australian Government helpfully raised some technical issues and, as a matter of accuracy and fairness, these adjustments have been made. And then that leads us to proposed finding 81, and that's agreed subject to the amendment in the third line where it currently says:

> "Had only initiated one inquiry."

And it removes the word "only". Those findings raise an issue more broadly which I touched on at the start about being proactive. I did so in terms of LWB, but there's an ongoing issue with the national body about to what extent should it be proactive in relation to pursuing investigations or seeking further information. It's acknowledged that there are a very large number of incidents reported nationally. It may well be that that figure slightly confuses the problem because, out of all those reports, there might be very few that require the sort of proactive approach that we would suggest, but that's a matter that no doubt will be worked through progressively by the Commission when it looks at the role of NDIS and the role of the Quality Commission. It's a complex issue, except to make one very broad observation: If a regulator has a reputation for being reactive and not proactive, human nature suggests that some people will take advantage of that.

The experience of most lawyers, I venture to suggest, is that once a regulator in any field of endeavour displays that it can take out the big stick and go to court if necessary, it usually has a very salutary effect on everyone else in that field. It's indicated by the ACCC, by their trading departments and a number of other regulators. It's subject to ongoing discussion in this Commission as to what the role of the regulator is and what resources are

available to them to be able to, in my words, initiate their own inquiries, moving away from what I mentioned earlier, but simply accepting what you're told by, in this case, the provider.

I don't wish to be heard any further on that issue; it's a general observation, but that's the state of proposed findings in relation to the Australian Government.

Commissioners, as I indicated at the start of this morning, I proposed to take a very broad and more universal view. Consequently, I don't intend to go to any of the other proposed findings, but, with your leave, I will reserve the right to reply if something is raised that requires a reply. But at this stage, they're my submissions.

CHAIR: Thank you very much, Mr Griffin. Is it convenient now to deal with the application from the Public Advocate of Victoria?

MR GRIFFIN: It is.

CHAIR: All right. We will do that. Just give me one moment, please. Yes. I think, Ms Fritze, that you've got an application to make?

MS FRITZE: Yes. If it pleases the Commission, I appear on behalf of the Public Advocate of Victoria, Dr Colleen Pearce. As noted, the Public Advocate has prepared brief written submissions dated 22 April of this year. With your leave, I seek to hand those up and rely on those written submissions today, which I note are directed substantially towards proposed finding 75 which Life Without Barriers has indicated they now accept.

CHAIR: That has the commendable attribute of brevity, Ms Fritze?

MS FRITZE: Thank you.

CHAIR: There should be more of it. All right. Well, let me inquire as to whether any of the parties and, in particular perhaps, the Commonwealth has any objection to what Ms Fritze proposes. Perhaps I should just check with you, are you proposing to add anything to the written submissions?

MS FRITZE: No, I'm not.

CHAIR: All right. Thank you. Does any party have any objection proposed by Ms Fritze, namely, that she, on behalf of the Office of the Public Advocate of Victoria, be given leave to file the written submissions of which copies have been made available, but she does not wish to make oral submissions in addition to those - that document. Yes?

MS MORGAN: There's no objection from the Australian Government. Thank you.

CHAIR: All right. Thank you very much. I will assume nobody else has any objection. In that case, pausing for just a moment, in that case, Ms Fritze, the written submissions on behalf of the Office of Public Advocate may be filed and they are therefore before the Royal Commission. Thank you very much.

MS FRITZE: Thank you.

CHAIR: Have you had any discussions as to who comes next, in particular, LWB or the Australian Government?

MR GRIFFIN: Counsel has received a, what I might describe, cryptic message, and I wonder whether we might have a short adjournment because it's suggested that I may have misstated the position in relation to the Australian Government. I would like the opportunity to speak to their counsel before we proceed.

MS MORGAN: I'm happy to proceed just to save time. I think I can address it orally quite quickly, Mr Griffin.

CHAIR: Yes, why don't we do that, and if there's something still to be resolved, that can be addressed perhaps over the luncheon adjournment. Yes.

MR GRIFFIN: Thank you.

MS MORGAN: Thank you, Chair. Could I ask first for the amended proposed factual findings to be brought up on the screen because it might assist my very short submissions if I could just address those factual findings.

CHAIR: Yes, Ms Morgan. Now, we had better make sure that we're talking about the same document. You're referring to the document that's been brought up on the screen in the course of Mr Griffin's submissions a few minutes ago.

MS MORGAN: Yes. Thank you, Chair.

CHAIR: All right. Thank you.

MS MORGAN: And if we could go to paragraph 76, which is at page 12, I think. Thank you. Now, what Mr Griffin submitted a moment ago is accurate in the sense that in relation to each of these amended proposed findings, the Australian Government acknowledges that the finding, as a matter of fact, that is being proposed is correct. The concern the Australian Government has expressed in its written submissions and which I reiterate is that the findings have sitting behind them a bit more nuance, and because we haven't been told what they may be deployed for in relation to future recommendations, we did want to make sure that our position is made clear in relation to each of these findings.

So in relation - just taking the first one as an example, finding 76, it is correct that at the time of public hearing 20, the NDIS Commission had not made the - had not commenced the monitoring and that is because, as set out in detail in our written submission, communications with LWB indicated that the process itself had - the pilot had only just commenced and monitoring would not actually be required, and, indeed, is still not required at this point. So, we accept that as a - as a statement of fact, it is accurate. Our concern is whether a recommendation in the future may not take into account that in terms of a temporal requirement to monitor, that hadn't yet occurred.

CHAIR: When you use the word "required", do you mean that a follow up or monitoring was not required under the legislation, or do you mean that in the light of what was known and conveyed to the NDIS Commission, no response was required because it would have been unnecessary?

MS MORGAN: Both, Chair.

CHAIR: Why the latter?

MS MORGAN: Because the communication which is detailed in our written submissions indicated that LWB had - was commencing its pilot program just prior to December 2021, and, as your - as, Chair, you will recollect, the hearing was occurring in this matter prior to that date. So, an attempt to monitor something that hadn't been rolled out nationally - so the pilot hadn't occurred and the national program was still six to nine months away - so, in effect, there was nothing yet to properly monitor that would provide information that would assist the NDIS Commission.

CHAIR: Yes, I see. Thank you.

MS MORGAN: Thank you, Chair. Moving on, then, to paragraph - proposed finding 77, as the Royal Commission is aware, quality audits are conducted according to the applicable NDIS rules and guidelines. The Royal Commission has received detailed evidence from the then NDIS Commissioner, Mr Graham Head AO in relation to the auditing regime in Public hearing 13. At present, the rules and guidelines do not require the NDIS Commission to provide that information to auditors, nor do they indicate what use auditors would make of that information for the purposes of any audit.

Now, the NDIS Commission has provided that information on a case-by-case basis in mid-term audits, taking into account the requirement for proportionality. Now, as the Royal Commission can imagine, and as Mr Griffin just noted, the scope of complaints and reportable incidents is significant, and any recommendation that all complaints and reportable incidents be provided to auditors would require an examination and testing of the audit system which is beyond the case study of this public hearing.

CHAIR: Proposed finding 77 doesn't say that the NDIS Commission should conduct audits on all complaints.

MS MORGAN: No.

CHAIR: It talks about not - the NDIS Commission does not currently make available to quality audits on a systematic basis information about complaints and reportable incidents relating to a registered NDIS provider that they are auditing.

I suppose something may turn on what a systematic basis is intended to convey, but, as I understand the point of the proposed finding, it is that although there may not be a legal obligation to do so with a particular case, there are circumstances in which, as the NDIS Commission itself recognises, where it would be appropriate to provide the auditors with the information in order to ensure or allow the auditor to do the job in the most comprehensive way possible. So systematic may refer to identifying criteria for

determining when the NDIS Commission would do what it does, as it accepts, from time to time.

MS MORGAN: That may well be right, Chair, and if that - that is what is intended, that needs to be tested in the context of the entire auditing system that is currently in place. So, we don't disagree with that; what we're concerned about is a recommendation that would come out of the examination of this particular incident, as opposed to the auditing regime more generally, which Mr Head addressed in his material for public hearing 13.

CHAIR: What about a recommendation in the terms that I suggested? That is, that the NDIS Commission should formulate and publish criteria for determining the circumstances in which it will do what is suggested in proposed finding 77; that is, provide auditors with information about complaints and reportable incidents relating to a registered NDIS provider?

