

**Independent review of the adequacy of the
regulation of the supports and services
provided to Ms Ann-Marie Smith, an NDIS
participant, who died on 6 April 2020**

**Report to the Commissioner of the NDIS Quality and Safeguards
Commission**

Alan Robertson SC

31 August 2020

The Hon. Alan Robertson SC

Independent Reviewer

Appointed by the Commissioner of the NDIS Quality and Safeguards Commission

Mr Graeme Head AO
Commissioner of the NDIS Quality and Safeguards Commission
National Office
Level 1, 121 Henry Street
Penrith, NSW 2750

Dear Mr Head

In accordance with the terms of reference published on 26 May 2020, I now provide to you the Report of my Review into a number of issues surrounding the death of Ms Ann-Marie Smith on 6 April 2020, particularly the systems and processes of the NDIS Commission in its regulation of the NDIS provider involved.

I note that you intend to publish the Report, subject to any redactions necessary to avoid prejudice to any criminal, regulatory or civil proceedings and any redactions identified as appropriate by me to protect the privacy of any individual. I therefore provide my Report to you in two forms: the first form is the complete Report, while the second form has been edited to give effect to my suggested redactions, necessary to avoid prejudice to legal proceedings and appropriate to protect the privacy of individuals.

Yours sincerely



Alan Robertson SC

31 August 2020

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Summary

Ms Ann-Marie Smith died on 6 April 2020 after a substantial period of neglect, having been living in squalid and appalling circumstances. She lived by herself in her own home and had a sole carer (Ms Rosa Maria or Rosemary Maione) employed by a registered service provider (Integrity Care (SA) Ltd (**Integrity Care**)). Ms Smith was a National Disability Insurance Scheme (**NDIS**) participant.

Under my terms of reference, the main concern of this Review has been to identify what the NDIS Quality and Safeguards Commission (**NDIS Commission** or **Commission**) did or should have done in relation to Ms Smith and whether there were any failings in how it carried out its functions. I am also asked by those terms of reference to recommend any changes that I consider appropriate in light of my findings: see term of reference 4. Failings, or otherwise, of other parties – whether government agencies or not – are not intended to be the focus.

I set out the terms of reference in full in Appendix 1 to this Report.

The NDIS Commission was established by amendments to the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**). The Commonwealth Parliament thereby gave the NDIS Commission, technically the Commissioner, specific functions and powers, which reflect the NDIS Quality and Safeguarding Framework agreed to by the Council of Australian Governments' Disability Reform Council on 9 December 2016.

Unless a power or function is conferred on it by statute, including statutory rules, the NDIS Commission has no authority. This becomes important when I am considering whether the Commission should have taken certain steps or whether there were one or more failures on the part of the Commission in carrying out its functions: see terms of reference 2 and 3.

It should be noted that, although set up later by the same Act, the NDIS Commission is distinct from the National Disability Insurance Agency (**NDIA**) which administers the NDIS. The NDIS Commission's functions are primarily concerned with the regulation of service providers and those employed or engaged by those service providers. It does not regulate the NDIA or have any role in the approval or funding of supports and services received by participants.

In my Review, there were two central matters concerning the performance by the NDIS Commission of its functions. The first was whether the Commission should have been aware earlier than it was of the neglect of Ms Smith, so that her death could have been avoided. In

fact, the Commission was not aware of that neglect until after Ms Smith's death. The second matter was whether the Commission should have taken earlier or better steps to ensure that there was no other NDIS participant in the same or similar circumstances to Ms Smith.

In the foreground was whether the NDIS Commission should have acted earlier to ban Ms Smith's sole carer, Ms Maione, from working in the disability sector at all. Related to that was whether the Commission should immediately have banned Ms Maione from working with people with disability, either permanently or for a specified period, once the Commission became aware that Ms Smith had died in appalling circumstances and that Ms Maione was her sole carer. I note that on 6 August 2020, the South Australia Police (SAPOL) charged Ms Maione with manslaughter. In this Report I make no assumption, and express no view, as to whether that charge is well-founded, or not.

The employer of Ms Maione, Integrity Care, was a service provider registered under the NDIS Act and regulated by the NDIS Commission. Also in the foreground therefore was whether the Commission should have allowed Integrity Care to maintain its registration at all or whether the Commission should have imposed other conditions on the registration of Integrity Care or whether the Commission should immediately, or earlier, have suspended or cancelled the registration of Integrity Care as a service provider.

In relation to Ms Smith's carer, the Commission had no information to justify banning Ms Maione from working in the disability sector before it was notified of Ms Smith's death on 20 April 2020: there were no complaints made to it and no incidents reported to it concerning Ms Smith.

The questions arise however whether the Commission should have acted to ban, or have been further advanced in relation to its investigation of issuing a banning order to, Ms Maione before 17 May 2020 when Integrity Care terminated Ms Maione's employment. Under the legislation as it stands, the Commission had power to ban Ms Maione from working in the disability sector while Ms Maione was employed by an NDIS provider, such as Integrity Care, and not thereafter.

The sequence of events was as follows.

As I have said, the Commission was informed of Ms Smith's death on 20 April 2020. On the same date, 20 April 2020, the Commission learnt from Integrity Care that Ms Maione's employment with Integrity Care had been suspended. It appears that that suspension occurred on 16 April 2020 pending an internal investigation by Integrity Care.

As I have said, on 17 May 2020 Integrity Care terminated Ms Maione’s employment. The Commission did not have prior notice of this. There is no suggestion in the material that I have that Ms Maione was, or has been since 17 May 2020, employed by an NDIS provider other than Integrity Care.

In the absence of information suggesting that there was an immediate danger to the health, safety or well-being of a person with a disability, the Commission was authorised to make a banning order against Ms Maione only after giving her an opportunity to make submissions to the Commission on the matter.

In these circumstances, although the Commission could have acted earlier in sending to Ms Maione a “show cause” letter and thereby giving her an opportunity to make submissions on the matter of whether or not a banning order should be made against her, the delay had no consequences.

In relation to Integrity Care, in summary, my conclusions are that although I make some criticisms of the manner in which the NDIS Commission maintained the registration of Integrity Care by giving it an extension of time in which to complete a quality assurance audit when it was in default of that obligation in the transition period, those matters of criticism were not causally related to the neglect and subsequent death of Ms Smith.

Once the NDIS Commission became aware of Ms Smith’s death and the circumstances which caused it, the Commission took a number of steps in relation to Integrity Care. I have not identified any significant failings in the nature or timing of those steps.

On 12 August 2020, the Commissioner announced that his Delegate, the Registrar of the Commission, had revoked the registration of Integrity Care under s 73P of the NDIS Act with effect from 14 August 2020 and consequently had also issued a banning order, with effect from 21 August 2020. I find that the Commissioner did not have a factual basis for acting earlier.

However, I do identify in this Report a number of structural impediments to the Commission acting earlier, including its inability to access participant data in real-time and its reliance on the providers that it regulates for timely and accurate information.

I make a number of recommendations as to how the Commission’s processes or systems and the legal framework governing its functions should be changed. My focus is not on all people with disability as many people with disability are not vulnerable, in the sense of at risk of harm or neglect. As it was put in a submission to me, a person is not at risk just because they

have a disability: a person is at risk because the disability gives them other kinds of risk factors. Those who are at risk of harm or neglect are a small but sizeable proportion of people with disability.

In brief, my recommendations are that:

- (1) The Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect. Every stage of decision-making, including corrective regulation, should be alive to factors indicating that a participant may be vulnerable to harm or neglect. (Although not within my terms of reference, the NDIA should also so act in the planning process and continually.) The Commission and the NDIA should have a freer and two-way flow of information for this purpose.
- (2) No vulnerable NDIS participant should have a sole carer providing services in the participant's own home. The relevant statutory instruments and guidelines should be amended to provide expressly for this.
- (3) For each vulnerable NDIS participant, there should be a specific person with overall responsibility for that participant's safety and wellbeing. That individual should be clearly identified by name and, ideally, introduced in person, to the vulnerable NDIS participant. (Although not within my terms of reference, that individual should be identified in a participant's plan.)
- (4) Consideration should be given to the Commission establishing its own equivalent to State and Territory based Community Visitor Schemes to provide for individual face-to-face contact with vulnerable NDIS participants. Such contact is also important in emphasising the personal values necessarily involved in providing services to individuals with disability. The NDIS Act should be amended to provide explicitly for this function. Until that happens, the Commission should continue to support the State and Territory Community Visitor Schemes and any doubt about State and Territory powers under those schemes in relation to NDIS participants should be resolved between the law officers of the Commonwealth and of these States and Territories. The State and Territory Community Visitor Schemes will of course continue to apply directly in relation to those with disability who are not NDIS participants.
- (5) Because of the inherent limitations in record based systems in preventing harm or the risk of harm to vulnerable participants, the Commission should conduct

occasional visits to assess the safety and wellbeing of selected individual NDIS participants, whether or not a complaint has been made or a “reportable incident” notified. The Commission should miss no opportunity for face-to-face assessment of vulnerable participants. (Although not within my terms of reference the NDIA should also so act.) The Commission and the NDIA should have a freer and two-way flow of information for this purpose so that the NDIS Commission’s selection of participants to visit is an informed one.

- (6) The statutory definition of “reportable incident” in s 73Z of the NDIS Act should be amended to make it clear that it includes a real or immediate threat of one of the listed types of harm. The word “complaints” in s 73X of the NDIS Act should be defined to remove any doubt that it includes concerns and observations in relation to the provision of supports or services by NDIS providers.
- (7) The Commission must at all times be able to know whether a person is or is not an NDIS participant. The Commission should also have readily available access to information held by the NDIA concerning what supports a participant is receiving and the provider of such supports. The Commission should not depend on providers to provide it with such information only after a request.
- (8) There should continue to be improvements to the exchange of information and more formal lines of communication between those running the State and Territory emergency services (including police) and schemes for people with disability and the Commonwealth agencies, being the Commission and the NDIA, and vice versa.
- (9) To this end, s 67A(1)(e) of the Act should be amended so that the word “serious” is deleted. A threat to an individual’s life, health or safety should be enough to authorise the use of the protected Commission information. Also the word “necessary” should be replaced with a word such as “needed” so that the information may be used even if it is not essential to preventing or lessening a threat to an individual’s life, health or safety. Consideration should also be given to defining the word “threat” in the expression “prevent or lessen a threat” so that it includes preventing or lessening for the future a threat which has passed. (Corresponding amendments should be made to, or considered for, s 60(2)(e) for protected NDIA information.)
- (10) The Commissioner should have statutory power to ban a person from working in the disability sector even where that person is no longer so employed or engaged.

This aspect is the subject of the National Disability Insurance Scheme Amendment (Strengthening Banning Orders) Bill 2020 currently before the Commonwealth Parliament. The Commissioner should have the same power in relation to NDIS service providers, that is, to include as subject to the power to ban those entities no longer providing those services.

My Review was non-statutory. It therefore followed that I had no power to compel anyone to produce documents or to answer questions. My terms of reference also specified that I should avoid prejudice to any legal proceedings. Nevertheless, the State of South Australia cooperated in my Review. The NDIA also cooperated in respect of those matters within my terms of reference that may have affected it. Neither Ms Maione nor Integrity Care participated.

I was appointed by the Commissioner of the NDIS Commission. My Report is to him and he has said he will be publishing my Report subject only to redactions necessary to avoid prejudice to any criminal, regulatory or civil proceedings and any redactions that are otherwise appropriate, as determined by me, to protect the privacy of an individual. Some parts of the published version of my Report are therefore subject to redactions to excise certain personal information as well as to avoid prejudice to legal proceedings.

Acknowledgements

Ms Carolyn Strange, the NDIS Commission's General Counsel, throughout gave me high quality and diligent support.

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I had full cooperation from each of the officers of the NDIS Commission to whom I needed to speak.

All of these people who provided willing help had their day to day work to do as well. I am grateful to them.

Such are the times in which we live during the present pandemic, I was given most of this support and assistance remotely, by email.

Encore Event Technologies provided or equipped the venues, one in Sydney and one in Adelaide, for the interviews I conducted remotely over two days with witnesses in Adelaide.

I have had the very great advantage of first-rate assistance from Mr Thomas Liu, Barrister, of 7 Wentworth Selborne, Phillip Street, Sydney. He worked hard, ably and promptly, and most capably took on work that would otherwise have fallen to me. I am particularly grateful to him.

I thank each of these people for their help. I am, of course, responsible for any deficiencies in the Report.

Introduction

It is important first to place this Review in context, both the recent history of disability reform and the present response by government.

The National Disability Insurance Scheme (**Scheme** or **NDIS**) is to be traced back to the *Productivity Commission Report* of 2011.

The Commonwealth Government asked the Productivity Commission to undertake a public inquiry into a long-term disability care and support scheme.

Among other things, the inquiry examined:

- how a scheme should be designed and funded to better meet the long-term needs of people with disability, their families and carers
- how to determine the people most in need of support, the services that should be available to them, and service delivery arrangements
- the costs, benefits, feasibility and funding options of alternative schemes
- how the scheme will interact with the health, aged care, informal care, income support and injury insurance systems
- its impacts on the workforce
- how any scheme should be introduced and governed
- what protections and safeguards should be part of the Scheme.

Key points of that *Report* were:

- Most families and individuals cannot adequately prepare for the risk and financial impact of significant disability. The costs of lifetime care can be so substantial that the risks and costs need to be pooled.
- The current disability support system is underfunded, unfair, fragmented, and inefficient, and gives people with a disability little choice and no certainty of access to appropriate supports. The stresses on the system are growing, with rising costs for all governments.
- There should be a new national scheme - the National Disability Insurance Scheme (NDIS) - that provides insurance cover for all Australians in the event of significant disability. Funding of the scheme should be a core function of government (just like Medicare).
- The main function (and source of cost) of the NDIS would be to fund long-term high quality care and support (but not income replacement) for people with significant disabilities. Everyone would be insured and around 410 000 people would receive scheme funding support.
- The NDIS would have other roles. It would aim to better link the community and people with disabilities, including by using not-for-profit organisations. It would also provide information to people, help break down stereotypes, and ensure quality assurance and diffusion of best practice among providers.
- The benefits of the scheme would significantly outweigh the costs. People would know that, if they or a member of their family acquired a significant disability, there would be a properly financed, comprehensive, cohesive system to support them. The NDIS would only have to produce an annual gain of \$3800 per participant to meet a cost-benefit test. Given the scope of the benefits, that test would be passed easily.
- The scheme should involve a common set of eligibility criteria, entitlements to individually tailored supports based on the same assessment process, certainty of funding based on need, genuine choice over how their needs were met (including choice of provider) and portability of entitlements across borders. There would be local area coordinators and disability support organisations to provide grass roots support. The insurance scheme would take a long-term view and have a strong incentive to fund cost effective early interventions, and collect data to monitor outcomes and ensure efficiency.
- The above features would be best met by a having a single agency overseeing the NDIS - the National Disability Insurance Agency. It would be created by, and report to, all Australian

governments. It would have strong governance arrangements, with an independent commercial board, an advisory council of key stakeholders, clear guidelines to ensure a sustainable and efficient scheme, and legislation that protected the scheme from political influences.

- It would be the assessor and funder, but not the provider of care and support. Services would be provided by non-government organisations, disability service organisations, state and territory disability service providers, individuals and mainstream businesses. Increased funding, choice and certainty are the key features of the recommended scheme. Advocacy would be funded outside the scheme.
- An alternative but inferior option would be a 'federated' NDIS. This would give state and territory governments control over their own systems, but with some common core features. Such an arrangement could easily revert to the current flawed and unfair system, with 'agreements' breaking down into disputes about who is to pay, how much and for what.
- People would have much more choice in the proposed NDIS. Their support packages would be tailored to their individual needs. People could choose their own provider(s), ask an intermediary to assemble the best package on their behalf, cash out their funding allocation and direct the funding to areas of need (with appropriate probity controls and support), or choose a combination of these options.
- The NDIS would cover the same types of supports currently provided by specialist providers (but with sufficient funding), give people more opportunity to choose mainstream services, and encourage innovative approaches to support.

...

At that stage, the NDIS Commission had not been established.

The revised Explanatory Memorandum for the bill for the *National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Act 2017* (at p 1) described the process leading to the Act in the following way:

In August 2011, the Prime Minister released the Productivity Commission Inquiry Report, *Disability Care and Support*, which identified that disability care and support in Australia was 'underfunded, unfair, fragmented and inefficient', and that major reform was needed.

Since the release of this report, the Commonwealth and all state and territory governments have agreed on the need for major reform in the form of a National Disability Insurance Scheme, which:

- will take an insurance approach that shares the costs of disability services and supports across the community;
- will fund reasonable and necessary services and supports directly related to an eligible person's individual ongoing disability support needs; and
- will enable people with disability to exercise more choice and control in their lives, through a person-centred, self-directed approach, with individualised funding.

The Bill establishes a scheme that gives effect to these critical principles, and gives effect in part to Australia's obligations under the United Nations *Convention on the Rights of Persons with Disabilities*.

There has been a subsequent Productivity Commission report which was the National Disability Insurance Scheme (NDIS) Costs Study report released on 19 October 2017 and it outlined the Commission's findings and recommendations on NDIS costs.

A further final study report by the Productivity Commission was handed to the Australian Government on 25 January 2019 and was released on 1 February 2019. This was the Final Report of its Review of the National Disability Agreement.

The report found that a new National Disability Agreement (**NDA**) between the Australian, State and Territory Governments was needed to facilitate cooperation, enhance accountability and clarify roles and responsibilities. The Productivity Commission made a number of recommendations for a new NDA having at its core the wellbeing and needs of all people with disability and their families and carers.

As I have mentioned, later legislation established the NDIS Quality and Safeguards Commission. This was the *National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Act 2017*.

As summarised in the Explanatory Memorandum, the National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017 would establish an independent national Commission, to protect and prevent people with disability from experiencing harm arising from poor quality or unsafe supports or services under the NDIS.

The same Explanatory Memorandum stated that a series of recent inquiries and reports had documented the weaknesses of the then current safeguarding arrangements for disability services, many of which resulted from a disconnection between quality assurance and oversight regulatory functions. These inquiries included the Senate Inquiry, Victorian government inquiries, and the Royal Commission into Institutional Responses into Child Sexual Abuse. The inquiries found failures to uncover, report and respond to abuse, and inadequate national screening of workers. They called for nationally consistent provider accreditation and the use of behaviour support strategies that do not involve restrictive practices to reduce challenging behaviours.

