Reportable incidents

Detailed Guidance for Registered NDIS Providers

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Key terms

Table 1: Key terms and definition

| Term | Definition |
| --- | --- |
| **Act** | The National Disability Insurance Scheme Act 2013. |
| **NDIS Commission** | The NDIS Quality and Safeguards Commission. |
| **Impacted person** | A person with disability who has been affected by an incident that has occurred during the provision of NDIS supports and services. |
| **Incident** | An incident is defined as an act, omission, event or circumstance.  It may mean any of the following:   * Acts, omissions, events or circumstances that occur in connection with providing NDIS supports or services to a person with disability and have, or could have, caused harm to the person with disability * Acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person * Reportable incidents that have or are alleged to have occurred in connection with providing NDIS supports or services to a person with disability |
| **Key personnel** | A member of the group of persons who is responsible for the executive decisions of the registered NDIS provider and any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the registered NDIS provider. See s 11A of the Act. |
| **NDIS** | National Disability Insurance Scheme. |
| **NDIS provider** | A person (other than the NDIA) who receives:   * funding under the arrangements set out in Chapter 2 of the Act; or * NDIS amounts (other than as a participant); or * a person or entity who provides supports or services to people with disability other than under the NDIS and who is prescribed by the NDIS rules as an NDIS provider. See s 9 of the Act. |
| **NDIS (Incident Management and Reportable Incident) Rules 2018** | The Rules require registered NDIS providers to establish an incident management system that meets minimum requirements and that is appropriate for the size of a registered NDIS provider and the supports or services they provide. The rules also set out the obligations on registered NDIS providers to notify, investigate and respond to reportable incidents. |
| **NDIS Practice Standards** | Consist of a core module and several supplementary modules that apply according to the types of supports and services NDIS providers deliver, and the corporate structure of the organisation. The NDIS Practice Standards are included in the NDIS (Provider Registration and Practice Standards) Rules and in the NDIS (Practice Standards – Worker Screening) Rules. |
| **Person with disability** | A person with disability who is an NDIS participant and receives supports or services from an NDIS provider. |
| **Registered NDIS provider** | Means a person or entity registered under s 73E of the Act to provide supports and services to people with disability. |
| **Relevant Personnel** | * A member of the registered NDIS provider’s key personnel. * A supervisor or manager of the person * The person specified in the incident management system as being responsible for reporting incidents that are reportable incidents to the NDIS Commission (Specified personnel).[[1]](#footnote-1) |
| **Reportable incidents** | Reportable incidents are serious incidents or alleged incidents which result in harm to an NDIS participant and occur in connection with NDIS supports and services. Specific types of reportable incidents include:  The death of a person with disability.  Serious injury of a person with disability.  Abuse or neglect of a person with disability.  Unlawful sexual or physical contact with, or assault of, a person with disability (excluding, in the case of unlawful physical assault, contact with, and impact on, the person that is negligible).  Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity.  The use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person or a behaviour support plan for the person. |
| **Specified personnel** | Person named in the incident management system of a registered NDIS provider as being responsible for taking all reasonable steps to ensure that reportable incidents that occur in connection with the provision of supports or services are notified to the NDIS Commission. |
| **Subject of the allegation** | A worker, person with disability or any other person who has been accused of being involved with an incident that has occurred in connection with the provision of NDIS supports and services to a person with disability. |
| **Trauma informed care** | The provision of care that acknowledges how trauma affects people’s lives and their service needs. Awareness and sensitivity to the way in which people with disability may experience trauma differently. |
| **Worker** | Includes employees, contractors and people otherwise engaged for example, on a volunteer basis, by an NDIS provider. |

**Overview**

Registered NDIS providers (you) are required to notify the NDIS Commission of ‘reportable incidents’.

This is one part of your requirement to have an incident management system.

Reportable Incidents are specific types of serious incidents that have, or are alleged to have, occurred in connection with the provision of supports and services by registered NDIS providers. These are:

* The death of a person with disability
* Serious injury of a person with disability
* Abuse or neglect of a person with disability
* Unlawful sexual or physical contact with, or assault of, a person with disability
* Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person
* The use of a restrictive practice in relation to a person with disability that is unauthorised use or not in accordance with a behaviour support plan

Reporting to the NDIS Commission does not replace your existing obligations to report particular events to other agencies, such as reporting any crimes to police.

There are set timeframes for you to notify the NDIS Commission. There are:

* W**ithin 24 hours** of key personnel becoming aware of a reportable incident or allegation  
    
  An exception to this rule is notifying the NDIS Commission of the use of a restrictive practice that is unauthorised or not in accordance with a behaviour support plan. In these instances, the registered NDIS provider must notify the NDIS Commission within five business days of being made aware of the incident.  If, however, the incident has resulted in harm to a person with disability, it must be reported within 24 hours.

AND

* W**ithin five business days** of key personnel becoming aware of a reportable incident, to provide additional information to that provided in the immediate notification form  
    
  The five day form is also to be used for incidents involving the unauthorised use of a restrictive practice, other than those resulting in serious injury to a person with disability.

This guidance has been developed to assist you in identifying, and notifying, reportable incidents to the NDIS Commission.

Further guidance for registered NDIS providers is available on the NDIS Commission website, including detailed guidance about required incident management systems and the roles of workers providing services in responding to incidents.

Part 1: Background information about the NDIS Commission

# Background information about the NDIS Commission

The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is one of the largest social and economic policy reforms in Australian history. The NDIS supports Australians who are born with, or acquire, a permanent and significant disability before the age of 65 to lead a more independent and inclusive life.

The NDIS represents a fundamental change to how supports for people with disability are funded and delivered across Australia. It also represents a significant shift from services delivered under largely block-funded contractual relationships between providers and primarily state and territory governments, to one where people with disability are the purchasers and consumers of services from a diverse market under the NDIS.

Safeguarding

In Australia, there are well-established safeguards that help maintain a functioning society and protect human rights, starting with our most basic political and legal structures. These general mechanisms reflect the inherent dignity of all people and the need for protection from abuses of power, protecting people’s individual freedoms as well as limiting the risk of exploitation and harm.

Many people with disability will require no or minimal additional supports to ensure they can access general safeguards to an extent equal to other members of the community. However, vulnerable people who face increased risk of harm, abuse or neglect may require a more proactive approach for both protective reasons as well as to maximise their control over their own lives. This is particularly the case for some people with disability accessing specialist disability supports and services.

These specific safeguards aim to minimise the risk of harm to a person with disability, protect their right to be safe and empower them to achieve choice and control over their lives. They can include both corrective actions once harm has occurred, as well as preventative actions to build capacity and regulate practice.

There are a range of safeguarding mechanisms within disability support and service provision. These mechanisms broadly exist at four levels:

Figure 1: Levels of safeguarding mechanisms

This figure lists and describes the four levels of safeguarding mechanisms. There are two columns. The first column lists the level, alongside an icon representing that level. The second column describes the safeguarding mechanisms that exist within each level.
The system level is next to an icon of a computer. System level refers to Legislation, regulation and policy that mandates the right of people with disability and establishes the parameters for the provision of disability support

The Service level is next to an icon of a worker. Service level refers to processes to guide the provision of support at the disability support provider level including mandated reporting

The Community level is next to an icon of a group of people. Community level refers to External mechanisms to enable independent review and monitoring

The individual level is next to an icon of a hand writing or drawing on a piece of paper to show ownership and empowerment. Individual level refers to practices and mechanisms focused on supporting, empowering and protecting individuals and families as part of providing support

Care and support dynamic and vulnerability

Vulnerability can arise when a person requires care and support in daily life, for example in relying upon a family member, carer or support worker to provide physical assistance with daily tasks. This level of dependency can create a power dynamic between the carer and the person receiving care and support.

The great majority of people in care and support roles understand their responsibility to act with integrity in this regard, and to respect the rights of the person to whom they provide care and support. Where abuse and neglect does occur, it represents a transgression of a person’s basic human rights and an exploitation of vulnerability.

