

Draft Transcript

NDIS Commission Adelaide meetings – Public webcast

Tuesday, 21 July 2020 at 9am ACST

About This Document

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MR ROBERTSON: Good morning to you all. This is the second day of the video streamed Adelaide meetings of the independent review, which I explained yesterday. There were some, I'm told, 130 people listening on the video stream yesterday, which indicates I think the level of interest in this review. I think there was also probably a further number who rang in on the 1800 number by telephone, but I haven't got the numbers for that yet.

By way of summary, yesterday I heard from first of all Ms Samantha Taylor, the Registrar of the NDIS Commission. Then I heard from Professor Grant Davies, the South Australian Health and Community Services Complaints Commissioner. Then I heard from Ms Catherine Viney, the head of the Bapcare local area coordinator. She spoke from Tasmania. Then she was followed by a further person from Bapcare that then came in non-public session because the information related to the personal affairs of the late Ms Ann Marie Smith and/or related to, or potentially related to, criminal or civil proceedings, and as I explained yesterday, one of the things I'm required not to do is to prejudice proceedings of that sort.

Now, today I'm going to begin in a minute or two with Dr Caudrey, Dr David Caudrey. That will be a public session. Dr Caudrey has been South Australia's State Disability Advocate from January 2019. That's part of the Office of the Public Advocate. He's also cochair of the State Safeguarding Task Force, which was mentioned yesterday. Dr Caudrey I think will be speaking in public session.

Then, following him, the plan is to hear from Ms Lois Boswell, who's the Acting Chief Executive, Department of Human Services in South Australia, the South Australian Government department. I think all of that she expects to be in private session, but I'll find out from her when she arrives. Then after the lunch break, I'll hear from Professor Richard Bruggermann. That will be a public session. He's worked in the disability sector for many years and is a Professorial Fellow at Flinders University. He recently retired from his role as senior practitioner in the South Australian Department of Communities and Social Inclusion, which is now the Department of Human Services.

So I'll start then with Dr Caudrey. Welcome, Dr Caudrey. You can hear me okay in Adelaide.

DR DAVID CAUDREY: I can hear you perfectly well, thank you.

MR ROBERTSON: Thank you very much for attending today. I know you're a person with a busy schedule. Do you want to make any sort of general opening comments or shall I just go into the issues that I thought would be useful to raise with you today and get your evidence about?

DR DAVID CAUDREY: I would be very happy just to respond. I think you've introduced me and indicated my role and I'm sure that will come out further in answers to your questions.

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MR ROBERTSON: All right.

DR DAVID CAUDREY: I'm happy for that to happen.

MR ROBERTSON: I wonder whether a starting point isn't to set the scene by perhaps putting this proposition to you - tell me whether you agree with it. From your observation or perspective, the NDIS scheme, with some bumps along the way, perhaps, seems to be working pretty well for the great majority of participants in the scheme, but maybe not so well for people who are less capable of looking after themselves, if I can put it that way. Would you agree with that general observation?

DR DAVID CAUDREY: Yes. My primary role last year was to see whether South Australians were getting a good deal from the National Disability Insurance Scheme. We met with lots and lots of people, plenty of people who have lived experience of disability, who are participants, or their families, and the general feeling was that obviously the people who wanted to talk to me were people who were finding some kind of difficulty, so it was a bit of a biased sample, but at the end of the day the acid test question I always asked people was, "Would you like to go back to the old system?", and nobody wanted to go back to the old system, mostly because the old system had inadequate funding and, as a consequence, there was a huge amount of unmet need.

However, when you dig, there are lots of problems that they aired about the way the National Disability Insurance Scheme works and I have to say by and large my impression is that it works okay, well, for a large number of people, but there is a sizeable body of people who have more challenging issues - maybe they're poorly socially connected or they have cognitive impairment of one kind or another or their families are struggling for whatever reason - that really find the NDIS difficult.

I have to say too that from January of last year to the end of last year, when we were meeting with people, I could palpably see that things were improving when people got on to their second and third plans because they got to understand how the system works, but when they were dealing with their first plan, they often had a great deal of difficulty negotiating the system. I actually indicated in a report that I wrote for state ministers and for the NDIA at the end of 2019 that there were some what you might call straightforward administrative issues which I think were gradually getting better, although they were problematic, things like answering phones and returning emails and things of that kind, and then there were more kind of operational issues with just the way in which the scheme functioned and the way the bits moved together, but there were really some quite significant design faults and I think a lot of that was around the needs of people with more complex needs. So that's my general view.

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MR ROBERTSON: The needs of people with more complex needs - would that include a number of people who could be referred to as people who are at risk or vulnerable? Does that include that group or is the group coterminous with the at-risk or vulnerable people?

MR ROBERTSON: I think it should be coterminous. I think that's part of the issue. One of the recommendations of our interim report, the safeguarding interim report, is around the definitions of vulnerability or at risk and it is interesting that the NDIA, when it was dealing with people through the COVID crisis, had a concept of people who are at risk for whom they did welfare checks and the criteria that they used in terms of support needs, they were in the complex clients pathway - the bit that was missing was whether or not they were socially isolated.

So the task force that I'm on, the people with disabilities on it have been at pains to point out that you're not at risk just because you've got a disability, you're at risk because the disability gives you other kind of risk factors, and a lot of them are to do with the ability to understand the system or have somebody in your life that does and to be socially connected so that people can see what's going on. So that dimension of social connection, people in your life, people looking out for you, is something which is a tremendously important feature. So what we're recommending too is that the NDIA develop a concept of vulnerability where you need to do more regular checking on people's welfare effectively which actually includes some of these dimensions that they've also missed.

MR ROBERTSON: All right. So you think that the criteria which were developed in the COVID-19 space could well be examined to import them into the more general disability space - is that what you're saying?

DR DAVID CAUDREY: Yes, with modifications and learnings and the single biggest learning I think is that there needs to be a dimension about the vulnerability arising from social isolation or poor social connectivity, yes.

MR ROBERTSON: Well, now, so there's a definitional issue - or if it's not a definition, it's an identification issue. Then it seems to me one question that arises from that is, well, can such people be identified either on their way into the NDIS scheme or as part of the planning - that seems to be one issue, tell me whether you agree with that - and the other aspect of it at the moment seems to me well, what do you do, whether or not you've identified them in a sense going into the scheme - what do you do to have lines of communication or call it monitoring or call it pairs of eyes in the real world to make sure that harm in a sense doesn't befall them or that the risk of harm is identified, and so on? So what I'm asking for your comments on, Dr Caudrey, is whether you think there is room to identify such people at the planning stage and whether or not you do that in a sense there's scope for a mechanism or a monitoring, as I say, and who would do that.

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So let me ask you first about the planning stage. Do you think, from your perspective, that that could be done - that is, the identification of people at risk or vulnerable people, do you think that could be done at the planning stage?

DR DAVID CAUDREY: Yes. I think it's the stage that it has to be done at. There are some extra questions around who does the planning because the local area coordination service has been brought in to the working with individuals about the development of their plans, but ultimately the plan is signed off by the NDIA. But it really needs to be a lot of thought going into what needs to be in the plan.

So the first thing it needs to do in the planning process, I think, is to have some indicators of vulnerability, which then indicates that the person needs certain things in their plan. We're suggesting, for example, that if a person is seen as vulnerable, and it can be different things for different people because that's the flexibility of planning, but for example, you would want to make sure that they have regular health checks as part of the plan - not that the health check is necessarily done, you know, under the NDIS, but the fact that somebody is assisted to get their health care checks done so that they don't actually fall into parlous circumstances and have poor health. But it also is the stage where you would identify whether or not somebody needs support coordination in their plans and whether that support coordination needs to be ongoing.

The trouble with - the fundamental problem with the NDIA as I have seen it for quite a long time is that because they have not got comprehensive case management, for all sorts of reasons to do with not just wanting to disempower the individual, there isn't an obvious place that you go to that is with the individual around making sure that they're safe and they're getting the services that they need. So we've opted in our report to say that this role is probably the role of support coordination, for want of a better locus, if you like. But it does mean if you've got, say, a psychosocial disability and you are hard to engage with and you may be very socially isolated, then you need somebody in the plan that there is going to be support coordination in an ongoing way that provides that extra pair of eyes, that professionalism, that assists the individual and also provides the go-to place for the individual and anybody else if that person gets into strife.

