Statement of Anne Gale

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Date: 28 May 2021

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. This statement is true and correct to the best of my knowledge and belief.

2. I make this statement in my capacity as the Public Advocate and the Acting Principal Community Visitor for South Australia and am authorised to do so as per the provisions of the *Guardianship and Administration Act 1993* (SA) (in respect to the Public Advocate role) and the *Mental Health Act 2009* (SA) and the *Disability Service (Community Visitor Scheme) Regulations 2013* (SA) (in respect of the Acting Principal Community Visitor role).

Professional background

3. I am currently the South Australian Public Advocate (appointed in December 2015) and the Acting Principal Community Visitor (appointed in September 2019). I hold a Bachelor of Arts with Honours.

4. Prior to my current roles, I was Commissioner for Equal Opportunity; Deputy Commissioner, Consumer and Business Services; Deputy Chief Executive, SA

Department for Families and Communities. I have also held executive leadership roles in Ageing, Disability and Housing.

5. I am a member of a not for profit board, Access to Place, that provides community housing for people living with disability.

6. In May 2020, following the death of Ann Marie Smith, I was appointed as a member of the South Australian Safeguarding Task Force (**Task Force**) to examine gaps in safeguards for people with disabilities living in South Australia.

The role of the Public Advocate

7. The South Australian Public Advocate is a statutory officer appointed by the Governor under the *Guardianship and Administration Act 1993* (SA) to promote and protect the rights of people with a mental incapacity.

8. The Office of the Public Advocate (**OPA**) supports the Public Advocate. The OPA works with and on behalf of adults and has three main client groups:

   a. people with mental incapacity/impaired decision making capacity;

   b. family, carers and friends of people with mental incapacity/impaired decision making capacity; and

   c. people and organisations with an interest in issues arising from mental incapacity/impaired decision making capacity.

9. The main functions of the OPA are:

   a. **Guardianship** – The South Australian Civil and Administrative Tribunal (**SACAT**) has the power to decide whether a guardian should be appointed for a person with impaired decision making capacity (**protected person**). When a guardian needs to be appointed for a protected person with mental incapacity, to make lifestyle, accommodation and/or health decisions and SACAT considers that no other order would be appropriate, SACAT may appoint the Public Advocate as guardian of last resort. OPA will generally be notified and attend the SACAT hearing when an application for guardianship

is lodged and the applicant has asked for OPA to be appointed as the guardian. The Public Advocate may be appointed as a full or limited guardian or as a joint guardian with another person.

b. **Investigating** – The SACAT can direct the Public Advocate to investigate the circumstances of a person who is the subject of an application for a guardianship order or who has had an advance care directive revoked by the Tribunal under the *Advance Care Directives Act 2013* (SA). The OPA provides a report to assist the SACAT to make a decision.

c. **Resolving and Mediating** – The Public Advocate is authorised to mediate certain types of disputes under the *Advance Care Directives Act 2013* (SA), and the *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

d. **Informing and Educating** – The OPA provides information and education about the law (but not legal advice) and issues that are, or could be, affecting a person with impaired decision-making capacity.

e. **Advocating and Promoting Rights** – The OPA undertakes systemic advocacy as well as individual advocacy for its clients and some other individuals. The Public Advocate can make recommendations to ministers for legislative and/or operational change.

10. The clients of the OPA are some of the most vulnerable, complex and marginalised adults with cognitive impairment in the state.

11. In 2019–20, the OPA assisted 1,538 guardianship clients and worked with 482 new guardianship clients. The need for the services of the OPA is ever increasing.

12. As of February 2021, approximately 900 OPA clients were known to the National Disability Insurance Scheme (**NDIS**) and nearly all had approved plans. Work continues to ensure all OPA clients who are eligible are engaged in the NDIS. This number indicates that more than half of OPA clients have involvement with the NDIS.

13. In 2019–20, people under guardianship with impaired decision making capacity had conditions in the following areas: intellectual disability (27 per cent), mental illness (20 per cent), dementia (19 per cent), dual diagnosis (16 per cent), acquired brain injury (5 per cent) and other (13 per cent).

Role of the Community Visitor Scheme

14. The Community Visitor Scheme (**CVS**) is comprised of the Principal Community Visitor (**PCV**) and appointed Community Visitors.

15. The Principal Community Visitor is an independent statutory officer appointed by the Governor, reporting to the South Australian Minister for Health and Wellbeing on matters related to the scheme's functions under the *Mental Health Act 2009* (SA) and to the South Australian Minister for Human Services on matters related to the scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations 2013*. The Principal Community Visitor is supported by a small staff of public servants, known as the Office of the Community Visitor Scheme.

