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Details of Filing

Document Lodged:	Concise Statement
File Number:	NSD1256/2021
File Title:	COMMISSIONER OF THE NDIS QUALITY AND SAFEGUARDS COMMISSION v AUSTRALIAN FOUNDATION FOR DISABILITY ACN 000 112 729
Registry:	NEW SOUTH WALES REGISTRY - FEDERAL COURT OF AUSTRALIA

Dated: 3/12/2021 12:11:52 PM AEDT Registrar

Important Information

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Form NCF1

CONCISE STATEMENT

Federal Court of Australia No NSD of 2021

District Registry: New South Wales

Division: General

COMMISSIONER OF THE NDIS QUALITY AND SAFEGUARDS COMMISSION

Applicant

AUSTRALIAN FOUNDATION FOR DISABILITY (ACN 000 112 729)

Respondent

Filed on behalf of the Commissioner of the NDIS Quality and Safeguards Commission, the applicant

Prepared by Paul Vane-Tempest
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A. INTRODUCTION

1. On 23 May 2019, Ms Merna Aprem, who had conditions including epilepsy, died when left unsupervised in the bath at 9 Bundeena Road, Woodbine, NSW (**Woodbine**). Woodbine was, at all material times, a group home for persons with disabilities operated by the respondent (**Afford**). At all material times Afford was a registered NDIS provider under s 73E of the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**). The applicant (**Commissioner**) alleges that Afford failed to:

   (a) provide supports and services to Ms Aprem in a safe and competent manner, with care and skill, as required by s 6(c) of the **NDIS Code of Conduct** in s 6 of the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (Cth) (**Code of Conduct Rules**). By reason of this Afford contravened both ss 73J and 73V of the NDIS Act; and

   (b) comply with the requirement that Ms Aprem be able to access supports in a safe environment which was appropriate to her needs, as required by cl 24 of the **NDIS Practice Standards** at sch 1, pt 5 of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) (**PRPS Rules**). By reason of this Afford contravened s 73J of the NDIS Act.

2. The Commissioner seeks declaratory relief and civil penalties, and costs.

B. IMPORTANT FACTS GIVING RISE TO THE CLAIM

B1 Afford

3. Afford is a public company limited by guarantee. At all material times, it was the registered proprietor of Woodbine, a single-storey residential house. Afford operated Woodbine as a group home for persons with disabilities from around March 2019. Under the "group home" model, clients of Afford paid to reside in the home, and Afford provided them with supported independent living services.

4. In the financial year of Ms Aprem's death, Afford opened at least 19 new group homes and recorded a 35% growth in revenue. Afford's then-CEO, Mr Steven Herald, characterised the growth of its group home activities during that year as "exponential".

B2 Ms Aprem's residence at Eschol Park and Woodbine

5. Ms Aprem was 20 years old at the time of her death. As a child, she had been diagnosed with epilepsy, autism spectrum disorder and moderate to severe intellectual disability.

6. On 19 November 2018, Ms Aprem was referred to Afford by a support service for a group home placement. At the time of the referral, Afford was provided with a Functional Assessment Report, Supported Independent Living Assessment and Autonomy Assessment Scale (**SMAF Evaluation)** for Ms Aprem. Those documents referred to the diagnoses above [5]. The SMAF Evaluation indicated that Ms Aprem required supervision for washing and stated that Ms Aprem's mother was with Ms Aprem when she showered because of a fear of seizures.

7. Between around 22 December 2018 and Ms Aprem's transition to supported independent living at Woodbine in around mid-March 2019, Ms Aprem received respite care at an Afford facility at Eschol Park. She suffered seizures while under the care of Afford at Eschol Park, including a seizure which necessitated the calling of an ambulance on 26 December 2018 and a further seizure on 20 January 2019.

8. Ms Aprem moved to Woodbine on or around 14 March 2019. On 15 March 2019, an NDIS Plan was approved for her which provided for supported independent living. The plan stated that Ms Aprem needed supervision with personal care tasks as she could have seizures.

9. Ms Aprem moved out of Woodbine on 27 March 2019, but returned on 18 April 2019. During her residence at Woodbine, Ms Aprem lived with one or two other clients of Afford. Support workers employed by Afford provided supported independent living services to the clients at Woodbine, including Ms Aprem. Support workers were rostered on for shifts (including overnight shifts) and one or two workers were present at Woodbine at any given time.

10. The bathroom at Woodbine in which Ms Aprem died was fitted with an internally lockable doorknob which could not be unlocked from the outside.

B3 Afford's care management planning

11. At the time of Ms Aprem's death, Afford possessed documents which addressed her support needs, including:

    (a) an Epilepsy Management Plan dated 27 December 2018 (**EMP**); and

    (b) a Comprehensive Health Assessment Program dated 15 March 2019 (**CHAP**).

