Article Information

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Summary Alert: Sunnyfield Disability Services Case Study: Public Hearing 13, Disability Royal Commission

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) held a public hearing that focused on the experiences of several young people with disability living in house in Western Sydney operated by Sunnyfield Disability Services. The hearing, held over five days in May, highlighted issues of critical relevance to disability service providers.

Sunnyfield Case Study: Public Hearing 13

Held in Homebush from 24 May to 28 May 2021, Public Hearing 13 was the first of several Disability Royal Commission hearings examining how disability service providers prevent and respond to violence, abuse, neglect and exploitation. This particular case study examined the experience of three people with disability – Melissa*, Carl* and Chen*. These three individuals receive accommodation and support services from Sunnyfield Disability Services (**Sunnyfield**), and have done so since May 2017, over approximately four years.

Sunnyfield is a non-government disability service provider, operating 48 homes across NSW and the ACT, for 215 residents and with a staff of over 1,700. Sunnyfield operates as a member based, for purpose, not for profit registered charity providing support services for over 1,200 people living with a disability.

Melissa, Carl and Chen live together, and continue to reside, in what is commonly called a "group home" operated by Sunnyfield in Western Sydney. The focus of the case study was on their experiences as people with a disability. This focus stands in line with what Chairman, Ronald Sackville AO QC, coined *a new phase* of the Disability Royal Commission exploring the quality of National Disability Insurance Scheme (**NDIS**) funded services and supports, particularly in respect of NDIS participants who live in Specialist Disability Accommodation.

What a Provider Could Face if Called Before the Disability Royal Commission

So, in light of the Sunnyfield Case Study, what might a disability service provider face if called as a case study before the Disability Royal Commission?

Some Key Facts

There were:

- Five days of public hearing;
- Six witnesses called, including Chief Executive Officer, Caroline Cuddihy;
- Ten witness statements, including two statements from the Chief Executive Officer;
- 350 exhibits tendered, including 213 documents produced by Sunnyfield; and
- Post-hearing written and oral submissions.

The information requested from Sunnyfield was extensive, and the breadth of the notice to produce resulted in extensive documents being tendered.

Disability service providers should consider time frames for preparation and production, and the dedication

of resources and time demands on senior management and their board, if they receive a formal notice for, and/or are called before, the Disability Royal Commission.

Key Issues

The issues examined in the hearing crucially included:

1. Governance of service providers;
2. Communications between service providers, regulators and families and supporters of people with disability;
3. Recruitment, training and supervision of disability support workers;
4. Internal complaints handling and investigations (of allegations of violence, abuse, neglect or exploitation);
5. Role of external bodies (such as NDIS Quality and Safeguards Commission, NSW Ombudsman and police); and
6. Role of community visitors and similar oversight mechanisms.

By examining these issues, the Commission could investigate how current systems of funding and oversight of disability services protect, or fail to protect, people with disability from violence, abuse, neglect and exploitation.

> Disability service providers should aim to identify possible systemic issues within their organisation in respect of each of these six core areas.

Allegations and Evidence at the Hearing

The Commission heard evidence of violence and abuse by two support workers at the group home, including that Carl was punched and kicked. Chief executive Caroline Cuddihy gave evidence over three consecutive days, responding to questioning concerning the incidents at the group home between 2017-2020, and claims of systemic issues at Sunnyfield. Ms Cuddihy ultimately admitted to failing to protect Melissa, Carl and Chen from violence and abuse.

> Disability Service Providers should prepare for extensive questioning of senior management within their organisation if called as a case study before the Disability Royal Commission.

Evidence at the Hearing showed that Melissa received an eviction notice after Sunnyfield assessed her sister, Eliza*, as a reputational risk to the organisation. Eliza had lodged multiple complaints with both Sunnyfield directly, the NSW Ombudsman, and the NDIS's Quality and Safeguards Commission. The Commission was informed that a board report described Melissa as a "reputational risk". This led to Ms Cuddihy being interrogated as to whether asking Melissa to exit Sunnyfield's service was to *protect Sunnyfield's reputation* instead of *focusing on Melissa's wellbeing and best interests*. Ms Cuddihy contended the report was not intended to frame Melissa as the problem.

Allegations were also put to Ms Cuddihy that she had shielded Sunnyfield's board from the significant allegations against the two workers. Ms Cuddihy denied this, despite the commission hearing evidence of a draft board note she had written in more explicit language, before toning down the language in the final report. Ms Cuddihy strongly denied counsel assisting's suggestion that this was so that the report "would be more palatable to the Board."

> Disability service providers should be mindful of "frankness" in Board Reports, Minutes and Meetings (particularly, in maintaining a "true and frank" record of complaints and responses).

Remediation / Apology

The remediation process was also of interest throughout the hearing. Counsel assisting queried whether "it took having to come to the royal commission to make an apology", in response to admissions that Sunnyfield had not apologised to or met with either the residents or their familiar members after the events occurred.

> Disability service providers should consider remediation processes they have in place for victims and families in response to complaints and incidents.

Chairman's Closing Remarks

Of note, Chairman Sackville questioned,

"whether it is appropriate for an organisation such as Sunnyfield, which receives nearly $100 million per annum in public funding, to be governed by a board and administered by senior management, none of whom, … have lived experience with disability."