16. The CVS visits individuals who use:

    a. disability accommodation services (including support services) delivered by the Department of Human Services (**DHS**); or

    b. mental health services within treatment centres and authorised community mental health facilities in South Australia.

17. The work of the Community Visitors allows the CVS to monitor, report and advocate for individuals and on systemic issues for people using state run disability services and mental health services.

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

19. The CVS is hosted by DHS for administrative purposes only.

Scope of the Community Visitor Scheme

20. Under the Bilateral Agreement between the Commonwealth of Australia and the State of South Australia on the National Disability Insurance Scheme 2018, South Australia transferred responsibility for the funding and regulation of disability services to the Commonwealth and the NDIS.

21. The NDIS Quality and Safeguards Commission (**NDIS Commission**) responsibilities include:

    a. registration and regulation of NDIS providers;

    b. compliance monitoring, investigation and enforcement action;

    c. responding to complaints and reportable incidents, including abuse or neglect of a person with disability;

    d. national oversight in relation to behaviour support and monitoring the use of restrictive practices within the NDIS.

22. South Australia remains responsible for specific tasks:

    a. the screening of workers;

    b. the authorisation of restrictive practices.

23. Prior to May 2019, the CVS visited all disability accommodation services, supported residential facilities (SRFs) and day option programs provided or funded by the state government. The CVS ceased visits to non-government organisations from May 2019 but continued to visit state government disability accommodation services.

24. The NDIS Commission assumed responsibility for the regulation of NDIS service providers in South Australia from 1 July 2018. All non-government disability services provided by NDIS providers are now regulated by the NDIS Commission.

25. DHS continues to provide disability accommodation services on an in-kind basis. The term 'in-kind' refers to a temporary funding arrangement under which state

and territory governments continue to deliver existing disability related services and the cost of those services offset those states' and territories' financial contributions to the NDIS. In-kind services are not regulated by the NDIS Commission. South Australia retains state-based safeguarding mechanisms in relation to the delivery of state-based accommodation services, such as the DHS Incident Management Unit, the DHS incident reporting system and the DHS Internal Audit.

26. The CVS continues to visit and inspect state-funded DHS disability accommodation services. The CVS conducted 171 visits across 176 DHS disability accommodation sites during 2019-20 (compared with 493 visits to disability accommodation services in 2018-19). The decrease in visits is due to changes in the scope of the work of the CVS and the profound impact of COVID-19 and associated restrictions on visits since March 2020.

27. The CVS has never had statutory power to enter the private home of a person with a disability. The use of coercive powers to enter private homes raises significant human rights issues and many people with a disability do not consider it appropriate.

Visits to OPA clients by the CVS

28. On 24 September 2019, in my capacity as Public Advocate, I delegated specific functions of the Public Advocate to the PCV and Community Visitors under section 50 of the *Mental Health Act 2009* (SA). This delegation allows the PCV and Community Visitors to visit persons as directed by the Public Advocate, and to inquire into matters where the Public Advocate is appointed as guardian for areas such as health, accommodation, or lifestyle. It also allows the PCV and Community Visitors to inquire into:

a. any cases of abuse, neglect or suspected abuse or neglect;

b. the use of restrictive practices and compulsory treatment;

c. complaints by a client, guardian, medical agent, relative, carer or friend of the client;

d. any other matter observed by the PCV and Community Visitors indicating a significant risk to client health or safety; and

e. any other matter as directed by the Public Advocate.

29. This arrangement includes visits to some people in non-government organisations who are both a Public Advocate client (meaning that they are under the guardianship of the Public Advocate) and in receipt of NDIS services.

30. This arrangement does not replace visits by OPA staff, but provides additional scope for the CVS to assist the Public Advocate to visit some of the most vulnerable people participating in the NDIS.

Violence, abuse, neglect and exploitation of OPA clients with disability in South Australia

31. I am particularly concerned about OPA clients with disability who face heightened risks of violence, abuse, neglect and exploitation because they cannot access appropriate accommodation in a timely way. This problem has resulted in some OPA clients with disability spending periods of time in hospitals or other inappropriate housing. The problem is exacerbated by the following factors.

Locating affordable and appropriate housing

32. Locating appropriate housing involves a range of NDIA processes. Firstly, the NDIS plan must include a goal related to Home and Living Supports. Secondly, a Request for Home and Living Supports (**RHLS**) is made which may involve further assessments and subsequent approvals. Thirdly, if Specialist Disability Accommodation (**SDA**) applications are made, these are assessed by a different panel within the NDIS. The processes are sequential rather than concurrent, resulting in lengthy wait times that can take months. Once approval is granted, locating suitable accommodation then commences by a specialist/support

coordinator. Interim housing/alternative placements may be required, sometimes with short term accommodation assistance. Interim placements can be in a hospital, sometimes for months. The dilemma with short-term and medium-term accommodation options is that the NDIA will not approve these options unless a long-term accommodation option has also been identified.