The Explanatory Memorandum stated:

The NDIS represents a dramatic 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. The Commission will be a fit-for-purpose, evidence-based, risk-responsive regulator of the new and emerging NDIS provider market.

The new arrangements replace a complex and fragmented system of quality and safeguards in each State and Territory, delivering a nationally consistent approach. For providers, the new national approach will enable a single registration and regulatory system regardless of how many jurisdictions the provider operates in, reducing duplication and providing national consistency.

It was also recognised that:

The NDIS represents a significant reform to the way in which supports and services are delivered to people with disability. In the new market-based system, participants choose their providers and services, rather than providers being contracted for bulk services at an aggregate level by government agencies. This means service provider compliance requirements, currently managed through funding

agreements and government contracts, will no longer exist. This poses a significant risk in terms of provider quality and participant safety, particularly in an immature and rapidly expanding market. A more deregulated market-based environment will also result in the entry of a large number of new providers who may have limited or no experience in the sector, potentially using new and unproven business models, or who may have uncertain financial viability.

A robust national system for regulation is required to mitigate these risks and achieve a balance between the realisation of the NDIS vision to support people with disability to make informed choices, while also promoting high quality supports and services with appropriate safeguards in the new market environment. As the Commission will be established within the Act, the existing objects and principles concerning the rights of people with disability will underpin and inform the regulatory activities of the Commission.

At full scheme NDIS, the Commission will be responsible for overseeing quality supports and services for people with disability who are receiving NDIS supports and services such as Information, Linkages and Capacity (ILC) Building to connect people with disability, their families and carers, with community and mainstream supports and create greater inclusivity and accessibility. The primary focus of the Commission will be regulating NDIS providers to ensure that NDIS participants receive the standard of service they deserve. There are, however, a range of other providers who are providing similar services to people with disability. The Bill will cover ILC Building funded under the NDIS and the NDIS rules may prescribe providers of other programs for people with disability to be covered by the Commission's quality and safeguards arrangements.

Disability services delivered through other systems, such as health, education and justice, will continue be (sic) covered by the quality and safeguarding arrangements for those systems. Universal complaints and redress mechanisms, including police, fair trading bodies, professional and industry bodies, consumer protection laws and other regulatory and complaints systems will continue to be available to both NDIS participants and people with disability outside the NDIS.

The proposed changes will mean that people with disability, their families and carers are better off because they will have a single body to raise concerns about the quality of supports or services being delivered and access to nationally consistent and transparent information about NDIS providers.

Schedule 1 to the Bill amended the *National Disability Insurance Scheme Act 2013* (Cth) (**NDIS Act**) to establish the NDIS Quality and Safeguards Commission, as an independent statutory body with the following integrated regulatory functions:

- registration and regulation of NDIS providers, including Practice Standards and a Code of Conduct;
- compliance monitoring, investigation and enforcement action;
- responding to complaints and reportable incidents including abuse, and neglect of a person with disability;
- national policy setting for the screening of workers;
- national oversight and policy setting in relation to behaviour support and monitoring the use of restrictive practices, within the NDIS with the aim of reducing and eliminating such practices; and
- facilitating information sharing arrangements between the Commission, the National Disability Insurance Agency (the Agency), State and Territory and other Commonwealth regulatory bodies.

As summarised by the Full Court of the Federal Court in *National Disability Insurance Agency v WRMF* [2020] FCAFC 79; (2020) 378 ALR 449 at [1]-[2]:

The National Disability Insurance Scheme (**NDIS**) was established by the *National Disability Insurance Scheme Act 2013* (Cth) to provide funding directly to eligible persons with disabilities for support and services.

The National Disability Insurance Agency (**Agency**) is responsible for decisions about whether a person is eligible to participate in the NDIS and the nature of any supports and services that it provides or that it may fund. In summary, if a person is considered eligible, a plan is created that outlines the person's goals, the supports needed to help achieve those goals, and the funding available to the person. The plan must be approved by the Agency.

At [139]-[140] the Full Court said:

- (a) Section 17A enshrines and gives prominence in the legislative scheme to principles of autonomy and self-determination for people with disability.
- (b) Once a person is accepted to be a 'participant' within the meaning in Part 1 of Ch 3, the delivery of supports occurs through participant plans. Participant plans are the cornerstone of the assistance the legislative scheme intends be delivered to those who qualify as participants.
- (c) The entire process associated with participant plans must be directed - as far as reasonably practicable - in accordance with the objectives set out in s 31. Of relevance to the resolution of ground 4 are the objectives that the plan should:
 - (i) 'be directed by the participant' (para (b));
 - (ii) 'be underpinned by the right of the participant to exercise control over his or her own life' (para (g));
 - (iii) 'advance the inclusion and participation in the community of the participant with the aim of achieving his or her individual aspirations' (para (h));
 - (iv) 'maximise the choice and independence of the participant' (para (i)); and
 - (v) 'facilitate tailored and flexible responses to the individual goals and needs of the participant' (para (j)).
- (d) The CEO is required by s 32 to facilitate the preparation of a participant's plan. Section 33 prescribes two mandatory components for a participant's plan: a statement of a participant's goals and aspirations (s 33(1)), and a statement specifying a number of matters about the 'participant supports' to be provided, which includes specification of both general and reasonable and necessary supports which will be, respectively, provided and funded (s 33(2)(a) and (b)).
- (e) This statement of participant supports must be prepared with the participant and approved by the CEO: see s 33(2).
- (f) It is s 33(2)(b), read with s 33(5), which comprises the statutory task for the purposes of both the reviewable decision and the Tribunal's function on merits review.
- (g) The matters set out in s 33(5) are mandatory aspects of the CEO's approval function, and therefore on review, mandatory aspects of the Tribunal's review function. On any given review by the Tribunal, some of these aspects will feature more than others, depending on the factual circumstances. The matters go to both the CEO's function in s 33(2) of specifying the general supports the Agency will provide and the reasonable and necessary supports the Agency will fund.
- (h) The requirements of s 33(5) should be set out:
 - (5) In deciding whether or not to approve a statement of participant supports under subsection (2), the CEO must:
 - (a) have regard to the participant's statement of goals and aspirations; and
 - (b) have regard to relevant assessments conducted in relation to the participant; and
 - (c) be satisfied as mentioned in section 34 in relation to the reasonable and necessary supports that will be funded and the general supports that will be provided; and
 - (d) apply the National Disability Insurance Scheme rules (if any) made for the purposes of section 35; and
 - (e) have regard to the principle that a participant should manage his or her plan to the extent that he or she wishes to do so; and
 - (f) have regard to the operation and effectiveness of any previous plans of the participant.

..., the scheme in Ch 3 operates only in respect of individuals who can meet the threshold requirements set out in the Act to qualify as a 'participant', which include age, residence and disability requirements. The disability requirements are set out in s 24 ...

There have been a number of reviews of the NDIS or parts of it, both Commonwealth and State. Some are ongoing. I do not list them all.

Chief among these reviews, in terms of immediate relevance, is a current inquiry by the Joint Standing Committee on the National Disability Insurance Scheme, appointed by resolution by the House of Representatives on 4 July 2019 and the Senate on 22 July 2019. The terms of reference for the Joint Standing Committee's inquiry are as follows:

As part of the committee's role to inquire into the implementation, performance and governance of the National Disability Insurance Scheme (NDIS), the committee will inquire and report on the operation of the NDIS Quality and Safeguards Commission since it commenced operation on 1 July 2018, with particular reference to:

- a. The monitoring, investigation and enforcement powers available to the Commission, and how those powers are exercised in practice;
- b. The effectiveness of the Commission in responding to concerns, complaints and reportable incidents – including allegations of abuse and neglect of NDIS participants;
- c. The adequacy and effectiveness of the NDIS Code of Conduct and the NDIS Practice Standards;
- d. The adequacy and effectiveness of provider registration and worker screening arrangements, including the level of transparency and public access to information regarding the decisions and actions taken by the Commission.
- e. The effectiveness of communication and engagement between the Commission and state and territory authorities;
- f. The human and financial resources available to the Commission, and whether these resources are adequate for the Commission to properly execute its functions;
- g. Management of the transition period, including impacts on other commonwealth and state-based oversight, safeguarding, and community engagement programs; and
- h. Any related matters.

The closing date for submissions was 31 July 2020.

There is also the important Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, chaired by the Hon. Ronald Sackville AO QC. The Disability Royal Commission was established in April 2019 in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of, people with disability. These incidents might have happened recently or a long time ago.

The Disability Royal Commission is to investigate:

- preventing and better protecting people with disability from experiencing violence, abuse, neglect and exploitation
- achieving best practice in reporting, investigating and responding to violence, abuse, neglect and exploitation of people with disability
- promoting a more inclusive society that supports people with disability to be independent and live free from violence, abuse, neglect and exploitation.

Its terms of reference include inquiring into the following matters:

- (a) what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts;
- (b) what governments, institutions and the community should do to achieve best practice to encourage reporting of, and effective investigations of and responses to, violence against, and abuse, neglect and exploitation of, people with disability, including addressing failures in, and impediments to, reporting, investigating and responding to such conduct;

- (c) what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation;
- (d) any matter reasonably incidental to a matter referred to in paragraphs (a) to (c) or that you believe is reasonably relevant to your inquiry.

and without limiting the scope of the inquiry or the scope of any recommendations arising out of the inquiry, have regard to the following matters:

- (e) all forms of violence against, and abuse, neglect and exploitation of, people with disability, whatever the setting or context;
- (f) all aspects of quality and safety of services, including informal support, provided by governments, institutions and the community to people with disability, including the National Disability Insurance Scheme (NDIS) and the NDIS Quality and Safeguarding Framework agreed by all Australian Governments in 2017;
- (g) the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multilayered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability;
- (h) the critical role families, carers, advocates, the workforce and others play in providing care and support to people with disability;
- (i) examples of best practice and innovative models of preventing, reporting, investigating or responding to violence against, and abuse, neglect or exploitation of, people with disability;
- (j) the findings and recommendations of previous relevant reports and inquiries.

and to consider the following matters:

- (k) the need to establish accessible and appropriate arrangements for people with disability, and their families, carers and others, to engage with your inquiry and to provide evidence to you, and share information with you, about their experiences;
- (l) the need to focus your inquiry and recommendations on systemic issues, recognising nevertheless that you will be informed by individual experiences and may need to make referrals to appropriate authorities;
- (m) the need to establish mechanisms to facilitate the timely communication of information, or the furnishing of evidence, documents or things, in accordance with section 6P of the *Royal Commissions Act 1902* or any other relevant law, including, for example, for the purpose of enabling the timely investigation and prosecution of offences or assisting an inquiry on a related matter by the Royal Commission into Aged Care Quality and Safety;
- (n) the need to ensure that evidence that may be received by you that identifies particular individuals as having been subject to violence, abuse, neglect or exploitation is dealt with in a way that does not prejudice current or future criminal or civil proceedings or other contemporaneous inquiries;
- (o) the need to establish appropriate arrangements in relation to current and previous inquiries, in Australia and elsewhere, for evidence and information to be shared with you in ways consistent with relevant obligations so that the work of those inquiries, including, with any necessary consents, the testimony of witnesses, can be taken into account by you in a way that avoids unnecessary duplication, improves efficiency and avoids unnecessary trauma to witnesses.

The Royal Commission published its First Progress Report on 20 December 2019, providing an overview of the work undertaken by it since its establishment was announced in April 2019, and an outline of the Royal Commission's program for 2020. It published its Second Progress Report on 11 August 2020, summarising the work carried out by it during the period

1 January 2020 and 30 June 2020. The Chair said that a significant milestone will be the delivery of an Interim Report by 30 October 2020.

Its final report is due to be delivered to the Australian Government by 29 April 2022.

In relation to Ms Smith, the Chair of the Royal Commission issued a statement on 20 May 2020 stating, in part:

'The circumstances of Ms Smith's death are the subject of multiple investigations, including a major crime investigation by the South Australian Police.

'It is inappropriate for the Royal Commission to initiate an immediate inquiry into events where that might prejudice an ongoing criminal investigation or a possible future prosecution.

'For that reason, the Royal Commission will not at this time commence an inquiry into the specific circumstances surrounding Ms Smith's death.

'It is, however, open to the Royal Commission to undertake such an inquiry at a later stage and it will follow the progress of the other investigations,' said the Chair.

Mr Sackville said that many aspects concerning the treatment and death of Ms Smith fall under the Royal Commission's Terms of Reference, and will be part of the Royal Commission's ongoing inquiry.

...

'The Royal Commission will hold a public hearing on the experiences of violence, neglect, abuse and exploitation of people with disability in accommodation, including private homes, once it is possible to do so.

The Royal Commission is also investigating what must be done to improve accountability, including through safeguarding mechanisms, appropriate monitoring and oversight practices, and will be seeking community input on this topic in the coming months.

'These investigations will expose many of the underlying issues that are pertinent to the circumstances of Ms Smith's death,' said the Chair.

On 29 April 2020 the Queensland Government asked the Queensland Productivity Commission to undertake an inquiry into the NDIS market in Queensland. Its terms of reference are:

The Queensland Productivity Commission (QPC) is directed to conduct an Inquiry into NDIS transition and market development in Queensland. This includes investigating and reporting on market conditions and prospects to determine whether governance, regulation and policy settings support the operation of the NDIS market and promote participant outcomes.

The QPC should review the performance of the NDIS market during transition in Queensland, including:

- the degree to which the NDIS market has met the needs of participants, including whether thin markets or supply issues are contributing to the underutilisation of NDIS Plans;
- consideration of any impediments to supply, including in relation to the preparedness of the private and non-government sectors to enter the market;
- the productivity impacts of Queensland's investment in the NDIS, including enabling people with disability and carers to obtain employment, undertake education and training and ability to participate in the community;
- the effectiveness of provider markets, both in the private and non-government sectors; and a review of participant transition rates and factors, including identification of any cohorts that have not transitioned and why transition has not occurred.

In reviewing the performance of the NDIS market during transition, the QPC should give regard to the likely effectiveness of the actions or interventions by Queensland and the Commonwealth as part of transition, or as part of other inquiries including Joint Standing Committee reports about NDIS markets and readiness. This includes actions taken to address thin market, particularly in regional and remote settings.

The QPC should investigate and report on NDIS market conditions and prospects...

The final report is due on 30 April 2021.

One important recent review of the NDIS Act was to identify opportunities to make NDIS processes simpler and more straightforward, and remove legislative barriers to positive participant and provider experiences with the NDIS. The review was undertaken by an independent expert, Mr David Tune AO PSM.

The terms of reference were to consider:

1. opportunities to amend the NDIS Act to:
 - a. remove process impediments and increase the efficiency of the Scheme's administration
 - b. implement a new NDIS Participant Service Guarantee
2. any other matter relevant to the general operation of the NDIS Act in supporting positive participant and provider experiences.

In undertaking this review, regard should be given to:

1. the objectives and principles of the NDIS Act
2. the experiences of people with disability, their families and carers with the Scheme's administration and decision-making, including: access, planning, review and appeal processes
3. the roles and responsibilities of the Commonwealth and state and territory governments to support people with disability in their interaction with the NDIS, including advocacy, information and referral services
4. current NDIA operational reforms including the rollout and implementation of new NDIS participant planning pathways and reforms to the Specialist Disability Accommodation framework
5. recommendations agreed by the Council of Australian Governments from the 2015 Independent Review of the NDIS Act.

The review report was handed to the Commonwealth Government in December 2019.

As noted by Mr Tune at [1.15] of his report, previous reviews, reports and inquiries include:

- a. the 2015 Independent Review of the NDIS Act, as commissioned by the Council of Australian Governments (COAG) and required by the NDIS Act
- b. previous Productivity Commission inquiries, including its most recent review of NDIS costs in 2017
- c. previous and current inquiries of the Joint Standing Committee on the NDIS
- d. the NDIA's 2017 Pathways Review, released in February 2018
- e. the Quarterly Reports provided by the NDIA Board to the DRC, which are publicly available on the NDIS website.

Of the 29 recommendations in Mr Tune's report, the most relevant to my Review are:

3. The NDIA trials an arrangement where all planning related functions are undertaken with a person who has delegation to approve the plan, and compares the benefits of that approach with the roll out of Joint Planning Meetings.
4. The Commonwealth provides additional funding to support people with disability to navigate the NDIS, with a review of demand to occur as part of the next review of NDIS costs, currently scheduled for 2023.

...

...

11. The NDIA develops a comprehensive national outreach strategy for engaging with people with disability who are unaware of, or are reluctant to seek support from the NDIS, with a dedicated focus on Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and people with psychosocial disability.

...

15. The NDIA undertakes a review of its operational guidelines when funding Supported Independent Living, with an emphasis on increasing the involvement of participants, families and carers in the decision-making process and the principles of choice and control.
16. The NDIS Rules are amended to clarify that supports in a participant's plan should be used flexibly, except in limited circumstances, such as capital supports.
17. The NDIS Rules are amended to:
 - a. set out the factors the NDIA will consider in funding support coordination in a participant's plan
 - b. outline circumstances in which it is not appropriate for the providers of support coordination to be the provider of any other funded supports in a participant's plan, to protect participants from provider's conflicts of interest.
18. The NDIS Rules are amended to give the NDIA more defined powers to undertake market intervention on behalf of participants.

...

21. The NDIS Act is amended to introduce a new Category D rule-making power that sets out the matters the NDIA must consider when deciding whether to undertake an unscheduled plan review.
22. The NDIS Act is amended to introduce a new Category D rule-making power giving the NDIA the ability to amend a plan in appropriate circumstances.

...

On 28 August 2020, the Minister for the National Disability Insurance Scheme, Mr Stuart Robert, announced that the Government supports or supports in principle all 29 recommendations made in the review report. The detail may be found at:

www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme-2019-review-of-the-ndis-act-and-the-new-ndis-participant-service-guarantee/government-response-to-the-ndis-act-review

Following the death of Ms Smith, a number of specific investigations or reviews have been announced, including this Review established by the Commissioner.

South Australia Police are examining the question of any criminal liability in relation to Ms Smith's death.

I understand the South Australian Coroner will be conducting an inquiry.

A Safeguarding Task Force was set up by the South Australian Minister for Human Services on 21 May 2020.

Its terms of reference were:

The Task Force seeks to consider the gaps from a developmental, preventative and corrective perspective.

