Article Information

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Summary Alert: Disability Royal Commission Public Hearing 20

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Royal Commission) held a public hearing from 7 to 14 December 2021 to examine the roles and responsibilities of disability service provider, Life Without Barriers (LWB), in preventing and responding to violence, abuse, neglect and exploitation of people with disability who use its services. Tom Griffith, Isabelle Gatley and Alice O'Connell discuss the hearing, and the issues it raised for disability service providers, below.

Public Hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)

Public Hearing 20 (the hearing) was conducted virtually and concentrated on case studies relating to people living with disability in two shared disability residential settings operated by LWB in Melbourne and Lismore.

Opening, Senior Counsel Assisting Patrick Griffin SC indicated that the matters to be considered at the hearing were:

- allegations of violence, abuse and neglect experienced by residents in the group homes;
- the adequacy of measures taken by the service provider to prevent the violence, abuse and neglect of its clients;
- the adequacy of the service provider's response to the allegations; and
- the roles played by the National Disability Insurance Scheme Quality and Safeguards Commission (NDIS QSC) and the National Disability Insurance Agency (NDIA).

Senior Counsel Assisting explained that, despite there being wide variation in the experiences of the people living in the two shared homes, the case studies involved common underlying issues including questions of choice and control, independence and autonomy, understanding and respecting 'dignity of risk', resident compatibility, the adequacy of support and the role of the NDIS, NDIA and the NDIS QSC:

> *In essence, the two case studies raise the fundamental question of whether LWB (and the NDIA / NDIS QSC) could have done more to ensure that each of the residents could live safely, freely and independently in their "homes".*

Factual background of the two case studies examined

The following summary of the factual background of the Lismore and Melbourne case studies is derived from the opening address of Senior Counsel Assisting at the public hearing. The Royal Commission has not yet made findings with respect to those factual matters.

Case study 1 (the Lismore case study):

The Lismore case study focused on the experiences of two women, given the pseudonyms Sophie and Natalie, living with two other male residents in supported accommodation operated by LWB. Sophie lived in a shared house in Goonellabah with Natalie, Naomi and Tyler from 2011 until 2016 when all four residents moved to a house in Lismore.

SOPHIE
Sophie resided in the Lismore house until 2019. Sophie expressed, to her parents and the LWB staff, a strong desire to date men and experience intimate or sexual relationships and asked for support in pursuing those goals. Sophie was engaged at the start of 2014 and, after that relationship broke up over a year later, started looking for a relationship online. An "interim safety plan" was drawn up by LWB in January 2017 in response to its staff's concerns about the rules relating to male visitors at the home. The rules set out in the plan effectively prohibited Sophie from conducting a romantic or sexual relationship in her home.

In September 2017, when Sophie indicated to the LWB staff her plan to meet up with a man whom she had met online, the staff decided that, in accordance with the interim safety plan, the man was not permitted to come into the house after 6pm or sleep over. Sophie went on a date with the man and was sexually assaulted by him in an isolated park in Lismore. After this incident, Sophie's access to the internet was restricted in an attempt to restrict her ability to meet and communicate with men.

NATALIE
Natalie received personal care from male disability support workers including one man referred to as Worker 3, despite the availability of female disability support workers and her mother's request that Natalie not receive personal care from male workers. Worker 3 elected to perform Natalie's personal care even where there were female disability support workers on shift and available to perform that care. Concerns were raised by LWB staff over the course of 2012 – 2014 about Worker 3's conduct towards Natalie which, once acted on in 2015, lead to a police investigation that, after being closed and reopened once further evidence was provided, resulted in Worker 3 being charged with indecent and sexual assault. After the indecent and sexual assault, Natalie's personal care continued to be performed by male disability support workers despite LWB's promises to the contrary.

From 2013, Natalie's finances were managed by the Public Trustee and her discretionary spending was effectively managed by LWB until the NSW Civil and Administrative Tribunal replaced the Public Trustee with Natalie's mother and sister as joint financial managers in 2017. Natalie's mother has complained about the way LWB spent Natalie's money and failed to keep proper account of it.