33. The document marked **SOA.9999.0002.0003** is a flow chart prepared by OPA (for internal use and updated for the purposes of this statement) which illustrates the complexity of the process and the estimated associated timeframes.

34. However, there is also a specific group of clients that need individualised, tailored and customised housing solutions and this is difficult to achieve. The current system is new and many of the providers are still adjusting to a market-based, choice-oriented system.

35. The NDIA provides funding for Specialist Disability Accommodation (**SDA**) but it is expected that only 6% of participants with the NDIS will be eligible for this.[1] There are other OPA clients not eligible for SDA but who have high and complex needs with challenging behaviours.

36. In the former state government system, there was a centralised approach to filling supported accommodation vacancies across both the government and non-government sectors. This was the Disability SA, Accommodation Placement Panel (**APP**). The APP focussed on placing people who had an unmet need category one for supported accommodation. Category one included homelessness or imminent risk of homelessness.

37. Under the current system, there is no one source of information about specialist housing providers. The Housing Hub was developed as an information exchange for supply and demand for disability accommodation. However, it appears to be not well known to service providers. Housing providers are listing accommodation on the Housing Hub, but it is not known if all housing providers

[1] Specialist Disability Accommodation Provider and Investor Brief April 2018 at page 5

are using this platform and it is not clear that support coordinators are making use of this information.

38. OPA staff are reliant on Support Coordinators and Specialist Support Coordinators for:

    a. Request for Home and Living Supports (**RHLS**) assessment;

    b. Finding suitable accommodation that meets the client's needs;

    c. Advocating for Specialist Disability Accommodation (**SDA**) funding in the client's plan when required; and

    d. Undertaking a raft of other associated tasks to source housing.

    e. It is critical that Specialist/Support Coordinators are well versed and educated about housing options.

Need for a provider of last resort

39. There has been a significant increase in funding into the disability sector since the commencement of the NDIS. This has resulted in the rapid expansion of existing service providers and a growth in new providers entering the market.

40. In the current market, a service provider can choose who they want to provide services to. Many OPA clients require highly specialised support and have significant funding packages through the NDIS. Some service providers may agree to take on clients with complex needs and later withdraw services when they are unable to adequately provide the specialised support the person requires. For some OPA clients this failure of support results in a cycling through service providers and supports which can be further disruptive and destabilising in their lives. When services are withdrawn for clients with complex needs, it is difficult to source a substitute provider at short notice and highlights the need for a provider of last resort.

Case Study – Client A

Client A is a man with an acquired brain injury. He is reliant on a powered wheelchair and requires support in aspects of personal care, wound management and medication management.

The Public Advocate is appointed full guardian.

Client A has a history of homelessness and challenges in sustaining stable accommodation and support. Factors contributing to this situation include:

- anti-social behaviour
- refusing to take his medications and refusing personal care and other medical care
- frequent verbal and physical abuse, and threats of abuse, to support staff
- threats to damage or destroy property

Since June 2019 Client A has had at least four hospital admissions, moved accommodation four times and has had at least four different support and nursing services in place.

Service providers have withdrawn services to Client A as providers are unable to sustain a support team due to the complexity of needs and circumstances. There has been significant involvement and effort from numerous state government agencies such as Office of the Public Advocate, South Australian Housing Authority (**SAHA**), SA Health and Department of Human Services to secure safe, stable and appropriate long term accommodation and support for Client A.

The OPA continues to work with Client A and interested parties.

41. Specialist/support coordinator services are not always well versed in locating housing. Due to the market-based approach, there is not a one stop shop for accommodation. For participants with high and complex needs, locating the right accommodation in the right place can be a lengthy process. The knowledge base of the various market providers varies significantly.

42. In South Australia, the DHS and NDIA have been exploring ideas for increasing and educating specialist/support coordinators in the various housing opportunities including social housing, community housing and the private rental market. This work is relatively new, but all parties are committed to enhancing access to accommodation. The Housing Hub is one example and the SAHA has recently established a single housing register. The SA Housing Register is a web based platform that allows applicants for social and community housing to be registered and processed in the one system. Public and community housing

providers funded by the state government must use the register to select tenants for public and community housing.

43. In cases where a change of circumstances takes place in relation to housing, the process can take more than 28 days and where there is an urgent housing need, it places OPA clients at risk of homelessness or being placed in inappropriate housing settings (for example, hospitals and hotels).