The Task Force will provide written reports including recommendations to the State Government regarding areas that need to be addressed urgently in order to safeguard South Australian citizens with disability.

It made its interim report on 15 June 2020 concentrating on preventative measures and corrective matters. The Task Force made its final report on 31 July 2020.

In its Final Report, the Task Force identified the following gaps, so far as presently relevant:

7 Safeguarding Gaps

7.1 Safeguarding Gap 1

Potentially vulnerable participants are not routinely identified and assigned ongoing support coordination in their NDIS Plan.

7.2 Safeguarding Gap 2

The support coordinator can be from the same agency that provides other core services for the individual, creating a conflict of interest.

7.3 Safeguarding Gap 3

Participants are not routinely linked to community activities so they are often isolated.

7.4 Safeguarding Gap 4

Participants are not identified as potentially vulnerable by the NDIA and prioritised by LAC when carrying out the community connection role.

7.5 Safeguarding Gap 5 NDIS plans do not routinely include strategies to minimise participant risk e.g. coordination of health care (including dental, sexual and mental health), technology to aid independence and safety, capacity building for asserting rights, and recognition of cultural matters.

7.6 Safeguarding Gap 6

Participants and their families are unclear about how to raise matters of concern with the Commission and the Commission does not routinely undertake proactive inspections to vet the performance of service providers.

...

7.8 Safeguarding Gap 8

The Commission does not explicitly require of all providers of personal support that there be at least two support workers for that individual (not necessarily at the same time) and that workers in participants' homes have regular supervision.

7.9 Safeguarding Gap 9

Regular health checks are not routinely made available to all vulnerable NDIS participants and their NDIS plan does not routinely include coordination of their health care.

...

7.11 Safeguarding Gap 11

The DHS Screening Unit is not quickly and fully provided with relevant information by the Commission, the NDIA and some State agencies, compromising the availability of information on an individual worker that might affect their suitability to work with people with disabilities.

7.12 Safeguarding Gap 12

The commencement of the NDIS Quality and Safeguards Commissions on 1 July 2018 in South Australia has created issues with the scope of the Community Visitor Scheme.

...

[Emphasis in original.]

The Task Force recommended that the State Government communicate the matters raised in its report to the Commonwealth Government with special reference to Safeguarding Gaps 1 to 9, seeking a response on how these gaps must be addressed as soon as possible.

In relation to Safeguarding Gap 11, the Task Force recommended that South Australia Department of Human Services (**DHS**) revisit the information sharing guidelines as they impact on screening of workers and, in particular, the availability of relevant information from the Commonwealth.

In relation to Safeguarding Gap 12, the Task Force recommended that the State Government reaffirm the value of a community visitor scheme as an additional safeguard for potentially vulnerable participants and work with the Commonwealth to establish a complementary scheme.

The terms of reference for my Review are set out in full at Appendix 1.

I take the view that the starting point of my task is the circumstances of the particular individual, Ms Smith. From my consideration of her position, I am asked to identify what should have happened and whether there were any failings on the part of the NDIS Commission and from there to make recommendations to prevent the re-occurrence of such neglect, leading in Ms Smith's case to death, of a person with disability. Other reviews have had a more general focus and have moved from there, where necessary, to the position of an individual person with disability. As will emerge, this is an important distinction because a common theme in the submissions made to me is the tendency of the NDIS to promote the transactional rather than the personal.

It is important to be aware of the limited purpose of my Review, as established by the Commissioner. It is essentially to examine the adequacy of the regulation of the supports and services provided to Ms Smith and to identify any deficiencies in the Commission's quality and safeguards regulation which may have contributed to the death of Ms Smith, with a view to rectifying any such deficiencies. It has been a relatively short review of three months from commencement to providing my Report. It is left to other current reviews and, no doubt, future reviews to examine the NDIS system more broadly.

It is also important to bear in mind some other limitations of my Review.

First, it is non-statutory, in the sense that I have had no powers to require individuals or companies to attend before me or to answer questions or to produce documents.

Second, I am required to conduct the Review in a manner that avoids prejudice to any pending or current criminal or civil proceedings. In this context, both Ms Smith's service provider, Integrity Care, and Ms Smith's carer declined by their lawyers to participate in my review.

An additional limitation is the question of protected information, which is information about a person that is or was held in the records of the NDIA or of the Commission. As stated in my terms of reference, the disclosure of information for the purposes of the Review is to be governed by the provisions of the NDIS Act. It is this, as well as the related sensitivities of State agencies which have cooperated in my Review, which has meant that the published copy of my Report has been subject to redactions necessary to avoid prejudice to any criminal, regulatory or civil proceedings and to redactions identified as appropriate by me to protect the privacy of individuals.

Process

On beginning this Review, the procedure I adopted was first to write as a matter of courtesy to those who may have been interested in this Review having been established and my terms of reference. In this vein, I wrote to the following:

- Commissioner Grant Stevens APM, South Australia Police
- Dr David Caudrey, Disability Advocate for South Australia, Office of the Public Advocate
- Professor Grant Davies, Complaints Commissioner, Health and Community Services Complaints Commission South Australia
- Dr David Caudrey and Ms Kelly Vincent, Co-Chairs, South Australia Disability Task Force
- Ms Lois Boswell, Acting Chief Executive, Department of Human Services South Australia
- The Hon Michelle Lensink MLC, Minister for Human Services South Australia
- Ms Lesley Dwyer, Chief Executive Officer, Central Adelaide Local Health Network
- Ms Anne Gale, Public Advocate and Acting Principal Community Visitor, Office of the Public Advocate

- Ms Kendall Field, Chief Executive Officer, Disability Advocacy and Complaints Service of South Australia
- Mr Travis Moran, Senior Associate, Iles Selley Lawyers*
- Ms Catherine Viney, Disability Services Manager – Family and Community Services, Baptcare
- Mr Robert Hamilton, Head of Local Area Coordination, Uniting
- Mr Martin Hoffman, Chief Executive Officer, NDIA
- Mr Stephen Ey, Partner, Mangan Ey and Associates*
- Mr David Moody, Chief Executive Officer, National Disability Services
- Mr Phillip Herrmann, Policy and Communications Manager, Allied Health Professions Australia
- Ms Carmel Tebbutt, Chief Executive Officer, Mental Health Coordinating Council
- Mr David Sinclair, Executive Officer, Assistive Technology Suppliers Australia
- Ms Lyn Franco, Chief Executive Officer, Australian Community Industry Alliance
- Mr Andrew Rowley, Chief Executive Officer, Ability First Australia
- Ms Yvonne Keane, Chief Executive Officer, Early Childhood Intervention Australia
- Ms Jess Harper, Chief Executive Officer, Disability Intermediaries Australia
- Mr Ian Maynard, Chairperson and Non-Executive Director, Specialist Disability Accommodation Alliance
- Mr Rob White, Chief Executive Officer, Alliance 20
- Mr Rob McPhee, Chief Executive Officer, National Aboriginal and Community Controlled Health Organisation
- Ms Liz Reid, Chair, Australian Federation of Disability Organisations
- Ms Mary Sayers, Chief Executive Officer, Children and Young People with Disability Australia
- Ms Mary Mallett, Chief Executive Officer, Disability Advocacy Network Australia
- Ms Lorraine Powell, Consumer Co-Chair, National Mental Health Consumer and Carer Forum
- Ms Wendy Wright, Perth Community Connector, First Peoples Disability Network
- Mr Kevin Stone AM, Chair, Inclusion Australia
- Mr Dwayne Cranfield, Chief Executive Officer, National Ethnic Disability Alliance
- Mr Terry Burke, Co-Chair, Australian Autism Alliance
- Mr Jeff Smith, Chief Executive Officer, People with Disability Australia

- Ms Carolyn Frohmader, Executive Director, Women with Disabilities Australia
- Ms Bronwyn Morkham, National Director, Young People in Nursing Homes National Alliance
- Ms Kyle Miers, Chief Executive Officer, Deaf Australia
- Ms Samantha Jenkinson, Executive Director, People with Disabilities Western Australia

*The two names listed above with an asterisk were the lawyers for Integrity Care and the lawyers for Ms Smith's carer, Ms Maione, respectively. In each case, those parties declined to be involved in this Review.

As I have explained in the Introduction to this Report, not only did I have no power to compel people to attend my Review or to answer questions but also I was required to conduct my Review so as not to prejudice any civil or criminal proceedings.

Those from whom I received submissions, written or oral, are listed in Appendix 2 to this Report.

I had the benefit of hearing from a number of senior officials of the South Australian government who cooperated in and assisted me with my Review. These were:

- Ms Lois Boswell, Acting Chief Executive, Department of Human Services South Australia
- Professor Grant Davies, Complaints Commissioner, Health and Community Services Complaints Commission South Australia
- Ms Lesley Dwyer, Chief Executive Officer, Central Adelaide Local Health Network
- Dr David Caudrey, Disability Advocate for South Australia, Office of the Public Advocate
- Ms Anne Gale, Public Advocate and Acting Principal Community Visitor, Office of the Public Advocate
- Ms Stella Robinson, Director Safety and Quality, Department of Health South Australia

I also had the benefit of submissions from other organisations and individuals with long experience in working with people with disability. These were:

- Ms Kelly Vincent, Co-Chair, with Dr David Caudrey, South Australia Disability Task Force

- Ms Kendall Field, Chief Executive Officer, Disability Advocacy and Complaints Service of South Australia
- Ms Catherine Viney, Disability Services Manager – Family and Community Services, Baptcare and the employee of Baptcare who was the Local Area Coordinator for Ms Smith’s second plan
- Ms Lyn Franco, Chief Executive Officer, Australian Community Industry Alliance
- Ms Melanie Southwell, General Manager, Specialist Disability Accommodation Alliance
- Ms Mary Sayers, Chief Executive Officer, Children and Young People with Disability Australia
- Mr Keir Saltmarch, Consumer Co-Chair, and Ms Hayley Solich, Carer Co-Chair, National Mental Health Consumer and Carer Forum
- Ms Romola Hollywood, Director Policy and Advocacy, People with Disability Australia
- Ms Carolyn Frohmader, Executive Director, Women with Disabilities Australia
- Ms Dawn Brooks, Mother and administrator for her son with disabilities
- Ms Hilary Reid, Support Worker and Disability Advocate
- Professor Richard Bruggemann, Professorial Fellow, Disability and Social Inclusion Unit Flinders University
- Ms Karen Grob, Aunt of a woman with complex high care needs
- Ms Robyn Wallace, Physician in internal medicine
- Mr Peter Jessup, Ms Bronwyn Tregenza, Ms Judy Clutterbuck, Former Program Managers and Manager of the Department of Human Services Exceptional Needs Unit between 2007 - 2019
- Ms Mary Burgess, Public Advocate (Queensland)
- Ms Jackie Hayes, Team Leader, Purple Orange and members of the Co-Design Council comprising 8 people living with disability and family members. In addition to Ms Hayes, those members were:
 - Mr Robbi Williams – CEO, JFA Purple Orange
 - Mr Andrew Gibson – SKILL Project Leader, JFA Purple Orange
 - Dr Rachele Tuillo – Director: Identity and Mission
 - Ms Tammy Sahlberg - Disability advocate/sole trader
- Mr Kai Sinor, Senior Lawyer, MPS

- Ms Delphine Stagg, Chair, South Australia Council on Intellectual Disability Inc.
- Ms Kate Strohm, Director, Siblings Australia Inc.
- Ms Anne Shattock, Nurse
- Ms Marion Champion, Senior Manager Social Work, Norther Adelaide Local Health Network
- Ms Annette Herbert, Mother and carer
- Dr Rachele Tullio, Member, Purple Orange Co-design Council
- Ms Leanne Longfellow, Sister of the late Mr David Harris who was an NDIS participant
- Mr Vladimir Yuzhakov, Chief Executive Officer, PosiSense
- Dr Neisha K Wratten, specialist medical practitioner and mother of a son with a disability
- Mr Kevin Stone AM, Chief Executive Officer, Victorian Advocacy League for Individuals with Disability (VALID)

Advertisements were also placed four times in two newspapers circulating in South Australia, in the following terms. The first pair gave notice of the establishment of this Review and invited submissions. The second pair drew attention to the hearings proposed in Adelaide on 20 and 21 July 2020. I refer to these hearings more fully below.

Some publicity was also given to the Review in the television, radio and print media.

I interviewed, where necessary remotely, officers and employees of the Commission, both those based in Adelaide and at the Commission's head office.

I interviewed the two Delegates of the CEO of the NDIA who had approved Ms Smith's two plans for the purposes of the NDIS.

I also sent a list of issues for discussions to the CEO of the NDIA, Mr Martin Hoffman, and interviewed him on 14 August 2020. In a wide-ranging discussion, he engaged positively and frankly with those issues. In response to my list of issues, the NDIA also provided me with a written submission. On 25 August 2020, the General Manager, Complaints and Reviews, NDIA submitted a detailed response to a submission made by Baptcare dated 14 July 2020. I do not know when the Baptcare submission was provided to the NDIA but, because under my terms of reference my Report was due to the Commissioner on 31 August 2020, I have not been able fully to take into account that detail.

I had planned to meet interested parties in Adelaide on 20 and 21 July 2020 when it appeared that travel restrictions imposed because of COVID-19 would permit such a course. In the event it was necessary to conduct those meetings remotely, the people I was interviewing in Adelaide each going to a single venue fitted out for studio type transmission with a video feed. That these interviews would take place was advertised and many people took advantage of the video feed, there being over 200 such participants, including some overseas participants.

As I have explained in the Introduction to this Report, not all of these interviews were able to be in public but most of them were.

I had the benefit of two informative interviews with the Commissioner of the NDIS Quality and Safeguards Commission, Mr Graeme Head AO. The first was following the interim report of the Safeguarding Task Force set up by the South Australian Minister, with a view to identifying anything urgent arising from that interim report. The second was on 13 August 2020 and was to discuss with the Commissioner a number of issues that I considered may fall within the terms of reference, including any recommended changes within term of reference 4.

I gave some thought to whether I should try to contact any of Ms Smith's relations. I did not have contact details for them. I did not want to disturb their privacy unnecessarily. I thought that if any of them wanted to contact me they would hear about my Review through the media and other publicity. I decided not to seek to contact them directly. In the result, I did not hear from any of Ms Smith's family.

In total, I interviewed, in person or remotely, 33 people.

Legislative framework

To address the terms of reference, it is necessary to explain something of the legislative framework, including the statutory rules.

In that light, the relationship between the NDIS Quality and Safeguards Commission (**NDIS Commission** or **Commission**) and the NDIA (or the **Agency**) may be better understood.

Technically, the relevant functions and powers are those of the Commissioner: see ss 181D-181H. The Commission's function is to assist the Commissioner in the performance of the Commissioner's functions: see s 181B. Nevertheless, the Commission consists of the Commissioner as well as the staff of the Commission: see s 181A(2). It is therefore common,

and convenient, to refer to the Commission unless it is necessary to make a distinction between it and the Commissioner.

Section 209 of the *National Disability Insurance Scheme Act 2013* (Cth) (**Act**) confers a general power on the Minister to make rules called the National Disability Insurance Scheme rules.

Section 73V of the Act states that the National Disability Insurance Scheme rules may make provision for a code of conduct that applies to NDIS providers and persons employed or otherwise engaged by NDIS providers. The section creates a civil penalty if a person is subject to a requirement under the NDIS Code of Conduct and fails to comply with the requirement. The penalty is a civil penalty of 250 penalty units. Compliance with the NDIS Code of Conduct is a civil penalty provision.

An “NDIS provider” is defined in s 9 of the Act to mean, first, a person who receives funding under the arrangements set out in Chapter 2 or NDIS amounts, other than as a participant. This definition excludes the NDIA.

The *National Disability Insurance Scheme (Code of Conduct) Rules 2018* (**NDIS Code of Conduct**) commenced on 1 July 2018. They are made under s 73V of the Act.

They set out the NDIS Code of Conduct which, as stated in (3) of the Preamble, “applies to all NDIS providers and persons employed or otherwise engaged by them, regardless of whether they are registered.”

As stated in (4) of the Preamble, “the NDIS Code of Conduct sets minimum expectations, shapes the behaviour and culture of NDIS providers and persons employed or otherwise engaged by NDIS providers, and empowers consumers in relation to their rights.”

Importantly, (5) of the Preamble states that, “Anyone can raise a complaint about potential breaches of the NDIS Code of Conduct.”

Section 5 of the NDIS Code of Conduct refers to a person who is an NDIS provider or a person employed or otherwise engaged by an NDIS provider as a “Code-covered person”.

The NDIS Code of Conduct itself is set out in s 6 of that instrument and is in the following terms:

- In providing supports or services to people with disability, a Code-covered person must:
- (a) act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions; and
 - (b) respect the privacy of people with disability; and

- (c) provide supports and services in a safe and competent manner, with care and skill; and
- (d) act with integrity, honesty and transparency; and
- (e) promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability; and
- (f) take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability; and
- (g) take all reasonable steps to prevent and respond to sexual misconduct.

The complaint procedure or mechanism is as follows.

By s 73W, a registered NDIS provider must implement and maintain a complaints management and resolution system. That system is to be appropriate for the size of the provider and for the classes of supports or services provided by the provider. It is to acknowledge the role of advocates and other representatives of persons with disability; is to provide for cooperation with, and facilitate arrangements for, advocates and other representatives of persons with disability who are affected by the complaints process and who wish to be independently supported in that process by an advocate or other representative; and comply with any requirements prescribed by the National Disability Insurance Scheme rules. Non-compliance with s 73W constitutes a breach of a condition of registration.

By s 181G, the Commissioner has a number of complaints functions. The primary functions for present purposes relate to the rules made for the purposes of s 73X of the Act. Those functions are “the functions relating to the investigation, management, conciliation and resolution of complaints conferred on the Commissioner by the National Disability Insurance Scheme rules”.

The terms of s 73X(1) are important as it provides for the making of rules (see also s 209) which may “prescribe arrangements relating to the management and resolution of complaints arising out of, or in connection with, the provision of supports or services **by NDIS providers.**” (My emphasis).

The particular provisions of s 73X(2) do not limit the generality of s 73X(1), so it is convenient to turn straightaway to the rules. These are the *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018*. They commenced on 1 July 2018.