Guiding principles for quality and safeguarding

The guiding principles underpinning the NDIS Commission’s functions and approach, are set out in *the National Disability Insurance Scheme Act 2013* (the Act). The NDIS Commission supports the rights of people with disability to:

* Realise their potential for physical, social, emotional and intellectual development
* Participate in and contribute to community life including socially and economically
* Exercise choice and pursue their goals including taking reasonable risks and pursuing any grievance
* Be included in making decisions about their life
* Live a life of dignity, free from abuse, neglect and exploitation
* Have the roles of families, carers, and other significant persons in their lives recognised and respected
* Have the roles of advocates in representing the interests of people with disability acknowledged and respected

The NDIS Commission

The NDIS Commission is an independent government body that works to improve the quality and safety of NDIS services and supports, investigates and resolves problems, and strengthens the skills and knowledge of NDIS providers and people with disability.

Once the NDIS Commission is operational in all states and territories, it will deliver a new, nationally consistent approach to quality and safeguards in the NDIS. It works with people with disability and their carers, families and advocates, and NDIS providers to achieve this.

The NDIS Commission:

* Registers and regulates NDIS providers and oversees provider quality
* Monitors compliance with the NDIS Practice Standards and NDIS Code of Conduct
* Responds to concerns, complaints and reportable incidents
* Advises NDIS providers on their own complaints management and support people with disability to make complaints
* Advises registered NDIS providers on incident management systems and how to report serious incidents to the NDIS Commission
* Works with people with disability, NDIS providers and workers to improve their skills and knowledge
* Monitors providers’ use of restrictive practices in relation to people with disability and educates providers and people with disability about behaviour support strategies
* Works with states and territories to design and implement nationally consistent NDIS worker screening
* Provides market oversight by monitoring changes in the market that need attention
* Shares information with other regulatory bodies

Objectives of the NDIS Commission approach to incident management

Incidents offer NDIS providers an opportunity to review their operational practices to improve the quality and delivery of supports and services to NDIS people with disability and prevent future harm.

Registered NDIS providers must establish incident management arrangements to enable the identification of systemic issues and drive improvements in the quality of supports they deliver.

Effective incident management is underpinned by key principles. The principles are outlined in Figure 2: Principles of good incident management and resolution below.

Principles of good incident management and resolution

Figure 2: Principles of good incident management and resolution

This figure outlines the principles of good management and resolution. There are two columns. The first column contains a list of key principles, next to an icon representing each principle. The second column contains a description of the principle. 

The principle Centred on people with disability is next to an icon of a person in the centre of a circle with arrows pointing outward. Centred on people with disability means smnagement of an incident is respectful of, and responsive to, a person with disability’s preferences, needs and values while supporting the person’s safety and wellbeing.

The principle outcome focussed is next to an icon of a hand pointing to results on a page. Outcome focussed means management of an incident should reveal the factors which contributed to the incident occurring, and seek to prevent incidents from reoccurring, where appropriate.

The principle Clear, simple and consistent is next to an icon of a checklist. Clear, simple and consistent means the process for dealing with incidents is easy to understand, accessible and consistently applied.

The principle accountable is next to an icon of a calculator and pen. Accountable means providers are responsible for appropriately managing the response to incidents. Everyone involved in the management of an incident understands their role and responsibilities, and will be accountable for decisions or actions taken in regard to an incident.

The principle continual improvement is next to an icon of a bar chart where the bars increase in size over time. Continual improvement means the incident management process facilitates the ongoing identification of issues and implementation of changes to improve the quality and safety of NDIS supports and services.

The principle proportionate is next to an icon of a set of balanced scales. Proportionate means the nature of any investigation or actions following an incident will be proportionate to the harm caused and any risk of future harm to a person with disability.

*Source: NDIS Quality and Safeguards Commission*

Registered NDIS providers’ incident management requirements

People with disability have the right to live a life free from abuse, neglect, exploitation and violence.

In support of this, all providers - registered or unregistered - of NDIS funded supports and services are subject to the NDIS Code of Conduct and registered NDIS providers the NDIS Practice Standards. The Code of Conduct sets out the expectations for safe and ethical services and supports for both NDIS providers and workers. The NDIS Practice Standards set standards that registered NDIS providers must comply with in relation to their performance and demonstrate how they provide quality and safe supports and services to people with disability. The rules in which the standards are set out are available on the NDIS Commission website.

These frameworks require all providers of NDIS funded supports and services to meet certain standards in service delivery, and to take action to continually improve the quality of their supports. This includes:

* Providing supports and services in a safe and competent manner
* Promptly taking steps to raise and act on concerns about matters that may impact on the quality and safety of supports and services provided to people with disability
* Taking reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of people with disability
* Taking all reasonable steps to prevent and respond to sexual misconduct

Even where providers of NDIS funded supports and service and workers adhere to these frameworks, incidents may still occur in the course of service delivery. In these instances, NDIS providers have the opportunity to practice continuous improvement and should actively work to improve the quality of their supports and services.

The Act and the NDIS (Incident Management and Reportable Incident) Rules 2018 require registered NDIS providers to have an incident management system that meets minimum requirements. The incident management system will be appropriate for the size of a registered NDIS provider and the supports or services they provide. The rules also set out the obligations on registered NDIS providers to respond to, notify and investigate reportable incidents.

It is good practice for NDIS providers even when unregistered to have an appropriate and effective incident management system in place, and to know how to respond to any incident that may occur.

For the purpose of this document, an incident is an event or circumstance that occurred in connection with the provision of funded NDIS supports and services, which resulted in harm, or could have resulted in harm to a person with disability. There may be other circumstances that result in harm to a person with disability but are not related to NDIS supports and services, and may not be within the jurisdiction of the NDIS Commission.

Part 2: Overview of incident management

# Overview of incident management

All registered NDIS providers have the same minimum requirements for their incident management system. However the type of system maintained is likely to differ between registered NDIS providers, depending on their size and the types of supports or services they are delivering. As organisations change over time, registered NDIS providers must ensure that their incident management system continues to reflect the scale of the organisation and the complexity and risk associated with the supports and services delivered.

As part of their incident management system registered NDIS providers are required to notify the NDIS Commission of reportable incidents. Once this notification is made the registered NDIS provider needs to provide further information about any investigation or actions arising from the incident as may be requested by the NDIS Commission.

To ensure best practice registered NDIS providers should effectively monitor, report and investigate all incidents; provide trauma-informed support for people with disability throughout the process; and engage in continuous quality improvement activities. In order to achieve best practice registered NDIS providers should:

* Offer relevant worker training in trauma informed practice, incident management policy and procedures and any subsequent changes
* Appropriately train managers or senior roles to conduct internal investigation of incidents
* Maintain a quality function within the organisation that supports learning and continuous improvement, including policy changes

Further information and working definitions about reportable incidents are provided in the next section.

An overview of the incident process and notification to the NDIS Commission, is provided in Figure 3: Incident management process, and further explained below.

Registered NDIS providers will **identify** any incident and **monitor** responses taken by workers, including the immediate activities undertaken to ensure the safety and wellbeing of people with disability and workers.

Registered NDIS providers are required to appropriately assess and/or investigate all incidents having regard to whether a person with disability is impacted by an incident.

If an incident is deemed to be a **reportable incident**, it must be notified to the NDIS Commission by the relevant personnel using the reportable incidents portal and in the required timeframe. If an incident is deemed not to be a reportable incident, registered NDIS providers are required to refer to their **internal incident management** systems in order to manage the incident.

If an incident is deemed reportable the registered NDIS provider needs to carry out the relevant **investigation** about the reportable incident or take any action deemed appropriate by the NDIS Commission. Providers may be required to **give information** to the NDIS Commission in connection with any internal or external investigation or assessment that has been undertaken. The registered NDIS provider will need to respond to any **regulatory measures** requested by the NDIS Commission following a reportable incident.

Figure 3: Incident management process

This figure is a flowchart depicting the steps in incident management. 

The first box in the process is "Worker providing services identifies an incident". 

The next box is "worker provides immediate response to ensure health, safety and wellbeing of impacted person". 

The next box is "worker follows incident management system process" which includes "reporting incident to relevant personnel, protecting evidence, notifying an impacted person's support person or family, contacting police". 

The next box is "relevant personnel undertake assessment of incident". 

The next box is "relevant personnel determine if incident is a reportable incident". 

If the incident is reportable, the next box is "relevant personnel make a notification to the NDIS Commission and comply with reportable incidents process". 

The next box is "Provider undertakes investigation into incident if required". 