44. The above indicates a need for services that will not cease their support or accommodation for a person who has high and complex needs. A provider of 'last resort' is relevant in this context. A provider of 'last resort' is an accommodation or support service provider that can step in when the market fails to provide the required services.

45. OPA has seen some new arrangements emerge where service providers have taken on leases of properties to accommodate people they support. This results in both the accommodation and support services being provided by the one service provider (as discussed further below).

46. In these arrangements the lease is in the name of the support provider and the client becomes a 'sub-tenant' (or like) with fewer rights than if the property was in their name. Further, if the SIL arrangement fails because they are not able to cope with the complex needs of the client, then the tenancy is at risk.

Shortage of trained and experienced disability support workers

47. OPA staff face significant challenges in finding services with suitably trained and experienced staff. Historically, there have been challenges in attracting and retaining skilled staff in the disability workforce. This has been compounded by the rapid growth in the disability sector since the commencement of the NDIS. The workers' shortage is detailed in the National Disability Services report State of the Disability Sector Report 2020.

Lack of crisis response

48. A key concern of OPA is that, under current arrangements, there is no quick response or pathway to safeguard an NDIS participant if their support services or housing fail.

49. The NDIS Participant Service Guarantee states that the reasonable timeframe for a Change of Circumstances (**CoC**) is up to 28 days for a small change and 50 for a larger change in the plan. Guardianship staff can ring the NDIS 1300 number but it is unlikely they will have a same day outcome for a client in crisis. It is likely that whilst they wait for the CoC to be considered they will have to draw down on funding for other supports in the person's plan.

50. Marathon Health is the Exceptionally Complex Support Needs program in South Australia and can provide an after-hours response for NDIS participants who are in crisis. This response involves Specialist Support Coordinators who can access a participant's plan and connect the participant with service providers. This program is only available to approved referrers such as South Australia Police (**SAPOL**), South Australia Ambulance Services (**SAAS**) and SA Health (hospitals). OPA was successful in negotiating a trial to be an approved referrer to this service on the basis that OPA would only use this avenue in the event that the client is not engaged with one of the other listed referrers. Since this arrangement commenced in late 2020, OPA has had three interactions with Marathon Health, two of which were referrals. One of the two referrals was accepted and in this case Marathon Health was not able to provide an alternative outcome and the client remained as a social admission in hospital.

51. As discussed further below, under the former state government system there were a range of safeguards for clients in crisis. This included the Disability SA After Hours Service, and the Central Resource Allocations Unit where emergency funding and emergency respite could be sourced. Disability Services Accommodation Services was also a service provider of last resort. With the transition to the NDIS, guardianship staff are reliant on systems that are not set

up to be as dynamic as a person's life. Crisis situations may result in pressures in other state government systems such as social admissions to hospital to avoid homelessness, as is highlighted in the following case study:

> Client B is a man who enjoys music, arts and crafts, cooking, and social interaction with others. Client B has complex disability and mental health issues. He was living in specialist disability accommodation with supported independent living services for several years. During this time Client B had regular stays in hospital as a result of incidents where he had engaged in self-injurious behaviour. The service provider was unable to continue supporting Client B and he was admitted to hospital care in late 2019 where he remains.
>
> Since his admission there have been multiple incidents where Client B's behaviour has put himself and others at risk of harm.
>
> Some incidents have caused hospital staff to call a "Code Black". This response involves a physical restraint and (potentially) administration of additional PRN medication. A Code Black may also result in a period of 'shackling' of Client B to his bed.
>
> Many housing options have been explored by the specialist support coordinator and the OPA staff including registering through a number of housing platforms for SDA Robust housing vacancies. Exploring housing vacancies with numerous individual community housing providers and request for housing through South Australian Housing Authority have also been pursued. Additionally, exploring options where both the SIL and SDA are provided by the same support agency have been tried. For almost two years, no suitable vacancy has been identified. A government property has recently been secured and Client B will soon be discharged to a house.

Inquiries following the death of Ann Marie Smith

52. As noted above, I was a member of the Task Force established by the Minister for Human Services on 21 May 2020 with responsibility for examining and reporting quickly on gaps and areas that need strengthening in safeguarding arrangements for people with disabilities living in the State.

53. The remainder of this statement will address particular issues that were identified as safeguarding gaps by the Task Force and were also the subject of recommendations made by the Honourable Alan Robertson SC in his report, the *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*, which was published on 31 August 2020 (**Robertson Review**).

54. Ms Smith was not under the guardianship of the Public Advocate.

Identification of circumstances of heightened risk

55. At the outset, I believe it is important to emphasise that just because a person has a disability does not mean that they are vulnerable.