As explained in the simplified outline of Part 2, those rules provide first that all registered NDIS providers are required to implement and maintain a system to manage and resolve complaints about the supports and services they provide. The complaints management and resolution system must make sure that people can easily make a complaint and that all

complaints are dealt with fairly and quickly. Providers must make available information about how to make a complaint to the provider and to the Commissioner, and must keep records about complaints that they receive.

Second, again as explained in the simplified outline of Part 3, a person can make a complaint to the Commissioner about any issue connected with supports or services provided by an NDIS provider. Complaints can be made orally, in writing or by any other appropriate means, and can be made anonymously. A complaint can be withdrawn at any time.

If a person makes a complaint, under s 16(3) the Commissioner may decide to:

- (a) take no action, or defer taking action, in some cases (for example, if the complaint was not made in good faith or there is not enough information to continue); or
- (b) help the complainant and other affected people to work with the NDIS provider to resolve the complaint; or
- (c) undertake a resolution process.

Importantly, s 16(4) provides:

- (4) Before making a decision under subsection (3), the Commissioner may do one or more of the following:
 - (a) review documents provided to the Commissioner;
 - (b) visit the location at which the supports or services are provided by the NDIS provider, or the offices of the NDIS provider;
 - (c) discuss the issues raised in the complaint with the complainant, a person with disability affected by an issue raised in the complaint, the NDIS provider or any other person;
 - (d) work with the complainant, a person with disability affected by an issue raised in the complaint, the NDIS provider or a person employed or otherwise engaged by the NDIS provider to:
 - (i) provide advice and assistance; and
 - (ii) where possible and appropriate, assist the persons involved in the complaint to come to a mutually agreed resolution;
 - (e) request information relating to the issues raised in the complaint from any person;
 - (f) take any other action that the Commissioner considers is appropriate in the circumstances.

There is an issue as to whether the NDIS Commissioner needs a stronger power, which may not always be availed of, to do more than attempt to achieve resolution of a complaint. There should perhaps be another signpost here to the Commissioner's other powers where a complaint is not satisfactorily dealt with by a service provider.

Information about the outcome of the resolution process must generally be provided to the people involved in the complaint.

The Commissioner has the power to authorise inquiries into issues connected with complaints, or into a series of complaints, about supports or services provided by NDIS providers. An inquiry can be carried out even if a complaint has not been made to the Commissioner.

The Commissioner can publish a report setting out his or her findings in relation to an inquiry.

These rules do not in terms appear to require that a complaint be “serious” before it may be made or dealt with. Also the word “complaint” is not defined and a person with an observation about the condition or treatment of an NDIS participant or a concern falling short of a complaint would not readily fit within the statutory scheme.

There is also published by the Commission a “Fact Sheet”. It says:

What complaints can you raise

Concerns about the quality and safety of supports and services.

We take complaints about whether an NDIS funded service has been provided in a safe way and to an appropriate standard.

You can also complain about how an NDIS provider has dealt with your complaint.

If you are concerned about how you will be treated, you can make a confidential complaint.

We handle complaints about NDIS services nationally with the exception of WA, which will be available from 1 December 2020.

What complaints we don't take

- Complaints about the NDIA
- NDIS plan access
- NDIS participant plans

Please direct these to the NDIA.

If you're unsure who to contact, contact us and we can help direct you.

Making a complaint

We encourage you to try to talk directly to your NDIS service provider first to resolve a complaint. All registered providers must have an effective complaints management system. If you do not feel comfortable speaking to the provider or are not satisfied with the result of your complaint, please contact us.

Our complaint service is free, completely independent of the NDIS and confidential if needed. We promise to listen respectfully to your situation in full and discuss steps going forward.

In resolving an issue, we may:

- Request information to clarify the issues
- Help you communicate with an NDIS provider
- With your consent, speak to the NDIS provider
- Communicate responses from an NDIS provider to you.

You may withdraw your complaint at any time.

An issue may be referred to conciliation or investigation. Conciliation helps everyone to understand the issues and to reach an agreement on how an issue can be resolved.

An investigation may be conducted if serious compliance issues or risks to people with disability are raised in the complaint.

Where to go

"I'm not happy with an NDIS funded service"

The NDIS Commission

Call 1800 035 544

Visit www.ndiscommission.gov.au

"I'm not happy with an NDIA action or decision"

NDIA or Commonwealth Ombudsman

Call 1800 800 110

Visit www.ndis.gov.au

www.ombudsman.gov.au

"I'm not happy with a service provided by another agency or body"

Your state or territory complaints body

Find links on our website

Visit www.ndiscommission.gov.au

"I'm at immediate risk of harm, or have concerns about a person's wellbeing"

Call 000 immediately.

Who can make a complaint

Anyone can make a complaint.

This includes NDIS participants, other people with disability, friends, families, carers, advocates, workers etc.

If you need to make a complaint about your NDIS funded services:

Complaint contact form

www.ndiscommission.gov.au

Call us

1800 035 544 (freecall from landlines)

National Relay Service

www.relayservice.gov.au

then 1800 035 544

Translating and Interpreting Service

131 450

There is also a protocol relating to complaints handling as between the Commission and the NDIA. The protocol covers complaints, feedback, enquiries and participant critical incidents which may need to be referred (in whole or part) through established referral processes.

Reportable incidents

A reportable incident is defined by s 73Z(4) and (5). The second of these provisions authorise National Disability Insurance Scheme rules which may provide that a specified act, omission or event is a reportable incident or that a specified act, omission or event is not a reportable incident.

Section 73Z(4) is in the following terms:

(4) **Reportable incident** means:

(a) the death of a person with disability; or

- (b) serious injury of a person with disability; or
- (c) abuse or neglect of a person with disability; or
- (d) unlawful sexual or physical contact with, or assault of, a person with disability; or
- (e) sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or
- (f) 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 *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (**NDIS (Incident Management and Reportable Incidents) Rules**) contain rules authorised by s 73Z(5). Section 16 of those rules set out the following:

- (2) An act specified in paragraph 73Z(4)(d) of the Act that occurs in relation to a person with disability is not a **reportable incident** if:
 - (a) the act is unlawful physical contact with a person with disability; and
 - (b) the contact with, and impact on, the person with disability is negligible.
- (3) Despite paragraph 73Z(4)(f) of the Act, the use of a restrictive practice in relation to a person with disability where the use is in accordance with an authorisation (however described) of a State or Territory is a **reportable incident** if the use is not in accordance with a behaviour support plan for the person with disability.

Note: See also subsection 73Z(4) of the Act, which sets out the definition of **reportable incidents**.

- (4) Despite paragraph 73Z(4)(f) of the Act, the use of a restrictive practice in relation to a person with disability where the use is not in accordance with an authorisation (however described) of a State or Territory is not a **reportable incident** if:
 - (a) the use is in accordance with a behaviour support plan for the person with disability; and
 - (b) the State or Territory in which the restrictive practice is used does not have authorisation process in relation to the use of the restrictive practice.

Significantly, by s 73Z(1), the rules must prescribe arrangements relating to the notification and management of reportable incidents that occur, *or are alleged to have occurred*.

But it is also to be noted that the reportable incidents that occur or are alleged to have occurred must be *in connection with* the provision of supports or services by registered NDIS providers. (My emphasis.)

Plainly, a particular complaint may also be a reportable incident (although a complaint may be about something less serious than an incident that constitutes a reportable incident). The real significance of the concept of reportable incident is the obligation imposed by s 73Z on the registered NDIS provider.

As stated in the preamble to the NDIS (Incident Management and Reportable Incidents) Rules, registered NDIS providers must notify, investigate and respond to reportable incidents.

Section 18 is central. It states:

18 Duty of key personnel of registered NDIS providers in relation to reportable incidents

The following must take all reasonable steps to ensure that reportable incidents that occur in connection with the provision of supports or services by a registered NDIS provider are notified to the Commissioner:

- (a) members of the key personnel of the provider;
- (b) the person specified for the purposes of paragraph 10(1)(c) for the provider.

The term “key personnel” is defined in s 11A of the Act, as follows:

11A Definition of *key personnel*

- (1) Each of the following is one of the *key personnel* of a person or entity:
 - (a) a member of the group of persons who is responsible for the executive decisions of the person or entity;
 - (b) any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the person or entity.
- (2) Without limiting paragraph (1)(a), a reference in that paragraph to a person who is responsible for the executive decisions of a person or entity includes:
 - (a) if the person or entity is a body corporate that is incorporated, or taken to be incorporated, under the *Corporations Act 2001*—a director of the body corporate for the purposes of that Act; and
 - (b) in any other case—a member of the person’s or entity’s governing body.

Section 19 of the rules imposes an important duty on those employed or otherwise engaged by a registered NDIS provider. It states:

19 Duty of workers to notify registered NDIS provider of reportable incidents

If a person employed or otherwise engaged by a registered NDIS provider becomes aware that a reportable incident has occurred in connection with the provision of supports or services by the provider, the person must notify one of the following of that fact as soon as possible:

- (a) a member of the provider’s key personnel;
- (b) a supervisor or manager of the person;
- (c) the person specified for the purposes of paragraph 10(1)(c) for the provider.

It is s 20 of the rules which requires that certain reportable incidents must be notified to the Commissioner within 24 hours.

By s 21, other reportable incidents must be notified to the Commissioner within 5 business days.

By s 23, the registered NDIS provider must keep the Commissioner updated where the provider becomes aware of significant new information in relation to the incident.

Section 26 sets out the action the Commissioner may take in relation to reportable incidents.

It states:

26 Action by the Commissioner in relation to reportable incidents

- (1) The Commissioner may, upon receiving notification that a reportable incident has occurred in connection with the provision of supports or services by a registered NDIS provider, do one or more of the following:

- (a) 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);
- (b) 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;
- (c) 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;
- (d) 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;
- (e) carry out an inquiry in relation to the incident in accordance with section 27;
- (f) take any other action that the Commissioner considers reasonable in the circumstances.

Note: The Commissioner may also share information in relation to a reportable incident in accordance with section 67E of the Act and the *National Disability Insurance Scheme (Protection and Disclosure of Information—Commissioner) Rules 2018*.

- (2) If an investigation is carried out under paragraph (1)(c) or (d) in relation to a reportable incident, the Commissioner may take any action that the Commissioner considers appropriate.
- (3) Without limiting subsection (2), the Commissioner may provide, or require the registered NDIS provider to provide, information on the progress or outcome of the investigation to:
 - (a) the person with disability involved in the incident (or a representative of the person); and
 - (b) with the consent of the person with disability (or a representative of the person)—any other person.

An inquiry is referred to in s 26(1)(e). By s 27, an inquiry may be carried out whether or not notification of the reportable incident or reportable incidents has been received under s 20 or 21.

The Commissioner also has other powers under Division 8 of Part 3A, Chapter 4 of the Act. Those powers include the issuing of compliance notices under s 73ZM and banning orders under s 73ZN.

It may be seen that the model of regulation adopted is that the role of the NDIS Commission is not to supervise or regulate the NDIA, but is to regulate and supervise those providing services to the participants in the NDIS. It is by this means that the safety and wellbeing of NDIS participants is enhanced. As stated by the Commission in its Fact Sheet, which I have set out above, it does not take complaints about:

- the NDIA
- NDIS plan access
- NDIS participant plans

Similarly, the Commission does not have a general role in relation to the safety and wellbeing of NDIS participants. Nor does it have a direct role in the provision of services to NDIS

participants. Of course the aim is protecting and preventing harm to people with disability in the NDIS market. As stated in the preamble to the rules which I next consider, at the level of principle “The Commissioner works with providers to continuously improve the quality of the supports and services provided to NDIS participants.”

This point may be demonstrated by considering the *NDIS (Provider Registration and Practice Standards) Rules 2018 (NDIS Practice Standards)* and the accompanying *NDIS (Quality Indicators) Guidelines 2018*.

As stated in part of the Preamble to the NDIS Practice Standards, those rules set out some of the conditions that providers must comply with to become and remain registered NDIS providers. They also set out the NDIS Practice Standards that apply to all registered NDIS providers, and those that apply to be registered NDIS providers delivering more complex supports in areas such as behaviour support, early childhood supports, specialist support coordination and specialist disability accommodation.

It is not necessary for present purposes to go into the detail of the NDIS Practice Standards and related rules. They require that specified classes of supports provided under participants’ plans are to be provided only by NDIS providers who are registered under s 73E to provide those classes of support (s 73B). They prescribe matters going to the suitability of an applicant for registration to provide supports or services to people with disability, the suitability of the applicant’s key personnel to be involved in the provision of supports or services for which the applicant will be registered to provide, and prescribe other requirements for registration (s 73E).

These provisions are preventative measures – safeguards directed to preventing abuse or neglect of NDIS participants.

Term of Reference 1

There are two periods specified in this term of reference.

Period 1 begins with the death of Ms Smith's last surviving parent. It appears that Ms Smith's father died in late 2009 and her mother died some three months earlier. This period ends when Ms Smith became an NDIS participant. Ms Smith became a participant from 25 January 2018. It was on 1 July 2018 that South Australia completed its State-wide transition to the NDIS and NDIS Commission. Ms Smith's first participant's plan approved by a Delegate of the Chief Executive Officer (**CEO**) of the NDIA commenced on 21 November 2018. Any existing support arrangements were to continue as normal until her first plan was finalised.

Period 2 is from when Ms Smith became an NDIS participant (25 January 2018), until her death on 6 April 2020.

For each of these periods, I am to identify and describe:

- (a) the nature and level of the supports and services provided to Ms Smith as a person with a disability;
- (b) the extent to which any mechanisms that might have guarded against the particular vulnerability of Ms Smith, such as guardianship in relation to any lack of capacity, were available and were accessed by or on behalf of Ms Smith or applied or sought to be applied in relation to Ms Smith; and
- (c) the points, if any, at which concerns about Ms Smith's safety could or should have been identified and responded to by service providers, government agencies or regulators.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

Mechanisms that might have guarded against vulnerability

It remains to draw together the threads as to the extent to which any mechanisms that might have guarded against the particular vulnerability of Ms Smith, such as guardianship in relation to any lack of capacity, were available and were accessed by or on behalf of Ms Smith or applied or sought to be applied in relation to Ms Smith.

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

There is perhaps an implication in this term of reference that Ms Smith lacked capacity. I am not satisfied that the combination of immobility, isolation and a sole carer at her house providing in-home services amounted to any lack of capacity.

Under the *Guardianship and Administration Act 1993* (SA), “mental incapacity” is defined to mean the inability of a person to look after her own health, safety or welfare or to manage her own affairs, as a result of: (a) any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or (b) any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever.

That a person has a disability does not at all mean that they have a mental incapacity. This is because their inability, to use the word in the South Australian legislation, does not necessarily mean that they cannot look after their own health, safety or welfare or manage their own affairs. Neither does it mean that any such inability is because of either of the matters specified.

In my view, there is no persuasive evidence that Ms Smith had any lack of capacity: on the contrary, there is evidence in the material before the Delegates that she had capacity.

I draw this conclusion bearing in mind that a person’s capacity may change from time to time. If Ms Smith did lack capacity at any time, it was in the last weeks of her life.

For these reasons, I am also not satisfied that Ms Smith could have had a plan nominee appointed for her under s 86 and s 88 of the NDIS Act and that this was an available mechanism that might have guarded against her vulnerability. Section 86(2) provides that an appointment of a plan nominee may be made at the request of the participant or on the initiative of the CEO. There is no evidence that Ms Smith made such a request or intended to make such a request. Therefore, a nominee would only have been appointed for Ms Smith on the CEO’s (or a delegate’s) initiative. Section 88(4)(a) relevantly provides that the CEO, in appointing a nominee of a participant under s 86, must have regard to (amongst other things) whether there is a person who, under a law of a State, “has guardianship of the participant”. Ms Smith did not have a guardian and, as I have said, she was unlikely to have met the requirements to have one appointed under the South Australian law.

The *National Disability Insurance Scheme (Nominees) Rules 2013* provide at paragraph 3.1 that “[p]eople with disability are presumed to have capacity to make decisions that affect their own lives.” Paragraph 3.4 provides that “[i]t is only in rare and exceptional cases that

the CEO will find it necessary to appoint a nominee for a participant who has not requested that an appointment be made.” In deciding who to appoint as a nominee, paragraph 4.6(b) provides that the CEO is to “have regard to [the participant’s] wishes, however they are expressed (for example, a participant might express a wish in a non-verbal manner, or might express a wish to a third party, such as a disability support worker)”.

In view of these requirements, it is unlikely that the appointment of a plan nominee was an available or applicable mechanism for Ms Smith.

I am also required to consider any mechanisms that might have guarded against the particular vulnerability, apart from any lack of capacity, of Ms Smith.

If there had been a complaint to the Commission, that might have guarded against Ms Smith’s vulnerability but there were no complaints.

Likewise, there were no events which pointed to the need for Ms Smith to have access to an advocate or advocacy services, such as the Public Advocate or the Disability Advocacy and Complaints Service of South Australia Inc (DACSSA).

The Community Visitor Scheme in South Australia was unlikely to have been available because although it provides advocacy and assistance to clients, their carers and family members, the scheme as it stood is for people living with disability who are, relevantly, receiving care in a hospital or living in state-run disability accommodation. Ms Smith was living in her own home.

Ms Smith appears to have been a person who valued her privacy and she may well have chosen to be isolated and to have a sole carer. In the absence of intervention, it was these factors, combined with her immobility, which contributed to Ms Smith’s premature death.

I next consider the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 (NDIS Practice Standards)*.

The NDIS Practice Standards contain an obligation to provide supports in a safe manner. The Practice Standards were not so prescriptive as to require specifically that a vulnerable person such as Ms Smith have more than one carer.

According to the Preamble to those Rules, as then in force:

These rules set out some of the conditions that providers must comply with to become and remain registered NDIS providers. They also set out the NDIS Practice Standards that apply to all registered NDIS providers, and those that apply to providers delivering more complex supports in areas such as behaviour support, early childhood supports, specialist support coordination and specialist disability accommodation.

Under Schedule 1, Part 2 “Rights of participants and responsibilities of providers”, it is stated to be the right of each participant that each participant “can access supports free from violence, abuse, neglect, exploitation or discrimination.” However, by reason of the transitional arrangements in ss 25 and 29, to remain registered to provide the relevant class of supports during the transition period, Integrity Care was required to comply only with the standards specified in clauses 2 to 7, 14, 15, 20 and 24 of Schedule 1.