MS MORGAN: I think the general concern, Chair, would be that - how that would interact with the current guidelines and rules and how they would coexist. A recommendation that it be considered in light of the current rules and guidelines would be one that would easily be adopted and considered. I obviously don't have instructions directly as to whether such a recommendation in the form - in the way formulated by the Chair would be, to the extent it's necessary for us to accept it, would be accepted, but I have some concern that it's being pronounced without the background of the detail that was in Mr Head's material in public hearing 13.

CHAIR: All right. I follow that. Thank you very much.

MS MORGAN: Thank you. If I could then move on to proposed finding 79, I note that subparagraph 4 - so 78 there was an amendment which we don't need to deal with; 79 subparagraph (iv) I also don't need to deal with. But if I could ask the Commissioners to look at 79 subparagraph (vi), and this comes - is reflected in part by Mr Griffin's final comments in relation to the necessity for the - for a regulator to be proactive, not reactive.

And this finding, at subparagraph (vi) is actually a good example of why there needs to be an examination of that very topic much more thoroughly. Now, if one looks at what is being sought in that finding, the finding refers to the NDIS Commission not itself conducting what is described as "any subsequent checks of LWB's records".

Now, what isn't in that finding is any engagement with what the NDIS Commission's current powers are to check the LWB records to confirm what was being provided. The Commission may appreciate that those powers are contained in a separate piece of Commonwealth legislation called the *Regulatory Powers Act* and that permits Commonwealth regulatory agencies to apply for an investigation warrant. So, what the NDIS Commission would be concerned about is any failure to engage with what would be required for such a check. That would be to take advantage of or make application for a warrant.

Now, in light of the volume of reportable incidents and the need that Mr Griffin points to be proactive, not reactive, that would create, the NDIS Commission suggests, a very - sorry - that would - it would seem that the proposal would be pushing the NDIS

Commission to use compulsory powers under the *Regulatory Powers Act*, and if we are to -

CHAIR: I suppose - sorry, Ms Morgan, I suppose that depends upon what the words "did not conduct any subsequent check" might mean.

MS MORGAN: Indeed.

CHAIR: The subsequent check might mean please LWB produce some records so we can have a look at them.

MS MORGAN: This is a good example. That examination - we could have that examination, and, in this particular case, if we look at the facts of what happened, LWB made a mistake and themselves have identified that they did not provide something by mistake. So, if we had called LWB and said, "Just making sure you've given us everything", they would have said, "Yes, we have", but that would have been a mistake.

So in the circumstances of this case what would have been necessary to check is for the NDIS Commission to exercise its compulsory powers, and the question we have for the Royal Commission is, if that's what is proposed we should examine that more closely, and for the Royal Commission to give it consideration as to whether that is, in fact, the recommendation that the Royal Commission would be proposing, that the NDIS Commission exercises those compulsory powers more often and what that would impose on the NDIS Commission, as well as other aspects of the State which come into play when we have to seek a warrant under the *Regulatory Powers Act*.

CHAIR: If we were looking at this particular case, no doubt we would want to have a look at whether there was anything at all that put the NDIS Commission on notice that something that should have been provided had not been.

MS MORGAN: Indeed.

CHAIR: Is it your submission that there's nothing to indicate that that was the case here?

MS MORGAN: I think that's right. I think if you look at the factual background in this particular case study, yes, we would say that is exactly where the Royal Commission would end up because of the communications, and it was a unique - as my understanding, in relation to the - the documents that we're - that are being complained about are not documents when you looked at the suite of documents provided that were missing in the traditional sense.

CHAIR: All right. Well, if Mr Griffin has anything to the contrary to say on that, we will no doubt hear in reply. All right. Thank you.

MS MORGAN: Thank you. Moving on then to finding - proposed finding 80, subparagraph (iii). So here what - the Commissioners will appreciate that what the NDIS Commission accepted at Public hearing 20 was that the allegations, when they were made, should have been recognised as a reportable incident, and the obligation to notify was enlivened when Natalie was hospitalised in March 2020.

Now, there is considerable detail in the acting NDIS Commissioner, Ms Taylor's, statement as to what could have happened in relation to Jennifer's complaint if the NDIS Commission had used it to request LWB to notify a reportable incident. Ms Taylor's evidence was about what the NDIS Commission should or could have done in 2020.

The language of the proposed finding in subparagraph (iii) contains within it a direct criticism that, as at the time of Public hearing 20, certain steps had still not been taken. This issue was not taken up with Ms Taylor, and it would be a significant denial of procedural fairness for such a finding to be made. In particular, given that leading up to and during Public hearing 20, a detailed forensic examination was being conducted by the Royal Commission, including the consideration by senior representatives of LWB and the Acting NDIS Commissioner and their examination by Counsel Assisting, to suggest now that the NDIS Commission should request LWB to notify the NDIS Commission of Jennifer's June 2020 complaint, and to request LWB's records would be of no clear utility, especially in relation to the best deployment of the NDIS Commission's resources.

The submission - this submission is not about not acknowledging what should have been done in June 2020. The issue is the futility now of making the requests nominated in the proposed finding.

CHAIR: And it would be futile because?

MS MORGAN: This Royal Commission has led to the detailed forensic examination of the underlying complaints. The documents have been well ventilated. Both LWB senior executives and the NDIS Acting Commissioner have engaged with the factual background of what occurred. The NDIS Commission has acknowledged what should have occurred, and to now turn around, using resources, to have LWB adopt processes that are meant to inform the NDIS Commission of the reportable incident, when we are now well aware and have well examined the underlying factual - underlying factual matrix, we say, is not a positive use of the NDIS Commission's resources.

CHAIR: All right. Thank you.

MS MORGAN: And finally, then, Chair, in relation to proposed finding 81, the Australian Government acknowledges that this is a correct statement and there is one inquiry on foot, although, as a matter of factual application of the rules, it's, in fact, two separate inquiries, but it is, in effect, one inquiry. More importantly, though, Commissioners, to date the Royal Commission has not put to any witness appearing for the NDIS Commission that any other possible inquiries should have been conducted.

If this finding is to be used to base a recommendation as to the use of the inquiry powers, the Australian Government submits that it would require further inquiry by the Royal Commission with which, of course, the NDIS Commission is happy and enthusiastic to participate in. They are the submissions of the Australian Government on the findings.

CHAIR: Thank you very much. I will just inquire whether my colleagues have any questions they wish to put to you. First, Commissioner Galbally?

COMMISSIONER GALBALLY: No questions. Thank you.

CHAIR: And Commissioner McEwin.

COMMISSIONER McEWIN: No, thank you.

CHAIR: Thank you, Ms Callan, for your submissions.

COMMISSIONER MASON: Ms Morgan.

CHAIR: Sorry. I misidentified you. Thank you, Ms Morgan.

MS MORGAN: Thank you, Chair.

CHAIR: Are we now going to proceed with the submissions on behalf of LWB now or are you proposing that we adjourn now or later?

MR GRIFFIN: Mostly in the hands of Ms Callan, but given the fact that there might be a reply and the Commission might have questions at the end, it would be a useful use of our time if she's ready to proceed?

CHAIR: Yes, all right. Thank you. Ms Callan.

MS CALLAN: Yes, Commissioners, and I can commence now. There may be a point in time where I ask the Commission's indulgence to take the luncheon adjournment. There are certain matters that I need to take instructions on which haven't yet come through.

CHAIR: You don't have to ask our indulgence. We will be exceedingly keen, I'm sure, to take the luncheon adjournment. Go ahead. I apologise for indirectly misidentifying you as well.

MS CALLAN: It's a compliment, Commissioner. First, can I indicate to the Commission and more generally at the outset that LWB expresses and has expressed sincere regret and offers its apologies to the persons and their families who were affected by the instances of violence, abuse, breaches of policy, poor communication and other matters that have been considered during Public hearing 20.

In my submission, and I will come in a moment to the suggestion advanced by Counsel Assisting this morning that LWB has failed to demonstrate sufficient insight, that, viewed fairly, LWB's position in terms of the evidence which has been placed before this Commission and the position it has taken as reflected in its submissions are emblematic of an acceptance by LWB of deficiencies which have occurred in the provision of its services for which LWB takes responsibility. Also, a willingness to learn and a commitment to continuous improvement.

As the Commissioners will have come to appreciate, and I understand will be dealt with in a supplementary document being prepared by Counsel Assisting, ultimately there is very narrow terrain in terms of - I could describe it as dispute as between LWB and certain of the findings proposed by Counsel Assisting.

In its written submissions at paragraph 5, LWB set out a number of proposed findings as articulated in Counsel Assisting's submissions which are accepted. I will come to it in a moment, but, in my submission, that acceptance should be given full force and effect as an indication of LWB taking - having insight and taking responsibility in respect of those matters.