56. In my opinion, factors that contribute to a person being at heightened risk include, but are not limited to:

a. Having a mental incapacity and no one else in your life to assist you with decision making;

b. A lack of social connections or people who care for you and your wellbeing;

c. A lack of external eyes or people keeping an eye out for you e.g. neighbours, social connections, groups, clubs, education or employment;

d. Having a sole service provider/carer;

e. Living alone;

f. Exhibiting behaviours of concern which may increase the risk of the person being subject to the use of unregulated restrictive practices or having their rights being abrogated or impinged on;

g. Having communication difficulties or being non-verbal;

h. Being disempowered to make decisions and exercise choice and control in their life.

Risks associated with 'whole of life' providers

57. The OPA is particularly concerned about the heightened risks of abuse and neglect for NDIS participants whose supports and services are provided by a single service provider. As mentioned, it is common for OPA staff to receive proposals from Supported Independent Living (**SIL**) providers for accommodation and SIL to be provided for individual NDIS participants by the same agency. A further potential conflict of interest occurs when the same agency provides support coordination (or specialist support coordination) and SIL services.

58. In my view, there are a number of risks associated with this model of service, including a reduction in safeguarding. Having a range of different service providers involved in a person's life provides additional eyes to monitor the person's safety and wellbeing. A single service provider reduces the external oversight around the services / support for the NDIS participant. The client is only interacting with staff engaged by the SIL provider and may have limited means to raise concerns about the SIL provider or feel they cannot do so as it may mean that their accommodation will be under threat.

59. On 15 April 2021, I wrote to Mr Martin Hoffmann, CEO, NDIA to express my concerns in relation to the potential for conflict of interest to arise when the support provider and the accommodation provider are the same entity among other things. The document marked **SOA.9999.0002.0001** is a copy of my letter to Mr Hoffman.

60. Mr Hoffman responded to my letter on 10 May 2021. The document marked **SOA.9999.0002.0004** is a copy of Mr Hoffman's response.

61. Mr Hoffman has indicated his willingness to work together on the issues I have raised in my correspondence.

Risks where SIL is linked to accommodation

62. Where support services are linked to accommodation, people with disability are at increased risk of abuse and neglect. If the provider can no longer support the client and withdraws their services, the provider will generally also terminate the accommodation arrangement. In my experience, many service providers will not allow another service provider to support the client in the home and the client loses both their support service and their home. The client must then either source alternative accommodation or face homelessness.

63. There is a potential for a conflict of interest to arise if a service provider is both the SIL provider and the housing provider. As a landlord, a provider is responsible for providing suitable and safe housing. The provider must respond

to maintenance requests in a timely manner. Disputes can arise between landlord and tenant; for example, the landlord may pursue the tenant for compensation for damage to the property. Where a SIL provider is independent from the landlord, that provider may support the tenant to pursue maintenance issues or refer the tenant for advice in relation to any tenancy dispute. However, where the provider of the accommodation is also the SIL provider, this is unlikely to occur.

64. Linking services and housing also heightens risks of financial exploitation of people with disability. South Australian Housing Authority (**SAHA**) and Community Housing Providers (**CHP**) in South Australia charge rent at 25% of the tenant's disability support pension. OPA has experience of SIL providers offering combined SIL and accommodation services with a rent higher than CHP rates, and comparable to market rates. When OPA has challenged the affordability of the proposed arrangement, providers have agreed to supplement the rent. This raises issues including:

    a. Where the funds are drawn from (e.g. the client's NDIS plan);

    b. Whether the funds are being appropriately expended and who may authorise the expenditure.

65. OPA's position is that housing and support services should be separated so that when support services fail, other services will continue. The Independent Advisory Council (IAC) to the NDIS reported in November 2019 on challenges in housing and support and stated:

> "The IAC has long argued for the importance of the separation of housing and support being critical to participant choice and control to ensure that residents dissatisfied with supports do not have to move homes. This remains a contested issue with many providers (including National Disability Services) exerting pressure to remove the requirement. The NDIA position on this issue has weakened over time from a previous clear commitment to separation in 2014 to the very weak proposition that service agreements must be "separable": not even separate but to be able to be separated" [2]

66. However, in some cases, the OPA has consented to these arrangements as non-preferred decisions. Consenting to the arrangement may be the only option available in some circumstances such as to accommodate a person who may be facing homelessness.

67. OPA has reviewed documents called 'service agreements' that relate to the SIL services and also include reference to the housing arrangements. These documents vary greatly, do not align with legislation and as such provide limited or no legal protection for the client. It is preferable that OPA clients have a clear and enforceable housing arrangement such as a tenancy agreement or rooming house agreement under the *Residential Tenancy Act 1995* (SA) or an agreement under the *Supported Residential Facilities Act 1992* (SA).

68. The following case study demonstrates the impact on the client when accommodation and support are provided by the same provider.