In Part 3 of Schedule 1, under the heading “Provider governance and operational management”, the NDIS Practice Standards relating to the governance and operational management arrangements for registered NDIS providers are specified. It is stated in clause 10 that “Risks to participants, workers and the provider are identified and managed.”

Part 5 of Schedule 1 is headed “Support provision environment” and specifies the NDIS Practice Standards relating to the environment in which supports are provided to participants. One standard, clause 24, states, “Each participant can access supports in a safe environment that is appropriate to their needs.”

Again, Integrity Care was not required to comply with those clauses during the transition period.

The *National Disability Insurance Scheme (Code of Conduct) Rules 2018 (Code of Conduct)* set out the NDIS Code of Conduct, which applies to all NDIS providers and persons employed or otherwise engaged by them, regardless of whether they are registered. Each of those providers and persons is a “Code-covered person”. Under s 6 of the Code of Conduct, in providing supports or services to people with disability, a Code-covered person must, relevantly:

- provide supports and services in a safe and competent manner, with care and skill; and
- promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability; and
- take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability.

However, the Code of Conduct is not self-enforcing. Where, as here, there is no information available to the regulatory agency, that agency assumes and depends on compliance by the Code-covered person. Where that person is a registered NDIS provider then the reportable incidents mechanism should be available. There is also the statutory complaints mechanism. As I have said, there were no complaints and the neglect of Ms Smith, although a reportable

incident, did not in this case put in motion the arrangements for the notification and management of the reportable incidents.

In the absence of events putting in motion these provisions, reactively, the major available mechanism was the registration process which may have picked up deficiencies in the systems of the registered provider.

One “mechanism” which may have guarded against the particular vulnerability of Ms Smith, arising from her immobility, isolation and a sole carer providing at-home services, would have been the interest of neighbours or other members of the community or of friends and relations. I agree with the observation of the South Australian Safeguarding Task Force in its Final Report delivered on 31 July 2020 at page 22: “The best safeguard for any potentially vulnerable individual is to have a number of people in their lives, who make sure the person is not left to their own devices when things go wrong.”

Another mechanism would have been a rule, and the enforcement of a rule, that a person with the vulnerability of Ms Smith should not have been provided with a sole carer.

The Commission could specifically have required as a condition of registration that (a) vulnerable participants be identified by the service provider; (b) where the vulnerability included isolation and living alone at home and having in-home services, that a sole carer not be provided; and (c) there be regular supervision of in-home workers by service providers.

In circumstances such as the present, although I understand the policy that the applicable legal instruments (the NDIS Practice Standards and Code of Conduct) are intentionally not overly prescriptive but rather provide a framework whereby there should have been proper supervision and more than one carer, in my view these requirements should be made specific.

As observed by the South Australian Safeguarding Task Force in its Final Report at page 22: “At least one of the extra pair of eyes seeing what is going on should come from proper supervision of support workers by the service provider agency, and ensuring that more than one support worker is involved, even if the participant only wants a single person whom they trust and respect.” In my view, ensuring such requirements through the legal framework applicable to the provision of supports is consistent with the objects of the NDIS Act which requires balancing the object of enabling a person with disability to exercise choice and control (s 3(1)(e)) with the object of protecting and preventing people with disability from experiencing harm arising from poor quality or unsafe supports or services (s 3(1)(ga)).

Finally, if there had been a system of regular visits to persons with the vulnerability of Ms Smith even where such a person was living in her own home, the neglect of her, which led to her death, is unlikely to have occurred.

Points at which concerns could or should have been identified

It also remains to consider the points, if any, at which concerns about Ms Smith's safety could or should have been identified and responded to by service providers, government agencies or regulators.

I should deal with these matters separately, the "could" and the "should" in relation to first, service providers, second, government agencies and, third, regulators.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

Could or should the NDIA have identified concerns about Ms Smith's safety? The NDIA could have identified potential concerns at the time her first or second plan was being approved. These plans were put together without the benefit of seeing Ms Smith either in person or at her home where the services were to be provided. There was no clear mechanism for identifying Ms Smith's vulnerability. As with Disability SA, I consider that any conclusion that the NDIA should have identified concerns about Ms Smith's safety involves a substantial amount of hindsight and I do not draw that conclusion.

However, the NDIS Quality and Safeguarding Framework (**Framework**) dated 9 December 2016, which was agreed to by the Council of Australian Governments' Disability Reform Council, provides the following about the planning process as a safeguard (at page 29):

Effective planning is a key element of quality support in a person-centred system. Participants should be supported to identify and manage risk as they interact with the NDIS through access to the level of assistance they need to develop and implement their plans.

Individual planning, implementation and review processes should also include formal safeguards. These should be proportionate to the level of risk the participant faces, based on their capacity, their natural support network and the supports available to them, as well as the level of risk they choose to accept.

The Framework goes on to say (at page 30):

Participants who have few informal supports, are isolated, or who have more than one family member with a disability – placing extra strain on their family – may need some support to develop their plan and will be assisted by a local area coordinator.

As I recommend in this Report, the identification of vulnerable participants is entirely consistent with the Framework. So is the focus on the individual and their particular circumstances. The Framework states (at page 31):

Risk assessment: it is generally agreed that a holistic assessment of the risks a participant faces, which takes into account their family circumstances, informal supports and individual capabilities is critical to enabling informed choice. It is also critical to identifying those who may be most at risk of abuse, violence, neglect and exploitation or who may be vulnerable to other risks, such as service provider failure. Families and carers, in particular, can play an important role supporting individuals to make choices about their supports.

The structure of the Framework also emphasises that responsibility for safeguarding does not lie with a single government agency or service provider. Rather, safeguarding is a continuum starting with participant capacity (sections 2.1.1 to 2.1.3) through to the planning process (sections 2.2.1 to 2.2.3) and corrective regulation in the form of monitoring and responding to complaints and incidents (sections 2.3.1 to 2.3.3).

In view of these principles in the Framework, I make the following observations about the planning process in Ms Smith's case. Neither of the Delegates who approved Ms Smith's statement of participant supports under s 33(2) of the Act in her first plan or her second plan had a face-to-face, or any, meeting with her. This was despite a note in a document titled "Transfer Summary for NDIA Planner" dated 28 September 2017, and provided by Disability SA to the NDIA prior to the approval of Ms Smith's first plan, indicating that "[d]ue to deteriorating condition person experiences difficulties with understanding complex matters and wishes to have her friend present to assist, Face to face contact required." It may be that the note stemmed from Ms Smith's wish for the NDIS to be explained to her in person, but if it had been acted on and there had been face-to-face contact, particularly in Ms Smith's home, there would have been the opportunity to assess the state of the facilities there and the personal relationship of Ms Smith and her carer Ms Maione, and the interaction between them.

The employees of the Local Area Coordinators (LACs) who gathered information from Ms Smith to assist the planning Delegate for her first and her second plan also did not see Ms Smith face-to-face but rather spoke to her by telephone with her carer Ms Maione present on the call. This form of contact with a participant during the planning process was consistent with standard operating procedures and task completion checklists provided by the NDIA to LACs at that time. The applicable standard operating procedures and task completion checklists required a planning meeting with the participant but did not require that to be done face-to-face. Once the LAC gathered sufficient information to fill out the relevant parts of the

NDIA's Records Management system (**CRM**), the system assigned the pending plan for the approval of a Delegate. In the case of Ms Smith's second plan, the Delegate's main interaction was the Plan Alignment Meeting telephone call with the employee of the LAC who gathered Ms Smith's information. Following a short exchange of emails between that employee of the LAC and the Delegate about the budget to be specified, the Delegate approved a 24-month plan for Ms Smith.

It seems to me that the process adopted in Ms Smith's case did not fully utilise the planning process as a safeguarding and risk detection measure, consistent with the Act and Framework. Section 33(2) of the Act refers to a statement of participant supports that is "prepared *with* the participant and approved by the CEO" (My emphasis.). The two-step planning process, the first step by an employee of the LAC and the second step by the Delegate, which took place in Ms Smith's case, involved no direct interaction between the Delegate and Ms Smith. I think it does not sit easily with what is contemplated by s 33(2). In my view, a planning process involving direct engagement by the planning Delegate and the participant is not only more in line with the requirements of s 33(2) but also a better safeguard, consistent with the Framework, which could allow concerns about a participant's safety to be identified and responded to earlier.

I understand from a submission made to me by the NDIA that the planning process is currently being reviewed. In particular, I was told that the NDIA has trialled the use of "Joint Planning Meetings" in Queensland whereby the planning Delegate, the LAC and the participant meet face-to-face prior to the plan being approved. I understand that the NDIA's intention is that this trial may ultimately be rolled out across the Scheme. In my view, this would be a positive development which would allow the Delegate to perform the approval function in s 33(2) in a way that gives greater effect to the safeguarding purposes and objects of the NDIS. As relevant to this term of reference, if a Joint Planning Meeting had taken place in Ms Smith's home it could have been a relevant point at which concerns about her safety were identified and responded to.

Another aspect of the planning process which might have been a point at which concerns about Ms Smith's safety could or should have been detected concerns the three automatic extensions of the review date for her plan between 6 December 2019 and 16 January 2020. Those automatic extensions did not involve any decision-making by a Delegate but were seemingly implemented by the CRM system. The Delegate that approved Ms Smith's second plan said in an interview with me that the reason the CRM system automatically extended

Ms Smith's plan was to avoid the risk of cutting off her NDIS funding in the event that a new plan had not been approved by the specified plan review date.

In my view, although the reason for these automatic extensions to a participant's plan is understandable, as beneficial to the participant, those extensions potentially had the effect of blunting a point at which concerns about Ms Smith's safety could have been identified. The automatic extension of a participant's plan which does not involve a decision under s 33(2) of the Act is both problematic from a safeguarding point of view, particularly for the timely detection of vulnerability or risk factors during the planning process, and may not be in accordance with the requirements of the Act. This is because s 48(5) provides that the "CEO must conduct a review of a participant's plan before the plan's review date and in the circumstances, if any, specified in the plan." Section 49 of the Act provides that "[i]f the CEO conducts a review of a participant's plan under section 48, the CEO must facilitate the preparation of a new plan with the participant in accordance with Division 2." The note to s 49 explains that "[b]ecause the new plan is prepared in accordance with Division 2, a decision to approve the statement of participant supports in the plan would be made under subsection 33(2)". Such a decision must be made in accordance with the requirements in s 33(5) which, as the Framework (at 29) acknowledges, "is a key element of quality support in a person-centred system."

A decision to approve a statement of participant supports in a plan must be recognised as not merely relevant to funding but also as an important safeguarding mechanism. Therefore, opportunities to conduct the full assessment required by s 33(2) should not be missed and should be done in a timely manner. This is particularly so bearing in mind that a participant's vulnerability and risk factors may change over the duration of a plan. Ms Smith's case illustrates the fact that critical changes to a participant's circumstances can occur within a few months and that the planning process needs to be alive to these risks and developments.

My overarching observation on this matter is that, as emphasised by the Framework and the legislative scheme, the NDIS and the concept of participation in it comprise a fundamentally "person-centred system". A number of the steps taken in the course of preparing and approving Ms Smith's plans can be characterised as transactional rather than person-centred, insofar as they involved automated decision-making, no face-to-face contact and no observation of the setting in which Ms Smith was to have her funded supports delivered. Such contact may have allowed for greater focus on or awareness of Ms Smith's vulnerability and risk factors in the preparation and approval of her plans. Instead, the planning process

appeared to involve a form-driven approach whereby Ms Smith was given more or less the same supports she received from Disability SA in her first plan and, in preparing her second plan, there was an emphasis on checking whether her circumstances had changed since the first plan. There being no major changes identified, a further 24-month plan providing for substantially the same supports (with some increase in funding for peripheral supports) was approved.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

Ultimately, the kind of qualitative assessment required by the provisions of the NDIS Act concerning the preparation and approval of a participant's plan is not only relevant to the specification and funding of supports. A personal as opposed to transactional assessment of a participant during the planning process is a fundamental quality and safeguarding measure which operates alongside, and not separate from, the corrective and regulatory functions available under the Act.

In short, the planning process should be seen and used as a critical point for identifying and responding to concerns about a participant's vulnerability, risk factors and safety. Those administering that process should be encouraged and trained to use the measures available to them for that purpose. The South Australian Safeguarding Task Force Final Report notes (at 11) that "[t]he NDIS, built on choice and control insurance principles, has not seen itself as the case manager ultimately responsible for safeguarding vulnerable participants." While safeguarding is a continuum of responsibility, the NDIA should be responsible for using the planning process to identify vulnerability as one of its specific purposes. Such a view is consistent with the principles in the Framework referred to above.

The NDIA should develop and refine a concept of vulnerability and apply a qualitative assessment to identify such vulnerability as part of the planning process. The CRM records in Ms Smith's case contain a number of forms that ask questions about risk and vulnerability factors, but generally required only 'Yes' or 'No' responses with little room for nuance. As I have said above, simply asking these questions as part of a checklist appeared to be a largely transactional exercise and, in Ms Smith's case, did not generate the right quality of information about her vulnerability, safety and risk factors which might have been detected through a more qualitative process involving in-person contact and a specific focus in the planning process on identifying vulnerability and risk. I note the NDIA's submission that it is continuing to refine its approach to identifying and mitigating risks for participants who may

be vulnerable. The NDIA submitted that the Risk Assessment guidance has been recently updated and is used by all NDIA and Partner staff when undertaking pre-planning with participants.

Further, as part of the need for the NDIA to use the planning process as a specific tool to identify and respond to participant vulnerability, the specification and approval of reasonable and necessary supports in a plan should also, as the Framework says (at 29), “include formal safeguards...[that are] proportionate to the level of risk the participant faces”. The South Australian Safeguarding Task Force Final Report (at 9) states that “Support Coordination also needs to be automatically inserted into the plan of any potentially vulnerable participant.” That Report identifies this issue as ‘Safeguarding Gap 1’. A number of submissions I have received (including from Professor Richard Bruggemann) have made suggestions to the same effect. The South Australian Safeguarding Task Force as well as others who have made submissions to me (including Ms Mary Burgess, the Queensland Public Advocate, and Professor Grant Davies, the South Australia Health and Community Services Complaints Commissioner) have also suggested that plans should include strategies to minimise risks and gaps for participants by acknowledging and coordinating a participant’s healthcare needs.

In my view, there is considerable merit in these suggestions. Accepting that the NDIA should use the planning process to identify a participant’s vulnerability and risk factors, a Delegate’s decision-making under s 33 and s 34 of the NDIS Act should proactively consider the appropriateness of including funded support coordination in a participant’s plan which can provide “an essential second pair of eyes...in a participant’s life” (South Australian Safeguarding Task Force Final Report, 9). In August 2020, the NDIA published a Discussion Paper titled ‘Support Coordination under the NDIS’. That discussion paper noted that:

Research shows that external support is important for many individuals to successfully navigate market based systems, and that strong, trusting and collaborative relationships with both paid and unpaid people in a person’s support network are facilitators of successful plan implementation. Support coordination is a capacity building support funded under the NDIS. Support coordination is a concept that has evolved under the NDIS and was not previously a feature of the program-based disability service systems funded by state and territory governments. [Citation omitted.]

The omitted footnote from the above passage in the Discussion Paper refers to a study with the following citation: “Fleming P, McGilloway S, Herson M, et al. (2019) Individualised funding interventions to improve health and social care outcomes for people with a disability: a mixed-methods systematic review.”

Although the Discussion Paper is not specifically focused on the provision of funded support coordination as a safeguard against participant vulnerability, some of the observations in it are nonetheless relevant to Ms Smith's circumstance. For example, on page 7, it states that:

On average, a participant who is agency-managed or plan-managed that is receiving support coordination receives 5 hours of support coordination per month, although participants require varying levels of this type of support depending on their unique needs and circumstances.

As I have noted above, Ms Smith's plans were agency-managed, but she did not receive support coordination and there does not appear to have been an assessment of her "unique needs and circumstances" for the purposes of determining whether she needed support coordination in her plan. Had such an assessment been done, it could have been a point at which her vulnerability and concerns about her safety might have been identified and responded to.

Similarly, the planning process should avoid a mere acknowledgement of a participant's connection with the mainstream health system. In Ms Smith's case, both her first and second plans simply recorded "GP – check ups as needed" under the heading 'My Services and community involvement'. A planning process that adopts the identification of participant vulnerability and risk factors as a specific responsibility and objective should go further in contextualising the funded NDIS supports and how they coordinate with a participant's circumstances as a whole (while accepting that the NDIS does not fund mainstream health services). A planning process with these features is consistent with the principles relating to plans in s 31 of the Act, specifically s 31(k) which acknowledges that a participant's plan should "provide the context for the provision of disability services to the participant".

Could the Commission have identified concerns about Ms Smith's safety? In the events which happened, the Commission could not have identified any concerns about Ms Smith's safety in the absence of a complaint or a reportable incident being reported. Neither of those things occurred. If the Commission had had a proactive system of identifying and visiting vulnerable participants, then potentially it could have identified those concerns but it had no such system. It cannot now be known what Ms Smith's reaction may have been to a visit to her house by or on behalf of the Commission. Also, such a visit would have to have been timed so as to coincide with the neglect of her.

Should the Commission have identified concerns about Ms Smith's safety? In my view, in the circumstances this may only have occurred in the course of the Commission's registration process of the service provider, Integrity Care, which I consider under term of reference 2. That process may be criticised, in particular that the decision-making was too weighted

towards not jeopardising the service provider's extant registration status. Further, there was also no clear justification for the lengthy extension of the requirement to complete an audit, which is a fundamental quality and safety mechanism under the regulatory regime. However, I am not persuaded that a registration process without these features would allow me to conclude that the Commission should have identified concerns about Ms Smith's safety. Any relationship between the criticisms I have made and possible concerns about Ms Smith safety is too distant for me to draw that conclusion.

I consider the Commission's role and the performance of its functions in greater detail in addressing terms of reference 2 and 3.

Term of Reference 2

The registration of Integrity Care (SA) Ltd

Integrity Care was registered by the CEO of the NDIA as a registered provider of supports pursuant to s 70 of the NDIS Act. The registration was in force from 14 June 2017. From 1 July 2018, Integrity Care was deemed a registered NDIS provider: see s 7 of the *National Disability Insurance Scheme (Quality and Safeguards Commission and Other Measures) Transitional Rules 2018* (Cth). Its registration was thereby to remain in force until 31 October 2018.

