NDIS REVIEW – PARTICIPANT SAFEGUARDING

Background

Through the Independent Review of the NDIS, a review has been commissioned, looking at NDIS Participant Safeguarding (herein known as *the Paper*). https://www.ndisreview.gov.au/resources/paper/ndis-participant-safeguarding-proposals-paper

This Review comes as a result of the findings and feedback from;

- the Royal Commission into Violence, Abuse, Neglect and exploitation of People with Disability (Disability Royal Commission), and;
- the independent 'Robertson Review into the circumstances relating to the death of Ms Ann-Marie Smith recommendations to improve the safety of NDIS participants;
- The NDIS Quality and Safeguards Commission's Own Motion Inquiry into Aspects of Supported Accommodation in the NDIS.

The purpose of the Proposals Paper on Participant Safeguarding is to discuss ways of ensuring that participants are safe, empowered and aware of their rights and that all parts of the NDIS work effectively to promote this.

This paper relies heavily on the assumption of 'effective natural safeguards' (pg 7 NDIS Review, NDIS Participant Safeguarding), and 'strong participant capacity in how the NDIS can best promote the safety of participants'.

This assumption provides for a normalisation of the existence of 'effective natural safeguards' and its existence in the lives of some of our most vulnerable citizens. A concern with this perspective is that often some of our most vulnerable citizens do not live in environments that have 'effective natural safeguards', and it is arguable that the needs of these individuals require the greatest of protections. The current policy does not address this.

Royal Commission Hearing 33 Case Study

The aforementioned case study outlines the circumstances of two brothers living with disability, with their father, that were discovered, naked and locked in a bedroom, when their father had died. The circumstances in which those brothers lived, has since become the subject of an NDIS Review as to how they weren't 'picked up', how one brother had an NDIS Plan and the other brother did not, despite having very similar disabilities, and the brother that had the NDIS plan, had not had a significant

or appropriate level of ‘drawing down’ on his plan over an extended period of time, a matter that had not been identified as an issue at any time by the NDIS.

There was also an acknowledgement of the breakdown of government services to act in response to a number of complaints and concerns around neglect and abuse flagged with agencies that were mandated through legislation to intervene in the interests of the two brothers.

Many of these aspects although clearly evident, (hence the reports to authorities) were not followed up by the NDIS or the state government in that jurisdiction, despite the family having come to the attention of a number of authorities over an extended period of time.

This case study clearly identifies that there cannot always be an assumption of capacity of decisions makers, as it was accepted at the Royal Commission that the father probably did not really understand what the NDIS plan for his son was about, but neither did he really understand his responsibilities.

Despite this situation continuing, there was no intervention. The father was treated as the NDIS Nominee, despite his son being present at meetings, he was not actively engaged in discussions, for the most part it was identified that the NDIS Participant was not given primacy in those discussions, it was clear that there was no opportunity for choice and control by the NDIS Participant.

While choice and control is an imperative, for those that are not able to develop that capacity, are neglected, or possibly in a position where the nominated decision maker is not making decisions in the best interests of the NDIS participant, then what are the options?

The NDIS has developed additional frameworks around the management of NDIS Nominees, however, it is argued that this is not a comprehensive enough response to ensure the protection of Participants requiring greater consideration.

The Paper does not consider that the withdrawal or suspension of a NDIS Nominee does not in itself, as an act, have the capacity to impact on the broader wellbeing of the Participant. This concern is particularly relevant where there are families or circumstances subject to substance misuse, abuse and/or neglect.

Issues relating to substance misuse, abuse and/or neglect, are the most difficult to identify and respond to by NDIS staff (without the intelligence of authorised agencies), nor will they necessarily have the required level of expertise to identify the risk to the Participant in a meaningful way. This means that should a NDIS Nominee appear to be compliant with the requests or directions of the NDIS agency, risk to the Participant is not mitigated unless there is a demonstrated response from the Nominee as uncooperative or difficult.

As mentioned above, if the Nominee is suspended or terminated, this action does little to increase the wellbeing of the participant as an isolated action. It is on this basis that the requirement for the NDIS to identify a 'joined up' response to this need presents itself in a very real way.

After the identification of the circumstances in the identified Case Study, the NDIS reported it to the Royal Commission and it was found that the primacy of the rights of the individual living with disability were not considered. There appeared to be an assumption of lack of capacity of the NDIS participant, and coupled with the effects of an assertive father, there appeared to be no consideration of what the participant might want or need.

NDIS Nominee Fact Sheet

The NDIS acknowledged that revision of Nominee provisions was required and to that end provided a revised Fact Sheet and Operational Guidelines.

