



14 July 2020

The Hon. Alan Robertson SC
Independent Reviewer
Appointed by the Commissioner for the NDIS Quality and Safeguards
Commission

Dear Mr Robertson SC

Independent review into circumstances relating to the death of Ms Ann-Marie Smith

Disabled People's Organisations Australia (DPOA) is an alliance of four national Disabled People's Organisations (DPO's) that collectively represents millions of Australians with a disability:

- Women with Disabilities Australia (WWDA) – the national peak organisation representing women and girls with disability
- First People's Disability Network – the national peak organisation representing Aboriginal and Torres Strait Islander peoples with disability
- National Ethnic Disability Alliance – the national peak organisation representing people from Culturally and Linguistically Diverse (CALD/NESB) people with disability, and
- People with Disability Australia – a cross disability peak organisation representing all people with disability at the national level and in NSW.

DPOA writes to you in your capacity as the Independent Reviewer into circumstances relating to the death of Ms Ann-Marie Smith, appointed by the Commissioner for the NDIS Quality and Safeguards Commission (NDIS Commission). We are shocked and saddened by the tragic death of Ms Smith, which appears to have been preventable. The appalling conditions leading to Ms Smith's death, demonstrate the urgent need for wide-scale reform of the national approach for safeguards under the National Disability Insurance Scheme (NDIS) and the systems in place for preventing violence, abuse and neglect of people with disability more broadly.

Based on the news reports, it is been confirmed that:

1. Ms Smith was an NDIS participant and therefore had an NDIS plan which if implemented properly would have been subject to annual reviews.¹
2. Despite having a full-time carer, Ms Smith was living for over a year in a life-threatening situation, sitting in the same woven can chair which had also become her toilet, in the home where she lived alone.
3. The 'full time care' Ms Smith had been receiving since 2013 involved support from a carer for only six hours a day.
4. From 2018 with the introduction of the NDIS in South Australia supports had been provided by a sole carer employed by the NDIS provider Integrity Care (SA) under a 'person-centred support plan'.
5. Ms Smith's flesh had severe pressure sores and she was malnourished when taken to hospital on 5 April 2020. She died on 6 April 2020 from profound septic shock and multiple organ failure.
6. It was only after Ms Smith's death that Integrity Care (SA) applied for disability employee screening for her carer.²
7. Police were unable to identify any health practitioners who had provided services to Ms Smith, or any medical records for her, since 2015.³
8. Police have opened a manslaughter investigation and a coronial inquiry.⁴
9. The police investigation has revealed that two significant loans were taken out in Ms Smith's name, excessive amounts of money had been withdrawn from her account, and that her car had been used by unknown persons resulting in unpaid traffic fines.⁵

We believe that given that Ms Smith was an NDIS participant there are key questions regarding the operation of various functions within the NDIS including:

- local area co-ordination
- support co-ordination
- NDIS planning and review
- delivery of services and supports by providers
- the role of allied health and medical professionals
- access to community supports and activities, and
- access to independent advocacy.

¹ National Disability Insurance Commission. Information on NDIS plan reviews <<https://www.ndis.gov.au/news/1749-information-ndis-plan-reviews#:~:text=A%20plan%20review%20is%20an,This%20is%20standard%20practice.>>>

² Luke Henrique-Gomes. 'The death of Ann Marie Smith: a shocking case of neglect, or a failure of the system?' *The Guardian* (Australia edition). 31 May 2020 <<https://www.theguardian.com/australia-news/2020/may/31/the-death-of-ann-marie-smith-a-shocking-case-of-neglect-or-a-failure-of-the-system>> (source for the reported circumstances surrounding Ms Smith's death in this paragraph).

³ ABC News. 'Police launch search for jewellery, fridges missing from home of ann Marie Smith'. 17 June 2020 <<https://www.abc.net.au/news/2020-06-17/sa-police-searching-for-ann-marie-smith-missing-items/12365226>>.

⁴ Eugene Boisvert, 'SA Police investigating death of woman in 'disgusting and degrading circumstances' ABC NEWS. 15 May 2020 <<https://www.abc.net.au/news/2020-05-15/police-investigate-death-of-chairbound-woman-in-adelaide/12253326>>

⁵ ABC News, 'Police investigate disappearance of large inheritance and \$70,000 in loans taken out by Ann Smith' 20 June 2020 <<https://www.abc.net.au/news/2020-06-20/police-investigate-money-drained-from-bank-account-of-ann-smith/12376670>>.

The poor-quality care, neglect and deprivation to which Ms Smith was subject are forms of disability-based violence perpetrated over a protracted period in her own home. People with disability experience significantly higher rates of violence, abuse and neglect than non-disabled people. How to guard against and respond to such violations has been considered by numerous government inquiries in recent years and yet we continue to see horrific instances of maltreatment amounting to torture, and preventable deaths as a consequence. As a party to the *Convention on the Rights of Persons with Disabilities* (UNCPRD) Australia is obliged under Article 16(1) to:

‘take all appropriate legislative, administrative, social, education and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including gender-based aspects’.