> **Case Study – Client C**
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> Client C is a man with complex physical and mental health needs. He is under guardianship and a NDIS participant.
>
> A sole registered service provider supplied both the housing and the SIL supports to Client C.
>
> The client has a history of trauma and abuse and makes allegations against support staff on a regular basis. He also engages in verbal and physical abuse of staff and property damage.
>
> Client C requires a high level of staff support and the service provider had exhausted its pool of staff who were willing to work with the client. The service provider contacted OPA to advise that they could no longer support Client C due to his behaviours, which placed himself and others at risk of harm.

[2] Independent Advisory Council to the NDIS, *Challenges in housing and support under the NDIS* (Report, November 2019). Pg. 9

> The client remains in hospital as a social admission. He requires an accessible and robust SDA property to facilitate his discharge from hospital. OPA is currently working with the SSC, SA Health and DHS to determine appropriate housing for Client C.

Risks where support coordinators employed by same provider as SIL

69. Sourcing specialist disability services for people with specific and complex needs in a marketplace environment is challenging. Within the NDIS framework, this complex work is generally undertaken by a support coordinator engaged by the relevant NDIS participant (provided the participant's NDIS plan includes funding for support coordination).

70. Support coordinators may operate as individual consultants or may be employed by private or not-for-profit service providers. The level of knowledge and expertise of support coordinators appears to vary. Support coordinators are required to comply with the NDIS Code of Conduct and, if registered, relevant NDIS Practice Standards. I am not aware of any process for auditing or checking the quality or accuracy of advice provided by support coordinators.

71. Support coordinators, employed within service providers from where NDIS participants receive other services, are potentially conflicted in their ability to give impartial advice to a participant. There is a risk they have not investigated all housing and service options beyond what their employer may provide.

Unregistered providers

72. Another issue which increases vulnerability to abuse and neglect of people with disability is the presence of unregistered providers in the market. While unregistered NDIS providers and their workers must adhere to the NDIS Code of Conduct, they are not subject to a specific regulatory framework, including adhering to obligations to report certain types of incidents to the NDIS Commission. The OPA seeks to avoid using unregistered providers for its clients due to their unique needs but does experience thin markets in some cases particularly in regional and remote locations. In areas where there is limited availability of services, people may have no choice but to engage an

unregistered provider. At times, some providers subcontract to unregistered providers which can be unknown to the OPA at the time of engagement.

A risk assessment needs to be undertaken during the NDIS access and planning process

73. The access and planning process is the first point to identify and safeguard people with disability who may be vulnerable.

74. In the absence of the former state Disability SA case management services, the Local Area Coordinator (**LAC**) has an important role to play in safeguarding people by identifying those who may have impaired capacity and may also be vulnerable for other reasons. I am aware that service providers and support coordinators are reluctant to make applications to SACAT for reasons of conflict of interest and the potential impact the application will have on their relationship with the person.

75. Other state services such as SA Health and Mental Health continue to make these referrals to SACAT, however, as noted above new disability service providers may not understand the role of SACAT or be prepared to make applications.

76. An individual's vulnerability is not static. A person may be independent and well connected for the majority of their life, but if these circumstances change, they may find themselves more vulnerable. Conversely, people can become less vulnerable over time. It is critical that a NDIS participant's vulnerability is assessed on a case by case basis as and when required. This assessment must occur in person so that nuances can be identified.

77. I recommend that:

    a. safeguarding must be a focus at all stages of the NDIS process, but particularly at the beginning with a risk assessment at the access request stage and requires ongoing risk assessment at the planning, implementation and review stages.

The initial risk assessment should address potential vulnerability of the participant and ensure appropriate safeguarding arrangements are identified and support to access or implement those safeguards are funded in the plan. Safeguarding must also include measures to prevent harm such as: inclusion of separation of services in the plan and securing of services; minimising sole service provider arrangements; linkages to the community and capacity building. Therefore, LACs, planners and specialist/support coordinators need to be appropriately skilled to detect, address and respond to risks and incorporate safeguards in plans and service provision. For example, NDIS staff must be trained to identify risks of domestic violence and allocate appropriate funding for the NDIS participant to access appropriate support services.

b. The utilisation of a plan is monitored as an additional safeguard. Where a plan is not being utilised, there must be a mechanism to check on the welfare of the participant.

c. The risk assessment examines factors such as formal and informal safeguards in the participant's life. The NDIS plan ensures that appropriate funding is available within the plan for safeguarding measures. For example, to assist people in domestic violence situations.

d. Participants are provided with information about advocacy services and how they can raise concerns or complaints about service providers (or other people in their life) when they have worries and do not feel safe.

e. Participants are empowered to understand their own risk and how to mitigate it through training.

f. Those who support people with disability undertake training on Supported Decision Making (**SDM**) to better enable them to support people with disability.

g. The LAC / planner should consider through assessments and evidence whether the participant may have a mental incapacity and there is a potential need for a referral to SACAT and/or an advocacy service.