If the incident is not reportable, the flowchart skips to "provider undertakes investigation into incident if required". 

The final box is "provider initiates action in response to incident".

Part 3: Reportable incidents in the NDIS

# Reportable incidents in the NDIS

A registered NDIS provider needs to notify the NDIS Commission about reportable incidents. For an incident to be deemed a reportable incident it must satisfy the following two requirements:

* The incident must involve an act, event or omission defined in section 73Z(4) of the Act and section 16 of the NDIS (Incident Management and Reportable Incidents) Rules 2018
* The incident must have occurred or is alleged to have occurred in connection with the provision of supports or services by a registered NDIS provider

Registered NDIS providers must notify ***all*** reportable incidents (including allegations) to the NDIS Commission, even where the registered NDIS provider believes it has acted and responded appropriately.

A failure to comply with the requirement to notify, investigate and manage reportable incidents is a breach of a registered NDIS provider’s conditions of registration and may lead to compliance and enforcement action by the NDIS Commission.[[2]](#footnote-2)

Subsection 73Z(4) of the NDIS Act states that reportable incidents means:[[3]](#footnote-3)

1. the death of a person with disability; or
2. serious injury of a person with disability; or
3. abuse or neglect of a person with disability; or
4. unlawful sexual or physical contact with, or assault of, a person with disability; or
5. sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or
6. the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.

The definition of *reportable incident* captures not only incidents that are confirmed to have occurred, but also allegations of the incidents described above.[[4]](#footnote-4)

Information about the term ‘in connection with’ is provided below. This is followed by more detailed descriptions of the types of reportable incidents to support registered NDIS providers to comply with their reporting obligations.

What does ‘in connection with the provision of supports or services by a registered NDIS provider’ mean?

A registered NDIS provider is only required to notify the Commission of reportable incidents which have occurred, or are alleged to have occurred, if those incidents happened **in connection with** the provision of supports or services by that provider.

This meaning of the phrase ‘in connection with’ is intended to be broad.

It covers incidents that:

* may have occurred during the course of supports or services being provided;
* arise out of the provision, alteration or withdrawal of supports or services; and/or
* may not have occurred during the provision of supports but are connected because it arose out of the provision of supports or services.

Reportable incidents could occur in a variety of settings but as long as there is a connection with the service delivery by a registered NDIS provider, then they must be notified to the Commission.

Examples of where these incidents might occur include:

* In the private home of a person with disability
* In a residential care setting
* In supported accommodation
* In the premises of the registered NDIS provider (for example, the rooms where therapy services are provided)
* In the community where the registered NDIS provider is supporting the person with disability to access the community

Although an incident may occur at the time of service delivery, it may not be in connection with the service and is therefore not a reportable incident.

*Examples*

* An occupational therapist attends the home of a person with disability to conduct an assessment. While speaking with members of the person’s family, the person with disability puts their hand on the stovetop and suffers a serious injury. The incident occurred at the time of service delivery, but was not directly linked with or caused by the service delivery. This is not a reportable incident and does not require notification to the NDIS Commission.
* A person with disability is accompanied by a worker to attend a physiotherapy appointment. As they leave the office building, a tile falls off the roof and hits the person who sustains a serious injury and needs hospitalisation. Although this happened at the time a person was receiving a service from the registered NDIS provider, the service delivery was coincidental to the injury caused. The incident did not occur in connection with the service provision and does not need to be reported to the Commission.

Whether a reportable incident occurs in connection with the provision of services and supports also depends on the nature and extent of services being provided.

Where a person is living in supported accommodation, the registered NDIS provider involved usually has a responsibility for the supervision, health, safety and well-being of residents of the accommodation. This will often mean that reportable incidents which happen in the supported accommodation are in connection with the provision of services and supports and must be notified to the Commission. The exception to this would be where the reportable incident was entirely coincidental and unrelated to the provision of services, for example, a person suffers food poisoning after eating food delivered to the accommodation.

It is also not necessary for the registered NDIS provider to come to a conclusion about whether the service delivery ‘caused’ the reportable incident before deciding whether to notify the Commission. The phrase ‘in connection with’ does not mean that the registered NDIS provider directly caused the incident but simply there was some link between service provision and what happened to the person with disability.

An incident might also occur which is connected to the provision of supports or services but does not occur at the time those supports or services were provided. The connection to the service provision might be based in its role in contributing to the incident.

For example, a speech pathologist may develop an eating and drinking plan for a person with a disability who later chokes in their home when following this plan and requires hospitalisation (serious injury). While the incident did not occur at the time the plan was developed and provided by the speech pathologist, there may be connection between the injury and the plan if it did not adequately address choking risks to the person with disability.

Categories of reportable incidents

The death of a person with disability

All deaths of people with disability that occur in connection with the provision of NDIS supports or services must be notified to the NDIS Commission.

Once the connection between the NDIS supports/service and the person’s death is established, then the cause of the death (natural or unnatural) or whether the death was expected or not does not change whether the death is a reportable incident.

The place of death does not affect whether the death is a reportable incident so long as there is the required connection between the death and the service provision.

Once the connection is established, deaths are reportable if the person dies:

* In their own private home
* In supported accommodation
* In the community during community access
* In hospital or other health care facility

Registered NDIS providers do not need to establish the cause of death before reporting the death to the NDIS Commission. Providers are only required to consider if the death happened in the course of their involvement in providing supports or services to the person.

Usually only one registered NDIS provider providing NDIS support will be required to report the death of a person with disability to the NDIS Commission. There may however be some circumstances where the death occurred in connection with the supports and services provided by more than one registered NDIS provider.

For example, if a person’s death was the result of choking and occurred within supported accommodation, and a speech pathologist (also a registered NDIS provider) had in recent days supported the person with disability with a revised eating and drinking plan, then both providers may need to report the death because it occurred in connection with the provision of their services. Both the plan itself and the implementation of the plan by the direct care workers may have had a connection with the person’s death.

Additional reporting obligations for deaths

Each state and territory has specific requirements in relation to the obligations of providers to notify a death to other bodies, such as coroners and police.

If a death is required to be reported to the Coroner of a state or territory, it is their role to determine the date, place and circumstances, and medical cause of those deaths.

The NDIS Commission will work alongside state and territory coroners and other bodies to examine the circumstances of deaths of people with disability which occur in connection with NDIS service provision. The NDIS Commission is establishing strong working relationships and information sharing arrangements with state and territory bodies so it can respond in the most effective and efficient way to reportable incidents involving deaths of people with disability.

As there may be multiple reporting obligations, providers are strongly encouraged to have policies and procedures for managers and workers to understand how to respond to a death including who is responsible for notifying the NDIS Commission and other bodies and the timeframes which apply.

Serious injury of a person with disability

The serious injury of a person with disability must be notified to the NDIS Commission if it occurs or is alleged to have occurred in connection with the provision of NDIS supports and services.

In determining whether an injury is ‘serious’, consideration should be given to the level of harm caused. A serious injury includes, but is not limited to:

* Fractures
* Burns
* Deep cuts
* Extensive bruising, including large individual bruises, or a number of small bruises over the impacted person
* Head or brain injuries which might be indicated by concussion or loss of consciousness
* Any other injury requiring hospitalisation

If a person with disability is hospitalised in relation to a serious injury the incident should be classified as reportable. There will be instances in which a person with disability is hospitalised for reasons unrelated to serious injury, these instances are not reportable incidents.

Hospitalisation includes a person with disability’s presentation or admission to an emergency or other ward within a hospital facility, including short-stay admissions if they are related to the injury acquired.

Abuse or neglect of a person with disability

Incidents involving the abuse or neglect of a person with disability, either by a worker, another person with disability, or any other person, that have occurred in connection with the provision of NDIS supports and services must be notified to the NDIS Commission.