So that's why we're saying in the planning process you need to include ongoing support coordination for the certain vulnerable people and you need to tag the things that are needed around health and welfare that must be addressed for that individual in the plan. So it's not connecting up properly at the moment and therefore people are put at risk.

MR ROBERTSON: You've used the term "support coordination". That may be a technical term, I don't know. Can you just explain what the concept is and who would be delivering that support coordination? I can understand it as a

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general concept - you're in a sense connecting, I think, the participant with the support - but it sounds as though it's got more in it than that.

DR DAVID CAUDREY: Well, part of the problem with the NDIS - and probably I'm talking more about the NDIA, but you could also talk about the Quality and Safeguards Commission - is its complexity and the number of different players that do different things. If I just go back in time, in the days when I was Executive Director of Disability SA - this is prior to my retirement from that position in 2016 - we had the concept of a service coordinator and the service coordinator did many of the things that currently are done by a local area coordinator, by a planner, and by a support coordinator.

What the NDIS has done is to break up that comprehensive case management role because I think there's a belief that comprehensive case management can disempower the individual, take away their choice and control, which in good hands shouldn't happen. But the support coordination is really kind of a part of what service coordination used to do. What it does primarily is that it's in a plan in order to assist an individual in order to be able to negotiate which service providers they want and how to gain access to them. So it's put into a plan to help an individual, a participant, to gain access to the service system. It helps them choose which service providers they might want to use and how they would engage with them.

One of the problems has been that a lot of participants have access difficulties. For example, in the early days - probably less so now, but it's still a problem - if you don't have support coordination in your plan, the individual gets a plan which says you can have so much therapy and so much day programs and so much of this, that and the other, but you don't know how to get to those service providers, you don't know how to access it and how to sign on, so you need some help to do that.

So that's been the primary role of support coordination, is to help people through that process of getting their services all lined up. But the fundamental problems with it are it's in a plan, it's not necessarily in a plan, so there's a consequence you've got to know in advance that you need it. Otherwise you won't have it. But it's one of those things that you don't always know you need it until you are existing without it, if you get my drift.

MR ROBERTSON: Yes.

DR DAVID CAUDREY: So getting it into a plan in the first place is a problem. The second thing is that it's meant to be time limited because it's capacity building of the individual - you will learn to do it yourself, I will help you the first time around. So it's time limited and it will eventually fade away and it's a belief that you won't need it.

Where it was discovered that there were people floundering in the system, support coordination then had other arms like specialist support coordination.

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They introduced different pathways into the scheme, but at the end of the day we're aware that local area coordination helps the individual to navigate the community, support coordination helps you to navigate the service system, and I guess what we're suggesting is that there should be ongoing support coordination in the plans of vulnerable people because it's not like you need help, you develop the capacity, and then you won't need it again. And it's automatically put in so that it's not something you've got to think of putting in.

MR ROBERTSON: So does your picture involve this - first of all, a better way of discerning who are people who are at risk vulnerable, a better way of identifying that in the planning process, that then would feed into whether or not the plan contains support coordination - is that how you see it working?

DR DAVID CAUDREY: Yes, yes.

MR ROBERTSON: And then support coordination, is it any more than, at least at the entry point for the participant - is it any more than "Yes, I agree you should have support coordination and here is the person to telephone or speak to" to set it on its way? Is that how it would work from a participant's point of view?

DR DAVID CAUDREY: That's how it's deemed to work, in the sense that you go through the planning process - the journey that you go on as you enter the scheme and you deal with local area coordination, local area coordination will help you to develop your plan. The plan is put to a planner. Then once the plan is approved, then you're set to go and if you've got support coordination in the plan, then you're actually at liberty to choose a support coordinator.

So, if you like, there are multiple points at which the individual actually needs help. So the local area coordinator is meant to help you to get started. But once you're in the system and you've got support coordination in your plan, then the support coordinator will actually assist you to navigate the service system and get the services that you need. That's how it works. Some people of course don't really need that because they can do it themselves or they've got good family that can do it themselves and they don't need support coordination, but we're talking about the most vulnerable people.

MR ROBERTSON: Yes. And in this concept of vulnerable people, if we can just pause on that for a moment - I'll come back to the question of - you mentioned about pairs of eyes and being a sort of side benefit of people going for health checks, and so on, I'll come back to that issue, but how is it going to work in terms of the support coordination? You have in your plan, "Well, this is what you need", you've got the local area coordinator in a sense saying, "Well, these are the services that are available". Do you still need someone who in realtime, if I can use that expression - that is, rather than planning and this is the number you should ring, and so on, who for the vulnerable people who might not know they're vulnerable in the sense they might be saying, "Look, I've got a carer, I don't want any more" - who have you got in realtime

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who can at the end of the day pull it all together and say look, I'm looking at this person as an individual, they've been through this planning process, they've got this say, for example, support coordination in their plan - is there anybody in the system at the moment who looks at the individual as a whole person and says, "Well, this is working well" or "It's not working well" or "You haven't got your support coordination working properly"? So I'm assuming in this question you don't have a close family member, you are socially isolated. How does the system at the moment pull it all together from an individual's perspective?

DR DAVID CAUDREY: That is the fundamental problem in the sense that basically there are so many moving parts with so many roles and they all make sense to the NDIA, I suppose, and to the Quality and Safeguards Commission, all these different roles, the local area coordinator, the planner, the support coordinator, the specialist support coordinator, and then you've got all these different pathways. So this complexity leads to the quite obvious end point that if you're not careful, there is nobody that has a locus of responsibility to make sure in an overall sense that things are going well for the individual and there is no natural place for contacting when you think things are not going so well. That's because you've got so many different players.

The logic of the scheme since it's built on insurance principles and it's built on these processes that people go through is that ultimately it's responding to what the world has said for a long time, particularly the disability community, and so on - namely, to empower us, to give us the opportunity to take control of our own lives and to make our own decisions, all of which is totally desirable. It's when people turn out to be vulnerable or when things go bad, who do you contact and who takes responsibility, and there are too many loci where somebody has a responsibility for this thing or that thing or the other thing, but nobody has a kind of overall responsibility for the whole thing. There's no sense of where you go to, which means that ultimately it is built on the logic that the individual is responsible for the overarching thing.

I should actually say that one of the things that was said to me a lot by families last year when I was doing my first year in this role is that they've never had to work so hard before because in the past they would sign on with agency or agencies and the agencies would organise things and make things happen and they knew where to go to when there was a complaint or there was a problem. What they've got now with the NDIS is this wonderful empowerment, which means you're in control, you have a bucket of money and there's no unmet need as such - well, little - and as a consequence, knitting it together, making sure the plan happens, making sure the plan is implemented, making sure the local area coordinator gets called - this falls back on individuals and it falls back on families. So many is the parent of a person with intellectual disability who has said in the old days I might spend 5 to 10% of my time worrying about organising things for young Fred, now I reckon I spend 50% of my time, making phone calls, organising things, putting together all the bits of the scheme.

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So the scheme has got wonderful elements to it, but it's actually really like a beautiful jigsaw puzzle that if you can put it together, it's fine, it's lovely, it's wonderful, you don't have unmet need, but if you can't put it together or you struggle to put it together and there's a lot of work in putting it together for certain people.

So I think what you've described is exactly the fundamental problem, there is no one easy locus. That's why in a way in our interim report we've recommended that effectively support coordination takes this locus, for want of a better word - I mean, you could have said it should be local area coordination, but that would have its own problems and support coordination if it's not in the plan of everybody that's vulnerable is not useful either, but if we put it into the plans of people who are vulnerable, it's the best thing we've got as the go-to person, but they still have to take some kind of responsibility when things go belly up and the person needs help. You can't just wash your hands and say, "It's 5 o'clock on a Friday, it's not my problem."

MR ROBERTSON: Yes. Where as you see it at the moment does that responsibility or function lie? Is it something that the service providers do? I'm not telling you anything you don't know that the NDIS Quality and Safeguards Commission has as possibly its main role supervising the service providers, so is that where one would find this overall pulling it together or is that not a service provider's function?

DR DAVID CAUDREY: The service providers do it. Good-quality service providers, and I'm sure the vast majority are good-quality service providers, but the good-quality service providers will actually do things that just need to happen.

Just as an example, somebody is in an accommodation service and one of their residents who's going off to supported employment in some form, they fall over in the street and they need help. Now, you could actually say well, you call the ambulance or whatever, but the service provider who's the accommodation provider when they hear about it will go and do something and fetch something and take the person to hospital and sit with them while they're in hospital, all of which is not part of what they're paid to do simply because it's the right thing to do and it's what they've always done. So you do have an enormous amount of responsibility that falls on service providers.