The Operational Guidelines written to support the Fact Sheet and changes to the Nominee provisions provides an outline of how and when a Nominee may be suspended or terminated. In the event of a termination or suspension of a Nominee, there is a process where the Nominee must respond within a 28 Day period.

This process is simplistic and does not, again, consider the complexities of family and/or carer dynamics or dysfunction.

For the NDIS to assert control over the affairs of an individual in such a comprehensive, independent and self-regulated fashion could be considered an act that decries the commitment of the NDIS to consider the views of the NDIS Participant.

In cases where there may be conflict with the NDIS Nominee, Participant and the NDIS, a separation of decision making is surely beneficial to an efficient outcome, particularly if it is handled by a separate entity. The complexities in family and caregiver dynamics and relationships are an aspect that possibly requires greater consideration.

Another dimension is the consideration of the overall wellbeing of the NDIS participant. The termination or suspension of a Nominee due to perceived risk to the NDIS Participant is not an act that should divest the NDIS of responsibility. Where there is a perceived risk to the participant, Mandatory Reporting should follow. To act against a Nominee, without considering any greater risk to the participant (i.e., of losing the Nominee), can potentially put the Participant at additional risk.

Mandatory Reporting in cases of child abuse, neglect and abuse in situations where there is real or perceived risk is something that must be explored and considered.

Jurisdictional Responsibilities

Through the rollout of the NDIS nationally, there has been the development of Bilateral Agreements between the Federal and State Governments. Bilateral Agreements are at different stages in each state and territory jurisdiction, and potentially provide the opportunity to embed a coordinated response to those at risk of neglect, abuse and violence.

Responsibilities for the oversight of the wellbeing of our citizens does not just rest with one agency, but with agencies that have the legislated responsibility to intervene and act in the best interests of those that are vulnerable to exploitation, neglect and violence.

Within these processes, it should be clear that should a circumstance arise whereby an NDIS Planner (employee) is aware that there is possibly some concerns around the wellbeing of an NDIS Participant, besides investigating the termination or suspension of a NDIS Nominee, there must be a responsibility to escalate this concern to the appropriate agency (Police, Child Protection etc).

All Mandatory Reporting requirements should also be reportable to the NDIS Quality and Safeguards Commission.

In order to maintain consistency in the application of policy, the NDIS should not be the key decision maker as to who the NDIS Nominee should be, or whether they should be suspended or terminated.

NDIS decisions should be firmly rooted in the determination of plans and service provider oversight. The NDIS has not demonstrated the capacity to assess quality or safeguards in the care of NDIS participants, at any time, and it is not deemed to be a part of the NDIS Charter.

To this end, the process should be separated to ensure a 'Separation of Powers', allowing the NDIS to 'get on' with its mandated responsibilities (outlined in the Service Charter, https://www.google.com/search?q=ndis+service+charter&rlz=1C1AZAA_enAU802AU802&oq=ndis+service+charter&aqs=chrome..69i57j0i390i650l5j69i60l2.7709j0j4&sourceid=chrome&ie=UTF-8) of providing access to services for people living with disability.

The requirement to manage the capacity of NDIS Nominees, should rest with an independent agency, the Quality and Safeguards Commission. For the NDIS to take responsibility for this, especially in safeguarding matters where the NDIS is in dispute with the Nominee or Participant, confuses accountability and responsibility. The NDIS is not equipped to assess whether or not quality or safeguards have been breached and is not qualified to determine if an individual's rights have been impugned.

To remove conflict of interest concerns in these transactions, the NDIS should not take the responsibility for the determination or otherwise of the suitability of NDIS Nominees.

This discussion should be considered as a broader concern, for the wellbeing of the participant, and should bring with it the resources of those agencies that are mandated, and have the resources and expertise to respond appropriately should the need arise.

The mandate under which the Quality and Safeguards Commission was established clearly responds to the matter at the heart of this discussion:

The NDIS Quality and Safeguards Commission is an independent agency established to improve the quality and safety of NDIS supports and services.

We are working with NDIS participants, service providers, workers and the community to introduce a new nationally consistent approach so participants can access services and supports that promote choice, control and dignity.

The NDIS Commission:

- *responds to concerns, complaints and reportable incidents, including abuse and neglect of NDIS participants*
- *promotes the NDIS principles of choice and control, and works to empower participants to exercise their rights to access quality services as informed, protected consumers*

https://www.ndiscommission.gov.au/about/what-we-do#:~:text=responds%20to%20concerns%2C%20complaints%20and,services%20as%20informed%2C%20protected%20consumers

Recommendations

It is the intention of this response to encourage the NDIS to approach this opportunity in a way that responds to a 'whole of life' requirement.