Abuse of a person with disability

Types of abuse that meet the criteria for being a reportable incident, include:

* Physical abuse – non-accidental physical acts towards a person with disability that are intended to cause hurt or harm. Acts that result in that person experiencing significant pain, shock or other unpleasant sensation. In some circumstances, acts of physical abuse will also amount to unlawful physical contact or assault, and may cause a serious injury to the person with disability.
* Psychological or emotional abuse – verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person with disability or acknowledge the person with disability’s presence.
* Financial abuse – improper or illegal use of money (including NDIS funds where they are managed by the individual person with disability), property, resources or assets of a person with disability, including improperly withholding finances from that person, and coercing or misleading the person with disability as to how the funds or property will be used.
* Systemic abuse – a failure to recognise, provide, or attempt to provide adequate or appropriate services, including services that are appropriate to the person’s age, gender, culture, disability support needs or preferences, that has a significant physical, emotional or psychological impact on the person with disability.

#### A pattern of abuse

In addition to single instances of these types of abuse, there may also be a pattern of abuse that occurs in any or all of these categories. Patterns of abuse involve repeated behaviour towards a person with disability, which may not seem like instances of abuse when considered in isolation. For example, a worker may repeatedly verbally abuse a person with disability by shouting or constantly criticising the person. While this may not cause significant harm or suffering to the individual in each instance, the repetitive nature of the abuse constitutes a pattern of abuse. A pattern of abuse may also occur where the subject of the allegation seeks to abuse several people with disability over time or simultaneously, using a similar pattern of behaviour. A registered NDIS providers’ incident management systems must be able to record incidents in a way that allows for repeated minor instances of these types of behaviour to be identified easily so that any pattern of abuse can be identified and reported as a single reportable incident.

#### Responsibility for registered NDIS providers to manage incidents of inappropriate behaviour within their internal incident management systems

When considering whether behaviour constitutes abuse the focus is on the nature of the incident or allegation itself, and the impact on the person with disability. In making a determination regarding abuse by workers it is important to consider relevant codes of conduct that outline the nature of professional conduct and practice by workers which should occur when working with people with disability.

The NDIS Commission as the oversight body for reportable incidents and incident management more broadly has set clear expectations for registered NDIS providers in relation to their role in developing quality practice and providing quality services to people with disability; and in proactively managing incidents and behaviour, and responding promptly when incidents do occur.

There will be occurrences of the types of behaviour described above that do not constitute abuse and therefore are not reportable to the NDIS Commission. These occurrences should be appropriately managed by the registered NDIS provider, without making a reportable incident notification to the NDIS Commission as the first response. For example, where a person with disability pinches another person with disability on multiple occasions as an expression of frustration at their shared living arrangement, this does not amount to a reportable incident. This is an example of low-level negative physical interaction, which should be dealt with through quality service provision and internal incident management. In this circumstance, an appropriate response may be to reconsider whether the people with disability are suited to living together, or if there are additional support and strategies to positively manage the behaviour of the person with disability.

Neglect of a person with disability

Neglect includes an action, or a failure to act, by a person who has care or support responsibilities towards a person with disability. In determining neglect, the nature of a registered NDIS provider’s or worker’s care responsibilities provides the context against which the incident or allegation needs to be assessed.

Neglect can be a single significant incident where a registered NDIS provider or worker fails to fulfil a duty, resulting in actual harm to a person with disability, or where there is the potential for significant harm to a person with disability. Neglect can also be ongoing, repeated failures by a registered NDIS provider or worker to meet a person with disability’s physical or psychological needs.

You must report to the NDIS Commission all incidents of neglect of a person with disability that are occurred or alleged to have occurred in connection with the provision of supports and services.

Neglect can include a number of specific categories that must be reported including:

* Grossly inadequate care
* Failure to access medical care
* Supervisory neglect
* A reckless act or failure to act
* Failure to protect from abuse

#### Grossly inadequate care

Grossly inadequate care refers to a registered NDIS provider depriving a person with disability of the basic necessities of life, such as food, drink, shelter, medical care or clothing. This can include repeated refusal of required necessities, or a single instance of deprivation of these items. Allegations of grossly inadequate care do not include instances where a registered NDIS provider deprives a person with disability access to particular food or drink in line with an approved eating and drinking plan, or in line with an authorised restrictive practice that is contained in the person’s behaviour support plan.

#### Failure to access medical care

In these circumstances, a worker or registered NDIS provider deprives the person with disability from receiving required medical attention and care to access and treat a condition, or prevent an illness or condition from worsening. This can include repeated refusal of required medical care, or a single instance of deprivation of medical care. A failure to take a person with disability to a health professional for assessment if they appear unwell or delay in doing this could amount to neglect. Another example is the failure to ensure a person has regular recommended reviews by a general practitioner or medical specialist, such as a psychiatrist so their health needs can be monitored and addressed.

Failing to ensure a person has regular dental check-ups to monitor and maintain their dental health and prevent dental problems such as decay, infection or pain could also be a form of neglect.

#### Supervisory neglect

Supervisory neglect includes:

* An intentional or reckless failure to adequately supervise or support a person with disability that results in, or has the potential to result in, the death of, or significant harm to, the person with disability
* An intentional or reckless failure to adequately supervise or support a person with disability that also involves a gross breach of professional standards

For example, if a worker of a registered NDIS provider leaves a person with disability enclosed in a car on a hot day where the temperature in the car is likely to increase rapidly and cause significant harm to the person with disability, this intentional failure to adequately support a person with disability would amount to a reportable incident in the form of supervisory neglect.

#### A reckless act or failure to act

A reckless act, or failure to act, as a form of neglect by a registered NDIS provider or worker includes:

* A gross breach of professional standards
* An act or failure that results in or has the potential to result in the death of, or significant harm to, a person with disability

It is important to note that when a reckless act or failure to act is also an example of an unauthorised restrictive practice, then it must still be reported to the NDIS Commission within 24 hours.

#### Failure to protect from abuse

A failure to protect from abuse includes an obviously unreasonable failure to respond to information which strongly indicates the actual or potential serious abuse of a person with disability, in connection with the provision of NDIS supports and services by the registered NDIS provider.

Unlawful physical contact with, or assault of, a person with disability

Any unlawful physical contact with, or assault of, a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission.

This category encompasses any physical behaviour towards a person with disability that is an offence under any criminal statute of a state or territory. While the types of physical contact and assault offences that are unlawful will differ between each state and territory, a physical assault generally includes any act by which a person intentionally uses unjustified physical force against a person without the person’s consent. A physical assault can also occur if a person causes another person to reasonably fear that unjustified force would be used against them.

Even if a person who inflicts, or causes, the fear of physical harm does not intend to inflict the harm or cause the fear, they may still have committed an assault if they acted recklessly (i.e. the person ought to have known that their actions would cause physical harm or the fear of such harm).

There are also types of assault, such as common assault, that involve contact but that will not result in any physical injury to a person. Therefore, if a person is assaulted but does not sustain any injury, the assault is still unlawful, and must be reported as a reportable incident.

Assaults could include hitting, pushing, shoving, spitting, throwing objects towards other people or making threats of physical harm. There is publically available information about the specific offences that constitute unlawful physical contact or assault in each state and territory.

Some acts of physical contact with people with disability are not unlawful even if the person does not consent to these. In some situations, there is a lawful justification for these acts such as pushing a person out of the way of an oncoming car that would otherwise hit them.

It is important to note that alleged unlawful physical contact or assault incidents should be reported to the NDIS Commission when they occur, or when they are disclosed by a person with disability or other person. A registered NDIS provider should not wait for the conclusion of any police investigation into the incident before notifying the NDIS Commission.

When does unlawful physical contact not need to be reported to the NDIS Commission?

The Rules specify that in some circumstance an act of unlawful physical contact with a person with disability is not a reportable incident and therefore is not required to be reported to the NDIS Commission. Unlawful physical contact with a person with disability is not a reportable incident where the contact with, and impact on, the person with disability is deemed negligible.

The impact of the contact on the person with disability must also be negligible. This usually means the person had no reaction to the contact or only a minor reaction which was brief and barely noticeable.

Whether the impact is negligible needs to be assessed in each individual case. Even if the nature of the physical contact is negligible, it may still have a serious impact on the person, depending on their individual situation and the context of the contact.

**Negligible means that the contact made, and the impact of it on the person with disability, were too small to consider, or were insignificant to the person with disability**. For example, moving a person with disability out of harm’s way and the person is not upset about this or holding onto a person briefly to assist them to safely attend to their hygiene or care needs, the person resists but only momentarily.