When it comes to the Quality and Safeguards Commission, you're right in that the way in which - because it's called Quality and Safeguards Commission, people have a belief that it's the place to go to if you think that somebody is not getting a quality service or not being safe, but in practice often when things get reported, it then either gets seen as a complaint and the Commission naturally sees complaints coming from the participant or their nominee. So the general public who sees something wrong can't really go to the Quality and Safeguards Commission easily and say, "I think so and so is in

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strife" and the Quality and Safeguards Commission will do something about it. They're there - they see themselves I think in the registration, the restrictive practices, the incident management and basically they perform these tasks, which is about the accountability of the service providers.

And in a way I have to say the other thing that came out of my reports last year and what people were telling me was that what people really wanted to complain about most last year was the NDIA and its performance - not returning phone calls, not answering emails and all the shortcomings, which I indicated earlier - I think they're teething problems and I think they were getting better towards the end. But people wanted to be able to complain about the performance of the NDIA or about local area coordination and they can't because the Quality and Safeguards Commission really is about the quality of the services being offered by service providers, not about the NDIA itself.

So in a sense people get very frustrated because they see oh, here's this thing called the Quality and Safeguards Commission, but I'm getting a lousy service from the NDIA but I can't report it to them because they can't take that and I'm seeing something untoward happening to this individual, but they're not really taking stories about individuals. So then people say well, where do I go, who do I report it to if they're not taking those things? So I think that's a big problem. They need to have some mechanism to be able to take it and at least triage it to some other appropriate authority or deal with it themselves.

MR ROBERTSON: I think it ties in with something that I've been told that people want, which is a proactive as opposed to a reactive role. People have said to me the Quality and Safeguards Commission responds to things rather than in a sense gets out there and has a look at say individual participants in certain circumstances.

Now, that I think brings me to this issue which involves various names of bodies, but I think it all comes back to this point of needing to have pairs of eyes, people to actually look at what's happening day to day, and maybe that ties in with what we've just been discussing, but there used to be I understand in a number of the state jurisdictions, state and territory jurisdictions, before the NDIS - there used to be a scheme which did that work or could do that work called the Community Visitors Scheme that as such anyway has retracted from the people who are now participants in the NDIS scheme because it was a state-based system and then as well, which I think covers some of the same ground, in South Australia anyway, there's something called the Adult Safeguarding Unit. So the issue I'm asking you to address, Dr Caudrey, is what I'll call the feet on the ground issue, the realtime looking at individuals and their circumstances and the state of their accommodation and so on and how you see that as working so far as the NDIS scheme is concerned - when I say "working", I include how it should work if you think there's a gap there.

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DR DAVID CAUDREY: Yes. Well, firstly, as far as the Adult Safeguarding Unit is concerned, that was set up only last year and in its early days concentrated entirely on people over the age of 65. It originated in our Office for Ageing Well, but there was always an intention that it would be expanded to vulnerable adults of any age. And one of the recommendations of our interim report is that that expansion happens sooner rather than later.

Bearing in mind that what that role is is about reports of abuse and neglect that come to the Adult Safeguarding Unit and they have various powers under state law to make inquiries, to investigate, to visit, to basically follow through. It's not a mandatory reporting system, you're not obliged to report incidents of adult abuse and neglect, not like the children's space, but the Adult Safeguarding Unit, there's a mandatory response, if you like. If they get a notification, they must follow through. Of course it's mostly geared to situations where it's abuse within the community - by family, friends and other community members - rather than poor performance or abusive behaviour by the service provider because the service provider of course is regulated by the Quality and Safeguards Commission. So it's a question then of if that was to emerge, then it would have to go to the Quality and Safeguards Commission for follow-through.

One of the big gaps is that the Quality and Safeguards Commission, unlike it does in the aged care space, does not do regular, unannounced visits. It can do unannounced visits to service provider sites, but it doesn't have to - well, it doesn't in many instances. It will respond to - the point you made earlier, which is often responding to situations rather than being proactive. So that is another thing that we would certainly be recommending, that they have unannounced visits, regular visits, to service providers' sites.

With respect to the Community Visitors Scheme, yes, it does exist in six jurisdictions, not in Western Australia or Tasmania. They operate in different ways and have different powers in the different states. South Australia has still got a Community Visitors Scheme which goes to government service providers - in other words, government agencies, state government-run services, and also under delegation to visit people who are under the guardianship of the Public Advocate. It ceased going in to non-government organisations at the time of the Quality and Safeguards Commission starting because it was seen as a conflict of responsibilities, if you like. What we're recommending is that the Community Visitors Scheme does continue, but how it functions with respect to non-government entities has to be worked out in conjunction with the Quality and Safeguards Commission.

There was one other side to this and that is there was a desire by some that the Community Visitors Scheme would be able to go into people's private homes to see the services that were being offered in those homes. For example, if you have an attendant care arrangement and have, say, six hours a day of support from somebody in your own home, the community visitor could come and visit.

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When you tease that through, this is not a site that is owned or run or leased by a service provider and that was never the scope of the Community Visitors Scheme and people are really very nervous about people coming into your own homes and what their powers might be. So as a consequence, it's really been more like a voluntary approach to coming into your own home.

So we're still wrestling with that, but what we're really suggesting is that the Community Visitors Scheme has a place. It's not a magic bullet, it doesn't answer all questions, it has a place. It should be continued where it can. It should be done in conjunction with whatever the powers and responsibilities of the Quality and Safeguards Commission are and they ought to do unannounced regulatory visits and going into people's own homes is a fraught matter that needs to have further consideration, but nevertheless it may be that people want outside bodies to come in and that could be another extra pair of eyes. But the most vulnerable people of course don't actually ask for people to come in.

MR ROBERTSON: I suppose what I was focusing on - I understand that the Community Visitors Scheme is a state organisation and there's a question about how it intersects with the Commonwealth scheme, but in terms of the work they do, I suppose my question is whether because the NDIS is a national scheme - and you mentioned that in any event Community Visitors Schemes don't exist in some places, but my question I suppose one of approach is because the NDIS is a national scheme, do you see the work - not so much the scheme itself, but the work that is done under the Community Visitors Scheme - should be something that the NDIS Commission say looks at doing itself to complement what it otherwise does in terms of quality and safeguards?

DR DAVID CAUDREY: We've always had the view in South Australia that because there are so many powers that reside under the NDIS Act with the Quality and Safeguards Commission - you know, around registration and incident management and restrictive practices, and so on - there should be a national Community Visitors Scheme. The problem, of course, has been that there are already six schemes in place and they're somewhat different from one another, so pulling it together.

But that is the thing that would make sense because then you've got a complete suite of things. You've got unannounced visits the Commission can do, you've also got a Community Visitors Scheme which in a sense might even be seen as doing some of those things on behalf of the Quality and Safeguards Commission because an unannounced visit by a community visitor can identify a whole range of things.

There is the other added problem - in South Australia our community visitors are selected and trained and they're usually very experienced people in the human services field who often are retired, they're volunteers, whereas in

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other jurisdictions they're official visitors and they are not volunteers, they're paid. So there are issues about cost and so on. But in principle, to have a national scheme of community visitors - a Community Visitor Scheme run by the Quality and Safeguards Commission has always been our view as the way to go.

MR ROBERTSON: In terms of - without wishing to get hung up on labels, it's really in terms of the work that people in such a scheme would do. So if I've understood you correctly, part of what they would do would be to, in effect, visit from time to time a vulnerable participant as we've been discussing, see for themselves as a pair of eyes what's happening and whether everything is going well for that participant - is that as you see it?

DR DAVID CAUDREY: Yes, it's pretty well what it boils down to. There are obvious various guidelines and things that go into the training of people, and so on, but ultimately what it's about is the right to visit, to knock on a door - we're mostly talking about group homes, group day options, supported residential facilities, grouped arrangements with usually a single main service provider and basically the community visitor can go in and has a right to talk to the individual and then make inquiries as to anything - is the food good, do they treat you well, is it warm enough in your bedroom in the middle of winter, and a whole range of things which actually goes to the welfare of the people there.

And I have to say too that the non-government sector has been very welcoming of community visitors. Most chief executives of the bigger and the really good agencies really like this because basically the community visitor will go in and find things and then they report untoward matters for fixing in the first instance to the agency. So it operates like a kind of internal audit for them.