12. There was no Health Care Plan on Ms Aprem's file. Afford's *Procedure – Health Management* required that such a document be prepared.

13. The EMP was incomplete. Among other omissions, a section of the plan that required the identification of strategies to manage the risk of bathing or showering was left blank. The EMP was not signed by either of the support workers responsible for supporting Ms Aprem on the evening of her death.

14. The CHAP was also incomplete. There were two copies of the document: one (undated) version prepared by Afford staff and another (dated 15 March 2019) prepared by Ms Aprem's GP. Among other omissions, in a section of the CHAP prepared by Afford staff, the form recorded that Ms Aprem suffered from epilepsy but the "Epilepsy" section of the form was otherwise left blank. In a section of the form completed by Ms Aprem's GP, the question "*[h]as the person's seizure control been reviewed?"* was not answered and the question "*[h]as a referral been considered?*" was answered "*may be with her previous GP? But no new review?*".

15. A care record held by Afford dated 15 March 2019 stated: "*Merna's current GP doesn't have enough information because this is Merna's 2nd visit to her. GP need information from previous doctor. So can't make epilepsy plan. Her GP can't fill up papers for us + hospital due to lack of information*. *Advise us to ask Merna's mum.*" A further CHAP was not completed by Afford prior to Ms Aprem's death on 23 May 2019.

16. Afford utilised a computer system known as "CIMS" to maintain records about its clients' support needs. The CIMS record for Ms Aprem was substantially incomplete. Among other omissions, the "Disabilities" section of the "Client Dashboard" and the "Diagnosis" section of the "Participant Dashboard" did not refer to Ms Aprem's epilepsy. A section of the "Participant Dashboard" which referred to an "Epilepsy/Seizure Plan" was blank.

B4 Afford's Epilepsy and Seizure Management Procedure

17. At the time of Ms Aprem's death, Afford maintained a document entitled *Procedure – Epilepsy and Seizure Management* (**Epilepsy Procedure**). That document stated:

    (a) "*Every Client with epilepsy with ongoing seizures will be supervised at all times when bathing and showering*";

    (b) "*During the shower/bath a staff member must remain in the bathroom with the Clients … and observe them at all times*"; and

    (c) "*If the Client refuses supervision by a staff member, risk management procures [sic] are to be implemented*". The strategies were said to include monitoring devices, staff standing outside the door, and developing strategies in consultation with the client's treating doctors and family.

18. The Epilepsy Procedure also addressed the development and implementation of the EMP, together with requirements for training and the communication of information to staff.

B5 Events leading to Ms Aprem's death

19. On the evening of Ms Aprem's death, the Afford support workers working at Woodbine were Ms Emma Barringham and Ms Dorcas Boansi. There were two other clients in the home.

20. Neither Ms Barringham nor Ms Boansi had worked at Woodbine before and neither of them had completed a "buddy shift" there (being a shift with a more experienced member of staff). Neither Ms Barringham nor Ms Boansi was aware that Ms Aprem suffered from epilepsy and neither had seen her EMP or CHAP prior to commencing their shifts on 23 May 2019.

21. After Ms Aprem finished her dinner that evening, Ms Barringham assisted Ms Aprem to run a bath. After Ms Aprem was in the bath, with water coming up to around her waist level, Ms Aprem asked Ms Barringham to leave the bathroom. Ms Barringham then left the bathroom, leaving Ms Aprem unsupervised in the bath. She left the door ajar. Ms Barringham attended to other tasks including getting another client's things ready for a shower and for bed, and making a meal for another resident in the kitchen.

22. Ms Barringham returned to check on Ms Aprem at least 25 minutes (and likely considerably longer) after she had left Ms Aprem in the bath unsupervised. She found the bathroom door locked and could not get into the bathroom. Ms Aprem did not respond to knocking or calls. Ms Barringham and Ms Boansi sought to gain access to the bathroom and Ms Boansi was able to enter the bathroom only by unscrewing the door handle with a knife from the kitchen.

23. Ms Aprem was found in the bathtub unconscious with her nose and mouth submerged, and with vomit in the bathwater.

24. At least 22 minutes elapsed between the point at which Ms Barringham sought to access the bathroom and the point at which "000" was first called. An ambulance arrived shortly after Ms Barringham called "000" but Ms Aprem was unable to be revived.