Better incorporating this human right into everyday practice requires changes to systems including the effective implementation of the NDIS Practice Standards, regulation and screening of disability workers and oversight and investigation mechanisms.

The NDIS Practice Standards, together with the NDIS Code of Conduct, specify quality standards for the NDIS workforce and promote safe and ethical service delivery. A key right of NDIS participants in the NDIS Practice Standards relating to violence and abuse is that ‘[e]ach participant [must] access supports free from violence, abuse, neglect, exploitation or discrimination’.⁶ Indicators that this outcome has been achieved include instituting preventative mechanisms through appropriate policies, procedures and practices and acting upon, investigating and recording outcomes in response to allegations and incidents of violence and abuse.⁷

The governance and operational management responsibilities for NDIS providers require:

- supports provided to participants to be overseen by robust governance and operational management systems
- identification and management of risks to participants, workers and the provider, and
- a quality management system ensuring that the NDIS Standards are met including a ‘documented program of internal audits’.⁸

The degrading circumstances of Ms Smith’s death suggest that there were potentially fundamental shortcomings in her support plan, its implementation by her carer and the provider and the quality management systems in place. Considering reports that Ms Smith was unable to bathe or feed herself and could no longer use a wheelchair, the allocated six hours of support per day appears grossly inadequate to ensure her health and safety. The fact that Ms Smith had been living in the same

⁶ NDIS Quality and Safeguards Commission. (2020) *NDIS Practice Standards: NDIS Practice Standards and Quality Indicators*, Version 3, p. 7.

⁷ Ibid.

⁸ Ibid, pp. 7-9.

woven cane chair for over a year suggests that the provider may have had few, or no, systems in place for reviewing the quality of supports being provided to her, such as through auditing and sending other staff to visit her home.

We note that where supporting an NDIS participant involves high intensity daily personal care activities such as complex bowel care, urinary catheter management and complex wound management, their health status should be ‘subject to regular and timely review by an appropriately qualified health practitioner’ according to the NDIS Practice Standards.⁹ Although it seems likely that Ms Smith’s support plan would or should have incorporated some high intensity daily personal care activities, this process was clearly not being implemented. Media coverage suggests that Ms Smith’s death was not reported by the provider within the required 24 hour timeframe.¹⁰ We recommend that the Independent Review thoroughly investigate:

- Integrity Care (SA)’s governance and operational management and quality management systems and the support plan
- the NDIA’s planning and plan review processes in place for Ms Smith including measures to ensure that participants are able to direct and provide continual feedback on planning processes, where necessary with the support of independent advocates
- access to supports and community activities such as with family, friends, support people and contacts with the wider community (outside the home) as part of the NDIS plan.

How Ms Smith’s finances and property were being managed is another issue we urge the Independent Review to examine closely in light of reports of financial abuse and possible unauthorised use of her car. Were any arrangements, such as guardianship or financial management orders, in place to guard against such unethical and unlawful practices? Are law and/or policy reforms needed to ensure that people with disability are not exploited in this manner?

Providing safety clearances for disability workers is a state and territory government responsibility. We understand that a state audit of disability worker screening has been instigated in response to the failings surrounding screening processes in Ms Smith’s case. We urge the Independent Review to give consideration to:

- the issue of disability worker screening and the development of a nationally consistent approach and/or the publication of national guidelines
- issues surrounding attracting, retaining and regulating a suitably qualified disability workforce, taking into account that this workforce is heavily casualised with relatively low pay, and that NDIS service providers do not have guaranteed incomes due to the consumer driven NDIS funding model, and
- the training, supervision and support needed for front line workers to ensure that people with disability are provided with quality services and that NDIS workers are effectively supported within a safe working environment, both in terms of affordable training and upskilling and on-the-job supervision.

⁹ Ibid. pp. 18-21.

¹⁰ Luke Henrique-Gomes. (2020). op. cit.

DPOA further recommends that the Independent Review investigate the applicability of corporate manslaughter laws to Ms Smith's death. This assessment should include attention to federal corporate manslaughter laws and current proposals to introduce industrial manslaughter laws in states and territories. Would these laws and proposals extend to the death of Ms Smith and other situations of violence against people with disability that result in a person's death where a corporation's actions may have been the cause? We believe that disability service providers should be held criminally responsible for the deaths of their clients, in addition to disability workers, in appropriate cases. However, it is important to acknowledge that chronic underfunding of the disability services sector essentially creates risks for frontline workers forced to work with inadequate training and support on award-based minimum rates of pay. We note that the COVID-19 pandemic has revealed that around 40% of the disability support workforce is employed on a casual basis. Precarious employment with minimal training, ongoing supervision and professional development for support workers can in turn pose unacceptable risks to the safety of people with disability.