MR ROBERTSON: But it also I think may have this advantage, that these sophisticated schemes that we've been talking about - that is, the planning, the role of the local area coordinator, whether or not you have support coordination, then you have the service providers, you have the registration of the service providers, the audit of the service providers, you have reportable incidents and you have complaints - part of what I think you're talking about is that these people, call them community visitors - part of the work that they do, and which I think is your view needs to be done, is to look at how all this is working from the perspective of the individual participant because you can have very good plans, for example, but unless you know from the perspective of the participant how it's all working, then you might be left to reports, audits, complaints, and so on. So it seems to me to answer the description of the extra pair of eyes or line of communication particularly in relation to the people we've been talking about as vulnerable people.

DR DAVID CAUDREY: Yes. I agree. The only curly bit at the end of that, of course, is whether they go into people's private homes because that's

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where - the world is changing so much from what I remember over the course of my career, you know, where people lived in institutions and they lived in group homes. The same sort of thing is happening in aged care - that is, people by and large tend to live as long as they possibly can at least in their own home with support coming in and the vulnerability that that brings of course is around how do you then bring in the extra pairs of eyes? In some ways there are different sorts of vulnerabilities that happen in group homes - you know, the sort of vulnerability of a person having a support worker overnight who's on their own and you don't know what the support worker is doing with the individual and you see bruises in the morning. There's a whole range of things that need to flow from that.

But what actually happens in people's private homes needs to be teased out. So you'd have to - but there's also an understanding that the vast majority of people probably would, under the right circumstances, not be averse to a community visitor coming and visiting them. They probably would say, "Yes, please come in, I'd like to have a chat and a cup of tea and I'll tell you about how things are going for me" and that brings in the extra pair of eyes. So it's perfectly doable to extend it, but it's a question of what powers you want to give to the individual, to the community visitor.

MR ROBERTSON: Well, yes, I fully take your point that it's entirely consistent, entirely resonant with the principles in the legislation that people should stay in their own homes where they can and for as long as possible, but I wonder whether - that's a real issue, I wouldn't want to downplay that, and I understand that consistent with those principles you wouldn't want some heavy-handed approach whereby somebody said regularly, "Well, I've actually got the power to march through your front door even if I'm not invited." That doesn't seem to be really consistent with how the legislation is meant to work.

But one observation is sure that's a real issue, it might depend on how it's done, and I wonder whether that might be a sort of tail wagging the dog. In other words, if you've got the principle first - that is, you need this extra pair of eyes, you need the participant's perspective - then it becomes something that could work in all the cases where the person isn't in their own home, which raises its own particular problems, and then you just need to work out with some subtlety and care how the people still in their own homes might intersect.

I don't know whether there's any research or empirical evidence about how often people are - say in the South Australian system, how often they are resistant to community visitors coming into their own homes if it were done in a polite and respectful manner. Do you have any information along those lines?

DR DAVID CAUDREY: It's a question we haven't really asked because the scheme was only ever meant to be for group homes and grouped arrangements, and so on, it was never meant to be for going into people's own

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private homes. And if the fundamental principle is that this is by invitation and that therefore the individual is inviting you into their home, in a sense it's legally a different ballpark from where you were. It's really sort of like - it's more like - I wouldn't want to say a social visitation arrangement because that implies it's just like a friendly person like as in aged care. In aged care there's a Community Visitors Scheme which is really just people befriending and visiting and so on, it's not a kind of extra pair of eyes to hold the service provider accountable. I suspect that crops up from time to time, but it's not what its main purpose is.

So it's not beyond the wits to put together something where you've got the main body is a Community Visitors Scheme for those grouped arrangements and that hanging of it is a kind of more volunteer arrangement whereby people can say I'd like a community visitor to come too to be able to put that together. The whole thing would be so much easier if it was all done through the Quality and Safeguards Commission under the NDIS Act, however.

MR ROBERTSON: You'd still have, of course, questions of jurisdiction or interrelationship between Commonwealth and state agencies insofar as the state continues to look after people outside the federal scheme, so there would still be a place and of course, as you know, whenever people start talking about single schemes or uniform schemes, then that's got its own problems to put it all together. But there does remain - I'm not trying to downplay for a moment, there does remain - it goes back to where we started in a sense - the identification of the different types of vulnerable people. You could have somebody who doesn't know they're vulnerable. They could be perfectly content - say they're in their own home, they're perfectly content with what they see, maybe they're shy, maybe they've over the years become socially distant and reduced the number of friends, local friends, et cetera, and I think one has to include an opportunity at least for those people to be brought back, as it were, into the scheme by means of this sort of pair of eyes so that even if the person doesn't know that things are going wrong in effect.

DR DAVID CAUDREY: Yes. I think that's right. Ultimately there are people for whom the service system finds it difficult to engage for one reason or another. Supported residential facilities - the vast majority of people living in them have a psychosocial disability and when asked to engage with the NDIA or with the Quality and Safeguards Commission, they basically won't take phone calls, they throw stuff in the bin. They don't want to engage. It's the nature of the person. But yet they are vulnerable and they often need support services, but they don't ask for them and they don't want them and they actually try to keep them away.

So it's what I mean by kind of like assertive case management is that somehow or another you persevere to gain some kind of access into somebody's life so that you can actually effect good things for them even though they are not asking for it. With things like we're describing with the Community Visitors Scheme, at the end of the day our interim report identified

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12 safeguarding gaps and made five recommendations. The report in its more finalised form will probably add a gap or two and maybe a recommendation or two.

But the main thing is no one of them fixes the problem. It's sort of like - it's lots and lots of different things that bring it together. But I think the most fundamental thing is acknowledging the vulnerability and making sure that there is a form of case management in the life of vulnerable people - call it support coordination - and that these other things, like an Adult Safeguarding Unit, the Community Visitors Scheme, good health checks - all of these things need to be added to the process but no one of them on their own will do the job.

MR ROBERTSON: Well, can I put it this way, they are sort of complementary lines of communication with the participant or complementary pairs of eyes, in a sense the more the better. I'm not using pairs of eyes in a snooping sense --

DR DAVID CAUDREY: No, I appreciate that.

MR ROBERTSON: -- but people who care as either relations or friends or neighbours about the overall wellbeing of the disability participant who we're concentrating on at the moment.

DR DAVID CAUDREY: Yes.

MR ROBERTSON: Looking at it perhaps as a matter of first impression, you'd say oh, look, if you have case management like Dr Caudrey is suggesting, you're really derogating from the principle that they should be as much as possible self-determining and free to choose, and so on. Do you see any conflict there?

DR DAVID CAUDREY: Well, if case management is slavishly implemented according to a particular formulaic way of doing it, it is disempowering. Good case management is only there when it needs to be there so that when I'm talking about case management, I'm really saying look, if somebody is quite capable of knowing what they want, entering the service system, taking the money, organising everything, you don't need case management. But it's always thus been so. Case management has always been targeted to the people who are in strife or might be in strife or are at risk.

So I've never - case management - we've wrestled with this ever since time began because case management sounds very much condescending. It sounds like you're treating people as cases, sort of a vaguely medical model or something, and that somehow it's disempowering and disrespectful. Happy to find another word. Words could be support coordination. Over the years we didn't like the idea of case management. We called it options coordination, we called it service coordination. But at the end of the day, when you analyse

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what it is, it's a number of tasks that are performed by a person to assist an individual and who is there as the go-to person when things go wrong.

Whatever language you use, and it's not necessary for everybody, it's really - the best bet is if you can identify vulnerable people, then they have some kind of version of this, and it doesn't have to be one size fits all, but it needs to be thought through that there is this kind of failsafe.

MR ROBERTSON: Yes, all right. Well, Dr Caudrey, I see the time. I should thank you again very much for making the time to come and talk this morning and best wishes for your final report, which is I think due at the end of this month, isn't it?

DR DAVID CAUDREY: It is due at the end of this month. I'm sure you'll get a copy and will be able to know what we're saying before you do your final report.

MR ROBERTSON: Yes, good. Very good to talk to you, Dr Caudrey. Thank you very much.

DR DAVID CAUDREY: Thank you very much. Bye bye.

MR ROBERTSON: Bye now.

Ms Boswell, good morning. Can you hear me all right?

MS LOIS BOSWELL: Yes, thank you. Can you hear me?