CHAIR: Which portion of LWB, Ms Callan, is taking responsibility?

MS CALLAN: In my submission, Chair, it is not fair or appropriate to seek to somehow bifurcate the Board of LWB from, for instance, its senior executive. LWB as an organisation has taken the position that it has in this Commission, and, in my submission, it is LWB's position.

CHAIR: Does that mean that it is both the Board and the senior executive that should be regarded as taking full responsibility?

MS CALLAN: Yes.

CHAIR: What about the parts of the submission that seek to emphasise the division of responsibility between the Board and the executive?

MS CALLAN: That is in relation to, can I put it, the distinction between operational matters and the specific aspects that fall within the province of the Board concerning governance issues and overarching matters of policy and the like. That - the distinction in terms of role and responsibility ought not and, in my submission, does not by any means seek to adjust the position in terms of the overall responsibility the organisation takes as a whole that is comprised of, relevantly to your question, the Board and the senior executive.

CHAIR: Yes. Thank you.

MS CALLAN: As has been indicated by Counsel Assisting this morning, certain amendments to the findings that - the proposed findings that he contends for has further narrowed the terrain that I proposed to cover today. And in relation to a number of the findings in their amended form, which LWB accepts, the balance of the findings which remain in dispute, many of which I propose to rely on LWB's written submissions on those topics, and if I could indicate this as my understanding as to what remains in dispute: findings 11, 14, 26 and 27, and I rely on LWB's written submission on those topics.

CHAIR: Yes.

MS CALLAN: In respect of proposed finding 31 which is concerns Natalie's bowel care and the topic of maintaining documents and neglect, that is the first of three topics that I do propose to address orally today. Also in dispute are proposed findings 38, 39(ii), 40 and 45. In relation to those topics, again, I rely on LWB's written submissions.

The next, if I could describe it as, category of proposed findings which are in dispute, are numbers 47, 48, 53 and 54, and these concern or relate to the resident-to-resident violence in the Melbourne house, and that is the second key topic I propose to address orally. LWB

respectfully resists the current form of proposed findings 56 through to 61. Those findings concern staffing levels and associated matters at the Melbourne house, and on those matters I rely on the written submissions.

Similarly, rely on LWB's written submissions in relation to disputed proposed finding 69(ii) and (iii) and 70(ii). And, finally, and this is the third topic I propose to address orally, for reasons that I will expand upon, Life Without Barriers contends that the Commission ought not make proposed findings 72 and 73 which concern impressions of Ms Robb in the witness box and otherwise, and an overall impression as to whether she and LWB were more generally proactive or reactive in relation to deficiencies in the operations of LWB.

Now, in dealing with that third topic, I will also address, to the extent I can, certain further submissions which were made orally this morning by Counsel Assisting, and there is a particular matter that Counsel Assisting has sought a response from and on which I'm just finalising my instructions.

The suggestion this morning in Counsel Assisting's oral submissions that aspects of Life Without Barriers' written submissions had a flavour of the common law concept of confess and avoid is, in my submission, not an apt way to characterise the written submissions of LWB, and if there has been in any sense a suggestion or an implication that is what LWB is seeking to do, can I respectfully resist and persuade you, Commissioners, that is not what was intended by those written submissions.

In acknowledging and accepting proposed findings and acknowledging deficiencies, LWB has not sought to explain them away. There have been some instances where it was considered appropriate and hopefully of assistance to the Commission to provide some further matters of detail and context. In doing so, can I make the point that the submissions sought, to the extent possible, to avoid repeating detail that was already set out in the submissions of Counsel Assisting.

The other theme which was advanced by Counsel Assisting this morning was a hope that the submissions would reflect LWB's exploration of the issues that have been raised in this hearing, identification by LWB of undertaking a process of inquiring why and how, how to prevent, how to ameliorate. In that respect, first, the submissions of LWB are, in my submission, appropriately and necessarily limited by the evidence that is before this Commission. I do not understand or regard it as appropriate for LWB's written submissions to go beyond the evidence which is before this Commission in terms of expanding further or in other directions on issues of prevention or amelioration.

What the submissions do, where the evidence is before this Commission and appropriately to do so, there has been an indication of where processes or policies have been improved in the intervening period, and the evidence before this Commission, in my submission, from Mr Dolling and Ms Robbs, sets out in comprehensive detail in response to the detailed questions that were asked from the Commission, amongst other things - What were the events, how did LWB respond to them, what has changed since then? Associated questions, for, instance, in respect of staff training and the like.

CHAIR: Ms Callan, isn't it open to the Commission, on the basis of the evidence that has been presented and let me accept we have to operate within the confines of evidence that has been presented at the hearing, but isn't it open to the Commission to ask how could this have happened for so long? Why was it allowed to happen? What went wrong, and what did LWB and, in the way you've put it, LWB's Board, plus senior executive, what did they do to try and work out where things had gone so wrong?

That I think is the basic point that Mr Griffin's submissions are seeking to make, and it does seem to be a set of fairly obvious questions that arise from the large number of proposed findings that have been accepted. Just leave for the moment those that are in dispute. And I'm not concerned about the number of findings. What I'm referring to is the nature and extent of the apparent deficiencies over such a long time. Two different houses maintained by LWB, and the fundamental question is, how could this have occurred?

MS CALLAN: Yes, and Commissioner, it may be that there has been a misunderstanding or speaking at cross-purposes. I understand and LWB recognises that terrain is precisely the subject matter which this Royal Commission is charged to consider and examine, and that has been made very clear in the - amongst other things, the way in which this public hearing was pursued, and the - my concern is that there is a - was a suggestion from Counsel Assisting this morning that LWB had failed to demonstrate its own internal reflection on these matters. And to the extent that has been explored, and, in my submission, explored in detail in the evidence, that evidence is before this Commission upon which it will and should make its findings.

But if there are, so it's suggested, gaps in the evidence, the submissions of LWB could not - and it would not have been appropriate to try to fill those gaps at that juncture. To the extent that there is a desire by the Commission to have Life Without Barriers report in six months time, which has been proposed by Counsel Assisting, I anticipate instructions to the effect that certainly can and will be done.

CHAIR: Yes, all right. Thank you.

MS CALLAN: Can I deal with what I described as the first of the topics that I propose to address orally, which concerns proposed finding 31.

CHAIR: Yes. Could we bring that up, please, on the screen, if that's possible. Yes, thank you.

MS CALLAN: Commissioners, in considering proposed finding 31, LWB recognises, and can I say at the outset, the importance of maintaining accurate and up-to-date records such as, in this instance, specifically bowel charts, accepts recommendation 7 that LWB provide further information to the Commission in six months in respect to its process - progress in improving its record keeping and incident reporting.

And the other part of the background to proposed finding 31, in my submission, is LWB's acceptance of proposed findings 28, 29 and 30, being failures by LWB associated with the maintenance of complete records.

In terms of the position with proposed finding 31, I have addressed, or we have addressed, in written submissions the relevant statutory scheme commencing at paragraph 210 of LWB's written submissions. To the extent that there is what might be described as a working definition of the concept of neglect in LWB's document *Stop It Before It Starts*, in my submission, that is an apt working definition. It fits within what the NDIS has published in its guidance material as to what neglect is to be understood as comprising.

Commissioners, you might recall that the term "neglect" was the subject of particular attention by Counsel Assisting Mr Fogarty's questions of Ms Taylor, who, amongst other things, indicated that she was satisfied that providers understood what neglect means.

Here - and we make it clear in the submissions, but to respond to your observation, Chair, in particular - LWB accepts that their failure to keep records, where that could impact a medical condition in a material way, could constitute neglect. The point that is, however, sought to be advanced here in relation to LWB is that the facts of - that particularly emerged in March of 2020 do not fall within that term properly understood.

In particular, can I take the Commissioners to one document which we provided notice of that we - and hopefully is available to the Commission - and that is exhibit 20, 1899. The associated code for that document is LWB.1051.0013.0001.

CHAIR: That's a document that consists of a chart, essentially.

MS CALLAN: Yes. It's a spreadsheet-style document, and I hope what your Honours will find - I appreciate the formatting is not easy to follow, but in the fourth column, just conscious of the pseudonyms which have been applied, there's a surname in that fourth column. I'm concerned that not - if that's being displayed on the live screen, that that not undermine the position as to protecting identity, Commissioners. Is it possible for you, Commissioners, to consider that document without it being displayed on the live stream?