There has been ongoing confusion by NDIS participants, and the NDIS employees as to what their role is, what the role of other entities is, and who does what. This circumstance has inevitably resulted in NDIS participants 'falling through the gaps', vulnerable people remaining unprotected, and a very confused understanding by clients about what they can expect as service from the NDIS, Support Workers and services in this sector.

The development of the NDIS Participant Safeguarding Paper does nothing to ameliorate this confusion, nor has the subsequent work of the NDIS in this space, as

it appears that they as an entity continue to struggle to understand the extent of their mandate in this servicing space.

The withdrawal or suspension of a NDIS Nominees will not automatically make the NDIS Participant safer, or better off in their home or caregiving environs.

If the NDIS is of the view that they have the authority to remove and replace an Authorised Nominee (as stated in the Fact Sheet), https://ourguidelines.ndis.gov.au/home/having-someone-represent-you/appointing-nominee , it must follow that there is a Duty of Care to the NDIS Participant to follow through and ensure that the level of risk to that individual is also mitigated within that process.

The evidence proffered to the Royal Commission provides tangible examples time and again of where there has been no accountability or responsibility taken. This is true of service providers and the NDIS where, if there had been accountability requirements through Mandatory Reporting, at least some record and movement could have been made in responding to these issues.

What is even more concerning, is that the Royal Commission has heard evidence of these problems happening. What it did not shed light on is the number of unreported incidents. The question is, what can be done to alleviate the distress of those without a 'voice', accessing services including government services, and suffering because of poor decision making and lack of concern for overall welfare? What is needed is a mandatory process and responsibility taken by all governments and agencies.

The following recommendations summarise the discussion held in this paper and provide for consideration, a deeper contemplation of the circumstances that NDIS Participants that are not afforded the access to effective 'natural safeguards' in their lives must navigate.

It is simplistic to consider that the power to remove a decision maker from the NDIS decision making processes, might have had any real impact on the overall wellbeing of the brothers described in the Royal Commission Case Study.

The responsibility of Government is to protect and provide for its citizens and identify and respond to its most vulnerable. Public Policy is not only for those that have the good fortune to be afforded 'effective safeguards' but also those less fortunate.

Government must not resile from the fact that there are many that do not enjoy a level of personal security in their day to day lives, and that they require greater consideration and protection in this instance. This means that Government should require of itself a closer look at the capacity to make a real difference, for those that require more support to achieve what others already enjoy.

Additionally, it is evident that in our work with community members, there is a distinct reluctance to report accidents and injuries by Support Workers to authorities or employer bodies. There is also a demonstrated reluctance for NDIS participants to make the same reports. This stems from a fear of consequences of losing support or in the case of the former statement support workers.

Support Workers in this sector are not adequately trained or supported. To suppose that an unregulated workforce could adequately ensure the wellbeing of a client cohort is both casual, and perhaps a little too relaxed when considering how negligence, abuse, violence and exploitation might be mitigated.

***Recommendation 1**:*

The NDIS in line with Policy and Procedures regarding NDIS Nominees, consider that where there is considered risk to the NDIS Participant, that Mandatory Reporting takes place to appropriate agencies, and is recorded and reported to and by Government, to ensure that the overall wellbeing of the individual in question is always primary.

***Recommendation 2**:*

The decision to review the capacity of the NDIS Nominee should be escalated to the Quality and Safeguards Commission, at the same time, relevant authorities should be notified of concerns, as per Mandatory Reporting requirements in the appropriate jurisdiction. These actions are to be recorded and reported to Government to ensure that the appropriate actions are being undertaken and where necessary, mechanisms established though Bilateral Agreements are maintained and that a whole of government approach to accountability is upheld.

Recommendation 3:

The Quality and Safeguards Commission should be supported to ensure that they have the processes and capacity to meet the responsibility of following up on reported concerns around NDIS Nominee ability or capacity to act in the best interests of the NDIS Participant.

Recommendation 4*:*

The NDIS and the NDIS Quality and Safeguards Commission acknowledge that there are circumstances where NDIS participants, and other peoples living with

disability may not report a support worker for breach of their duties, accidents or injuries (particularly in thin markets), and as such endeavour to ensure that a much more rigorous pathway for detection and response exists to support the needs of some of our most vulnerable citizens.

Recommendation 5:

That Government make real efforts to regulate the disability sector workforce, implementing work level standards and career pathways that includes Quality and Safeguards components that actively contribute to the ongoing wellbeing of clients in this cohort.

Inherent in this process must be the recognition of the nature of this work, the vulnerability of the client, and the expectations of the Support Worker in their day to day activities.

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