MR ROBERTSON: Indeed I can. It's Alan Robertson here and I have assisting me Mr Tom Liu, who's with me here in Sydney. So I suppose the first question just for the technical people here - the first question to ask you is whether there's anything that you want to say that you're content to say in public session or would you prefer for everything to be in closed session?

MS LOIS BOSWELL: Basically, on the advice of SAPOL and the Crown Solicitor, we think we should do this in closed information so we can give you the information you need.

MR ROBERTSON: Thank you, Ms Boswell. I'll just ask the technical people then to do what they have to do and then I'll resume in public session at 2 o'clock South Australian time. So for those who are listening to the feed or listening on telephones, we'll be back in public session at 2pm Adelaide time.

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AFTERNOON SESSION

MR ROBERTSON: Welcome back, everybody, who can hear me, to the afternoon session of the second day of these Adelaide meetings. I welcome Mr Bruggemann, Professor Bruggemann, and I expect that my interview with him will last probably an hour or so.

Professor Bruggemann, welcome.

PROF RICHARD BRUGGEMANN: Thank you very much.

MR ROBERTSON: I wonder if I could start with before asking you to give sort of a short background of your interest and expertise before we get to the questions of substance, before we came on just now I indicated there had been quite a lot of interest on the video link. Have you had a chance to listen to anything that's been said in the public sessions?

PROF RICHARD BRUGGEMANN: I didn't know it was being video linked, to be quite honest, but no, I haven't. I don't know if I can review it in hindsight but I certainly would be interested in doing that. I'll check that out when I get home.

MR ROBERTSON: I'm not sure how the technology works but anything seems to be possible. So we'll see.

Could I ask you then to give a short Barack ground of your interest and expertise over the last, say, 10 or 20 years that you've been involved in

PROF RICHARD BRUGGEMANN: I was the chief executive officer of the Intellectual Disability Services Council in South Australia for 22 years, up until 2006 and that was a State body responsible for planning, providing funding services to people with intellectual disabilities. And we had a significant mandate to be able to work closer with a range of other government organisations, clubs, etc, to promote the inclusion of people with disabilities and particularly intellectual disabilities into the fabric of the South Australian community. So we worked with the football clubs and they established a league for people with intellectual disabilities.

So it was quite a unique organisation and we had a mandate, not just to provide services, but to ensure that people with intellectual disabilities had a capacity to be involved in and to contribute to the South Australian community.

When I retired from that, I was offered a couple of years at the Flinders University as a professorial fellow and I developed a program called the Associate Diploma in Disability Studies Leadership and it was about teaching the next generation of leaders in this area.

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I was then invited to become the senior practitioner in the Department of Human Services and in that role I was responsible for trying to reduce the dependence of the service system on restrictive practices, basically locking up, tying up, drugging up people with disabilities to control behaviour.

Since then, I've been appointed by the Attorney-General of South Australia as the authorising officer so that when people who lack cognitive capacity put themselves or other people at risk through their interactions, and where organisations want to deal with that by detaining them, they need to seek approval of the authorising officer. So I've been put into that position until the 9th of October.

MR ROBERTSON: This is in the COVID-19 pandemic.

PROF RICHARD BRUGGEMANN: In the COVID-19 environment, yes, specific to that environment. And I've had involvement in the South Australian Council on Intellectual Disability, which is a peak body, the peak body in South Australia, developing responses to people with intellectual disability how they can contribute to the South Australian community and really how they can understand how they benefit from the NDIS because this were a group, I don't think, that the NDIS actually knew existed in their entirety when it was set up.

So that's been my recent experience. My interest is the rights of people. The restrictive practices has a very strong rights focus and I believe one of the rights is the right to inclusion, to be a part of and to contribute to your community. Where we've seen people with intellectual disabilities given the opportunity to do that, they have done it splendidly and I don't know whether you had the opportunity to see a young woman called Sarah the other day talking about her job and how that actually is a huge source of protection to her because she's got people who are interested in her, who ring if she's not around and, in my view, inclusion and participation in communities is one of the really strong safeguards that we can have and develop for people who are vulnerable.

MR ROBERTSON: Thank you for that. Now, one of the matters that you're interested in is the matter you've just mentioned, which is how it can be seen whether people are - people with a disability are vulnerable or at risk, that is what are the indicators? Are they well understood? Would you care to talk about that for a moment?

PROF RICHARD BRUGGEMANN: Yes, and I'm not an expert in this area on vulnerability but I did actually - and I looked at a view websites and came away not much wiser. But if I was looking at what made me vulnerable, it would be things like isolation, some condition that perhaps impeded my capacity to community like Bell's Palsy. Whether I had loved ones or people

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who are interested in me, who took notice of what was happening to me, my health. So it wouldn't be very difficult, I don't think, to develop some indicators that would place somebody on a vulnerability index.

Remembering that not all people with disabilities are vulnerable. Some of them are very non-vulnerable, they are very well connected and vulnerability is also something that changes over time. So, you know, you may be vulnerable now, you may not be vulnerable tomorrow. And what I don't see is any capacity within the current planning processes of the NDIS for looking at issues of vulnerability or if they do exist, they certainly failed spectacularly on a number of occasions.

MR ROBERTSON: So do I interpret that to mean that one of the places at which the issue of vulnerability should be addressed is at the point at which a disabled person comes into the NDIS in the first place?

PROF RICHARD BRUGGEMANN: Yes, and this is - it's a vexed topic because in the previous paradigm that we had in South Australia, and around Australia, the system that the productivity system called a broken system, I would say it's an underfunded system rather than a broken system.

What might happen is that somebody's not doing well and they would go to our organisation and they would be appointed a case manager. Now, that case manager would be able to make a test of vulnerability and the person would need things and it's the needing things that the now NDIS does, they would do that through providing service or securing services for that person, allocating some funding that they could buy services. But they would also keep an eye on people and so depending on the level of vulnerability, they might have - they might keep in touch and that means going out to see the individual in their own home regularly, through to what we used to call light touch where somebody says, "Look, I'm pretty OK. Just keep in touch once a year or twice a year to check." You can imagine how intrusive it would be for somebody who wasn't vulnerable to be getting regular visits from a case manager. They wouldn't want it and neither should they have it.

So what we've done in this new system, unfortunately, is to divide the functions that used to be done by case managers, some of those functions to planners, some of them to the local area coordinators, some of them to support coordinators, and what's still missing, unfortunately, in this system is the process for monitoring and advocating on behalf of individuals and that's one of the roles that case managers have in that whole paradigm.

MR ROBERTSON: So the vulnerability could be identified, correct me if this is not what you're saying, but it could be identified at the point of entry into the NDIS scheme.

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PROF RICHARD BRUGGEMANN: Yes.

MR ROBERTSON: And on the planning reviews, I suppose.

PROF RICHARD BRUGGEMANN: Yes.

MR ROBERTSON: It could be done then.

PROF RICHARD BRUGGEMANN: Yes.

MR ROBERTSON: If it were done at that point, that would be done the way the scheme presently operates by a combination of the - a local area coordinator and the delegate approving the plan?

PROF RICHARD BRUGGEMANN: Yes. The local area coordinators were never meant to be involved in the planning process to the extent that they are. This is hopefully a short-term situation to deal with a huge backlog of planning that needs to be done.

The local area coordinators are supposed to be the people who did the contacts with communities and unfortunately that's not happening. I don't know what information you've had from local area coordinators but largely a lot of their time is enmeshed in the planning process at the present time.

But basically, even coming into the scheme, if you've got a physical disability and you need some help, you go to the NDIS, they prefer to do it over the Internet, if you can do it possibly that way, but even at that first step it falls down because many people with cognitive disabilities aren't aware they've got a disability, are in other service systems like the criminal justice system or the mental health system or the homelessness system and they're not going to be coming to the NDIS. When they get there, the template approach that's taken, unless the template has changed significantly, it won't pick up vulnerability.

Now, in the template, for example, in terms of mobility, where on this sort scale do you fit? You can run mild by yourself, you can walk, you can walk with a stick, you can't get out of bed, where do you sit? Here. In terms of eating, where do you sit? I can prepare a meal and eat it right through I need to be fed with a spoon. Where do you fit in that? Tick. You fill out those boxes and run it through the computer and you get a plan. That's a bit of an exaggeration, I have to say, but it's not dissimilar to that.

Now if we're going to continue with this template-driven process, maybe one of the things we need to do is to have some indicators in it about vulnerability. Now, have you got a range of friends? You know, do you feel confident that you could pick up the phone and talk to somebody?