The impact on the person with disability of an unlawful physical contact does not have to be physical in order for an incident to be reportable. Unlawful physical contact may also cause emotional or psychological impacts for a person with disability which are not negligible. For example, a person with disability may become withdrawn, or try to avoid a worker or another person with disability as a result of the unlawful physical contact, and this may have a more than negligible impact on their support needs and emotional wellbeing. In these types of circumstances, the incident would be reportable to the NDIS Commission.

The exclusion of some unlawful physical contact from being a reportable incident does not affect the need for the incident to be appropriately assessed and managed by the registered NDIS provider and dealt with in accordance with the registered NDIS provider’s internal incident management system. For example, where a person with disability is disarmed when seeking to harm another person with disability, an assessment or investigation to understand how this occurred, and how it could be prevented in the future should be undertaken.

Unlawful sexual contact with, or assault of, a person with disability

Any unlawful sexual contact or assault of a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission. Unlawful sexual contact or assault encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory or the Commonwealth.

Unlawful sexual contact and assault offences include, but are not limited to, the following:

* Sexual assault
* Indecent assault

Sexual assault

Sexual assault refers to:

* Specific offences involving a person having sexual intercourse with another person without their consent (this is sometimes referred to as rape, sexual intercourse without consent, or sexual penetration without consent depending on the language used in the relevant criminal statute of each state or territory).
* A situation where a person is forced, threatened, coerced or tricked into sexual acts, including those that are committed on the person with disability, against their will, without their consent, or where their consent is negated for other reasons such as those affecting their consciousness.

Indecent assault

Indecent assault usually involves touching (or threatening to touch) a person’s body in a sexual manner without the consent of the other person. For example, it can include kissing, or unwanted touching of a person’s breast, bottom or genitals. These offences are sometimes referred to as sexual touching depending on the language used in the relevant criminal statute of each state or territory. In Queensland indecent assault is classified as a form of sexual assault.

Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity

For sexual misconduct to constitute a reportable incident, the alleged misconduct must have been committed against, or in the presence of, a person with disability, in connection with the provision of NDIS supports or services. Given the nature of sexual misconduct, a worker would generally be the subject of allegation.

The term sexual misconduct is designed to address conduct of a sexual nature that can, but does not necessarily amount to a criminal offence. It also includes those sexual offences which are unlawful, but do not include any physical contact between the person and the subject of the allegation.

Sexual misconduct incidents include the following:

* Unlawful sexual conduct
* Sexually explicit comments and overtly sexual behaviour
* Crossing professional boundaries in a way that has sexual implications or connotations
* Grooming of the person for sexual activity

Unlawful sexual conduct

There are other types of unlawful sexual offences that do not involve sexual or physical contact, which must be reported to the Police, and are also a reportable incident. Even though these sexual conduct offences may be named or defined differently in state and territory legislation, they are still reportable incidents that must be notified to the Commission.

#### Acts of indecency

An act of indecency is when a person does something of a sexual nature with or towards another person but does not have any physical contact with them. For example, it can include the subject of the allegation acting out sexually in front of another person. Where these acts occur in connection with the provision of NDIS supports and services a reportable incident notification must be made to the NDIS Commission.

#### Other unlawful sexual conduct offences

There are a range of other unlawful non-contact sexual offences in each jurisdiction which involve conduct that must be notified to the NDIS Commission. These include but are not limited to:

* Grooming a child for sexual purposes
* Filming a person for sexual purposes without consent
* A pornography offence or an offence involving child abuse material

Some jurisdictions also have specific sexual offences that are designed to prevent the sexual exploitation of people with a cognitive impairment by their carers, or by anyone else who has knowledge of the person’s impairment and enters into a sexual relationship with the intent of taking advantage of the person.[[5]](#footnote-5) These offences may or may not involve conduct that comes within this category of reportable incidents.

Crimes which involve encouraging another person to commit a sexual offence against a person with disability (such as offences involving aiding, abetting, counselling or procuring) also constitute unlawful sexual conduct, and are required to be reported to the Police. These are also reportable incidents.

Sexually explicit comments and other overtly sexual behaviour

While it is not possible to provide a complete and definitive list of unacceptable sexual comments or behaviour involving people with disability, the following types of behaviour give strong guidance:

* Sexualised behaviour with or towards a person with disability (including sexual exhibitionism)
* Inappropriate conversations of a sexual nature (sexual discussions as part of life skills development are an example of an appropriate conversation)
* Inappropriate comments relating to sexual acts
* Personal correspondence and communications (including emails, social media and web forums) with a person with disability concerning the worker’s romantic, intimate or sexual feelings for the person with disability
* Inappropriate exposure of people with disability to sexual behaviour of others
* Watching people with disability undress in circumstances where supervision is not required, it does not relate to assistance with undertaking activities of daily living, and it is clearly inappropriate

Where these behaviours occur in connection with the provision of NDIS supports and services a reportable incident notification must be made to the NDIS Commission.

Crossing professional boundaries

The support relationship between a worker and a person with disability relies on a high degree of trust. All forms of sexual misconduct constitute a breach of this trust and a breach of the NDIS Code of Conduct.

It is important to distinguish between sexual misconduct and legitimate conversations around a person with disability’s sexual support needs, family planning or that which serve to meet a worker’s duty of care.

Sexual misconduct includes behaviour with a sexual aspect to it that can reasonably be construed as involving an inappropriate and overly personal or intimate relationship with, conduct towards, or focus on, a person with disability or group of people with disability.

The crossing of professional boundaries can only occur in the context of a worker-person with disability relationship.

A single serious example of boundaries being crossed, or where there are multiple examples over time of less serious breaches of this type, may constitute professional misconduct – particularly if the worker either knew, or ought to have known, that their behaviour was unacceptable, and should be notified as a reportable incident to the NDIS Commission.

The NDIS Code of Conduct, as well as other codes of conduct that might apply in your workplace, outline the expectations of workers in respect of their relationships with people with disability.

Grooming behaviour

Grooming refers to behaviour that is intended to befriend a person, in order to persuade them to engage in sexual activity. Behaviour should only be seen as ‘grooming’ where there is evidence of a pattern of conduct that is consistent with grooming a person with disability for sexual activity, and there is no other reasonable explanation for that pattern.

The types of behaviours that may lead to such a conclusion include, but are not limited to:

* Persuading a person with disability that they have a ‘special’ relationship with the worker, for example by:
  + Inappropriately giving gifts
  + Inappropriately showing special favours to them but not other people with disability
  + Asking the person with disability to keep the relationship to themselves
* ‘Testing boundaries’, for example by:
  + Undressing in front of a person with disability
  + Encouraging inappropriate physical contact (even where it is not overtly sexual)
  + ‘Accidental’ intimate touching
  + Showing the person indecent sexual images or written material
* Extending a relationship with a person with disability outside of work (except where it may be appropriate, for example, where there was a pre-existing friendship with the person with disability’s family, or as part of regular social interactions in the community)
* Inappropriate personal communication (including emails, telephone calls, text messaging, social media and web forums) that inappropriately explores sexual feelings or intimate personal feelings with a person with disability

A worker or another person in the context of NDIS support provision requesting that a person with disability keep any aspect of their relationship secret, or using tactics to keep any aspect of the relationship secret, would generally increase the likelihood that grooming is occurring.

The unauthorised use of a restrictive practice in relation to a person with disability

Restrictive practices involve the use of practices that have the effect of restricting the rights or freedom of movement of a person with disability. This can include restraint (chemical, mechanical, social or physical) and seclusion (keeping someone in isolation).

Role of the NDIS Commission in relation to the use of restrictive practices generally

In addition to oversight of the unauthorised use of restrictive practices, the NDIS Commission also aims to reduce and eliminate the use of restrictive practices in the NDIS. State and territory authorisation arrangements are intended to protect people with disability from being inappropriately treated or controlled. The NDIS (Restrictive Practices and Behaviour Support) Rules also regulate the following restrictive practices through behaviour support plans:

* **Seclusion**, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted
* **Chemical restraint**, which is the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition
* **Mechanical restraint**, which is the use of a device to prevent, restrict, or subdue a person’s movement for the primary purpose of influencing a person’s behaviour but does not include the use of devices for therapeutic or non-behavioural purposes
* **Physical restraint**, which is the use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person
* **Environmental restraints**, which restrict a person’s free access to all parts of their environment, including items and activities

The unauthorised use of a restrictive practice

The use or alleged use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a state or territory in relation to the person with disability must be notified to the NDIS Commission. This includes the emergency use of a restrictive practice.