By operation of s 73K of the NDIS Act, if Integrity Care submitted an application for renewal of its registration within 6 months before 31 October 2018, the date identified as the end of the period for which its initial registration was in force, the registration would continue in force until the NDIS Commissioner made a decision on the application under s 73E(1).

The certificate of registration set out the classes of supports under participants' plans in relation to which Integrity Care was registered.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 12 August 2020, the Delegate decided to revoke the registration of Integrity Care under s 73P of the NDIS Act with effect from 14 August 2020 and consequently to also make a banning order under s 73ZN(1)(a), with effect from 21 August 2020.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

The NDIS Commission's response to the notification of Ms Smith's death

On 20 April 2020, the NDIS Commission was notified of Ms Smith's death through a communication from the South Australia Office of the Public Advocate. On the same day, the Commission's complaints team also received a notification from the South Australian Health and Community Services Complaints Commission (HCSCC). These notifications to the Commission came about two weeks after Ms Smith died in the Royal Adelaide Hospital on 6 April 2020.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 21 April 2020, the Commission registered its interest in Ms Smith’s case with the South Australian Coroner and internally escalated the case to the South Australia State Director of the Commission.

On 27 April 2020, the Commission commenced its investigation into the death of Ms Smith.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 12 May 2020, the Commission and the NDIA’s South Australian State Director discussed an approach to support other participants that may be in similar situations to Ms Smith.

On 14 May 2020, the Commission and the NDIA undertook work to identify all participants receiving supports from Integrity Care. The NDIA then contacted all of the identified participants as part of its COVID-19 outbound call welfare checks.

On 15 May 2020, the Deputy Registrar of the Commission, as delegate of the Commissioner, issued to Integrity Care a Compliance Notice under s 73ZM of the Act.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 21 May 2020, the Deputy Registrar, as delegate of the Commissioner, issued to Integrity Care an Infringement Notice dated 20 May 2020 under s 103 of the *Regulatory Powers (Standard Provisions) Act 2014* (Cth) (**Regulatory Powers Act**).

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 26 May 2020, the Commissioner issued to all NDIS providers registered to provide supports categorised as “[a]ssistance with daily personal activities” an information request pursuant to s 73F(2)(i) of the NDIS Act (**Information Request**). The Information Request informed its recipients that the Commission “recognises that any NDIS participant who is provided with ‘Assistance with daily personal activities’ in their own home may be particularly vulnerable if those supports are provided by the same individual NDIS worker for any extended period of time.” The Information Request required its recipients to complete and return a questionnaire by 10 June 2020.

The questionnaire contained five questions. The fourth question asked: “Does your organisation have arrangements in place to oversee the provision of supports where these are provided to a person living alone by only one worker so that you meet obligations under the

NDIS Code of Conduct and applicable NDIS Practice Standards set out in the background to this notice?” The form stated, “If your answer to Q4 is ‘yes’ you do not have to answer any more questions”. If the answer to Question 4 was ‘no’, the form asked the registered NDIS provider to “explain the areas where your organisation is not meeting the NDIS Code of Conduct or the NDIS Practice Standards with reference to the applicable NDIS Practice Standards set out in the background to this notice.”

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

On 22 June 2020, the Commissioner issued an ‘Urgent Reminder’ to registered NDIS providers who received but had not responded to the Information Request dated 26 May 2020.

As at 23 June 2020, of the 2466 providers who received the Information Request, 1783 had responded. On 7 July 2020, the Commissioner sent a further information request to 473 providers who responded to the 26 May 2020 Information Request and who, based on the provider’s “response to the request of 26 May 2020”, met the following three criteria:

1. you do provide ‘Assistance with daily personal activities’ in the home of NDIS participants who live alone, and
2. some of these participants receive those supports from just one particular worker and no other, and
3. there are arrangements in place to oversee the provision of those supports, meeting the obligations set out in the background to this notice.

The providers who received the 7 July 2020 further information request were asked to respond in two parts by filling in a template spreadsheet created by the Commission. Part 1 required the provider to “[p]rovide information about the NDIS participants that are supported by you (the provider) in their own home by only one single worker”. This was to be provided by 21 July 2020. Part 2 required the provider to identify, for the period of 1 January 2020 to 30 June 2020, the “[f]requency and nature of communication with each participant” listed in Part 1; the “[f]requency and nature of performance assessment for the worker supporting the participant”; and the “[k]ey personnel assurance of communication and performance assessment activities”, including the “form of assurance” for both “Participant satisfaction” and “Worker Performance”. In responding to Part 2, the providers were also asked to state how they were satisfied that the NDIS Practice Standards and the Code of Conduct are being met in respect of each participant listed in Part 1. Part 2 was to be provided by 14 August 2020.

362 providers responded to the further information notice issued on 7 July 2020 with the information requested in Part 1. That information concerned around 1500 participants. The NDIS Commission has provided the data from Part 1 to the NDIA for risk checking, which includes:

- verifying the support provision to the participants;
- considering any contacts made with the participants recently to determine their well-being, as part of COVID-19 activities;
- determining whether there are other providers involved in the support of the relevant participants; and
- assessing the level or volume of activity against participant plans.

The NDIA will provide the Commission with risk information for the relevant participants. This information along with the Commission's analysis of the quality assurance information due from providers on 14 August 2020 will inform any further compliance activity and priorities.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

Term of Reference 3

I have examined in the previous section of this report how the NDIS Commission carried out its functions in relation to Integrity Care prior to the Commission being notified of Ms Smith's death.

I have also examined how the NDIS Commission carried out its functions in response to the notification of Ms Smith's death. This included the steps the Commission took to identify and address risks to the safety or wellbeing of NDIS participants who might be in circumstances of vulnerability similar to, or approaching, those in which Ms Smith was living before her death.

Under this term of reference, I identify any failings in how the NDIS Commission carried out its functions as I have so examined them.

Before being notified of Ms Smith's death

The relevant functions of the NDIS Commission, in the absence of a reportable incident being notified to it and in the absence of any complaint to it relating to Ms Smith, were in relation to the registration of Integrity Care and, relatedly, the audit of Integrity Care. I consider separately the exercise by the Commission of the power to make a banning order against Ms Maione: see s 73ZN.

Although I have made some criticisms in the previous section of the way in which the Commission exercised its registration function, I do not regard any of the matters to which I have referred as causative of the neglect and subsequent death of Ms Smith.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

In the circumstances, I see no failing on the part of the Commission in this respect. For completeness, I also note that the decision-maker who approved the 20 month extension of time to complete an audit for 26 providers in default of that obligation, one of which was Integrity Care, was not a senior executive officer of the Commission. The Commissioner subsequently changed the delegation to make decisions varying conditions for provider registration so that now only the Registrar has that delegation.

In relation to Ms Maione, the Commission had no information to justify banning Ms Maione from working in the disability sector before it was notified of Ms Smith's death on 20 April

2020: there were no complaints made to it and no incidents reported to it concerning Ms Smith.

After being notified of Ms Smith's death

After the Commission was notified of Ms Smith's death on 20 April 2020, it took two types of action in the exercise of its functions. (Again I consider separately the exercise by the Commission of the power to make a banning order against Ms Maione: see s 73ZN.)

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

Secondly, the Commission took general regulatory action by using its information request powers under the Act to identify other service providers and participants who might be in unsafe situations involving the provision of care in the participant's home with a sole worker.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

In the circumstances, I see no failing on the part of the Commission in this respect.

Another matter to be considered here is the "fine" of \$12,600.00 imposed on Integrity Care by notice given by a Delegate, the Deputy Registrar, on 21 May 2020. The true nature of this "fine" was that it was an amount payable under an Infringement Notice pursuant to s 103 of the Regulatory Powers Act. The Delegate decided to do this on the basis that she believed on reasonable grounds that Integrity Care had contravened s 73J of the NDIS Act, a provision subject to an infringement notice by virtue of s 73ZL of the same Act.

The notice stated that Integrity Care contravened s 73J of the NDIS Act by failing to notify the Commissioner of a reportable incident within the 24 hour notification period that applied to the notification under s 20 of the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (**Reportable Incidents Rules**). That, the notice stated, constituted a breach of a condition of Integrity Care's registration as a registered NDIS provider.

The amount of \$12,600.00 was not the Commission's assessment of the gravity of the contravention. Neither was it intended to reflect the gravity of the circumstances of Ms Smith's neglect or her death. The amount was calculated in accordance with s 104(2) of the Regulatory Powers Act. It constituted 60 penalty units, a penalty unit being \$210 at that time.

If the person to whom the notice is given pays the amount within 28 days, then, in the case of a civil penalty provision, proceedings in a court seeking a civil penalty order will not be brought in relation to the alleged contravention. The amount specified in the Infringement Notice was paid by Integrity Care on 26 June 2020. This was not an admission of liability for the alleged contravention (s 107(1)(e) of the Regulatory Powers Act, and any liability of the person for the alleged contravention is discharged (s 107(1)(a)).

If the amount had not been paid, and the matter had gone to court, s 104(2) was in the following terms:

- (2) If the notice relates to only one alleged contravention of the provision by the person, the amount to be stated in the notice for the purposes of paragraph (1)(f) is the lesser of:
 - (a) one-fifth of the maximum penalty that a court could impose on the person for that contravention; and
 - (b) 12 penalty units where the person is an individual, or 60 penalty units where the person is a body corporate.

A contravention of s 73J of the NDIS Act attracted a civil penalty of 250 penalty units.

Section 82 of the Regulatory Powers Act provides that the civil penalty specified is multiplied by five for a body corporate, taking it to 1250 penalty units per contravention. The maximum penalty that a court could impose for a contravention of s 73J was therefore \$262,500.00.

In my view, there was no failing in how the Commission carried out its functions by deciding that it would utilise the Infringement Notice power rather than commence an action in court for a civil penalty in respect of the alleged failure to notify the Commission of Ms Smith's death within 24 hours. The Infringement Notice power allowed the Commission to impose an immediate monetary penalty on Integrity Care for a relatively straightforward matter, subject to Integrity Care wishing to contest the matter. It was reasonable to view this course, insofar as it concerned the alleged failure to notify the Commission of Ms Smith's death within 24 hours, as preferable to seeking a civil penalty in court, which would have involved greater uncertainty, expense and time for the Commission.

A further matter is whether the NDIS Commission should have taken immediate or quicker steps under s 73ZN to make a banning order against Integrity Care or Ms Maione, who was Ms Smith's sole carer.

Under that section, s 73ZN, the Commissioner may give a written notice prohibiting or restricting specified activities by an NDIS provider if, for example, there is an immediate danger to the health, safety or wellbeing of a person with a disability if the person who may be the subject of a banning order continues to be an NDIS provider. A person who is subject

to a banning order cannot be registered as an NDIS provider in a way that is inconsistent with the order.

However, by s 73ZN, the Commissioner may generally only make a banning order against a person after giving the person an opportunity to make submissions to the Commissioner on the matter. This is unless the Commissioner's grounds for making the banning order were or included "that there is an immediate danger to the health, safety or wellbeing of a person with a disability": see s 73ZN(8).

Ms Smith having died, reasonable administrative action therefore involved finding out whether there were one or more people in immediate danger to their health safety or wellbeing. This the Commission embarked on doing by means of notices to service providers requesting information and by the Compliance Notice issued to Integrity Care requiring it to complete physical welfare checks conducted by an independent health professional.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

In relation to Ms Maione, the questions arise whether the Commission should have acted to ban, or have been further advanced in relation to its investigation of issuing a banning order to, Ms Maione before 17 May 2020 when Integrity Care terminated Ms Maione's employment. Under the legislation as it stands, the Commission had power to ban Ms Maione from working in the disability sector while Ms Maione was employed by an NDIS provider, such as Integrity Care, and not thereafter.

It will be recalled that on 20 April 2020, the day the Commission was informed of Ms Smith's death, the Commission was informed by Integrity Care that Ms Maione's employment with Integrity Care had been suspended. It appears that that suspension occurred on 16 April 2020 pending an internal investigation by Integrity Care.

There is no suggestion in the material that I have that Ms Maione was, or has been since 17 May 2020, employed by an NDIS provider other than Integrity Care.

In the absence of information suggesting that was an immediate danger to the health, safety or well-being of a person with a disability, the Commissioner was authorised to make a banning order against Ms Maione only after giving her an opportunity to make submissions to the Commissioner on the matter.

In these circumstances, although the Commission could have acted earlier in giving Ms Maione an opportunity to make submissions on the matter of whether or not a banning order should be made against her, the delay had no consequences. Again, I make no assumption, and express no view, as to whether the charge against Ms Maione is well-founded, or not.

I next set out my views about the proposed amendments to the Act.

Are the amendments dealing with the banning of carers in the bill currently before the Commonwealth Parliament, the bill for the National Disability Insurance Scheme Amendment (Strengthening Banning Orders) Act 2020 adequate for the task?

The first thing the bill does is to expand the power of the Commissioner in s 55A so as to permit the Commissioner to require information or produce a document relevant to an “other person” who need no longer be a person employed or otherwise engaged by an NDIS provider where that “other person” is subject to a banning order. The information the Commissioner may require is information that may be relevant to whether that “other person” is providing supports or services in contravention of the banning order.

More immediately relevant are the provisions proposed to be added to s 73ZN dealing with banning orders themselves. Under the Act as it presently stands, the Commissioner’s power to make a banning order is relevantly limited to “a person who is employed or otherwise engaged by an NDIS provider”. The amendment would allow a banning order in respect of a person who is “or was” employed or otherwise engaged by an NDIS provider.

A further provision proposed by the bill, s 73ZN(2A), would expand the Commissioner’s power to make a banning order to a person who has not previously been either an NDIS provider or previously employed or otherwise engaged by an NDIS provider. This power would be available where the Commissioner reasonably believes that the person is not suitable to be involved in the provision of specified supports or specified services to people with disability.

The existing provisions in relation to procedural fairness would apply to these new powers.

The last substantive amendment is to s 73ZS. A new provision would be added dealing with the NDIS Provider Register so that it may include information in relation to a person against whom a banning order is made under either of the new provisions: that is, a person who was no longer employed or otherwise engaged by an NDIS provider or a person who had not previously been so employed or engaged where the Commissioner reasonably believes that the person was not suitable to be so involved.

Although not causally related to the neglect and subsequent death of Ms Smith, these amendments seem to me to be necessary to meet those circumstances. For example, as I have said above, the Commissioner presently has no power to make a banning order in respect of Ms Smith's carer because she is no longer "a person who is employed or otherwise engaged by an NDIS provider". Neither does the Commissioner presently have power to make a "pre-emptive" banning order where a person is coming from another sector, and has not previously been employed or otherwise engaged by an NDIS provider. A ready example, mentioned in the Explanatory Memorandum to the bill, would be where the Aged Care Quality and Safety Commissioner had taken action in respect of the person. In those circumstances, the Commissioner may reasonably believe that the person is not suitable to be involved in the provision of specified supports or specified services to people with disability.

There may however be a gap in relation to former NDIS service providers which should be filled so as to put the matter beyond argument. The issue is whether the Bill should explicitly enable the Commissioner to ban a provider that has been but is no longer a provider of NDIS services. As the Act stands, an NDIS provider in s 73ZN(1) does not include explicitly a person who is no longer an NDIS provider. Further, I doubt that s 73ZN(1)(a) would always be available because there would be a number of persons who are no longer an NDIS provider but whose registration has never been revoked. Under s 73E(5)(e), registration is in force for a period and thus may expire rather than be revoked. It is arguable therefore that s 73ZN as it currently stands does not empower the Commissioner to ban a person who is no longer a provider of NDIS services.

I take the view that it is arguable that "the person" in s 73ZN(1)(b)(i) refers back to "an NDIS provider", that is an NDIS provider as defined in s 9 of the Act. That definition is cast in the present tense, for example, "a person... who receives funding... or... NDIS amounts".

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

In my view, this constituted reasonable administrative action in the context of steps taken after being notified of Ms Smith's death and did not constitute a failing in how the Commission carried out its functions.

The question may be asked whether the Commission should have identified earlier which classes of participant were at most risk or vulnerable and that it should have sent out

information requests to the registered NDIS providers sooner, and before notification of Ms Smith's death.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

The Commission's first Information Request following notification of Ms Smith's death went out to providers registered to provide the item 7 class of supports but specifically identified in that context that any NDIS participant provided such services "in their own home may be particularly vulnerable if those supports are provided by the same individual NDIS worker for any extended period of time. This vulnerability is likely to be greater where the NDIS participant lives alone." That level of specificity of risk identification does not appear in the NDIS Practice Standards.

The problem was not so much that there was evidence before the Commission indicating earlier that item 7 or a subset within that class posed an elevated risk. Rather, with hindsight, the legislative framework should probably have been more nuanced from the start and recognised that item 7 encompasses a very wide range of supports and services which do not all carry the same level of risk.

I have no material before me suggesting that the Commission had received any complaints or reportable incidents concerning other participants and providers which might have alerted it earlier to the specific risk associated with this subset within item 7.

In my view the circumstances do not suggest a failing in how the Commission carried out its functions.

What the circumstances set out above, concerning the Commission's Information Request to providers, illustrate is a broader point about the "failures" that occurred in Ms Smith's case. The relevant failures were not functional, in the sense that the Commission failed to adequately perform its regulatory role. Rather, the failures were mainly structural in that the legal framework regulating the provision of the types of services received by Ms Smith did not allow the Commission, in advance of being notified of her death and the relevant circumstances, to be sufficiently alive to the risks of having a sole carer in the home or to Ms Smith's particular vulnerability. As I have said above, without a complaint or a reportable incident being notified, there was no prospect of the Commission being specifically aware of Ms Smith's circumstances such that it could have taken pre-emptive action. The steps taken

by the Commission after being notified of Ms Smith's death also demonstrate the existing structural limitations.

I noted in an earlier section of this Report where I outline the legislative framework that the model of regulation adopted under the NDIS Act is that the NDIS Commission has no role in regulating the NDIA or the planning process but rather regulates and supervises those providing services to the participants in the NDIS. The problem with that model of regulation which has been exposed by Ms Smith's case is that the Commission, as regulator of providers, is too dependent on those providers providing it with accurate and timely information. The Commission does not have real-time access to participant data, including participants' plans which would allow it to know immediately what supports a participant is receiving without asking the provider or the NDIA.