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Now remember, many of the people we're talking about have no expressive communication and so this would need to be done with some sensitivity but it could be done and either it's not being done at the present time or it's not being done and being effective at the present time.

MR ROBERTSON: Well, can I just go back to a point you made five minutes ago, which is that vulnerability or risk changes over time. If you have a two-year plan, for example, or a three-year plan, you wouldn't necessarily catch increasing vulnerability until the next time the plan needed to be redone.

PROF RICHARD BRUGGEMANN: Yes, that's correct. I've heard some, what I think, are quite horrific stories from families where circumstances have changed and they can't get an immediate review. Now, again, in the old broken paradigm that we had, sorry about that little inference, but you could ring your case manager and say "This has occurred and I'm not coping." There would be an immediate response. And I don't see that happening at the present time.

Many families are now saying the most abusive system that they're in is the NDIS and that its lack of understanding of the dynamics within their family life and the need to respond to that quickly just isn't there. And causes unneeded and unwarranted stress.

MR ROBERTSON: If a person in the plan had - I suppose one place they could go would be back to the local area coordinator. If they had in their plan support coordination, could they go there or is that not an appropriate -

PROF RICHARD BRUGGEMANN: They could. But the support coordinator, in my understanding, and I'm not 100% across this, but my understanding is that they are more about how do you put the packages stuff together for the individual. So, you know, you might need this service and that service and they are the ones who know who provide those sorts of things and put that package together for you.

What it doesn't do, and what the LACs might do is to provide that ongoing monitoring. But as I've said, they've been very much involved in the planning process rather than doing what the LACs are supposed to be doing or what the original idea of them doing was about.

I can't help but feel that for some people, something other than, you know, I call it case management, that monitoring and advocating has been lost from the system and needs to be put in for some people.

MR ROBERTSON: So can I then, just so we don't get hung up on terminology, when you speak of case management, you're talking about a person who has

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the responsibility of monitoring and advocating the wellbeing of NDIS participants, particularly the vulnerable?

PROF RICHARD BRUGGEMANN: Yes. Now in the old paradigm it had a wider purview but we now need to remember some of those have been taken over by the planning process, etc. But what is still missing, in my view, is that monitoring and advocacy.

MR ROBERTSON: So that would be able to look at changes over time in terms of risk and vulnerability?

PROF RICHARD BRUGGEMANN: Yes, yes.

MR ROBERTSON: And what, your vision would be that it would be a place of first resort for a participant?

PROF RICHARD BRUGGEMANN: Yes, and easy resort, as well. Because at the present time it's very, very difficult to interface with the NDIS. And particularly if you have a cognitive disability. So the process whereby that could be done would be the case manager makes a regular contact. "Hi, it's just Bill, everything OK? Great." Or it could be "If you need to ring me, get in touch. Here's my phone number and it's me to talk to not the 1300 number." And then that person's got the capacity to hear the issue and to take some action to advocate on behalf of that individual to the NDIS.

The NDIS is incredibly difficult for anyone with any degree of cognitive disability to have meaningful contact with.

MR ROBERTSON: And could I ask you this, would this role, this monitoring advocacy role, would that, in your view, have the advantage of reducing the template transactional nature of the planning and bring it back to what I understand you to think is a preferable approach or a necessary approach in addition, which is what I will call a relationship, person relationship approach?

PROF RICHARD BRUGGEMANN: Yes. That's a really good term, a personal relationship approach. And, you know, I've called it case management, that might be a bit strong. But, you know, someone who is easily contactable and can - and then advocates for the individual because of their lack of capacity to communicate, etc.

I still think that in the planning process, there needs to be a way of determining vulnerability and one of the outcomes of that might be that you have a person who does - who is that person who is personally accessible to you.

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MR ROBERTSON: Would you see that this person as being necessary primarily for the vulnerable? You're not suggesting, are you, that everybody in the system needs it because some of them are strong-minded and capable and the mistakes should not be made of making as synonyms disability on the one hand and vulnerability?

PROF BRUGGEMANN: No. A number of years ago a colleague and I did a review of what could go wrong with the NDIS and we interviewed a young woman, she was a lawyer in a wheelchair, and she was getting a bit of service from here and a bit of service from there and had to jump through hoops with each organisation and she said, "I can't wait to do my plan, get my money, set up what I want and get everybody out of my life." And she doesn't want anybody intruding in her life, and neither should anybody intrude in her life. So it really needs to be a clear understanding of how the vulnerability is not just because of the disability but because of a number of other factors that impact on your capacity to, you know, communicate and to be involved in your community.

MR ROBERTSON: How would you deal on this scenario, how would you deal with people who vulnerable, at risk, but aren't aware that they're at risk?

PROF RICHARD BRUGGEMANN: Yes, well -

MR ROBERTSON: There would be people in that category, I would think?

PROF RICHARD BRUGGEMANN: That's right. One of the guiding foundations of the NDIS is choice and control, and if you don't understand your vulnerability, you will make wrong choices, and choice and control, I think, is one of the issues that we've never really addressed in our discussions about the progress of the NDIS.

So I think that where someone is vulnerable, if you said to them look, we think you might need this and they said, "I do not want it", OK, that's a difficult situation, not one that we haven't dealt with before in our service systems but usually that takes some dialogue, you know, somebody who has got skills to explain to the individual what their vulnerabilities are, who can work with them to understand those things. Not done by some template approach, you know, it does need some human touch. Like Richard, you think you're doing really well but do you know these are the sorts of things that are happening to you and you may need a little bit more help. Do you agree with that? OK, I didn't see that. Or they might be more - many of us highly value our independence, I do, and we don't want people puddling in our lives and I could imagine myself being one of those people who would deny my own level of vulnerability when the time comes. But I would hope that I would have friends and if not friends, you know, sort of a case manager who might be explaining to me, well,

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"Richard, you know, you might think you're doing well but you're not actually doing as well as you think you are."

MR ROBERTSON: Take as an example, somebody might say, assessing it objectively, this person's at risk because they're socially isolated, they don't seem to have many friends. Putting it to the participant, they might say "That's exactly how I like it."

PROF RICHARD BRUGGEMANN: Yes.

MR ROBERTSON: And I suppose then that just goes in as a factor saying well, that still exposes them to risk, however. But then you need, at the least, I would think, some subtle, personal to and fro, maybe, maybe a little bit of reasoning or persuasion.

PROF RICHARD BRUGGEMANN: Yes, yes. And, as I said, I'm not sure how I'd react in that situation where I thought I was still highly competent and the reality was that I wasn't. And actually, I've seen people in this situation and, you know, you can get offside with them very quickly when you, you know, in a really positive framework, tell them that they're not doing as well as they think they are.

So, you know, we'll never solve all of these problems or, you know, we won't have, you know, textbook solutions for these things. But for the huge mass of people that we're talking about where vulnerability is an issue, I think we can identify it and put in place some things to deal with it.

MR ROBERTSON: Alright, thank you. What I wanted to next ask you about was I've heard from quite a few people about the complaints mechanism or the reportable incidents mechanism. Now, we'll get to whether that's working as it should, but is it your view that if that's all there is, complaints, including, say, worries and concerns, but complaints; reportable incidents, in a sense that deals with the question, well, has something gone wrong?

PROF RICHARD BRUGGEMANN: Yes.

MR ROBERTSON: So it's a floor in the system, it prevents people from harm, maybe, is that as you see the nature of the complaints and incidents?

PROF RICHARD BRUGGEMANN: At the present time, yes, yes. I think it's - there's a real inadequacy in this. What it does is to check that the bad things aren't happening. Now, what it doesn't do is to ensure that the good things are happening. Now, again, for many people of cognitive disabilities, what are the good things about? If we take our own lives and what are the good things to us? The two things that got us there were our development of skills and our growing use of those skills through independence.

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This is espoused by many organisations in their mission statements, etc. But often falls down completely. There's a new system called active support and basically what this is about is instead of breakfast in a group home of say four people being four bowls, four lots of cornflakes and four lots of milk, there's your breakfast. It's "Richard, what would you like for breakfast?" "Bacon and eggs." "OK, this is how we do bacon and eggs. We go to the fridge and we crack the eggs." You teach them skills and they can do what they want because they've got the skills to do it themselves.

I've seen so many organisations where the espoused practices is active support but when you actually go to a household it's four lots of cornflakes in a bowl because it's easier. So when I did a review of day programs a few years ago, I saw so many people just sitting around doing nothing.