CHAIR: We will do our best. It might be removed. It won't be displayed. I'm told it's not being displayed to the general public, Ms Callan, it's not - so we can use that. Looking at the numbers at the left-hand side of this spreadsheet, which number should we be looking across?

MS CALLAN: The first aspect to draw your attention, the letters across the top of the columns, column E provides the date -

CHAIR: Yes.

MS CALLAN: - of the particular event. Column G describes the category of what is being reported. And then column J sets out the author of the note, which then appears in column K. And so, row 2, the note which appears in that row is a note which was made contemporaneously on 5 March 2020, and that was the date that Natalie was assisted to the GP. And the note goes on to provide contemporaneous evidence that the prescribed, or recommended, Movicol and Neural-B were purchased.

And then at line 4, still looking into that notes column, there's an indication as to the author's observations of Natalie that day, and there's a reference to medication being

administered. And in its context, in my submission, that should be understood as a reference to the Movicol and Neural-B. The extra comment column immediately to the right contains in that note, still at row 4, a further reference to medication being administered. And then -

CHAIR: Sorry, what do you say the evidence shows was the purpose of the medication being administered?

MS CALLAN: Well, there is a - amongst other things, an assertion that the evidence doesn't indicate for this Commission's understanding whether the Movicol was administered or taken by Natalie during this critical period of time. In my submission, and I will take the Commissioners to one or two further entries here, this does provide contemporaneous evidence indicating first the extent to which LWB staff were alive to and monitoring Natalie's health, particularly in relation to her bowel issues, but also it provides some contemporaneous evidence that, in fact, medication was being administered.

Now, that doesn't detract from the point which is accepted in relation to proposed findings 28 to 30. The specific charts which ought to have been maintained were not, but, of course, a bowel chart was maintained for the period 1 through to 9 March 2020, again during this critical period.

CHAIR: Ms Callan, can I just make sure I've understood the way in which this is put. You are disputing proposed finding 31.

MS CALLAN: Yes.

CHAIR: Proposed finding 31 is that LWB failed to treat the lead-up to and hospitalisation of Natalie as a reportable incident that should have been reported to the NDIS Commission. Your proposition, as I understand it, is that the failure - the conceded failure of LWB to maintain proper records between the period 1 December 2019 to 29 February 2020, a period of three months, that was not "neglect" for the purposes of the relevant provisions, and thus the obligation to report this as a reportable incident was not enlivened. Is that the point?

MS CALLAN: And I was seeking to take the Commission to the particular evidence -

CHAIR: Yes. Now, can I - I just want to understand something.

MS CALLAN: Yes.

CHAIR: It is accepted by LWB that for three months, up to a period - I think nine days before Natalie's admission to hospital. I think that was on 9 March, wasn't it?

MS CALLAN: Yes.

CHAIR: No - the medical records were not kept, specifically bowel charts, and that's accepted in paragraph 203 of LWB's submissions. What does the evidence tell us about Natalie's state of health during that three-month period?

MS CALLAN: It's limited, but what the evidence, for instance, by reference to this spreadsheet document shows you, Commissioners, is that certainly during the precise period of time in the nine days - sorry - in the four or five days before her admission to hospital, that LWB workers were alive to and considered her health, particularly her bowel health, and acted upon it.

CHAIR: Ms Callan, I do understand that, but in order to make a judgment as to the significance of the failure to keep the medical records for a three-month period, presumably we would need to have some understanding of whether Natalie's state of health was such that the failure to keep records created a risk to her health. It wouldn't necessarily have to be in relation specifically to the bowel problem that emerged.

I saw to my delight that I was actually quoted by the High Court the other day in a decision I gave as to how to identify a risk for the purposes of the *Civil Liability Act*, but here we're not concerned, are we, about whether a three-month gap in keeping records was necessarily causally related to the hospital admission that occurred nine days after records were recommenced? We're concerned, aren't we, to determine whether the failure of LWB to keep the records during, or to maintain the records during, a period of three months, created some sort of significant risk for a person in their care as far as her health was concerned?

Now, is it your proposition that Natalie was in perfectly good health for that three-month period, that nothing would have given rise to any suggestion that the health records needed to be kept up to date?

MS CALLAN: I don't make that suggestion, Commissioner, and I'm grateful for the recognition that there is no, as I understand it, contemplation here that there is a causal relationship between the absence of records and Natalie's admission to hospital. But where - and building upon that position where neglect is, amongst other things, or a working definition, to be understood is a failure to provide for a person's medical needs, in my submission, where there is no suggested causal link between the failure to maintain a document, in this case, and Natalie's health deterioration, which emerged and resulted in her hospitalisation on 9 March.

CHAIR: Why does there need to be a causal relationship in order to establish a case of neglect? In paragraph 215, you cite the ordinary meaning of the word neglect and definition 2(a):

> "Lack of attention to what ought to be done, the fact of leaving something undone or unattended to."

Well, that's exactly what happened here, isn't it?

MS CALLAN: It does in respect of the documents, Commissioner, but neglect ultimately, as understood in this context, is about a failure to provide for the person's medical needs. In my submission, I'm not sure I can take the position very much further but the - in terms of attending to Natalie's medical needs, ultimately, the focus and the question is whether or how LWB's conduct contributed to the deterioration of her condition.

CHAIR: I understand the submission that you say that unless there was a causal link between the failure to keep records and the condition for which Natalie was hospitalised on 9 March, there can't be a finding of neglect. What I'm putting to you is that a finding of neglect in this context does not require a causal relationship between the failure to do that which ought to have been done and the conditions that ultimately affected the individual.

Looking after somebody's needs, medical needs, involves in a situation like this, one would have thought, keeping accurate medical records. There's just - I'm finding it a little difficult to see how this can't be neglect in this particular context. If we were looking at a different issue, namely, whether the failure to keep records was the cause of Natalie's hospitalisation and bowel obstruction and thus gives rise to some kind of cause of action, there may be very different questions to be asked. But here, we're just asking whether the carer was neglectful - committed neglect, if you like - by failing to keep records for a period of three months that directly related to the health of the person concerned. It's a bit difficult to see how that doesn't answer the description.

MS CALLAN: I'm not sure I can take this much further.

CHAIR: All right. Okay. Thank you.

MS CALLAN: Commissioner, the only other point I wish to make on this point is that LWB has accepted, and this is in Mr Doley's evidence - for the record, it's at transcript 478 - that LWB at the time - effectively, immediately after Natalie's hospitalisation - should have conducted an investigation to understand whether or not neglect had occurred in all the circumstances.

CHAIR: Yes. Do we now move on to proposed findings 47, 48, 53 and 54?

MS CALLAN: Yes.

CHAIR: All right.

MS CALLAN: Commissioners, in respect of proposed amended finding 47, LWB's primary position is for a finding in the ultimate terms which are set out in its submissions, and I will pull up a reference to that.

CHAIR: You deal with proposed findings 47 to 54 at paragraphs 282 and following of your submission.

MS CALLAN: 294.

CHAIR: 294.

MS CALLAN: I'm going to have to come back to the reference. Sorry, it's at paragraph 301.

CHAIR: 301.

MS CALLAN: That is LWB's primary position, which is that the Commission make a factual finding in terms of recorded incidents - the number of recorded incidents of resident-to-resident violence. But if, contrary to that, the Commission is minded to make a finding in the terms which have now been proposed in an amended form by Counsel Assisting, then that is accepted. The - LWB -

CHAIR: Sorry, you are accepting the finding that appears on the screen at the moment.

MS CALLAN: LWB seeks to persuade the Commission to make a finding in the alternate form which appears at paragraph 301 of its submissions for the reasons developed in its submissions that it is - the Commission does not have evidence upon which to give the descriptor high frequency.

CHAIR: All right. So, you're proposing, in fact, to a finding in terms of paragraph 301 in lieu of the finding that is on the screen?

MS CALLAN: Correct.

CHAIR: Right. I understand.

MS CALLAN: As to proposed finding 48, LWB has set out at paragraph 303 of its submissions a modified form of that finding which, can I submit, does not seek to detract from the finding which is available on the evidence, but which does seek to employ what I might describe as more factual language to avoid characterising residents' behaviours of concern in terms which imply perpetration of violence, and that is a topic which is developed in LWB's written submissions in relation to the way in which it submits the Commission would and LWB does approach instances of resident-to-resident violence amongst - amongst a group of people with complex behaviours of concern.

CHAIR: So, you're proposing a modification of the language in proposed finding 48.

MS CALLAN: Exactly. It's not directed at seeking to minimise the effect of the evidence, nor the behaviour or its impact, and nor is it seeking to minimise LWB's responsibilities in relation to that behaviour and its impact, but it suggests that the language that's set out at paragraph 303 is more mindful of the context in which that violence is occurring.