During the Adelaide public meetings, the Registrar of the Commission, Ms Samantha Taylor, explained the Commission's approach to obtaining information for the exercise of its regulatory functions as follows:

If we require further information, the Commission constantly goes back to providers seeking further information, if that is necessary for us to assure ourselves that that incident is being managed and that risk of harm to any other participant is being avoided. We can require if a more detailed investigation is warranted, we can require a provider to undertake a more detailed investigation. We can require a provider to then report to us on that more detailed investigation and, as I said earlier, we can also undertake our own investigations where we believe that the provider has failed in their obligations or a worker has failed in their obligations under the code.

MR ROBERTSON: Does that involve sometimes the Commission dealing directly with the participants, say, if it's a complaint of that nature or how is that done?

MS TAYLOR: Sometimes we will engage with the participant if we think that it's important to engage with the participant because we think that they will bring a perspective to our investigations. Certainly, I'll be honest and say we're not obviously in incidents where there has often been a very traumatic experience for a participant. We would not - our first port of call would not necessarily be to that participant, although we would want to assure ourselves that there were people who were significant in the life of that participant involved with their direct support. Often people don't want the regulator there when something bad has happened to them but certainly where people are wishing to speak to us we will absolutely make ourselves available or reach out.

This explanation of the Commission's general approach is reasonable, in my view, within the existing regulatory framework. However, it also highlights some of the limitations in that framework which I have touched on in this part of the Report. Ultimately, in my opinion, a system for quality and safeguarding centred on individuals should regard each of those individuals, each participant, and the information he or she can provide about their experience of receiving supports and services as an available and vital source of qualitative information for the Commission in the exercise of its regulatory functions.

An example of the Commission's dependence on providers to give it information, and how this may limit its ability to take proactive action, appears from its first Information Request dated 26 May 2020. The questionnaire in that Information Request ended by asking relevant providers to "explain the areas where your organisation is not meeting the NDIS Code of Conduct or the NDIS Practice Standards".

A further illustration of this structural problem is evident from the response rate to the Commission's two information requests. Of the 2466 providers who received the first Information Request, only 1783 (about 72 percent) had responded by or shortly after the specified timeframe. The Commission then sent a further information request requiring a more detailed two-part response to 473 providers out of the 1783 who responded to the first Information Request and met certain response criteria. Only 362 providers provided a Part 1 response to the further information request by the specified time. Those 362 responses identified about 1500 participants who may fall into a vulnerable category with a sole worker. Although this is a significant number of participants to identify, it also highlights that the Commission's dependence on timely and accurate provider responses means that there are potentially several other vulnerable or at-risk participants who have not been identified and cannot be easily identified using the currently available information gathering mechanisms.

Another structural issue is that aspects of the application of the NDIS Practice Standards and the applicable Schedule in that instrument depends on decisions made at the planning phase. For example, the more rigorous and prescriptive Schedule 2 requirements in the NDIS Practice Standards could only apply to the benefit of an individual participant where a plan specified and funded a participant to receive supports in a relevant category attracting the application of Schedule 2.

These structural matters I have identified inform a number of the recommendations that I make in the following section of this Report. In particular, my view is that the Commission should have access to more information about participants and the supports they are receiving, which would allow it to make its own assessments about vulnerability and risk factors. The Commission's access to that information, and its ability to assess it and to take proactive action, should not depend on ad hoc responses by providers, on complaints and on reportable incidents.

Screening of workers

It may be asked whether the NDIS Commission failed in its regulation of the screening of workers so as better to prevent harm to a vulnerable NDIS participant, Ms Smith.

As explained to me by the Registrar of the NDIS Commission, Ms Taylor, the Commission does not presently have a role in the screening of workers. The Commission's role at present is to require registered providers to screen workers through State and Territory screening mechanisms. The NDIS Commission has no direct role. This division of responsibilities appears to reflect Part 3 of the Intergovernmental Agreement on Nationally Consistent Worker Screening for the National Disability Insurance Scheme (which took effect from 1 July 2018).

In my view, there were no failings by the NDIS Commission in this respect. Although Ms Smith's carer was not screened by the South Australia screening mechanism until after Ms Smith's death, that mechanism would not in fact have prevented that carer from providing care to Ms Smith. More importantly for the purposes of my Review, screening of a worker as a preventative measure was not part of the NDIS Commission's functions. The Commission's direct functions in this area are reflected in the *National Disability Insurance Scheme (Practice Standards—Worker Screening) Rules 2018 (Worker Screening Rules)*, which relate to its chief role as the regulator of providers. Division 4 of Part 2 of those rules concerns worker screening requirements imposed on registered NDIS providers. Section 13(2) provides that “[s]ubject to the exceptions contained in this Division, a registered NDIS provider must only allow a worker to engage in a risk assessed role, if the worker has a clearance.” Therefore, the Commission could only have realistically been alerted to the fact that Ms Smith's sole carer was not screened during the period she provided supports and services to Ms Smith if that had been detected through the audit and registration process.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

The Registrar also accepted that it was important to move towards a nationally consistent approach to screening of workers within the NDIS, because the criteria for screening and determining who can work within the NDIS must be consistent in a national scheme. People move across jurisdictional borders and the Registrar said it was important for there to be a

consistent way of determining the thresholds for what constitutes a worker who would be able safely to support a person with disability.

The Registrar said the NDIS Commission was supporting the States and Territories together in moving towards a nationally consistent approach to screening of workers within the NDIS. Most States and Territories have introduced new legislation to commence those new national screening arrangements that will now commence from 1 February 2021.

The role of the NDIS Commission will be to hold a database that contains the clearance information and very high-level information about every worker that has been screened in the NDIS. That would be a service effectively to help NDIS providers comply with their screening obligations whether under the NDIS Act and rules or State or Territory law. Providers will be able to use that database to associate themselves with workers and to identify whether or not those workers had been screened, or to verify that screening as well as having the worker themselves providing their screening clearance to their provider. In South Australia there would be some adjustments to the arrangements to meet those nationally consistent approaches without diminishing the requirements that are presently in place.

In the lead up to those national arrangements, each State and Territory has specified to the Commission the transitional or interim worker screening arrangements that they wish the Commission to impose upon NDIS providers until the date that the new national arrangements come into place. Arrangements had been set up by the South Australian Government about how screening should occur to comply with the laws in South Australia. Those arrangements are reflected in Part 4 of the Worker Screening Rules.

The database that the Commission will have in February 2021 will take data from State and Territory clearance agencies and those agencies will feed the data in real-time into that database. It will be a real-time monitoring of clearance records within the NDIS. The screening units across the country will have relationships with each other to share information as well as sharing information arrangements between each worker screening unit and the NDIS Commission.

The NDIS Commission has in place many information sharing arrangements already in the States and Territories and is working on further arrangements from 1 February 2021. It is also formalising arrangements for information sharing to meet the conditions that have been established through revisions to the Worker Screening Rules that occurred on 1 July 2020.

Alongside the arrangements being developed for worker screening is the issue of worker capability and suitability. This is a broader issue that has been raised by a number of submissions to me and which concerns one of the Commissioner's core functions in s 181E(e) of the NDIS Act, "to promote continuous improvement amongst NDIS providers and the delivery of progressively higher standards of supports and services to people with disability". The importance of this issue is also highlighted by Ms Smith's case.

Although a number of submissions to me point out that there are many dedicated and caring people working in the disability sector, several submissions also identify the supply and quality of the disability sector workforce as significant challenges.

Some who have made submissions support worker registration and minimum qualification requirements for anyone working in the disability sector. I understand that the Commission has not adopted this approach but is currently developing the NDIS Workforce Capability Framework which reflects the Australian Government's Growing the NDIS Market and Workforce Strategy, released in early 2019. According to the NDIS Commission's website:

The Capability Framework will translate the NDIS principles, Practice Standards and Code of Conduct into clear and observable behaviours that service providers and workers should demonstrate when delivering services to people with disability.

The Capability Framework will include:

- **core capabilities** that all service providers and workers will be expected to have
- **complementary capabilities** required by workers who assist participants with tasks that require specific knowledge or expertise
- **technical capabilities** for those who deliver higher-intensity services that require specialised knowledge or expertise.

The National Mental Health Consumer and Carer Forum, in its submission to me, said it was encouraged by the NDIS Commission's development of the Capability Framework.

I understand that the Capability Framework is currently in its testing phase, which should be completed by about November 2020.

It is not possible to know whether the implementation of a Workforce Capability Framework, and the additional training and development that might have come with it, could or would have been a mechanism guarding against the neglect and harm Ms Smith experienced in the period before her death. According to the Commission's latest 6-month Activity Report, as at 31 December 2019, 147,718 people have completed the Worker Orientation Module.

[There follows parts of the Report to the Commissioner which are not able to be disclosed to the public, consistently with the constraints in my terms of reference.]

In my opinion, even with uniform screening and assessment against a Capability Framework, it will remain necessary for carers continually to be trained in relation to the capabilities, disabilities and needs of the individuals whose care is given to them.

Term of Reference 4

I am asked by this term of reference to recommend any changes to the NDIS Commission's processes or systems, or the legal framework governing the Commission's functions, that I consider appropriate.

In making these recommendations, my focus is not on all people with disability as most people with disability are not vulnerable, in the sense of at risk of harm or neglect. Yet those who are at risk of harm or neglect are a significant proportion of people with disability. I received many submissions reinforcing this observation. The following submission from the Queensland Public Advocate, Ms Mary Burgess, gets to the heart of the issue:

While it is important to avoid being overprotective of vulnerable individuals, and recognise that not all people with disability are vulnerable and in need of protection, it is critically important that the NDIS has systems of monitoring and oversight that will identify risks to vulnerable participants, and act on them before the person suffers harm.

My perspective in conducting this Review and in preparing this Report is that of the individual and the effect on that person, the NDIS participant, of the Commission's processes or systems. The processes and systems are not ends in themselves.

Submissions to me, which I accept, suggested that for most NDIS participants fundamentally the system worked well. However, I also accept the submissions both from organisations and individuals with lived experience of the system that it can be very difficult to navigate, especially for participants who have few informal supports (such as actively engaged family members providing advocacy) and for those who have a cognitive disability.

My recommendations, together with some further explanation of them, are as follows.

- (1) The Commission should act to identify earlier those people with disability who are vulnerable to harm or neglect. Every stage of decision-making, including corrective regulation, should be alive to factors indicating that a participant may be vulnerable to harm or neglect. (Although not within my terms of reference, the NDIA should also so act in the planning process and continually.) The Commission and the NDIA should have a freer and two-way flow of information for this purpose.*

This recommendation stems from two considerations. First, the NDIS Commission is not itself involved in the planning process or the point at which a person enters the NDIS. Indeed, as things stand, it does not ordinarily have access to a participant's plan or the information around it. What the NDIS Commission does by way of regulation of the service provider is therefore general in that its primary field of operation is on the operational quality of a provider, its workers and the supports and services it delivers.

Second, it goes without saying that the Commission's resources are finite. Being aware earlier of people with disability who are vulnerable to harm or neglect would enable the Commission to direct its resources to those potentially acute circumstances, even where those circumstances arise outside the scope of periodic audits, a complaint being made or the notification of a reportable incident which are the Commission's major levers.

Much recent work has been done in the context of the COVID-19 pandemic to identify NDIS participants who are vulnerable and to contact those participants as part of a coordinated outreach initiative. This work should continue and the results adopted by both the NDIA and the NDIS Commission. As it was put to me, in making the assessment, there needs to be a dimension added about the vulnerability arising from social isolation or poor social connectivity.

As submitted by the Queensland Public Advocate, Ms Smith was extremely vulnerable because of her level of physical disability, her dependence on others for her daily care and her limited (or non-existent) social or family networks. Despite her level of capacity, her level of vulnerability exposed her to the same risks of abuse, exploitation and neglect as those often experienced by people with impaired decision-making capacity.

As I have set out earlier in this Report, the NDIA submitted that it is continuing to refine its approach to identifying and mitigating risks for participants who may be vulnerable. The NDIA submitted that the Risk Assessment guidance had been recently updated and is used by all NDIA and Partner staff when undertaking pre-planning with participants.

- (2) *No vulnerable NDIS participant should have a sole carer providing services in the participant's own home. The relevant statutory instruments and guidelines should be amended to provide expressly for this.*

The critical circumstance in the case of Ms Smith was that she became invisible to everybody but her sole carer. She had no or limited mobility and became isolated from all but her sole carer. At the relevant time, Ms Smith appears to have had no interactions with her relatives or her neighbours or people in her local area. She did not see her general practitioner. It is not the case that every vulnerable participant would suffer harm in these circumstances because vulnerabilities differ between individuals. But there is a substantial risk of harm which would be avoided if there

were more than a single pair of eyes. The regular presence of at least one other human, another carer, would reduce the risk.

In making this recommendation, I am mindful that imposing such an express requirement on service providers can create operational challenges (especially for smaller providers) and that a core objective of the NDIS Act, as set out in s 3(1)(e), is to “enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports”. However, in my view, Ms Smith’s case highlights the need to balance those valid considerations and objectives against another, and equally important, objective which is to “protect and prevent people with disability from experiencing harm arising from poor quality or unsafe supports or services” (s 3(1)(ga)). Administrative and regulatory action under the NDIS Act should, at every stage, seek to strike an appropriate balance of these different objectives.

- (3) *For each vulnerable NDIS participant, there should be a specific person with overall responsibility for that participant’s safety and wellbeing. That individual should be clearly identified by name and, ideally, introduced in person, to the vulnerable NDIS participant. (Although not within my terms of reference, that individual should be identified in a participant’s plan.)*

As I have said, a number of submissions referred to the complex nature of the NDIS and the result that for some participants navigating the system, using the services in their plan was very difficult and time-consuming. Submissions also referred to the piecemeal provision of care to those who wanted it. As it was put to me in submissions, the NDIS has many moving parts, with many roles. This complexity may lead to an end point where there is nobody that has a locus of responsibility to make sure that things are going well overall for the individual. Because there are so many different players, there is no natural person to contact when things are not going so well.

None of this is intended to detract from the principles of a participant’s choice and autonomy. In my view, as Ms Smith’s terrible circumstances showed, there is a missing element which is, however described, a person with overall responsibility for the individual vulnerable NDIS participant’s safety and wellbeing. In so recommending, I do not wish to debate the nomenclature: whether local area coordinator, case manager, or support coordinator.

As put to me in a number of submissions, having such a person with this role in the life of a vulnerable participant will also help and support that participant to develop capacity and to utilise the existing safeguarding tools such as making a complaint to the Commission or providing feedback to and about a provider. A number of submissions from peak body organisations recommended that there be guaranteed and ongoing funding for support coordination to take up this role throughout a participant's involvement in the NDIS. Those submissions point out that a person with such a role can help identify a participant's vulnerability, including changes in the circumstances of vulnerability which might require extra safeguards over time. One submission suggested, reasonably in my view, that a person with this role meet at least annually with the participant, including at least one face-to-face meeting per year, and that where a service such as support coordination is not available due to factors such as remoteness, for example, a planning delegate from the NDIA perform this function. This overlaps with my next recommendation. It is, in my opinion, necessary to counteract what is seen by many who made submissions to me as the transactional nature of the NDIS. Personal contact by a human being, not straitened by software, is persuasive evidence, to a participant, of the necessary humanity of the Scheme. The recent experience of contacting individuals by telephone as part of the COVID-19 exercise has illustrated this effect.

- (4) Consideration should be given to the Commission establishing its own equivalent to State and Territory based Community Visitor Schemes to provide for individual face-to-face contact with vulnerable NDIS participants. Such contact is also important in emphasising the personal values necessarily involved in providing services to individuals with disability. The NDIS Act should be amended to provide explicitly for this function. Until that happens, the Commission should continue to support the State and Territory Community Visitor Schemes and any doubt about State and Territory powers under those schemes in relation to NDIS participants should be resolved between the law officers of the Commonwealth and of these States and Territories. The State and Territory Community Visitor Schemes will of course continue to apply directly in relation to those with disability who are not NDIS participants.*

In my view, a human assessment, face-to-face, of a vulnerable participant will provide a quicker and more accurate result in assessing risk to that person. I regard this as a complementary adjunct to the NDIS Commission's regulatory functions in relation to service providers and their employees. After all, it is the safety and well-being of the individual participants which is the object of the entire system.

WestWood Spice described the background and purpose of Community Visitor Schemes in its Community Visitor Schemes Review of December 2018 as follows (at page 8):

In 2016-17 CVS made over 12,000 visits to adult disability services. The broad purpose common to all the CVS considered by this review is to visit people with disability and independently monitor if their human rights are being met by the service systems they rely on. At their best, CVS achieve important outcomes for people with disability in services, encouraging them to express their views, listening, building capacity in asserting rights or linking with supported decision-making processes and advocates. Visiting in person and talking assists people with disability to build confidence and experience in expressing their views and needs. By tracking service responses to issues CVS can also demonstrate that it is worth complaining, as well as being safe to do so.

Disability services indicated strong support for CVS in all the jurisdictions with schemes. As well as assisting in the local resolution of issues and complaints they play a capacity-building role in identifying good practice. They also escalate serious matters and enable systemic issues to be identified.

(Footnote omitted.)

The same Community Visitor Schemes Review found (at page 11):

CVS provide local, independent support to vulnerable NDIS participants by:

- Upholding an individual's human rights and ensuring service provision is appropriate in order to prevent violence, abuse and exploitation.
- Supporting appropriate decision making reflecting the wishes of individuals.
- Facilitating local capacity building to achieve resolution of issues in services at the earliest possible stage.
- Adding to regulatory intelligence on services and systemic issues to the state or territory as well as to the NDIS Commission.

More informally, as it was put to me, there is a place for a Community Visitor Scheme because it can be that extra pair of eyes of somebody coming in and being able to talk to individuals about how things are going in their lives and having some kind of external input. Then the community visitor can refer any matters of concern to the appropriate investigating authority. In this respect, community visitors are expert "complainants".

The advantage of the NDIS Commission having this function in relation to NDIS participants is that the result would be national and uniform in circumstances where two of the States and Territories do not have a Community Visitor Scheme, and as between those jurisdictions which do have such a scheme there is some variation. As also noted in the Community Visitor Schemes Review by WestWood Spice (at page 8):

There are currently six different state and territory-based schemes involved in visiting disability services in Australia. Schemes vary in scope, scale and design. As well as

vulnerable NDIS participants, some schemes visit people in forensic disability facilities, mental health units or children in Out of Home Care.