Now, when I was doing some training on restrictive practices, I said to the workers, these are hands-on workers, "I'm going to give you two nasty choices", I'm rambling a bit, I'm sorry.

MR ROBERTSON: No, you go head.

PROF RICHARD BRUGGEMANN: Here's your choice. Three times a year you can get a slap across the face, it will sting, won't leave any marks and won't do any permanent damage. Or every day of your life you can be bored out of your brains, not learning any new skills, dependent on other people and leading a boring life. Which do you choose? Now when I retired from my position, I think the score was something like 1,850 people would take the slaps, three people would take the boring lives and one person was so upset by the choice that I said don't bother about it.

Now, what do we report to the Commission? We report the slaps. And rightly so. But there's no mechanism for the Commission to know the good things that are supposed to be happening through the NDIS, the things like inclusion and participation and moving to work, that those things are really happening. And within organisations, I found very little evidence that information from boards and CEOs is getting to workers.

So one of the things I went out when I was the senior practitioner, and I was going out in sort of helping rather than scolding mode, was to say to people "What are your organisations restrictive practices policies?" I didn't meet one person in all of my visits who was able to tell me what the restrictive practices policy was. And these are the people who, on a day-by-day basis are implementing those policies.

So when you're doing your own thing, you're basically engendering the policies of the organisation. And equally, CEOs of organisations often have no clue

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about what their workers are doing. I've written a number of examples about this, which I can provide to you, and it astounds me that, you know, things can happen and organisations not know about them.

Now this requires proactive investigation. Not huge stuff, getting out and about and seeing what happens in your organisation. A lot of that stuff now is perceived as meddling. I think it's one of the things that's really missing at the present time.

MR ROBERTSON: If I interpret this correctly, you say you need a complaints mechanism, a reportable incidents mechanism but you also need something more proactive, active support. Who in the scheme of things would you think - that is what organisation do you think would be well placed to provide that. Would that be the service provider, would that be the commission? Who do you think?

PROF RICHARD BRUGGEMANN: Well, that's a very good point. I think one of the things that's been extremely destroyed in the NDIS system is the leadership of disability issues. For example, my old department, the Department of Human Services had some complaints from an endocrinologist and a dietetics about the diet of people with intellectual disabilities.

I can see nowhere in the current system where that leadership occurs, and, you know, what does the NDIA do? It basically distributes money and it's got a process for doing that. What does the NDIS do? Well, they, you know, they basically look at complaints and - in the area of restrictive practices they do provide leadership, Dr Jeffrey Chan, who is a senior practitioner, is providing leadership about restrictive practices. But it doesn't happen anywhere else.

I think this is a huge loss in the system that we, you know, for example, many years ago, my old organisation had a legal issues committee and we'd, you know, our case managers would say a lot of our clients are being tested by these telemarketing companies or, you know, they've signed up to contracts that they don't understand and they can't fulfil. And so we work with the law bodies in South Australia to develop processes to, you know, to assist people. Again, I don't see any of that leadership in Australia. These are huge gaps in our system.

MR ROBERTSON: Do you think - just going back a couple of steps to the person that identified as having an overall monitoring advocacy role, would that work as the proactive support or could that only feed into active supports? In other words, would the active support that you're speaking of still have to be from one of the government agencies such as either the Commission or the authority?

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PROF RICHARD BRUGGEMANN: It's a good question. I don't know where that comes from. I think certainly a good case manager or personal, you know, person who took that personal interest, would be able to see the things allegedly, or supposed to be happening weren't happening.

Where the locus of changing that occurs I'm not sure. It should be organisations themselves. These are organisation that is have things emblazoned in their corporate mission statements and often these mission statements are just failing.

Now, of course, one of the things that occurs is that if you look at the annual reports of disability agencies, and, indeed, nearly every agency, they are glowing references about, you know, the good work that organisations do.

I've never seen an organisation publish in their annual report, last year we had 52 complaints and we did really badly in 47 of those and here's what we've done to fix it. Never knows that they have these problems. The parents whose sons and daughters who are in these services know they have these problems. The organisations know and yet there's there fantasy that all of these organisations are perfect.

A few years ago, I looked at the annual reports of about six or seven organisations and I found not one reference to any outcome for clients like how many people who had an annual plan, how many of those plans are actually fulfilled? Nothing. They reported nothing.

There was a sort of almost a template format, you know, words from the CEO and the chair, financials, a couple of star clients who had done incredible things, but nothing about how well they're performing and doing the things that were in their mission statements.

I think, quite frankly, organisations should be required to publish in their annual reports the things that have gone wrong, what they've done to fix them, and what they are doing about achieving the things they put in their mission statements. Otherwise they're just rhetoric.

MR ROBERTSON: Alright, thank you for that. One of the things, and I'm not sure whether you've got anything to say about this, but there's an issue about, I'll call it staffing, and there's been a fair amount of work put into trying to have, I'll call a uniform national screening process. Is that, in your view, it will keep out people of a certain type who have had incidents with the police or whatever it might be, I'm not sure what the parameters of the screening is, but plainly it's a good idea to have it done nationally, in part because obviously the NDIS is a national system. Do you see that as being, in other words, to keep out people who don't pass the screen, do you see that as adequate for the disability sector?

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PROF RICHARD BRUGGEMANN: No. It's a good first step. It basically, you know, it finds those people who have been caught, largely. We ran an institution here in South Australia, Strathmont Centre. There was a man we employed his brother worked for us, he was an excellent worker. He came into our organisation so he could work with people who could not communicate so he could punch them up. We found a number of people with severe injuries. We actually had to put in surveillance and saw this occurring and he was charged and convicted of assault.

One of the women in his care died of internal injuries. There was never enough evidence to convict him of murder, or manslaughter, and we subsequently put in place personality testing. Again, it's not perfect. Some people are able to work their way through that. But it's another safeguard. I don't think it's good enough just to say we catch the people who have done something. That basically eliminating those who are too smart to get caught, quite frankly.

But even then, that only gives you what you caught before your floor. The people you don't want to employ, it doesn't talk about who you do want to employ. That's an issue of great concern to me at the present time.

When I went out and about, I came to the view that many of the people who worked with our vulnerable clients were themselves in danger of being disabled. They were disabled by working in the system. You know, they did the minimum. My grandson did his certificate III/IV in care. His first day in a group home, 7:00 in the morning, a flurry of activity, getting people up, showering, toileting, dressing, breakfast, dishes, and when do we do now? "Sit down, mate, and watch television until it's time to get lunch ready." Flurry of activity, "Sit down, mate, until it's time to get home." You sit around and wait to go home so you can lead your life. Your work is no longer your life.

There with as a Gallop poll done a couple of years ago that said around the world 85% of workers are disconnected from their jobs. In Australia, it was 74%. How disability workers relate to that I don't know. If it was three times better than the average it would mean that 25% of the people who work with people with disabilities are largely not interested in their jobs. I think the fact that we've got two royal commissions on the go at the present time in respect to aged care and disability services is an indicator that there's something dreadfully wrong. And at a time when managers are not monitoring, in my view, and increasingly a lot of these services are being provided at distance, so, you know, they're not being in an institution where there's direct supervision, they are being provided in the community or in the person's home where there's not day-to-day supervision, and also in an environment where if you say to somebody, "Look, John, you're not really doing your job well" the next day you've got a Work Cover claim and a claim of bullying.

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You know, we're not dealing with this terribly well, in my view.

MR ROBERTSON: If I can just interrupt you. So what you're talking about now is so you say, well, screening takes out the bad, but it doesn't mean - is this what you're saying - it doesn't mean that you actually get a quality or best quality, even, in terms of the carers, the workers, not perhaps as an end in itself, but as affecting immediately the quality of the participants' wellbeing?

PROF RICHARD BRUGGEMANN: Correct, exactly. I think that it's a major issue and, you know, if all we do is to weed out the bad, I don't know how we'll ever progress to providing services that are developmental, that are inclusive, that are trying to ensure that people maximise their potential.

You know, the interesting thing is when you motivate the staff and say, look, this is the role that you can have in people's lives. You can really make a difference. I've seen so many people, and there are people who do this. I'm not wanting to give an impression that this is a 100% issue. But there are people who do splendid things, who go above and beyond, not necessarily in terms of the hours that they're working but just in terms of the attitudes that they bring to their job.