CHAIR: Yes, all right. Looking at the modification, I'm not sure it conveys anything that is in substance different to the original version, but I follow why you want to do it.

MS CALLAN: Yes. I'm grateful to the Commission. The next and final matter to address orally in relation to this second topic is the suggestion in Counsel Assisting's submission, which was also addressed orally this morning, that there is a use - that there was a normalisation of violence in the Melbourne house, and that links up with some submissions I wanted to make in relation to proposed findings 53 and 54, which both contain a word that LWB respectfully seeks to resist, and that is the word "eliminate" - that is, the elimination of violence.

And in addressing that topic, can I emphasise that LWB has and continues to accept it could have done more to reduce the incidence of resident-to-resident violence in the

Melbourne house. But for reasons developed in LWB's written submissions, it doesn't accept that it or any other service provider could have eliminated violence from occurring in a supported independent living house.

CHAIR: Does that mean it shouldn't try?

MS CALLAN: No. That does not follow, and that, I think, may be the point that has perhaps, with respect, been misunderstood in the position that LWB has taken, and Counsel Assisting's response to it. The other - aside from the word "normalised", in Counsel Assisting's submissions this morning he referred to an attitude of inevitability, and I think he even used the word "sanguine". In that respect, I would respectfully resist such descriptors of LWB's attitude to seeking to minimise absolutely the incidents of resident-to-resident violence.

In my submission, the evidence which is set out in LWB's submissions at paragraph 315 demonstrate that it was, throughout the relevant time, never taking a complacent attitude to resident-to-resident violence. It was endeavouring to confront the complexity of the situation that it was - that had developed in the Melbourne house. But it is, as I've already indicated, accepted by LWB that what it - what was done was insufficient, and that more could have been done.

CHAIR: When you look at proposed finding 54 which is on the screen, the proposed finding says:

> "LWB didn't adequately train or support the house staff or work directly with residents to reduce or eliminate resident-to-resident violence and conflict."

It is a reference to training that would have as its goal the reduction or elimination, if possible, resident-to-resident violence. The fact that it might be very difficult to eliminate altogether doesn't detract from the need to have training that has that as its goal, and no doubt in some cases there would be success. It may be that there are particular houses with people with similar disabilities where the policies and practices in place have worked exceedingly well and there is no resident-to-resident violence. I think there may be a bit of semantic quibbling going on here.

MS CALLAN: And I have sought to minimise that, Chair. The work of this Commission is too important to descend into those - to such semantic criticism. It's accepted that there may be not only policies and practice but also, Commissioner, households where, as it happily transpires, the compatibility between the residents minimises instances or reduces instances of resident-to-resident violence.

The topic of training, which is addressed at proposed finding 54, the alternate phrasing which is proposed by LWB, recognises that the training and support which was provided to those house staff was not always effective in reducing such incidents. And that demonstrates, and LWB has sought to put evidence before the Commission of the focus which it places on training. And in this context, that focus is very much through the prism of managing, dealing with behaviours of concern.

That is, in particular, very much an emphasis on going behind and beyond the impact of the behaviour, which might be violent, and addressing the nature of the behaviours of concern, the context in which it is occurring, all of which occurs in training staff in relation to their behaviour support plan.

So the - in my submission, the challenge and the - in the form of the proposed findings by Counsel Assisting at proposed finding 53 and 54, is that it carries the implication, squarely, that it is possible to elimination resident-to-resident violence, and for the reasons that are developed in LWB's written submissions, that is not, in my submission, a appropriate way of conceiving of such instances, given the context in which they occur.

All of that being said, it is not to be understood as LWB normalising violence, nor that there is any lack of desire to minimise it wherever it's possible through a range of approaches, be they at the policy level, at the training level, and also having regard to matters, amongst other things, of resident compatibility.

CHAIR: Ms Callan, I think you said you needed a lunch break in order, among other things possibly to eat, to get some instructions. Would it be convenient to take that break now?

MS CALLAN: Yes.

CHAIR: And then we can return, you can complete your submissions, and let us know what the position is on the matters that you wish to get instructions on, and we'll provide an opportunity, if my colleagues wish to ask questions, they can do that. Then there's an opportunity for Mr Griffin to reply if he wishes to do so. So shall we take the adjournment now. And Mr Griffin, should we take one hour and come back at 1.40?

MR GRIFFIN: Yes.

CHAIR: 1.50, I'm sorry.

MR GRIFFIN: Yes, Chair.

CHAIR: We'll come back at 1.50. Thank you, Ms Callan.

ADJOURNED 12.50 PM

RESUMED 1.50 PM

CHAIR: Yes, Ms Callan.

MS CALLAN: Thank you, Commissioners. Before - sorry - during Counsel Assisting's submissions, he extended what he described as an invitation to the Commissioners to consider whether they would invite Life Without Barriers to provide a report in perhaps six months time. Can I indicate squarely that Life Without Barriers is certainly prepared to provide such a report.

As I understand it, the goal is that a report be provided to the Commission. Counsel Assisting referred to it particularly from the Board's perspective, and in that sense what I understand might be included is an indication as, for instance, the extent to which the Board has been engaged with Public hearing 20 and the issues that emerged therein.

CHAIR: Ms Callan, I think all we need to know at this stage is that LWB is amenable to providing a report. I think, then, the next step would be for the office of Solicitor Assisting, with the advice of Counsel Assisting the Royal Commission to indicate in writing what information we might seek. And the mode in which that information could be addressed. It might be possible, for example, not just in relation to Life Without Barriers, but perhaps other service providers, for there to be a supplementary hearing at which some of these matters will be explored further. So, I suggest that the best approach is that for that to be formalised, and that, of course, will involve discussions, consultations with those instructing you, and they no doubt will get instructions from LWB on any proposals.

MS CALLAN: I understand. That sounds eminently sensible. Thank you, Commissioner.

CHAIR: Thank you.

MS CALLAN: One of the themes which seemed to emerge, in my submission, particularly this morning, was the distinction, if there be one, between the Board and the role of the senior executive of Life Without Barriers, and I already addressed briefly before lunch on where the roles and responsibilities may differ, but where the overarching responsibility lies for the organisation. In my submission, the position with Life Without Barriers as Counsel Assisting considered it ought be is one where the culture, attitude and standards of that organisation fall within the province not only of the chief executive, but also, amongst other things, with the Board, in alignment with their appropriate division of burden, that is, at the operational level and at the overarching level.

But one concern which seems to be reflected in some of the comments that have been made by Counsel Assisting and some observations by yourself, Chair, caused me to suggest that to the extent the Commission wishes to consider more directly the role of the Board of an organisation such as this - that is, a disability service provider - it may be - and, Chair, you may have this in mind - that can be addressed via supplementary hearing or some type of round-table forum because some of the issues which seem to have emerged just effectively through the submission process suggest a desire to have clarity, but also perhaps for the Commission to provide some real guidance to these organisations about the best practice and the right approach that might be taken in relation to the responsibilities of these organisations.

CHAIR: Ms Callan, as you will be aware, the terms of reference for the Royal Commission require us to look at systemic issues, and one purpose of a hearing such as this, which this particular hearing, of course, is concentrated upon Life Without Barriers, but there have been other hearings that have looked at the actions of other service providers or organisations, part of our job is to determine how we extract systemic issues from the inquiries, investigations that we've held, and we have to make a judgment as to how they're best pursued between now and the date we have to report, which is 29 September 2023. So, the short answer is no doubt we will be in touch.

MS CALLAN: Okay. All right. Can I turn to squarely address submissions which were made in writing and orally this morning by Counsel Assisting in relation to the evidence of the Life Without Barriers CEO, Claire Robbs. The observation that was made by Counsel Assisting this morning was that it is not the role of the Royal Commission to determine whether Ms Robbs is the CEO of Life Without Barriers, and I'm fortified to hear that is clear.

And with that in mind, I address criticisms which have been made by Counsel Assisting which might otherwise be understood as entering into that terrain as to her suitability in her role. The submissions that were made this morning by Counsel Assisting to some extent interact with the written submissions which sit behind proposed finding 72, and LWB's written submissions go some way to outlining the reasons why we resist and submit, respectfully, the Commission would not be persuaded to make that finding.

CHAIR: All right. Just - sorry to interrupt, but if we could have proposed finding 72 to 74 brought up on the screen, that might help those who are following. Thank you.

MS CALLAN: Yes.

CHAIR: Yes. Go ahead, Ms Callan.

