

PUBLIC SUBMISSION

Joint Standing Committee on the National Disability Insurance Scheme

19th. November 2020

Dear Committee members,

I wish to make the following brief submission following on from appearing in a support role for Ms Georgi Hadden on the 17th. November.

During the above proceedings, a member asked the question of Ms Hadden as to the likely cause of the difficulties she had experienced with the NDIS Quality and Safeguards Commission. As I was present with Ms Hadden when she met with

and on the 2nd November 2020, I would like to offer the following observations. In doing so it should be appreciated that I have been actively involved in overseeing Ms Hadden's care since mid 2016.

The matters under discussion at the above meeting on 2/11/2020 were the investigations undertaken by the Quality and Safeguards Commission in response to complaints lodged by Ms Hadden into the care she had received from two providers: and From my observations and involvement in these matters it is my professional opinion that both enquiries were cursory, superficial and grossly inadequate.

In response to a question by Ms Hadden into the above, both and repeated a number of times that although the Commission was empowered to undertake investigations, it was not their practice to actually do so. Rather they explained that on receipt of a complaint that met the threshold of seriousness, a summary of the complaint would be sent to the service provider with a request to respond. The normal practice was then for the provider to employ the services of third party (who they chose) to enquire into the incident. The Commission did not require to see this report but would be satisfied with a summary sent by the service provider. No attempt was made to ensure the accuracy of this summary and they were unsure if they ever received or asked for a copy. On receipt of this response from the service provider the Commission would then determine the matter without the content of the response being forwarded to the complainant for comment. In both cases involving Ms Hadden, the investigation was closed at this point. The weaknesses inherent in this approach are multiple:

1. The service provider is free to choose who undertakes the investigation. This is not at arm's length and is open to accusations of lack of independence, mutual financial benefit, and undue influence
2. The Commission does not require to receive a copy of the investigation and is thus not in a position to determine the adequacy of how it was conducted nor the accuracy of any summary provided
3. The response of the service provider is not provided to the complaint for comment. Not only is this inequitable, in that the service provider gets to see the complaint, whilst the

complainant is not afforded the same access, but no reaction is sought from the complainant as to its accuracy or sufficiency.

4. No attempt is made by the Commission to obtain detailed independent witness statements, examine any additional evidence submitted or available, or examine inconsistencies. In both of the complaints lodged by Ms Hadden a great deal of additional evidence was available but was never examined or referred to. Ms Hadden is unusual in this regard in that being an ex-Police Officer she kept exemplary and extensive evidence in the form of notes, photographs, audio and video recordings, emails, text messages and the names of witnesses. None of this was apparently utilised or referred to.
5. Considerable barriers are placed in the way of the complainant obtaining access to the processes of the Commission, the correspondence with the service provider or the substance or adequacy of any investigation. Ms Hadden was told that she did not have an automatic right of access, and that all the Commission could do would be to seek the permission of the provider to allow such access. If this was refused the Commission was powerless to provide such access. Ms Hadden was advised that she would have to make one or more requests under the FOI in the hope of obtaining such access. Not only is this obstructive, time consuming and costly, it also gives the subject of any complaint control over the process and thus the outcome.

One can only speculate as to the reasons for this preferential treatment of service providers. One likely clue however was provided by [redacted] who said, at the meeting on the 2/11/2020 that the Commission was established to assist service providers rather than ensure the quality of service provided to the clients and their families. This is surely a misreading of their mission and would explain the apparent preferential treatment given to service providers over NDIS clients.

In summary, it would appear that the grossly inadequate “investigations” conducted by the Commission into Ms Hadden’s complaints arose from a very distorted conception of their role (to preference providers over clients) and a gross failure of the investigatory process.

For the Commission to properly fulfil its legislative obligations, both of the above deficiencies need to be corrected. Specifically with respect to Ms Hadden’s complaints, they should be properly investigated and responded to as she experienced septic shock and pneumonia in the case of [redacted] and a suicide attempt and possible physical and or sexual assault in the case of [redacted]. These are surely matters deserving of serious attention and thorough investigation.

Thank you for considering this submission.

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