Governance and Representation

The board of Sunnyfield comprised only one member who had previously worked in disability services, and had no members with an intellectual disability. Chairman Sackville accordingly noted that the board members, being largely people with financial or commercial experience, gave rise to a concerning impression that Sunnyfield is a commercial organisation.

> Disability service providers should consider the representation of persons within their Management and Board who have a lived experience with disability.

Proposed Adverse Findings Against Sunnyfield

An additional day of the hearing was held on Friday, 10 September 2021, in order to outline proposed findings concerning the experiences of Melissa, Carl and Chen in the Sunnyfield group home.

In that hearing, senior counsel assisting, Kate Eastman SC proposed that 24 adverse findings should be made against the provider. The findings centred around *how much* Sunnyfield's systemic governance failures contributed to the incidents that developed inside the group home.

Despite Sunnyfield's attempts to attribute responsibility for the conduct of the two former employees, Counsel Assisting submitted that it was open to the Commission to find (or should find) that fault also lay with Sunnyfield's board. Counsel assisting submitted that significant adverse findings should be made against the provider, including:

1. It deliberately delayed communications concerning its intention to evict Melissa from Sunnyfield, and failing to discuss alternative options with Eliza prior to issuing the eviction notice in order to protect Sunnyfield's interests and reputation over Melissa's interests;
2. The absence of a person/s with disability on the Sunnyfield Board failed to ensure people with disability were appropriately represented and involved in decision making. Composition of the Sunnyfield Board was weighted towards those with financial or commercial experience, rather than people with direct experience of providing support services to people with disability;
3. Board directors were not conducting regular visits to Sunnyfield's shared independent living houses or engaging directly with residents and their families. The Senior Leadership Team (**SLT**) and management were unduly reliant on reporting from staff concerning the operations and activities within group houses;
4. Sunnyfield's incident reporting system failed and its managers failed to listen closely and to value and respond appropriately to all feedback, concerns and complaints raised by the residents' families;
5. Sunnyfield did not have appropriately robust systems in place to supervise the two workers and prevent them intimidating other staff, enabling a toxic workplace culture to pervade the group home;
6. Sunnyfield inappropriately took a defensive stance towards complaints/concerns raised by Eliza and external clinicians supporting Melissa. Adopting a protectionist approach towards its staff, contributed to its failure to recognise red flags in relation to the conduct of the two workers;
7. One of the worker's failure to provide their complete work history, along with not being asked to explain gaps in their CV when recruited by Sunnyfield, impaired Sunnyfield from conducting thorough pre-employment checks and screening; and
8. While Melissa, Carl and Chen were subject to violence and abuse from the two workers at the house, responsibility also lies with Sunnyfield, its Board, its CEO and its SLT.

Sunnyfield representatives disputed the proposed adverse finding that its own board and SLT were responsible for the abuse experienced by residents. In its responsive submissions, Sunnyfield maintained that this would be both harsh and unnecessary. In Reply, counsel assisting accepted the significance of the finding, but highlighted to the commissioners "the seriousness of the experience of Melissa, Carl and Chen" who "were not protected with respect to their privacy or their dignity or their safety" in their own home.

A further proposed adverse finding, was also lodged against the NSW Ombudsman for failing to inform Sunnyfield that an accused support worker had already been fired for misconduct in a previous job, having faced numerous concerning allegations. Counsel assisting found the NSW Ombudsman should have disclosed to Sunnyfield the information gathered

about one of the workers involved in the misconduct.

Key Takeaways for Disability Service Providers

While the Disability Royal Commission is yet to make findings about the Sunnyfield case, we suggest there are a number of key takeaways for disability service providers (our recommendations being general in nature):

- Implement an operational system for Board directors to make visits to the provider's shared independent living houses, hold meetings with the residents of those houses, their families and/or supporters. These systems might mitigate against the risk of information being lost in communications between senior leadership and staff (who may be unwilling or unable to provide detailed, accurate accounts of their concerns or of their own or others' misconduct);

- Ensure composition of the Board is not solely weighted toward those with financial or commercial experience, but also focus on how the direct and lived experience of people with a disability can be represented;

- Ensure there are appropriately robust systems in place to monitor the conduct of staff;

- Prioritise affording choice and control to residents with respect to the service and residency agreements;

- Consider existence of policies and/or procedures in relation to preventing, identifying, reporting, investigating and responding to violence against and/or abuse, neglect or exploitation of disability service users. Perform analysis of compliance with, effectiveness of, and processes for ongoing and responsive review of, policies and procedures;

- Consider methods for promoting an open, instead of defensive, approach towards complaints. Avoid labelling complainants as difficult or unreasonable so as to reduce staff being negatively influenced in the way they approach and deal with complaints;

- Ask for employees to explain gaps in their CV during the recruitment and worker screening process;

- While reputational risk is a relevant consideration, counsel assisting submitted that service providers should consider their risk management more broadly than merely from the perspective of the impact of risk on the organisation itself, and that risks should be considered in a person-centred way and focused on the interests of the people with a disability receiving services.

**Melissa, Eliza, Carl and Chen are all pseudonyms agreed by the commission to protect their privacy.*

refers to a key takeaway for service providers