MS CALLAN: Yes. And just for the Commissioners' assistance, this is - to the extent that it was dealt with in writing by Counsel Assisting, our response in writing commences at paragraph 384. In - can I start with the following point: in my submission, full weight should be given to the sincere and, in my respectful submission, detailed apology which was delivered by Ms Robbs in her evidence. And it ought - that apology ought not be understood by this Commission as in some way undermined by the manner in which Ms Robbs sought to engage with the varied issues upon which she was examined. And it's echoed in what I said at the outset of my oral submissions today, but Life Without Barriers stands by that apology and has sought, amongst other things, to reflect its position in that regard in the position it has taken throughout this hearing, including in these closing submissions.

In terms of the Commission's ultimate impression of Ms Robbs emerging from her oral evidence, in my submission, it is not the case that the Commission would infer a reluctance to accept any significant deficiency in the operations or services of Life Without Barriers. But, in my submission, her presentation in the witness box reflected, amongst other things, her desire not only to grapple with the deficiencies which have emerged plainly in this hearing, but also to do so whilst recognising what she regards as the extraordinary work done by Life Without Barriers for thousands of people each year.

The other point I wish to make is that her evidence ought be assessed in the context of Mr Doley having given evidence the day before and, for instance, Ms Robbs is in no way seeking to resile from the concessions which have been made by or on behalf of the organisation. She, in my submission, made a number of further considered concessions throughout her evidence, and there's a - examples of those in our written submissions at paragraph 392.

Just taking a step back, though, as the Commission will have gleaned, Ms Robbs comes to her position as CEO against a background of considerable experience in the disability service industry. She commenced her career in frontline service delivery, and she has navigated this organisation over the last 11 years and, amongst other things, seen the growth that has occurred with this organisation, which has already been referred to by Counsel Assisting. And, in my submission, he's quite right, and the Commission should regard the growth of the organisation as a testament to it doing what it does well.

Of course, recognising that, as has been exposed and considered during this Public hearing, that there have been deficiencies and some in a systematic sense which need to be and are being addressed.

But the suggestion, for instance, by Counsel Assisting this morning that sort of implied that there was a lack of curiosity by Ms Robbs or a failure to have and maintain keen insight into what the organisation is doing is, with respect, not well founded, having regard to the evidence. A particular passage of her examination deals with this point if I can refer the Commissioners. Part of the transcript on day 6, it was at transcript page 502 to 503, but it's set out as well in LWB's written submissions at paragraph 407. I'm in the Commissioners' hands as to where they can more readily turn it up.

CHAIR: Yes. One way or another we will have it. Thank you.

MS CALLAN: Yes. In my submission, when Ms Robbs was asked squarely whether she has a process in place that enables her to avoid the line of people reporting to her, and from time to time going to frontline staff, unfiltered by management, she responds squarely that she does, and she thinks it's important for all leaders to do so. She speaks about visiting various facilities run by LWB to talk to the staff and describes that as one of the better parts of her job.

Now, she was asked how often she does so or what percentage of time, and she observes that she doesn't have a fixed sort of percentage. She then goes on to describe why she finds it most helpful to understand what's happening on the ground. In my submission, what she addresses squarely and reflects is exactly the desire for insight and the natural curiosity which Counsel Assisting spoke of as being so important for a CEO, particularly of an organisation such as this.

CHAIR: Ms Callan, while we're on the transcript -

MS CALLAN: Yes.

CHAIR: - could we go to page 494 of the transcript, but the relevant passage is extracted in Counsel Assisting's written submissions at paragraph 212.

MS CALLAN: Yes.

CHAIR: That's the passage in which it's put to Ms Robbs that LWB had responsibility, at least in a significant moral sense, for what happened to Sophie, and Ms Robbs declined to accept that proposition, and Mr Griffin you will see in the passage indicated he was troubled by the answer. Is there some reason why we shouldn't be troubled by the answer?

MS CALLAN: In my submission, there's two preliminary points that needs to be made. The first is that what Ms Robbs is responding to was the suggestion that the LWB was in part responsible and, as I understood it, she was - she sought to draw a distinction between responsible in the legal sense and responsible in the general moral sense. And my - in my respectful submission, a fair reading of that exchange indicates that she was focused on responsibility in the legal sense and why that had implications for the nature of reporting which occurs to the Board. But, for instance, further in this transcript at page 507 -

CHAIR: Yes.

MS CALLAN: - Ms Robbs states squarely - and this, in my submission, part of it, at about point 37 she says:

> "I don't think my evidence was that we had no responsibility for Sophie in any way. My recollection was that the questions were more granular than that. I think we always have a responsibility for doing our best to make sure people are safe."

And that's where in response to question asked by you, Chair, in terms of reconciling her evidence with the apology that was extended. That -

CHAIR: That answer is not exactly precisely responsive to the question I asked, I don't think. The question that was asked was, in effect, does Life Without Barriers have some responsibility for what happened to Sophie, and the answer is:

> "Well, in general we try to do our best to make sure people are safe."

MS CALLAN: Yes. And that conveys, in my submission, a response - a sense of responsibility. But the - where Ms Robbs spoke about the questions being more granular, that, for instance, in my submission, indicates that the way that she was engaged with Counsel Assisting in those questions which appear at 494 -

CHAIR: Yes.

MS CALLAN: - was directed at the - if I can put it this way - more granular topic of Board reporting, and the distinction that she was drawing between the general sense of moral responsibility and the reporting that must occur in - specifically under the governance structures where legal responsibility has arisen.

CHAIR: Can you point - can you point to anything in the apology or elsewhere - and by asking the question, I'm not suggesting it's not there, but can you point to anything in the apology or apologies that have been given or other material where Ms Robbs accepts that there was moral responsibility on the part of LWB for what happened to Sophie?

MS CALLAN: Yes.

CHAIR: Now, I understand your submission about the answer given at page 507 of the transcript, but at the moment I'm not sure that the answer amounts to a specific acceptance of moral responsibility - in part; obviously it wasn't the sole cause. But, as you know, you

can have a causal relationship between events that - where one doesn't have to be the sole cause of the other.

MS CALLAN: Yes. I will turn up what I can in relation to that.

CHAIR: All right. By all means, take that on notice, but I would be interested if you can point to anything like that.

MS CALLAN: Yes. That - whilst this topic is and this transcript has been turned up, in my submission, the other - an associated points which can conveniently be made is as to the topic of reporting to the Board. Now, I had rather understood by the amended form of proposed finding 13 circulated by Counsel Assisting yesterday, which is, in substance, in the form suggested in the written submissions of LWB, that there was acceptance as to the rationale of that ultimate form of the finding because of the points developed in LWB's written submissions concerning the distinction between the role and responsibility of the Board as against senior executive, and why, in those circumstances, the sexual assault of Sophie certainly should have been managed differently and, in that respect, starting with it being reported in LWB's incident management system, then subsequent events occurring, including an internal investigation and escalation to senior management.

The evidence before the Commission, including in Ms Robbs' statement of 12 April, explains, in terms which I understood were accepted by Counsel Assisting, that the form and nature of reporting to the Board is informed by the role and responsibilities of the Board. Amongst other things, the Board does want to know - in my submission, this is clear from the evidence - about serious incidents, such as what occurred in relation to Sophie, and it is informed in that respect through the reports that are currently received in general in an aggregate style.

Having regard to the particular focus of this Commission on this topic with Sophie's case study generating the focus, as conveyed in the statement of Ms Robbs of 12 April, it is proposed that further independent expert consideration be given to the content and form of Board reporting in order to ensure that the Board is squarely grappling with the importance of it being kept appropriately informed, and that information can, in due course, guide the way in which LWB responds to deficiencies, but also develops its policies.

CHAIR: Ms Callan, at paragraph 407 of LWB's submissions, after listing a number of changes in procedures, initiatives, the first sentence says:

> "As CEO of LWB, Ms Robbs bore ultimate executive responsibility for these initiatives."

If that's right, why doesn't Ms Robbs bear ultimate executive responsibility for the failures?

MS CALLAN: As the executive, yes.

CHAIR: As an executive, yes. All right.

MS CALLAN: But - the other point to address which emerged Counsel Assisting's submissions this morning in relation to Ms Robbs' evidence requires me to take you,

Commissioners, to page 493 of the transcript. My note, at least, was the submission made from this morning was concern expressed by Counsel Assisting that in Ms Robbs evidence she would have done, or she would do things differently - this is in the context of the events surrounding the sexual assault of Sophie - and it suggested that Ms Robbs' answer was, "No".