Community Visitors hold their roles as statutory appointees under a variety of legislative instruments. Appointments are made by the State Governor, Public Guardian or relevant Minister, usually for three-year terms. In two schemes, the appointees are volunteers. Visitors work within frameworks established with a co-ordinating department and have powers relating to announced and unannounced visiting. Western Australia and Tasmania do not currently operate CVS for disability services.

In those circumstances, funding by the Commonwealth may be administratively complex. The Productivity Commission had, I think, the same point in mind in saying in its original report that an alternative but inferior option would be a 'federated' NDIS. It said: “This would give state and territory governments control over their own systems, but with some common core features. Such an arrangement could easily revert to the current flawed and unfair system, with 'agreements' breaking down into disputes about who is to pay, how much and for what.”

The NDIS Commission operating its own equivalent Community Visitor Scheme is also consistent with the Commissioner’s core function in s 181E(b) of the NDIS Act “to develop a nationally consistent approach to managing quality and safeguards for people with disability receiving supports or services, including those received under the National Disability Insurance Scheme”.

I do not suggest that this function, if given to the NDIS Commission, be called the Community Visitor Scheme as that nomenclature has its own history which is not precisely apposite where institutional living is no longer central.

I take it as a given that except in extreme circumstances, authorised by statute, such a visitor would not be able to go into a person’s home without that person’s consent, but I do not think that that consideration should prevent such a function from otherwise operating. Ms Smith may not have consented to a visitor, especially if it was a person she did not know, but a visitor was not available under the Community Visitor Scheme in South Australia, as I understand it, because Ms Smith was an NDIS participant and thus outside the “jurisdiction” of the Scheme.

Until there is an NDIS Commission equivalent in place, the State and Territory based schemes will continue in relation to those NDIS participants which the State and Territory authorities consider to be within the scope of that scheme. One example is people who are NDIS participants and under the guardianship of the Public Advocate.

The Community Visitor Scheme in South Australia (**SA CVS**) was described to me by the South Australia Public Advocate and Acting Principal Community Visitor as follows.

The scheme was established under the South Australia *Mental Health Act* and was extended to disability services under the *Disability Services (Community Visitor Scheme) Regulations 2013 (Disability Regulations)*.

The SA CVS is for people living with disability or mental illness who are: receiving care in a mental health treatment centre or hospital; or attending a community mental health facility; or living in state-run disability accommodation.

The SA CVS undertakes visits to services and provides advocacy and assistance to clients, their carers and family members in relation to care and service provision.

The SA CVS is independent, enabling patients/residents, carers and family members to speak with individuals who are not associated with the provision of support and services.

The South Australia Public Advocate and Acting Principal Community Visitor in her submission said the Disability Regulations empower the SA CVS to:

- conduct regular visits and inspections of disability accommodation, supported residential facilities and disability day options programs in order to assess and report on services provided to clients, identify any gaps in service provision and report on this to improve the quality, accountability and transparency of disability services;
- act as advocates for disability clients to promote the proper resolution of issues relating to their care, treatment or control, including issues raised by a guardian, medical agent, relative, carer, friend or any other person who is providing them support;
- refer matters of concern relating to the organisation or delivery of disability services in South Australia or the care, treatment or control of an individual to the Minister, Minister's delegate, or any other appropriate person or body;
- ensure plans, policy and practise development is influenced by the experience of people with a disability and their relative, guardian, carer, friend or supporter.

The South Australia Public Advocate and Acting Principal Community Visitor in her submission said that for the purposes of carrying out functions of a community visitor, a community visitor may enter disability accommodation premises or day options programs premises and, while there, may: meet with a resident or person attending a day options program; with the permission of the manager of the premises, inspect the premises or any equipment or other thing on the premises; and request any person to produce documents or records; and examine documents or records produced and request to take extracts from, or make copies of, any of them.

The SA CVS does not have statutory power to enter the private home of a person with a disability.

In mid-May 2019, the SA CVS ceased visits to non-government run organisations, supported residential facilities and day options programs as responsibility for those facilities shifted to the NDIS Commission on 1 July 2018 in South Australia.

Under current arrangements in South Australia, the SA CVS has the power to visit Accommodation Services provided by the South Australia Department of Human Services. It also has the ability to visit people who are NDIS participants and under the guardianship of the Public Advocate.

In late 2019, the Principal Community Visitor and the South Australian Office of the Public Advocate (OPA) agreed that Community Visitors may visit people under the guardianship of the OPA who receive services funded through the NDIS. The arrangement has been achieved by delegation of the Public Advocate's powers to the SA CVS.

The OPA aims to conduct regular (and at a minimum, annual) visits to clients for whom they are a guardian. These visits are part of the OPA's approach to good practice, as it is not a statutory function of the Public Advocate under the South Australia *Guardianship and Administration Act 1993*.

There is, I understand, a difference of legal opinion about whether some State and Territory based schemes can operate in relation to NDIS participants under Commonwealth legislation by reason of s 109 of the Constitution. But that issue should be able to be resolved either between the respective Solicitors-General or Attorneys-General or, if that failed, by amendment to the Commonwealth legislation to put the intention of the Commonwealth legislature beyond doubt.

- (5) *Because of the inherent limitations in record based systems in preventing harm or the risk of harm to vulnerable participants, the Commission should conduct occasional visits to assess the safety and wellbeing of selected individual NDIS participants, whether or not a complaint has been made or a "reportable incident" notified. The Commission should miss no opportunity for face-to-face assessment of vulnerable participants. (Although not within my terms of reference the NDIA should also so act.) The Commission and the NDIA should have a freer and two-way flow of information for this purpose so that the NDIS Commission's selection of participants to visit is an informed one.*

At present, in addressing quality and safety, the NDIS Commission is substantially dependent on setting standards and imposing obligations on service providers and

their workers. By its nature, audit is after the event albeit with some prospective elements which may help a service provider improve its operational capabilities. As the circumstances of Ms Smith demonstrate, even where there is a system of reportable incidents and complaints there is still a gap in terms of preventing harm or the risk of harm to vulnerable participants. The registration process and the requirement that registered providers complete periodic quality assurance audits (even where it involves sampling of participant experience) do not necessarily fill that gap. It seems to me that the possibility of a visit to a vulnerable participant would have two benefits. First, the service providers and their employees would be aware of that possibility and would therefore increase their vigilance. Second, a visit would enable the NDIS Commission to be aware at first hand and before the event of an emerging or present risk to a participant.

The Commission's ability to identify and select potentially vulnerable participants to visit in this way should not depend mainly on information and data it collects from the providers that it regulates. A freer flow of information between the Commission and the NDIA will allow both those agencies to take informed action with the benefit of additional and more independent sources of information.

- (6) *The statutory definition of "reportable incident" in s 73Z of the NDIS Act should be amended to make it clear that it includes a real or immediate threat of one of the listed types of harm. The word "complaints" in s 73X of the NDIS Act should be defined to remove any doubt that it includes concerns and observations in relation to the provision of supports or services by NDIS providers.*

Although there is some suggestion in the material before me that the legislation is administered by the NDIS Commission so that a broad meaning is given to "reportable incident" and "complaints", both these matters should be put beyond doubt. In the case of a "reportable incident" important obligations are imposed on the provider and therefore those obligations should be clear. In the case of "complaints", a number of submissions to me were to the effect that, at least in some cases, the word became an obstacle to dealing with the substance of a concern for the safety and wellbeing of an NDIS participant. It should go without saying that reportable incidents of substance and "complaints" of substance should be investigated with rigour. A late submission suggested that the Commission should where necessary outsource such matters to approved investigators. I have not had time to examine the need for, or the practicalities of, such a course. Much would depend on staffing levels

and capabilities within the Commission. If the Commission has not considered this course, it seems to me to be an idea worthy of consideration.

- (7) *The Commission must at all times be able to know whether a person is or is not an NDIS participant. The Commission should also have readily available access to information held by the NDIA concerning what supports a participant is receiving and the provider of such supports. The Commission should not depend on providers to provide it with such information only after a request.*

This may be thought to be a technical issue but nevertheless I think it is a significant one. It was, at best, inefficient that in the case of Ms Smith it took the NDIS Commission some time to find out whether she was an NDIS participant. Similarly, in my view, the Commission should have ready access to information concerning what supports an NDIS participant is receiving and from which provider. The focus of the NDIS Commission on the regulation of providers does not seem to me to be a reason why the Commission should depend on those providers for that information and it being provided on request.

In light of s 60(2)(d)(i) and (ii) and s 67A(1)(d)(i) and (ii) of the NDIS Act, I see no obstacle to the free exchange of information between the NDIS Commission and the NDIA. If legal advice to those agencies is to a different effect, then I recommend that the provisions should be amended to allow that free exchange.

- (8) *There should continue to be improvements to the exchange of information and more formal lines of communication between those running the State and Territory emergency services (including police) and schemes for people with disability and the Commonwealth agencies, being the Commission and the NDIA, and vice versa.*

Work has been done by the NDIS Commission to improve communications and the exchange of information between the relevant State and Territory services for people with disability and the Commonwealth agencies. On each side a “no wrong door” principle is said to operate. In making this recommendation I am mindful of the fact that the Commission is still a relatively new regulator, having only come into existence from 1 July 2018, and that it is in the process of formalising protocols and instruments with various State and Territory agencies for the sharing of information and formal cooperation.

- (9) *To this end, s 67A(1)(e) of the Act should be amended so that the word “serious” is deleted. A threat to an individual’s life, health or safety should be enough to authorise the use of the protected Commission information. Also the word “necessary” should be replaced with a word such as “needed” so that the information may be used even if it is not essential to preventing or lessening a threat to an individual’s life, health or safety. Consideration should also be given to defining the word “threat” in the*

expression “prevent or lessen a threat” so that it includes preventing or lessening for the future a threat which has passed. (Corresponding amendments should be made to, or considered for, s 60(2)(e) for protected NDIA information.)

Officials quite properly take seriously the statutory limitations on the use of NDIS Commission (and NDIA) information. In my view the flow of information would be improved without risk to privacy if a threat, rather than a serious threat, to an individual’s life, health or safety was sufficient to authorise the use of the protected Commission information. Similarly, the word “necessary” has a number of meanings some of which, in my view, are overly restrictive. It was also brought to my attention that the expression “prevent or lessen a threat” was limited to an event which had not yet occurred. I do not see any reason why this limitation should be preserved and I therefore recommend that consideration should be given to including preventing or lessening for the future a threat which has passed.

- (10) *The Commissioner should have statutory power to ban a person from working in the disability sector even where that person is no longer so employed or engaged. This aspect is the subject of the National Disability Insurance Scheme Amendment (Strengthening Banning Orders) Bill 2020 currently before the Commonwealth Parliament. The Commissioner should have the same power in relation to NDIS service providers, that is, to include as subject to the power to ban those entities no longer providing those services.*

I agree with the need for the amendments contained in the National Disability Insurance Scheme Amendment (Strengthening Banning Orders) Bill 2020. However, I think it at least arguable that in the current Bill there remains a gap where a service provider has ceased to provide the services. In the circumstances which presently apply to current service providers, the Commissioner should have the power to ban a service provider even where that entity is no longer providing those services.

Appendix 1 – Terms of Reference for the Independent Review



NDIS Quality
and Safeguards
Commission

Terms of Reference

Ms Ann-Marie Smith (formerly of Bradman Court, Kensington Gardens, SA), an NDIS participant, died on 6 April 2020 in appalling circumstances.

The death of Ms Smith is the subject of active investigation by the NDIS Quality and Safeguards Commission (NDIS Commission) and by South Australia Police.

The death of Ms Smith also raises questions about the adequacy of the regulation of the supports and services provided to Ms Smith, including regulation in relation to quality and safeguarding pursuant to the functions and powers of the Commissioner of the NDIS Commission.

The NDIS Commission is engaging The Hon. Mr Alan Robertson SC (the Independent Reviewer) to conduct an independent review of this matter for the Commissioner in accordance with the following terms of reference. In conducting the review the Independent Reviewer will not be subject to any direction by the Commissioner or any officers of the NDIS Commission and will be provided with all reasonable facilities, resources and other assistance required for the effective conduct of the review.

The Independent Reviewer is to:

1. Identify and describe, for each of the periods specified below:
 - (a) the nature and level of the supports and services provided to Ms Smith as a person with disability;
 - (b) the extent to which any mechanisms that might have guarded against the particular vulnerability of Ms Smith, such as guardianship in relation to any lack of capacity, were available and were accessed by or on behalf of Ms Smith or applied or sought to be applied in relation to Ms Smith; and
 - (c) the points, if any, at which concerns about Ms Smith's safety could or should have been identified and responded to by service providers, government agencies or regulators,

recognising that Ms Smith may have been living in relative isolation since around 2009 following the death of her parents, and recognising the particular vulnerability of people with disability living in isolation.

Periods

Period 1: from the death of Ms Smith's last surviving parent, until when Ms Smith became an NDIS participant

Period 2: from when Ms Smith became an NDIS participant, until Ms Smith's death on 6 April 2020.

2. Examine how the NDIS Commission carried out its functions:
 - (a) in relation to Integrity Care (SA) Limited (Integrity Care) prior to the Commission being notified of Ms Smith's death; and
 - (b) in response to the notification of Ms Smith's death, including the taking of any action to identify and address risks to the safety or well-being of NDIS participants who might be in circumstances of vulnerability similar to, or approaching, those in which Ms Smith was living before her death.
3. Identify any failings in how the NDIS Commission carried out its functions as examined under paragraph 2.
4. Recommend any changes to the NDIS Commission's processes or systems, or the legal framework governing the NDIS Commission's functions, that the Independent Reviewer considers appropriate in light of his findings under paragraph 3.
5. By 31 August 2020 provide to the Commissioner of the NDIS Commission his report in relation to these matters, noting that, during the course of his work, the Independent Reviewer is to raise in writing with the Commissioner any issues or concerns he identifies that he considers require more urgent attention.

The review is to be conducted in a manner that avoids prejudice to any pending or current criminal or civil proceedings.

The disclosure of information for the purposes of the review is to be governed by the provisions of the *National Disability Insurance Scheme Act 2013*.

The recommendations of the Independent Reviewer are to be consistent with the general principles set out in section 4 of the *National Disability Insurance Scheme Act 2013*, which guide action under the Act.

The Commissioner of the NDIS Commission intends to publish the report of the review, subject only to any redactions necessary to avoid prejudice to any criminal, regulatory or civil proceedings and any redactions identified as appropriate by the Independent Reviewer to protect the privacy of any individual.

Appendix 2 – List of those who made submissions to the Independent Review

- Dr David Caudrey, Disability Advocate for South Australia, Office of the Public Advocate
- Professor Grant Davies, Complaints Commissioner, Health and Community Services South Australia
- Dr David Caudrey and Ms Kelly Vincent, Co-Chairs, South Australia Disability Taskforce
- Ms Lois Boswell, Acting Chief Executive, Department of Human Services South Australia
- Ms Lesley Dwyer, Chief Executive Officer, Central Adelaide Local Health Network
- Ms Anne Gale, Public Advocate and Acting Principal Community Visitor, Office of the Public Advocate
- Ms Kendall Field, Chief Executive Officer, Disability Advocacy and Complaints Service of South Australia
- Ms Catherine Viney, Disability Services Manager – Family and Community Services, Baptcare and the relevant employee of Baptcare, the Local Area Coordinator for Ms Smith’s second plan
- Mr Martin Hoffman, Chief Executive Officer, National Disability Insurance Agency (NDIA)
- The NDIA planning Delegate who approved Ms Smith’s first plan
- The NDIA planning Delegate who approved Ms Smith’s second plan
- The General Manager, Complaints and Reviews, NDIA
- Ms Stella Robinson, Director Safety and Quality, Department of Health South Australia
- Ms Lyn Franco, Chief Executive Officer, Australian Community Industry Alliance
- Ms Melanie Southwell, General Manager, Specialist Disability Accommodation Alliance
- Mr Andrew Stewart, NDIS consumer and Commission client and Managing Director, Hearing Connections
- Ms Mary Sayers, Chief Executive Officer, Children and Young People with Disability Australia

- Mr Keir Saltmarch, Consumer Co-Chair, and Ms Hayley Solich, Carer Co-Chair, National Mental Health Consumer and Carer Forum
- Ms Romola Hollywood, Director Policy and Advocacy, People with Disability Australia
- Ms Annette Herbert, Mother and carer
- Mr Kai Sinor, Senior Lawyer, MPS
- Ms Carolyn Frohmader, Executive Director, Women with Disabilities Australia
- Mr Chris Pazera, Retired public servant
- Mr Gordon Thackray, Individual with an interest in the matter
- Ms Hilary Reid, Support Worker and Disability Advocate
- Professor Richard Bruggemann, Professorial Fellow, Disability and Social Inclusion Unit Flinders University
- Ms Karen Grob, Aunt of a participant with complex high care needs
- Ms Robyn Wallace, Physician in internal medicine
- Mr Peter Jessup, Ms Bronwyn Tregenza, Ms Judy Clutterbuck, Former Program Managers and Manager of the Department of Human Services Exceptional Needs Unit between 2007 - 2019
- Ms Mary Burgess, Public Advocate (Queensland)
- Ms Jackie Hayes, Team Leader, Purple Orange
- Ms Delphine Stagg, Chair, South Australia Council on Intellectual Disability Inc.
- Ms Kate Strohm, Director, Siblings Australia Inc.
- Ms Anne Shattock, Nurse
- Mr Keith Banfield, Individual with an interest in the matter
- Dr Rachele Tullio, Member, purple Orange Co-design Council
- Ms Leanne Longfellow, Sister of the late Mr David Harris
- Ms Colin Smith, Individual with an interest in the matter
- Ms Dawn Brooks, Administrator for her son with disabilities
- Mr David Sinclair, Executive Officer, Assistive Technology Suppliers Australia
- Mr Vladimir Yuzhakov, Chief Executive Officer, PosiSense
- Ms Marion Champion, Senior Manager Social Work, Norther Adelaide Local Health Network
- Dr Neisha K Wratten, Specialist medical practitioner and mother of a son with a disability

- Mr Robert Hamilton, Head of Local Area Coordination, Uniting
- Mr Kevin Stone AM, Chief Executive Officer, Victorian Advocacy League for Individuals with Disability (VALID)

Not included in this list is a small number of submissions which, with the author's consent, I referred to the NDIA as falling outside my terms of reference.

One person in the list set out above also made a submission which was said to be confidential.