There are four occasions when this means that the use of a restrictive practice is reportable to the NDIS Commission:

* When the use of the restrictive practice for a person with disability does not have authorisation (however described) by the relevant state or territory body
* When the restrictive practice is used for a person with disability in a state or territory which does not have an authorisation process for that practice AND the practice is not used according to a behaviour support plan
* When the restrictive practice is used for a person with disability according to an authorisation (however described) by the relevant state or territory body BUT the practice is not used according to a behaviour support plan or interim behaviour support plan because the person does not have such a plan
* When the restrictive practice is being used according to an authorisation (however described) by the relevant state or territory body, but the restrictive practice used was not included in the person with disability’s behaviour support plan
* When a restrictive practice is being used according to an authorisation (however described) by the relevant state of territory body, but the restrictive practice is being applied in a way which is inconsistent or contrary to the requirements or directions in the person’s behaviour support plan

However, in circumstances where the state or territory in which the restrictive practice is used does not have an authorisation process for restrictive practices, and the restrictive practice is used is according to the person’s behaviour support plan, then this is not a reportable incident.

If one of the above situations apply, then the type of restrictive practice used, for example whether it was chemical restraint or physical restraint, does not affect whether its use should be reported as a reportable incident.

Whenever the use of a restrictive practice, whether or not authorised, results in serious injury to a person, this is a reportable incident requiring notification to the NDIS Commission as would be the case for any other incident resulting in serious injury to a person with disability.

Part 4: Managing reportable incidents

# Managing reportable incidents

The NDIS Commission has an oversight role in relation to reportable incidents. The actions undertaken by a registered NDIS provider in response to an incident will be reviewed by the NDIS Commission to ensure that they have responded immediately to support the person with disability. The NDIS Commission reviews the registered NDIS provider’s investigation process and subsequent outcomes and actions taken.

The aim of the NDIS Commission’s reportable incidents oversight is to support the safety and wellbeing of people with disability. Our objectives in doing so include:

* Promoting timely and effective responses to reportable incidents to address the safety and wellbeing of people with disability
* Ensuring effective and appropriate monitoring and investigation of reportable incidents
* Learning from reportable incidents and patterns of incidents, to reduce the risk of harm to people with disability, and improve the quality of services and the service system
* Ensuring the accountability of registered NDIS providers to people with disability

There are three key stages to managing reportable incidents:

1. Identify and notify
2. Investigate and act
3. Provide any final report

Identification and notification

There are criteria defining reportable incidents, specific personnel who will notify the Commission and set timeframes for notification and providing further information. These timeframes are critical to ensuring an incident is effectively managed.

All reportable incidents, except for the unauthorised use of a restrictive practice that has not resulted in serious injury, must be notified to the NDIS Commission within 24 hours of the registered NDIS provider becoming aware of the incident. Most unauthorised uses of restrictive practices must be notified within 5 days.

It is assumed that a registered NDIS provider has become aware of an incident once a person employed, or otherwise engaged by a registered NDIS provider has notified one of the following individuals:

* A member of the registered NDIS provider’s key personnel
* A supervisor or manager of the person
* A person noted in the registered NDIS provider’s incident management system as responsible for notifying the NDIS Commission of reportable incidents[[6]](#footnote-6)

If a person with disability discloses an incident that occurred in the past it should be treated in the same way as any other reportable incident, noting that the immediate response may differ.

A registered NDIS provider is only required to notify the NDIS Commission of reportable incidents that are connected to the service they are providing. If a registered NDIS provider (such as a support coordinator or allied health professional) witnesses an incident or conduct involving another NDIS provider this should be raised as a concern of ‘provider non-reporting’ to the **reportable incidents team** of the NDIS Commission by phone or email. A reportable incident form is not required. This may happen when:

1. They witness or become aware of an incident that is **not** in connection with the services they themselves are providing, such as seeing a worker of another NDIS provider abuse a person with disability
2. They believe the registered NDIS provider linked to the incident may not have notified the NDIS Commission

The NDIS Commission would then contact the NDIS provider to request a reportable incident notification if no notification had been submitted.

Figure 4: Process for notification of reportable incidents illustrates the reporting process a registered NDIS provider is required to follow when an incident occurs in connection with the delivery of NDIS supports and services.

Figure 4: Process for notification of reportable incidents

This figure is a flowchart depicting the process for notification of reportable incidents. 
The first box in the process is "Registered provider becomes aware of an incident". 
The next box is "Worker providing services responds to the immediate needs of the person and others to ensure safety and wellbeing". 
The next box is "Worker follows organisation's incident management system to do the following: Report the incident to the relevant personnel, Notify a person's family or support person, Contact police (where required)."
The next box is "Providers relevant personnel determines if the incident is reportable?". There are three different pathways from this box.
If the incident is not reportable, the next box is "NDIS provider continues to manage the incident internally".
If the incident is reportable, but is not an unauthorised restrictive practice, the next box is "Complete NDIS Commission Immediate notification form". The next box is "Complete NDIS Commission 5 day notification form".
If the incident is reportable, and is also an unauthorised restrictive practice, the next box is "Complete NDIS Commission 5 day notification form".
The next box is "NDIS Commission acknowledges receipt and commenses oversight". There are two boxes that flow on from this.
The first box is "NDIS provider continutes to manage the incident internally".
The second box is "NDIS Commission requests additional information (if required). The next box is "NDIS Commission requests additional regulatory action to be taken". The next box is "NDIS Commission instructs provider to undertake an investigation and/or complete a Final Report (60 day) as deemed appropriate for the incident".

Incident identification and recording

If a worker providing services becomes aware of an incident, they have a duty to notify one of the following as soon as possible:

* A member of the registered NDIS provider’s key personnel
* A supervisor or manager
* The person specified in the incident management system as being responsible for reporting incidents that are reportable incidents to the NDIS Commission[[7]](#footnote-7)

For some registered NDIS providers, such as smaller registered NDIS providers or sole traders, the worker may also be the person responsible for notifying a reportable incident or allegation of a reportable incident to the NDIS Commission.

A worker providing services may become aware of a possible reportable incident in numerous ways, including by witnessing signs of possible abuse; disclosure by a person with disability; witnessing the event; or receiving information provided by another person. When workers become aware of a reportable incident they must:

* Record the details of what the impacted person (or other person) has told them, using their exact words if possible
* Be sure not to interview the person who allegedly committed the abuse. However, if a worker witnesses any abuse, they must record what they have seen and heard
* Record details of any witnesses
* Record what has been seen and following actions
* Be sure not to include anything that was not directly heard or seen
* Be sure not to include opinions or interpretations

Workers should give any notes they have taken in relation to an incident to their relevant personnel – unless the supervisor or other person is alleged to be involved in the incident or have a potential conflict of interest (for example a personal relationship with the subject of the allegation). If a worker has concerns, they should seek advice from senior management. The registered NDIS provider should ensure that workers keep a copy of their notes.

A registered NDIS provider’s incident management system must clearly specify who is responsible for notifying the NDIS Commission of a reportable incident. Relevant personnel are responsible for identifying whether the incident is a reportable incident that occurred in connection with the provision of supports or services and taking all reasonable steps to ensure that reportable incidents that occur in connection with the provision of supports or services are notified to the NDIS Commission. Relevant personnel can contact the NDIS Commission for guidance in making this decision if they are uncertain.

Notifications to the NDIS Commission about a reportable incident provide specific information about the incident and any steps already taken. Initial notifications within 24 hours can be made in writing, or by phone. The five day notification must be in writing. The NDIS Commission may request further information as a result of the notification.

NDIS Quality and Safeguards Commission: Immediate notification form

The Immediate Notification Form (available both as a written form and an online [form](https://www.ndiscommission.gov.au/)) must be completed by registered NDIS providers within 24 hours of becoming aware of any reportable incident or allegation occurring, except for an unauthorised use of a restrictive practice or the use of a restrictive practice which is in accordance with an authorisation of a State or Territory but which is not in accordance with a behaviour support plan.