Commissioners, at page 493, line 25, Ms Robbs was asked by Counsel Assisting:

> "With the benefit of hindsight, if those events were to occur in 2021, would you take a different course in relation to the Board?"

Now, what Ms Robbs answers, in my submission, does not convey any suggestion that things - that nothing would have been done differently. She makes it clear that she would have expected to be an incident entered into the incidents system, then it would have been assessed by the national safeguarding unit, and it would have been managed differently.

In my submission, particularly in circumstances where Counsel Assisting has, as I understand it, accepted the position reflected in amended proposed finding 13, Ms Robbs ought not be in any sense criticised for the evidence that she gave in answer to that question. And just coming back to the question of the Board's engagement with the issues which have emerged during this hearing, if you, Commissioners, would turn to page 495 of Ms Robbs' evidence, at the top of the page Mr Griffin at line 5 asks her:

> "Have any of those board members expressed a view they would have liked to have known about it if it occurs on their watch?"

And that's a reference to the events surrounding Sophie. Ms Robbs' evidence refers to her conversation with the directors of the Board which she says:

> "Have made us reflect on a number of things in the organisation, one being around the suitability of the reporting, the robustness of the systems."

She describes that as considering it to be exactly the type of conversation you would want a chief executive in a Board to have around matters like this when they - it's brought to our attention through processes like the Royal Commission. And, in my submission, that speaks volumes as to, in fact, the extent to which the Board has been engaged with the work of this Royal Commission, but also the open and direct dialogue between the chief executive and the Board in relation to the matters that have emerged during Public hearing 20.

CHAIR: Ms Callan, you appreciate that one of the submissions made by Mr Griffin is that Ms Robbs was reluctant on occasions to make concessions. Can I direct your attention to transcript 496, commencing at line 29, through to 497, line 30? This is the questioning relating to a concession by Mr Doley that the rules relating to Sophie's intimate relationships as applied to her were inappropriate. And that passage, in effect, and I suppose I'm the one asking the questions, addresses whether Ms Robbs is accepting the concession made by Mr Doley. And the question I want to put to you, is, is it a fair reading of that passage that Ms Robbs was reluctant to make the concession that Mr Doley very freely made.

MS CALLAN: The concession that was made by Mr Doley included the use of the word inappropriate, and, in my submission, a fair reading of this portion of the transcript is that is - it is a particular word in that is the characterisation which Ms Robbs expressed difficulty with. And that, in my submission, must be seen in circumstances where it is accepted by Life Without Barriers that those rules did not sufficiently respect Sophie's dignity of risk and privacy, and didn't sufficiently support her right to intimacy. The notion of appropriateness carries with it, in my submission, connotations which it's clear Ms Robbs had difficulty with, given the extent to which it appears, in my submission, from the evidence, that the LWB staff were endeavouring to grapple with the issue. It's accepted that there is a balance that must be struck in an area which is not straightforward and that that was not struck.

CHAIR: When you read that passage as a whole, it seems tolerably clear that the reason Ms Robbs was cavilling with the use of the word "appropriate" was that she had in her mind that everybody was trying to do the right thing.

MS CALLAN: Yes.

CHAIR: The problem with that is that, as was discussed this morning to some extent, you can attempt to do the right thing, but if you're not achieving what you're attempting to do, what you've done can still be and is inappropriate, and that's the way Ms Robbs seems to have approached it; that as long as it was done with good intent, then she has difficulty accepting the word "inappropriate". Your own description of what LWB now accepts about that policy is a pretty good description of "inappropriate" I would have thought.

MS CALLAN: In my submission, it's the very nature in which Ms Robbs understood that term "appropriate" to be - that explains not only her evidence, but why this ought not be regarded as an example of her being reluctant to make concessions because -

CHAIR: Yes. We may be on common ground. I think that may be the point.

MS CALLAN: But - and can I say, with respect, because Ms Robbs effectively is revealing her thought processes as to what she was understanding by the term "appropriate", the reason that it may read as though she's resisting a concession is because she is seeking to emphasise that there was the right intention, albeit the execution was done poorly and with tragic consequences.

CHAIR: Yes.

MS CALLAN: But it's with that in mind that, in my submission, this isn't an example of her failing to make an appropriate concession when it's understood properly.

CHAIR: Yes.

MS CALLAN: She says squarely on page 497, line 29 and 30:

> "I would have liked us to be able to come up with a different way to manage the risk and Sophie's goals."

Once again, I don't want to get stuck on semantics, but I think that the disconnect in the questions and her responses is, perhaps, one that is a semantic one and ought not be regarded as her resistant to appropriate concessions.

The - there's just one other matter that I wanted to address from this morning's submissions by Counsel Assisting, and that was made at a general level, which suggested, again on this topic of reporting to the Board, that the notion of "reputational damage" might have had some role to play. That concept comes as a surprise to me in circumstances where I don't understand there to be any evidence before this Commission that that reputational damage was a consideration for LWB's executive or its Board in terms of the way that it conducts its affairs pertinently in terms of the subject matter of this public hearing.

I am aware that that concept was explored by this Commission in Public hearing 13, and that was a term that was found in some of the documents in the evidence in that public hearing. Can I suggest that the bottom line is there's no evidence to support an inference that that is a concern or it affected the way in which LWB has conducted itself in relation to these matters or more generally, and I would ask the Commission not to take that any further.

The final topic to address, or the final aspect of the topic, the third topic to address, is proposed finding 73.

CHAIR: Yes, that is up on the screen.

MS CALLAN: Yes. Commissioners, the written submissions from Life Without Barriers from paragraph 397 onwards grapple with this proposed finding. Can I say plainly enough, and as you would expect, Life Without Barriers is concerned to respond directly when revelations emerge about substandard care and support, including to the extent it arises in the operations of LWB.

That fact ought not more broadly give rise to a conclusion by this Commission that the position of Ms Robbs, the CEO, or LWB more generally is to sit back and take a reactive approach, amongst - for, amongst other reasons, those outlined by Counsel Assisting which is, it gets to the real difficulties with an organisation taking such a reactive approach.

In my submission, there is a body of evidence before this Commission which demonstrates the proactive approach which is taken by the organisation, and that's dealt with in - at length at paragraph 406 of LWB's written submissions. It deals not only with the existence and implementation of, in my submission, what are comprehensive policies and procedures. Also, in relation to the training of staff. But, further, in relation to the way in which reports are provided to the Board and the Board's active interest in seeking to be properly informed.

CHAIR: Ms Callan, is this a submission as to what the position is now with LWB, or what it was at all material times, or what it has been since 2019? What's the temporal aspect of this submission?

MS CALLAN: Well, in my submission, the finding is not expressed in temporal terms - that is, finding 73 - other than it's expressed in the past tense, that it did not take a proactive approach. We have sought to address it in the - in its terms, which is to point to, over a period of time, examples that demonstrates pro-activity. It's difficult, in my submission, to respond to a proposed finding which lacks that temporal dimensions-

CHAIR: I suppose there's a certain lack of precision in it, but pretty clearly, it's intended, read in context, I would have thought, to refer to the events that have been the subject of evidence over a period of time -

MS CALLAN: Yes.

CHAIR: - rather than as at, say, April 2022, or even December 2021. Many of the developments that are referred to at paragraph 406 are actually from 2021 on. Not all of them, but some of them are. Many of them are, in fact. So, if we read, and Mr Griffin no doubt can clarify this, if we read proposed finding 73 as intended to be related to the period in respect of which evidence was given about LWB's actions or inaction, then is that proposed finding 73 justified on the evidence?

MS CALLAN: Can I correct, if there's any misapprehension, Chair, as to the timeframes that concern - sorry, I will start again. The broad assertion of a reactive rather than a proactive approach was understood to be referable to the period covered by the public hearing, which is a broad period from 2011 to 2020. The evidence which has been specifically pointed to as demonstrative of a proactive approach by the organisation covers a period of time at least from 2014 onwards. That was, if I can take the Commission to paragraph - or it's at page 122 of Ms Robbs' statement of 17 November 2021.

CHAIR: Can we bring that up on the screen.

MS CALLAN: Yes, so the bottom of page 122.

CHAIR: Yes, well, being a Luddite, I have a paper copy.

MS CALLAN: So do I. So do I. Ultimately, feels more reliable. Chair, you might observe question 38 which is asked by the Commission and in the preparation of his statement seeks to have identified proactive strategies adopted or steps taken by LWB to prevent the occurrence of resident-to-resident violence, abuse and/or other conflict. This was specific to the Melbourne house over that period of 2014 to 2019. And in answer to that question, which I recognise was specific to the Melbourne house, but, in my submission, produced an answer which is more generally indicative of a proactive approach by the organisation, Ms Robbs from paragraph 346 onwards addresses various steps taken to improve and, in my submission, proactively deal with monitoring, detecting and/or rectifying deficiencies.