I was talking to one guy and he said - I was saying how you've all got a capacity to help people to find something and to promote good things in their lives. He said, "I know what you're talking about." He said, "We've got this guy in our house and he's mad keen about fish, not fishing but just fish." And he said, "My cousin works in the fish market so I arranged for him to go to the fish market with me." And he said it was the most wonderful thing he's ever done. You could see this guy got a real buzz from doing something that actually involved this guy in something that he wanted to do. And he was empowered. The staff member was empowered.

I have to say, it took some convincing of his supervisor to enable this to happen. That's another matter. But here is someone making a difference and seeing my job is actually not the boring crap job that I thought it was. I can actually make a difference in people's lives.

We should be motivating everyone that works in this sector to do that and we are failing dramatically at the present time, in my view.

MR ROBERTSON: Is it in part because the quality and safeguards aspect of the Commission takes this, in a sense, lowest common denominator approach to quality, that is preventing the bad from happening.

PROF RICHARD BRUGGEMANN: Yes.

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MR ROBERTSON: Is that in part, in your view, because a major mechanism, leaving aside registration and so on of the service providers, but a major mechanism is the reportable incidents and complaints mechanism?

PROF RICHARD BRUGGEMANN: Yes, I believe it is. Look, I can understand why. You know, if you're looking after this man and he gets punched up or his pyjamas are stolen or something happens, ultimately you can be sued or the police can be involved, if he dies the coroner will be involved and that causes heat and tension.

But if he's not learning new skills, and he's not complaining because he doesn't understand that he could develop more skills, and his parents are complaining because they're eternally grateful that you're providing services to this man, it's no wonder that the emphasis has been more on the safety than the quality.

You know, quality in my view, what's quality of life? It's different for all of us. But it's about largely being able - having the capacity to be able to do the things that we want to do, and, you know, they might be grand or they might be very modest, but if you look at the lives of many people with intellectual disabilities and other cognitive disabilities, whatever modest aspirations they had or whatever capacity they had to achieve things, those things are not being achieved and in my view that's the real test of the quality part of quality and safety.

MR ROBERTSON: Can I just change the subject slightly just to dwell a moment on what I will call complaints but perhaps should have a broader aspect to it. And I don't know whether you can assist me with this area. You've got a concerned relative, you've got a concerned neighbour, concerned citizen, they've got to worry about whether somebody with a disability has got an injury, is going through a hard time, bewildered maybe, and so on. Can that person, in your opinion, readily enliven, invigorate the system, looking at the disability system overall?

PROF RICHARD BRUGGEMANN: I don't believe they can at the present time and it's interesting, one family member has done her own little poll of her friends and has said that they've all thought that the group that might do this are the police and I hadn't thought of that and in those old days that I described pre the NDIS, we had arrangements with the police whereby they worked with our afterhours service so if there were things that they saw and their view was this might be a person with an intellectual disability there could be that contact and some quick response.

So I don't know that there is at the present time. You know, police are in our communities all the time. Often, you know, it wouldn't be that much for them to knock on the door, just say - you'd have to develop protocols for this - everything OK? We can help you with anything? And report anything, you

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know, then to an agency, I guess who would that be? Who takes that responsibility for those things that happen out of hours?

MR ROBERTSON: It's a question, I think, in a sense, since those days it's got more complex for the person in the street, the concerned relative and so on because my impression is that State responsibilities, the federal responsibilities, the division between them aren't well understood.

PROF RICHARD BRUGGEMANN: No, that's true.

MR ROBERTSON: And for the person outside the system to set the system in motion, they'd need to know, at least in the first instance, what's the doorway? How do I get my concerns looked into? And of course the concerns may not be a complaint as such, they may be no more than a concern as to whether a person's being looked after properly or suffered some sort of injury and so on.

But so I mean the first thing you'd need to know, I suppose, if you were going to access the system successfully, is whether the person you were looking at was or wasn't an NDIS participant, which you wouldn't ordinarily no, probably.

PROF RICHARD BRUGGEMANN: No, you wouldn't because it might be a number of things. People with mental illnesses or other conditions, elderly people. In South Australia we're developing the adult safeguarding unit and it deals with issues of people at the present time 65 and over and that will reduce over the next few years to all adults. And they've certainly - they don't investigate but they could certainly be the place to which, for example, if the police are taking the front line approach, that these things could be referred. I mean this is all a work in progress, I have to say, though. But that could be developed so that there could be a really coherent system to deal with these things.

It's not just that, you know, these things that go wrong, there are sometimes immediate things that have to be fixed. A few years ago, there was an organisation in one of our country locations in one of their group homes, a staff member allegedly punched a resident. Now, as soon as that's known, the standard procedure is that person gets stood down and this didn't happen and the parents were really concerned because the person was still there with other vulnerable people, may have influenced them as witnesses, etc, or assaulted them, and she took it up with the manager and the manager said, "It's the weekend, I can't do anything about it. I can't get staff." She then took it up with the local boss of the community case managers that I've mentioned, and she rang the manager and was told that he couldn't do it and the case manager said, "Why don't you do the shift yourself?" She wasn't going to do that.

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She then rang her boss in Adelaide who had to ring the CEO of the organisation, who was also pretty laid back about, you know, not removing this guy, until he was reminded that he'd be putting his funding at risk. So on a Saturday afternoon, he eventually got the message that he had to get this guy out of that house then. Not next week, then. And I don't know how that would happen at the present time. Who tells him what to do? The NDIS? Do they work on weekends? I don't know. There are certainly some system issues that have to be worked through.

MR ROBERTSON: I think I've heard the expression that there's no wrong - there should be no wrong door so that the State agencies would, if they received a complaint, and that would include the police, I would imagine, should have systems in place so that they work out, to the extent they can, readily work out whether it's their jurisdiction to deal with or whether it's the federal agencies and vice versa, because otherwise you're going to get people trying to access the system, whether through a 1800 number or otherwise, and still being outside the system two or three phone calls later, maybe.

PROF RICHARD BRUGGEMANN: Yes. I mean what I don't know also is whether the NDIA and the NDIS Commission, you know, offer something around the clock because disability services around the clock, you know, I can remember emergencies where it occurred at 1:00 in the morning where my staff had to go and go to houses, get things sorted out, put in place things immediately because we're talking about people in one instance, two men who were severely and multiply disabled who had to be hydrated regularly. It's not just a matter of well, next day's OK, it's immediate. Again, I see no capacity for that in the current system.

A lot of those things, I think, were just discounted because when they were inventing this scheme, it was not - it wasn't sort of - I don't even think the Commonwealth knew the nature of the disabilities that some people had, quite frankly.

MR ROBERTSON: Well, Professor Bruggemann, thank you for all you've said and the opinions you've expressed. Some of what I've asked you and some what you said travels outside my immediate terms of reference.

PROF RICHARD BRUGGEMANN: Yes, I understand that.

MR ROBERTSON: I'm trying to understand the system as a whole before focussing back on the particular issues. But I wonder whether the last thing I could ask you is - well, two things really. One is whether there's anything you want to add now to what you've said, and, secondly, if you do, and I don't want to propose an obligation on you, but if you do review what others have said in the public hearings over the last two days, whether you'd send me an email with any thoughts that occur to you about what's been said.

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PROF RICHARD BRUGGEMANN: I'd be happy to do that. And in terms of things that we might do, I think there are some immediate things that need to come, you know, that we need to be looking at in terms of safeguards. But I think there are some things we don't know. You know, the complex relationships between people who are abused and their abusers, and this relates not only to people with disabilities, it's an issue in the domestic violence area as well. Women who get bashed up by their husbands and stay with them and, you know, love them and support them and, you know, what's this all about? And there are lots of these things that we don't understand. I've got a list of those and I think that there are some things where we need some research and some development of programs.

You know, the abuse occurs because, you know, there are nasty people and there are vulnerable people who are easy to abuse. There's a responsibility for that abuse not occurring. But how do we make people who are vulnerable less vulnerable? How do we give them the skills? You know, my fundamental belief is that being included, being visible in your community, and having people who take some interest and care in you is one of the ways that we deal with that.

So I would be certainly happy to do that and thank you very much for the opportunity to be able to chat to you today.

MR ROBERTSON: Thank you very much for your time this afternoon, Professor.

PROF RICHARD BRUGGEMANN: Thank you very much.

MR ROBERTSON: What I will do now is formally close these hearings, what I call the Adelaide hearings, and thank everybody who has given their time to make this a valuable set of hearings. Some of it has been not in the public domain for the reasons that I've explained, but it's all been very valuable information to me.

So I will ask now for the link to be disconnected. Thank you.