All reportable incidents, including the use of a restrictive practice causing serious injury, must be notified to the NDIS Commission within 24 hours of you becoming aware of the incident. Any unauthorised use of restrictive practices not causing serious injury must be notified within 5 days.

The notification must include the following information to the NDIS Commission:

* The name and contact details of the registered NDIS Provider, the person making the notification and the persons involved in the reportable incident, including the person with disability affected by the reportable incident, and any subject/s of an allegation
* A description of the reportable incident, including (if known) the time, date and place the Incident occurred
* A description of the impact on, or harm caused to, the person with disability (Note: where the reportable incident is a death, this information does not need to be provided)
* The immediate actions taken in response to the reportable incident, including any actions relating to the health, safety and wellbeing of the person with disability affected by the incident, including medical treatment provided, and whether the incident has been reported to the police or any other body

The NDIS Commission will acknowledge receipt of the notification within 24 hours.

Providing further information for an immediate notification

If the specific information required in the form is not available within 24 hours of the registered NDIS provider becoming aware that a reportable incident has occurred, remaining information may be provided to the NDIS Commission within five business days.[[8]](#footnote-8)

Registered NDIS providers also have five business days to notify the NDIS Commission of:

* The names and contact details of any witnesses to the reportable incident (including workers, people with disability or third parties)
* Any further actions proposed to be taken in response to the reportable incident[[9]](#footnote-9)

The NDIS Commission will acknowledge receipt of the notification within 24 hours of receiving the additional information[[10]](#footnote-10)

NDIS Quality and Safeguards Commission: Reportable incident: Five day notification

The Five Day Notification [form](https://www.ndiscommission.gov.au/document/656) must be completed by registered NDIS providers within 5 business days of becoming aware of a reportable incident or allegation of the use of an unauthorised restrictive practice or the use of a restrictive practice in accordance with an authorisation of a State or Territory but not in accordance with a behaviour support plan (section 21 of the NDIS Rules); and as a follow up notification for all other reportable incidents (section 20 of the NDIS Rules).

The reportable incident 5 day notification form requires the registered NDIS provider to provide information from the immediate notification form as well as the following additional information:

* The name and contact details of the support person for the impacted person with disability
* The name and contact details of the individual or person with disability who is the subject of allegation
* A description of the impact on, or harm caused to, the person with disability
* The name and contact details of any witnesses to the reportable incident
* A description of support provided and further action being considered for the person with disability impacted by the incident and for the subject of the allegation
* A description of the risk processes being undertaken by the registered NDIS provider
* If applicable circumstances surrounding the death of a person with disability
* If applicable details surrounding the use of unauthorised restrictive practice in relation to a person with disability

*Both notification forms must be submitted to the NDIS Commission with copies of all documents relating to the incident. This includes incident reports, file notes, risk management assessments and/or plans, person with disability’s plans relevant to the incident such as a behaviour support plan, as well as copies of correspondence between relevant persons or agencies.*

Sending a notification to the NDIS Commission

NDIS providers are able to use the online reportable incident notification form to submit required notifications to the NDIS Commission. If for any reason you need to complete the NDIS Commission approved paper form, once it is completed it must be emailed directly to the NDIS Commission at [*reportableincidents@ndiscommission.gov.au*](mailto:reportableincidents@ndiscommission.gov.au)*.*

Following the review of an incident notification the NDIS Commission will determine if the incident is reportable or non-reportable. If the NDIS Commission deems the incident to be non-reportable no further action will be taken by the NDIS Commission, which will redirect the registered NDIS provider to their internal incident management systems.

Registered NDIS providers need to be aware of inherent risks associated with the transmission of information via email and otherwise over the internet. If a registered NDIS provider has concerns, the NDIS Commission has other ways of obtaining and providing information including mail, telephone and the NDIS Commission's secure file transfer system, File Point. If a registered NDIS provider would like to report an incident through File Point outside of business hours, they can email [*reportableincidents@ndiscommission.gov.au*](mailto:reportableincidents@ndiscommission.gov.au)*.*

#### Withholding certain information

While a report of an incident is still required, a registered NDIS provider is not required to obtain or notify the NDIS Commission of certain information if obtaining that information would, or could reasonably be expected to, prejudice a criminal or investigation into the reportable incident, or cause harm to a person with disability.[[11]](#footnote-11)

Amending a notification after submission

If the registered NDIS provider becomes aware of significant new information in relation to a reportable incident that has already been reported and it relates to a change in the kind of reportable incident or is an occurrence of a further reportable incident the registered NDIS provider must notify the NDIS Commission in writing via email at [*reportableincidents@ndiscommission.gov.au*](mailto:reportableincidents@ndiscommission.gov.au). The notification must be made as soon as reasonably practicable after the registered NDIS provider becomes aware of the information.

Where a separate reportable incident has occurred, the applicable notification form should be used.

Investigate and act

Following the submission of a notification the NDIS Commission carefully considers the circumstances surrounding, and outcomes resulting from the incident. The NDIS Commission may take regulatory action, including requiring the registered NDIS provider to undertake specified remedial action, carry out an internal investigation regarding the incident or engage an independent expert to investigate and report on the incident. The NDIS Commission also has the power to carry out an inquiry in relation to a reportable incident.

Following the assessment of a reportable incident notification, the NDIS Commission may take the following actions:

* Refer the reportable incident to another person or body with relevant responsibilities in relation to the reportable incident (for example, child protection authorities)
* Require or request the registered NDIS provider to undertake specified regulatory action in relation to the reportable incident within a specified period, including regulatory action to ensure the health, safety and wellbeing of the person with disability affected. Actions to prevent future reoccurrences, uplift quality and prevent harm to other persons with disability may also be required or requested
* Require the registered NDIS provider to carry out an internal investigation in relation to the reportable incident
* Require the registered NDIS provider to engage an appropriately qualified and independent expert, at the expense of the registered NDIS provider, to carry out an investigation in relation to the reportable incident
* Conduct an inquiry in relation to the reportable incident
* Take any other action considered reasonable in the circumstances, for example giving information in relation to the reportable incident to police

Any action taken by the NDIS Commission in response to a reportable incident must have regard for the rules of procedural fairness.

The circumstances in which an incident must be investigated are set out in the ***Guidance on Incident Management Systems****.* The guidance also sets out a detailed investigation process to assist registered NDIS providers with undertaking effective investigation of incidents.

Undertaking an investigation

Registered NDIS providers are required to appropriately assess all incidents, with the assessment having regard to the views of any person with disability impacted by the incident, and including the following:

* Whether the incident could have been prevented
* How well the incident was managed and resolved
* What, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact
* Whether other persons or bodies need to be notified of the incident[[12]](#footnote-12)

A registered NDIS provider may choose, or the NDIS Commission may require the registered NDIS provider, to undertake an internal investigation about a reportable incident or to engage, at the registered NDIS provider’s expense, an external expert to undertake the investigation. Both internal and external investigators need to be appropriately qualified to conduct serious investigations of this sort, including investigating serious incidents that may involve a criminal element.

The NDIS Commission may provide, or require a registered NDIS provider to provide, information on the progress or outcome of an investigation to the person with disability who was involved in the reportable incident or their representative or, with the consent of the person with disability, any other person.

Depending on the circumstances, key personnel may also be required to notify reportable incidents to other authorities, including police or child welfare agencies. This is a responsibility beyond notifying the reportable incident to the NDIS Commission.

More detailed guidance regarding best practice investigation processes is available on the NDIS Commission’s website – *Incident Management - Conducting an Investigation.*

Corrective action

Corrective action refers to steps taken by registered NDIS providers in response to a reportable incident. Corrective steps may include, but are not limited to:

* Disciplinary action or dismissal
* Training or education of workers
* Modification of the environment
* Development or amendment of a policy or procedure
* Changes to the way in which supports or services are provided
* Practice improvements

A number of reportable incidents won’t require further action to be taken by the registered NDIS provider. For example, the death of a person with disability from natural causes i.e. death occurred while the person was in the care of a registered NDIS provider, but the registered NDIS provider’s services weren’t found to have contributed to the death.

Where appropriate, the NDIS Commission may require a registered NDIS provider to take remedial measures. The NDIS Commission may work with the registered NDIS provider to implement the measures and monitor progress. Remedial measures may include, but are not limited to, providing ongoing support to people with disability impacted by a reportable incident, staff training and updating policy and procedures.