Safeguarding at-risk NDIS participants

A person with 'overall responsibility' for at risk NDIS participants

78. In the previous state government system, a person with disability had a Service Coordinator or 'case manager' through Disability SA. A person with disability knew their case manager and could contact them during business hours. The case manager worked holistically with the person to assist them to connect to both paid disability supports as well as mainstream community supports. The case manager assisted the person with a range of matters, including applications to SACAT and other legal processes. The case management role was complemented by the Disability SA After-Hours Service that clients and families could ring directly for assistance outside of normal business hours.

79. Under current arrangements, there are multiple contact points for NDIS participants but no single person or role has overall responsibility for connecting the participant to paid supports and mainstream supports and being a single point of contact to assist the participant navigate a range of systems. The closest thing to this is the role of support coordination. The document marked **SOA.9999.0001.0001** lists the range of roles within the NDIS and which a person with disability may need to interact with. This is a significant paradigm shift for many people with disability who, in the previous state system, would simply contact their Disability SA case manager.

80. In the NDIS, the role of the Support Coordinator assists the participant in sourcing funded disability supports. This role only comes into play once a NDIS participant has a plan. It is time limited and not all participants are allocated funding for support coordination. Once funding for support coordination is exhausted, a participant's appointed support coordinator will no longer provide a service and the participant is left with no one to coordinate their paid supports.

81. The LAC can connect a person with disability to mainstream supports and services in the community. They will also assist the person to access the NDIS but generally work with people with less complex needs. The LAC does not assist a potential participant to collect the required supporting evidence to meet the requirements to access the NDIS.

82. The absence of a person who has overall responsibility for assisting NDIS participants has resulted in the following consequences:

a. There is a lack of support for vulnerable people during the access process. LAC staff are often not experienced enough to engage the clients of OPA, many of whom will not readily engage or do not identify as needing service or having a disability.

b. The lack of a consistent, trusted person in the life of a person with disability has put pressure on OPA staff to fill the gaps by undertaking tasks that fall outside of their traditional remit.

c. There is no obvious person to work through crises and coordinate responses to homelessness, social hospital admissions, hospital discharge or correctional release. The NDIA, LAC and usually the support coordinator are limited to office hours. Marathon Health is only available to approved referrers for after-hours crises, but the referring organisation is expected to maintain the lead for handling the crisis. As mentioned, we are often limited to the sole option of a social admission to hospital in emergency situations.

d. There is no proactive approach to identifying people who may have a mental incapacity and progressing a SACAT application for formal appointment of a guardian. As mentioned, Health and Mental Health continue to progress SACAT applications but other services such as support coordinators and disability service providers see it as putting them in potential conflict with the person.

83. There are many people who do not need a case manager, but for people such as the clients of the OPA, there is an urgent need for such a role. When funding for support coordination runs out, which it often does, the OPA staff take on the role of case manager by default.

84. NDIS plans should nominate a name and direct contact number (which is not the general 1800 number) in the NDIS who has overall responsibility for assisting each vulnerable NDIS participant. Support Coordination needs to be expanded to provide a service that is accessible in the planning process, is available when needed, and is independent of service provision.

Face-to-face visits

Visits to OPA clients

85. It is OPA policy to conduct regular (and at a minimum, annual), face to face visits to clients under guardianship of the Public Advocate. This is consistent with the Australian Guardianship and Administration Council national standards of guardianship. An individual may receive more visits depending on their circumstances.

86. When the Public Advocate is appointed as guardian, OPA staff will endeavour to meet face-to-face with the client to establish their wishes. If a client is non-verbal, ascertaining wishes can be difficult. However, OPA staff will also contact other interested parties such as carers or family members.

87. During the COVID-19 pandemic, "visits" were undertaken by telephone or other audio-visual means. If an urgent matter required a face-to-face visit this would be done with approval of the Public Advocate. Face-to-face visits resumed as the preferred method of contact from December 2020.

Community visiting in the context of the NDIS

88. The NDIS services provided to people in non-government facilities are subject to oversight by the NDIS Quality and Safeguards Commission (**NDIS Commission**). The NDIS Commission commenced operating in South Australia

on 1 July 2018. Non-government organisations (**NGOs**) and Supported Residential Facilities (**SRFs**) are subject to regulation by the NDIS Commission which has a range of quality checks such as audits, registration and complaints handling, and will visit these individuals and/or facilities if concerns are raised through a combination of these checks. However, the NDIS Commission does not operate a proactive visitation scheme to NDIS participants.