So that deals at a documentary level, as she describes. For instance, at paragraph 350 as to the content and structure of policies, not only to reflect legislative standards and requirements, but also evolving views regarding best practice. Over the page, page 124 of her statement, she describes initiatives and improvements that are made in relation to access and training.

And at paragraph 355 she sets out a number of enhancements for systems and processes for preventing, recording and reporting to complaints. What might be observed is that the - it was from December 2017 that the eyesight system was implemented in terms of the recording of incidents, and it's been a theme throughout the evidence as to the significance of that system in triggering steps to be taken, including, amongst other things, investigations into events.

But she also refers to initiatives from just working through, I guess, bearing in mind the temporal question that you asked, Chair, September 2019, December 2019, November 2019, changes and initiatives. It is certainly recognised that the content of this statement reveals initiatives and proactive conduct by the organisation, effectively from 2017 onwards. In my submission, that ought not be read or understood as indicating a lack of pro-activity before that time, but where an organisation is - and, in my submission, it's demonstrated here - alive to the importance of maintaining best practice, scrutinising and improving its processes, it's not surprising that the evidence that was collated in 2021 referred to this period of time in the three or four years before because, of course, that in itself suggests the position as it has developed over the last three or four years, which, in my submission, it can be or ought be inferred was an improvement upon systems that had been developed, in my submission, proactively at earlier points in time, but have, as can be seen here, been the subject of proactive attention. I hope that makes sense.

CHAIR: I think it makes sense. I'm not entirely sure it answers proposed finding 73-

MS CALLAN: Well.

CHAIR: - which refers not to the development of policies but a proactive approach to the monitoring, directing - detecting and/or rectifying deficiencies in the operations. As one of the themes of the hearing, and that has been repeated by Mr Given this morning, is you can have the best policies in the world. They're not much help if they're not implemented and monitored very clearly and I think, at least on my reading, that's what proposed finding 73 is directed.

MS CALLAN: Well, in that respect, can I particularly emphasise what's set out in Ms Robbs' statement at paragraph 355, page 124, which moves beyond that question of policy, and it recognised that the policies have a role, but the significance is their adherence.

What's set out at 355, in my submission, squarely deals with the criticism in proposed finding 73 because it's about the systems and processes for preventing, recording, reporting and responding to complaints and incidents which, in my submission, the fact of a system to deal with incidents is not by its nature a reactive approach of an organisation, particularly in circumstances where, as set out here, there are, for instance, described at paragraph (c) that campaign in with the name *Stop It Before It Starts* which, in my submission, is a particular good example of a proactive approach by the organisation on this topic, but also the introduction of specific roles to strengthen the management of critical incidents and complaints through the office of special counsel and the national complaints manager role. And over the page, amongst other things, the creation of the National Safeguarding Unit.

In my submission, those reforms particularly provide the Commission with evidence which would cause it to hesitate from making proposed finding 73, which is expressed in such broad untemporal terms, but also uses, in my submission, a loaded expression of a failure to take a proactive approach where there is evidence before this Commission to the contrary.

Over at paragraph 356 Ms Robbs details what the organisation has done by way of initiatives to promote and support a rights informed approach to service provision. And, for instance, at paragraph 359, page 132, Ms Robbs squarely addresses what the Board had done in the last 12 months. She describes it and focuses on to seek to ensure that there are in place key performance indicators and other measures along with regular reporting to the Board so as to enable it to be well informed.

All of those matters, in my submission, are reflective of a proactive approach, not only to monitoring, detecting and rectifying deficiencies, but also to seek to minimise instances, amongst other things, of harm, violence, neglect and otherwise with the - might come about during LWB's operations.

Concluding comments from me, and I recognise there may well be questions, in my submission, Life Without Barriers has an overarching focus and role in changing lives for the better and, amongst other things, it recognises the very important work which is being done by this Royal Commission, and it seeks to demonstrate real learning and real sense of responsibility which - from which it does not shy away in terms of the events which have been the subject of focus in this hearing.

And the organisation, as I've indicated when we resumed after lunch, is certainly concerned to provide information and a report to the Commission at whatever interval it considers would be most useful to provide the Commission with further information and, if it's the right term, reassurance as to how squarely the organisation has grappled with the matters that have emerged during the hearing.

CHAIR: Yes. Thank you, Ms Callan. I will ask my colleagues whether they have any questions. First, I will ask Commissioner Galbally whether she has any questions to put to you.

COMMISSIONER GALBALLY: Thank you, Chair. Ms Callan, I would like to take you back to this morning just before lunch when you said you respectfully resist the wording of finding 53 and 54 regarding the word "eliminate" in the context of elimination of resident-to-resident violence in supported independent living houses; is that right? Yes. You went on to say that LWB doesn't accept that it or any other service provider could have eliminated violence from occurring in a supported independent living house; is that correct?

MS CALLAN: Yes.

COMMISSIONER GALBALLY: Are you suggesting, then, that resident-to-resident violence is inevitable in supported independent living houses, and, if so, why?

MS CALLAN: Commissioner, inevitability carries with it a connotation which I did seek to resist, which was the suggestion that that somehow meant that it was normalised or acceptable. But the position of LWB in relation to resident-to-resident violence is that in circumstances where it emerges from behaviours of concern and the complexity which almost necessarily occurs in a group home involving a number of residents in that supported environment, the notion of it being eliminated suggests in a way that behaviours of concern will be eliminated, and the position of Life Without Barriers is that plainly that's not the case. There is a keen concern to provide support and to formulate and then adhere to behaviour support plans to the best extent possible to manage behaviours of concern, but that's the reason for the resistance to the term.

COMMISSIONER GALBALLY: So you're saying that the behaviours of concern are - don't relate to the environment of the group home, the supported independent living, that could accentuate the behaviours of concern. Am I -

MS CALLAN: We do accept that the environment of the group home may well affect the instance of behaviours of concern.

COMMISSIONER GALBALLY: Thank you.

CHAIR: Yes. Thank you, Commissioner Galbally. Commissioner McEwin.

COMMISSIONER McEWIN: No. No, thank you.

CHAIR: In that case, thank you, Ms Callan, for your submissions. Mr Griffin, do you have anything in reply?

MR GRIFFIN: I don't, Chair.

CHAIR: Thank you very. In that case, I would like to thank the parties that have provided written submissions to the Royal Commission arising out of this Public hearing and also to thank the counsel today who presented oral submissions. We are grateful for the assistance that has been provided. As I indicated, we plan to produce a Commissioners' report in due course, and that will involve taking into careful consideration the submissions that have been provided in writing and which have been supplemented orally today.

I would also like to express the appreciation of the Commissioners to all those who again have been involved in preparing the hearing that has been held today. It's difficult to appreciate from outside just how much goes into preparing a hearing, even if it's confined to the presentation of submissions, particularly with the constraints that are imposed by reason of the COVID-19 variants that create difficulties of a quite unexpected kind. So we do express our appreciation to all of the staff and outside bodies that have been involved in preparation for and the conduct of this hearing. So thank you very much. And we will now adjourn and -

MR GRIFFIN: Before you do, Commissioner, I wonder if I might have the indulgence of you, Chair, and the Commissioners, firstly to reiterate the thanks you've expressed to various people, but it won't have gone unnoticed to people participating in this hearing that

I commenced this hearing with the assistance of Ben Fogarty and Belinda Baker as my junior counsel.

Since the public hearing concluded in December, Belinda Baker has been appointed a judge of the Supreme Court of the ACT and as a consequence she has disappeared from the scene in terms of this hearing today. Can I take the opportunity to say that she has been a great asset to this Commission, and to me as Senior Counsel Assisting. She has also been a great asset to the Office of the Director of Public Prosecutions in New South Wales and for the New South Wales bar. She has played an enormously valuable role in this particular hearing, and I just wanted to put on the record my thanks on behalf of everyone else for her work.

CHAIR: Thank you, Mr Griffin. Ms Baker is not entirely unknown to me. She was my associate when I was on the Federal Court, and her progression to the ACT Supreme Court is entirely appropriate for the service and skills and dedication that she showed as an associate all those years ago. Well, in her case it probably doesn't seem so long; in my case it does. I have no doubt that Ms Baker will be an adornment to the Bench in the ACT. Thank you very much.

ADJOURNED 2.50 PM