Registered NDIS providers are audited against the NDIS Practice Standards and they are required to make their records available as part of the quality assurance component of this process. In addition the NDIS Commission may call upon registered NDIS providers to submit records in relation to the investigation of incidents. Such information may include: the number and frequency of incidents; when and where incidents occur; the type of incidents that occur; and who is involved in incidents (for example, whether particular workers and/or people with disability are involved in multiple incidents).

Provide any final report

In certain circumstances, registered NDIS providers can be required to give the NDIS Commission a final report with information about any internal or external investigation or assessment that has been undertaken in relation to the reportable incident, including:[[13]](#footnote-13)

* The name and position of the person who undertook the investigation
* When the investigation was undertaken
* Details of any findings made
* Details of any corrective or other action taken after the investigation
* A copy of any report of the investigation or assessment
* Information about whether persons with disability impacted by the incident (or their representative) have been kept informed of the progress, findings and actions relating to the investigation or assessment
* Any other information required by the NDIS Commission[[14]](#footnote-14)

The final report needs to be provided to the NDIS Commission within 60 business days following the initial notification. The NDIS Commission may extend the period for providing the final report. For example, if there is a concurrent police investigation the reportable incident investigation will be justifiably delayed.

Keep a record

Providers are required to maintain a record of the incident in their incident management system. At a minimum the registered NDIS provider’s record must include:

* **Description of the incident** – including the impact on, or harm caused to, any person with disability
* **Nature of the incident** – details of whether the incident is a reportable incident
* **Details of the incident** – if known, the time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified
* **Assessment** – details of assessment of the incident in relation to (among other things) whether it could have been prevented, how well it was managed and resolved, and whether anyone else needs to be notified of it
* **Contact details** – the names and contact details of the persons involved in the incident and any witnesses to it
* **Response** – the actions taken in response to the incident
* **Consultations** – any consultations with the person with disability affected by the incident and whether the person has been given reports or findings regarding the incident
* **Investigation** – if an investigation is undertaken by the registered NDIS provider in relation to the incident – the details and outcomes of the investigation, and
* **Documenter** – the name, position and contact details of the person making the record of the incident

It is important to note that although the NDIS Commission only requires registered NDIS providers to maintain these details, it is better practice to retain additional information. For further information on the requirements of a registered NDIS provider incident management system and practice please see the separate guidance available on the NDIS Commission [website](https://www.ndiscommission.gov.au/).

It may be difficult for the NDIS Commission to assess the standard of investigations undertaken by an organisation if they have insufficient detail about how the investigation was planned and conducted.

Part 5: Monitoring and compliance of registered NDIS providers

# Monitoring and compliance of registered NDIS providers

The NDIS Commission is responsible for providing oversight of reportable incidents and overseeing registered NDIS providers’ responses to incidents. The focus of the NDIS Commission’s approach is to proactively engage with NDIS providers to educate, advise and encourage them to identify and understand their obligations and improve their practice. The NDIS Commission will work with providers to build their capacity to respond effectively to incidents and improve their systems to prevent similar incidents occurring again.

What registered NDIS providers can expect from the NDIS Commission in relation to a reportable incident

When a registered NDIS provider notifies the NDIS Commission of a reportable incident, there are a number of things they can expect from the NDIS Commission. This includes:

* Responses from the NDIS Commission within required timeframes
* Initial assessment of the reportable incident, to determine if it is actually reportable, and whether further action is required. If further action is required, the Commission may do one of the following things:
  + Refer the incident to another person or body with responsibility in relation to the incident (such as a State or Territory agency responsible for child protection)
  + Require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the health, safety and wellbeing of persons with disability affected by the incident
  + Require the provider to carry out an internal investigation in relation to the incident, in the manner and within the timeframe specified in by the Commissioner, and to provide a report on the investigation to the Commissioner
  + Require the provider to engage an appropriately qualified and independent expert, at the expense of the provider, to carry out an investigation in relation to the incident, in the manner and within the timeframe specified in by the Commissioner, and to provide a report on the investigation to the Commissioner
  + Carry out an inquiry in relation to the incident
  + Take any other action that the Commissioner considers reasonable in the circumstances
* The NDIS Commission may also make recommendations to the registered NDIS provider regarding the incident, including how the incident was investigated or assessed, the quality of information provided to the NDIS Commission through notifications and final reports, and whether procedural fairness was adhered to by the registered NDIS provider
* Adherence by the NDIS Commission to procedural fairness rules in taking action in relation to a reportable incident

The NDIS Commission’s approach to compliance

The NDIS Commission takes a responsive and proportionate approach to regulation, applying the strongest actions to the most serious issues and breaches. The NDIS Commission can escalate actions if an initial response or action does not achieve the intended outcome. The range of tools and response are shown in Figure 5: Compliance pyramid below.

Figure 5: Compliance pyramid

This figure depicts the range of tools and responses available from a compliance perspective. There is a pyramid with seven tiers. 
The bottom tier (least serioues) containts the text "Education, persuasion, compliance support".
The second tier contains the text "Registration, Audit, Investigation".
The third tier contains the text "Compliance Notice, Enforceable Undertaking".
The fourth tier contains the text "Infringement notice".
The fifth tier contains the text "Civil penalties".
The sixth tier contains the text "Revoke Registration".
The top tier (most serious) contains the text "Ban".
Running diagonally alongside the two edges of the pyramid are banners of text. The text on the left-hand side says "Publication", and the text on the right-hand side says "Seriousness/harm/provider willingness".

Monitoring and compliance is important to the NDIS Commission’s work as a regulator, details of the NDIS Commissions strategy are set out in the NDIS Compliance and Enforcement Policy.[[15]](#footnote-15)

The NDIS Commission will monitor registered NDIS providers for compliance with the conditions of their registration, including responses to reportable incidents. If an NDIS provider is not complying or unable to comply with the registration requirements, the NDIS Commission can take compliance action as detailed in Figure 5: Compliance pyramid.

Find out more

You can find out more information and access resources on the NDIS Commission www.ndiscommission.gov.au

You can contact the NDIS Commission Reportable Incidents Team at [*reportableincidents@ndiscommission.gov.au*](mailto:reportableincidents@ndiscommission.gov.au)or 1800 035 544

1. NDIS (Incident Management and Reportable Incidents) Rules 2018 s19. [↑](#footnote-ref-1)
2. *National Disability Insurance Scheme Act 2013,* paragraph 73F(2)(g) and s 73J [↑](#footnote-ref-2)
3. National Disability Insurance Scheme Act 2013, s 73Z(4) and s 16 of the NDIS (Incident Management and Reportable Incident) Rules. [↑](#footnote-ref-3)
4. *National Disability Insurance Scheme Act 2013* s 73Z(1) [↑](#footnote-ref-4)
5. See, eg, s 66F *Crimes Act 1900* (NSW). [↑](#footnote-ref-5)
6. NDIS (Incident Management and Reportable Incidents) Rules 2018 s18, s19, s20 and s21. [↑](#footnote-ref-6)
7. NDIS (Incident Management and Reportable Incidents) Rules 2018 s19. [↑](#footnote-ref-7)
8. NDIS (Incident Management and Reportable Incident) Rules 2018, s 20(3). [↑](#footnote-ref-8)
9. NDIS (Incident Management and Reportable Incident) Rules 2018, s 20(4). [↑](#footnote-ref-9)
10. NDIS (Incident Management and Reportable Incident) Rules 2018, s 20(4). [↑](#footnote-ref-10)
11. See s 22. For further information, see below. [↑](#footnote-ref-11)
12. NDIS (Incident Management and Reportable Incident) Rules 2018, s 10(3). [↑](#footnote-ref-12)
13. NDIS (Incident Management and Reportable Incident) Rules, s 24. [↑](#footnote-ref-13)
14. NDIS (Incident Management and Reportable Incident) Rules, s 24(2). [↑](#footnote-ref-14)
15. NDIS Quality and Safeguards Commission. (2018). Compliance and Enforcement Policy. Retrieved from, https://www.ndiscommission.gov.au/sites/default/files/documents/2018-07/Compliance%20and%20Enforcement%20Policy.pdf. [↑](#footnote-ref-15)