89. An NDIS participant may not have the capacity or support to make a complaint or, they may be fearful of potential consequences in doing so, particularly if the complaint relates to a service provider that the person relies upon for personal support.

90. The NDIS is still a relatively young scheme. Many new providers have entered the disability services market and are developing their processes and capacity to deliver the services. The absence of regular, routine inspections by a regulator or other independent body leaves vulnerable people at risk if service providers are inexperienced or under-resourced.

91. The CVS has both a proactive and reactive role in protecting the wellbeing of vulnerable people. It can respond to complaints as required, but also refers the complaint back to the organisation. It will also engage with individuals and service providers to identify and refer issues affecting the wellbeing of vulnerable people. The CVS is an additional means of identifying non-compliant activity at the local level. However, the CVS is not a complaint investigator nor an enforcement agency.

92. In addition to non-compliance issues, the CVS can comment on the broader quality of life of a person and help resolve issues or access services.

93. Establishing a dedicated national Community Visitor Scheme for all NDIS participants, auspiced by the NDIS Commission, would assist in protecting the rights of vulnerable people in the community. This could be in partnership with States and Territories.

94. The Community Visitor Scheme has only ever visited disability accommodation services, SRFs and day options, but the scheme could be extended to include visits to people in their own homes (with the permission of the individual or their guardian) with appropriate legal arrangements with the NDIS Commission.

95. The Safeguarding Taskforce 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.* (recommendation 5).

Information Sharing

Could enhanced information sharing arrangements improve safeguarding of vulnerable NDIS participants, particularly in relation to the sharing of information between a) the NDIA and QSC; and b) state and Commonwealth agencies?

96. Increased information sharing will enhance the safety of vulnerable NDIS participants. There are some arrangements in place but still room for improvement.

97. Although the Public Advocate is a statutory officer, it still works within the State's Information Sharing Guidelines (**ISG**) and Information Privacy Principles. These are designed to give providers of services to children, young people and adults, confidence in sharing information to prevent harm or, respond to current threats to safety and wellbeing. Information sharing between the OPA and other State government agencies currently works well to address risks and concerns.

98. The OPA has an information sharing agreement with the NDIS Commission to also address such matters. The Public Advocate has direct contact with the State Director of the NDIS Commission.

99. The sharing of information at senior levels in the NDIS Commission operates well at the local level and the OPA has established effective partnerships. The time to investigate complaints can cause difficulty for decision making regarding

possible changes for OPA clients, while an investigation is underway. For example, the OPA may seek to change a service provider, and an investigation may establish no issues, or a complaint is unfounded. The OPA must ensure the client is safe while the investigation is underway.

100. In relation to reportable incidents, the obligation is on the service provider to notify the OPA of the outcome. The OPA is informed of very serious incidents more frequently now. The resolution is for the OPA to require providers to inform them as a part of any service agreement. A more systemic approach to informing OPA of the outcome of all reportable incidents would be beneficial.

101. The NDIS Commission does not routinely undertake visits to services. The OPA visit clients with a focus on the welfare of the individual client rather than a quality assurance and compliance check of support and service provision.

102. The OPA is awaiting the formalisation of the head Memorandum of Understanding for Information Sharing between the National Disability Insurance Scheme and the South Australian State Government Agencies. The Department of Human Services (**DHS**) is currently negotiating this on behalf of State government agencies. Once the South Australian Attorney-General's Department's (**AGD**) Schedule under this agreement is signed off, the AGD will no longer be reliant on DHS as a third party to provide NDIA data. This will result in faster access to NDIA data. This Schedule will cover both the OPA and the Public Trustee (**PT**) within AGD. In the interim, the OPA and PT are reliant on data from the NDIA via DHS. This agreement does not necessarily allow for the ad hoc sharing of information in a crisis but will assist in providing an overall picture of which OPA clients are known to the NDIS and the size of packages.

103. The Public Advocate convenes a six weekly meeting with the DHS, NDIA, the PT, SACAT and the NDIS Commission. This network supports communication in the event of the need to share information.

104. The OPA participates in the state escalation pathway with the NDIA which is another conduit for lower level localised issues. This means that local level NDIS matters affecting OPA clients which cannot be dealt with in the normal course of operations can be escalated to more senior staff at a state level in the NDIA. This pathway has worked responsively in a crisis where OPA clients are at risk. However, the OPA and other state agencies are working with the NDIA to deal with urgent matters of escalation for clients/participants with extraordinary needs to establish ways for this process to be more efficient in future.

Signed: A Gale

Date: 28 May 2021

Witness:

Date: 28 May 2021