C. RELIEF SOUGHT FROM THE COURT

25. The Commissioner seeks the relief set out in the Originating Application.

D. PRIMARY LEGAL GROUNDS FOR THE RELIEF SOUGHT

26. Section 73F(1)(a) of the NDIS Act provides that the registration of a person as a registered NDIS provider is subject to certain conditions specified in ss 73F(2), including:

    (a) a condition that the person comply with all applicable requirements of the NDIS Code of Conduct (see sub-s 73F(2)(b)); and

    (b) a condition that the person comply with all applicable standards and other requirements of the NDIS Practice Standards (see sub-s 73F(2)(c)).

27. Section 73J of the NDIS Act provides that a person contravenes that section if the person is a registered NDIS provider and breaches a condition to which the registration is subject.

28. Section 73V(3) of the NDIS Act provides that a person contravenes that section if the person is subject to a requirement under the NDIS Code of Conduct and fails to comply with that requirement.

29. At all material times:

    (a) Afford was required to comply with s 6(c) of the NDIS Code of Conduct because it was a "*Code-covered person*" within the meaning of s 5(2)(a) of the Code of Conduct Rules.

    (b) Section 6(c) of the NDIS Code of Conduct required that Afford, in providing supports or services to Ms Aprem, provided supports and services in a safe and competent manner, with care and skill.

30. At all material times:

    (a) Afford was required to comply with the standard specified in cl 24 of the NDIS Practice Standards at sch 1, pt 5 of the PRPS Rules as a transitioned provider to which sub-s 26(1) of the PRPS Rules applied, by reason of sub-s 26(2).

    (b) The standard specified in cl 24 of the NDIS Practice Standards required that Afford ensure that Ms Aprem could access supports in a safe environment that was appropriate to her needs.

31. The Commissioner contends that Afford failed to provide supports to Ms Aprem in a safe and competent manner with care and skill, as required by s 6(c) of the NDIS Code of Conduct, and thereby contravened ss 73J and 73V of the NDIS Act, as a result of its failure to:

(a) develop and implement adequate measures in Ms Aprem's EMP for the management of Ms Aprem's epilepsy, including as regards bathing or showering;

(b) ensure that review of Ms Aprem's seizure control had taken place for the purpose of Ms Aprem's CHAP;

(c) ensure that an action plan was developed and implemented to address the risks posed by Ms Aprem's epilepsy for the purpose of Ms Aprem's CHAP or at all;

(d) identify and implement measures to protect Ms Aprem against the risks associated with her having a seizure whilst bathing;

(e) ensure that Ms Aprem was adequately supervised, or adequate alternative risk management procedures were in place, whilst bathing on 23 May 2019;

(f) ensure that Ms Aprem's diagnoses and support needs were adequately documented in client records, including the "CIMS" system; and/or

(g) take adequate steps to ensure that the support workers responsible for providing supports and services to Ms Aprem on 23 May 2019 were made aware of any or all of the following:

i. Ms Aprem was diagnosed with epilepsy;

ii. Ms Aprem could experience seizures;

iii. the terms of Ms Aprem's EMP and/or CHAP; and/or

iv. measures required to address the risks posed by Ms Aprem's epilepsy whilst bathing.

32. The Commissioner contends that Afford failed to ensure that Ms Aprem could access supports in a safe environment that was appropriate to her needs, as set out in cl 24 of the NDIS Practice Standards, and thereby contravened s 73J of the NDIS Act a result of its failure to:

(a) identify the risk to Ms Aprem's safety when bathing posed by the door to the bathroom adjacent to her bedroom at Woodbine being fitted with an internally lockable doorknob which could not be unlocked from the outside;

(b) take any or any adequate steps to mitigate that risk;

(c) ensure that staff could readily access all areas of the Woodbine property which were occupied by Ms Aprem, including the bathroom; and/or

(d) adequately supervise Ms Aprem whilst bathing on 23 May 2019.

33. The Commissioner seeks declaratory relief in respect of the contraventions pursuant to s 21 of the *Federal Court of Australia Act 1976* (Cth) and pecuniary penalties pursuant to s 82(3) of the *Regulatory Powers (Standard Provisions) Act 2014* (Cth), read with s 73ZK of the NDIS Act.

E. ALLEGED HARM

34. The Commissioner contends that each of Afford's failures to provide supports to Ms Aprem in a safe and competent manner with care and skill and its failure to ensure that Ms Aprem could access supports in a safe environment which was appropriate to her needs placed

Ms Aprem's safety at real and significant risk. The Commissioner further contends that Ms Aprem's death may have been caused or contributed to thereby.

This concise statement was settled by Kristina Stern SC and Matt Sherman of counsel.

CERTIFICATE OF LAWYER

I, Paul Vane-Tempest, certify to the Court that, in relation to the concise statement filed on behalf of the applicant, the factual and legal material available to me at present provides a proper basis for each allegation in the pleading.

Date: 2 December 2021

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Signed by Paul Vane-Tempest
Lawyer for the Applicant