Ms Smith's death raises concerns about oversight mechanisms the NDIS Commission has in place to register and regulate NDIS providers, monitor compliance against the NDIS Code of Conduct and NDIS Practice Standards, and respond to concerns, complaints and reportable incidents including abuse and neglect of NDIS participants, particularly where an NDIS participant is unable to make a complaint or provide feedback without support. We recommend that the Independent Review undertake a comprehensive assessment of existing processes instituted by the NDIS Commission to perform these roles and consider the need to bolster, or create additional, state and territory-based oversight mechanisms for disability services. One option is placing greater focus on community visitor schemes. The South Australian Community Visitor Scheme, for example, inspects mental health facilities and state-run disability accommodation. People with disability living in their own homes who have high support needs are not covered by this scheme. If Ms Smith's home had been inspected on a regular basis by an independent body, it is likely that the life-threatening problems with her care and support arrangements would have come to the attention of authorities much sooner.

DPOA is concerned that the NDIS Commission's processes for responding to concerns, complaints and reportable incidents, including abuse and neglect of NDIS participants, are not sufficient to protect the rights and safety of all people with disability. Given that the NDIS Commission has taken action against a relatively small number of individuals and providers when compared to incident reports received,¹¹ DPOA is particularly concerned that its investigative functions may be hampered by limited resourcing. While the NDIS Commission is authorised to investigate complaints and reports of non-compliance with quality and safeguards requirements applying to NDIS providers, this leaves people with disability who do

¹¹ Luke Henriques-Gomes. 'NDIS providers used unauthorised restraints more than 65,000 times, watchdog reports'. *The Guardian* (Australia edition). 27 May 2020 <<https://www.theguardian.com/australia-news/2020/may/27/ndis-providers-used-unauthorised-restraints-more-than-65000-times-watchdog-reports>>.

not have an NDIS plan with inadequate protection against and in response to violence, abuse, neglect and exploitation.

In DPOA's view the Australian Government should take immediate action to establish a national independent statutory protection watchdog focused on all forms of violence against people with disability and operating across all settings, regardless of whether an individual has an NDIS Plan. We note that under Article 16(3) of the UNCRPD States parties 'shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities' In response to Australia's most recent periodic reports under the UNCRPD, the Committee on the Rights of Persons with Disabilities in considering our compliance with Article 16 recommended that Australia:

'Establish a national accessible oversight, complaint and redress mechanism for persons with disabilities who have experienced violence, abuse, exploitation and neglect in all settings, including all those not eligible for the National Disability Insurance Scheme and, particularly, older women with disabilities.'¹²

We recommend that the proposed mechanism be established under specific purpose legislation with broad functions and powers to protect, investigate and enforce findings in relation to situations of violence, abuse and neglect of people with disability. This national protection mechanism should operate within an explicit human rights framework and include as a minimum the following core functions:

- a 'no wrong door' complaint handling function – the ability to receive, investigate, determine, and make recommendations in relation to complaints raised
- the ability to initiate 'own motion' complaints and to undertake own motion enquiries into systemic issues
- the power to make recommendations to relevant respondents, including Commonwealth and State and territory governments, for remedial action
- the ability to conduct policy and programme reviews and 'audits'
- the ability to publicly report on the outcomes of systemic enquiries and group, policy and programme reviews, or audits, including through the tabling of an Annual Report to Parliament
- the ability to develop and publish policy recommendations, guidelines, and standards to promote service quality improvement
- the ability to collect, develop and publish information, and conduct professional and public educational programs, and
- the power to enable enforcement of its recommendations, including for redress and reparation for harms perpetrated.¹³

Currently the National Disability Abuse and Neglect Hotline provides a service for reporting abuse and neglect of people with disability. DPOA recommends that this

¹² Committee on the Rights of Persons with Disabilities. (2019) *Concluding observations on the combined second and third periodic reports of Australia*. 15 October 2019. CRPD/C/AUS/CO/2-3. p. 9.

¹³ See Australian Cross Disability Alliance. (August 2015) Submission. Senate Community Affairs Reference Committee. Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings. pp. 12-13.

hotline be abolished, and resources re-allocated to the establishment of the proposed statutory national protection mechanism.

Thank you for the opportunity to make a submission to this vital review, which has far-reaching implications for protecting the rights, dignity, safety and wellbeing of people with disability. We urge the Independent Review to refer its recommendations for consideration by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and to encourage governments take action in response to its recommendations as a matter of priority where appropriate.

If you would like further information or to arrange a meeting with the CEOs of DPO Australia, please contact me by email on _____ or by phone on _____

Yours sincerely

Romola Hollywood
Director Policy and Advocacy, People with Disability Australia

for and on behalf of Disabled People's Organisations Australia