As a result of her incontinence and need for support to mobilise, Natalie was prone to bowel issues, including constipation, which resulted in her hospitalisation on a number of occasions. LWB staff were required to complete and monitor bowel movement charts in respect of Natalie. Bowel charts were not completed for a number of months before 1 March 2020 and Natalie was hospitalised on 9 March 2020 for an impacted bowel that her mother was later told was close to having ruptured.

Case study 2 (the Melbourne case study):

The Melbourne case study focused on the experiences of a group of residents comprised of Rebecca, Robert, Amanda and Marco, who lived in a shared house in Melbourne together from 2011 to today (except Rebecca who moved out in November 2019), and two other residents, Stevie and Katie. An atmosphere of tension and conflict was said to exist at the house as a result of the difficulties that the residents and the LWB staff faced in managing a number of the residents' behaviours of concern. Incidences where conflict escalated into aggression, abuse and violence between residents are said to have affected the ability of some residents, in particular, Rebecca, to live safely in the home. Rebecca moved out of the residence in December 2013, largely as a result of Stevie's behaviours of concern. Katie, whose behaviours of concern were similar to those of Stevie, moved into the house in May 2014.

Other issues relevant to the Melbourne case study included the frequent turnover of staff, the documentation, monitoring and reporting of the situation in the house to more senior management within LWB, the maintenance and cleanliness of the house, the difficulties that residents' families experienced in communicating with LWB and LWB's management's failures in addressing problems raised by the residents' families.

Issues considered by the Royal Commission

- A number of challenging issues arose for consideration by the Royal Commission with respect to sexuality and intimate relationships. In his opening address, Senior Counsel Assisting emphasised the complexity that surrounds the balancing of a disability service provider's duty of care with the dignity and autonomy of a person with disability under its care. The specific issues examined by the Royal Commission arose from Sophie's evidence in the Lismore case study and included:
    - the extent of LWB's facilitation or frustration of Sophie's ambition to form an intimate relationship "on her own turf" and in a safe environment;
    - whether LWB responded appropriately to Sophie's desire to have an intimate relationship by facilitating her goals of intimacy or whether the response frustrated those goals and caused undue risk to Sophie; and

    - the adequacy of the support provided by LWB to Sophie after her sexual assault and the appropriateness of LWB's response to the assault in restricting her access to the internet and, hence, her ability to meet and communicate with men.
- A further issue for consideration in relation to Sophie's experiences was the appropriateness of the care and support provided to her by LWB with respect to managing her behaviours of concern and assisting her in becoming independent, noting the difference between her support needs and those of the other three residents of the home.
- The following issues for consideration by the Royal Commission arose from Worker 3's behaviour towards Natalie, which ultimately resulted in his dismissal following findings of neglect by LWB:
    - What was the response to the incident by the upper levels of LWB's management, and what consideration was given by the Board and Board committees to the incident?
    - What consideration was given by LWB to the need to reconsider its policies (particularly in respect to personal care) in light of the events?
    - The appropriateness of LWB's conduct towards Natalie and her mother following the incident, including the continuation of Natalie's personal care being performed by male disability support workers.
- Concerning Natalie's finances, the Royal Commission considered the support provided by LWB to Natalie in spending her money and whether LWB should have done more to assist Natalie in making financial decisions (for example, through preparing weekly, monthly or yearly budgets).
- The Royal Commission also considered the adequacy of LWB's response, at the individual and institutional level, to Natalie being hospitalised with a bowel obstruction and LWB's failure to document and to keep proper records of Natalie's bowel movements.
- In hearing the Melbourne case study, the Royal Commission looked broadly at the adequacy of LWB's response to various issues after they were brought to its management's attention by the families of the residents. More specifically, Senior Counsel Assisting in his opening address set out the following list of issues considered by the Royal Commission:
    - *whether LWB, or the Department could have better assessed resident compatibility, both when residents were accepted into the home, and on an ongoing basis;*
    - *whether LWB should have consulted with residents, their family and other advocates prior to accepting new residents into the house;*
    - *whether LWB (both at support worker level and at higher levels of management) adequately responded to resident-to-resident violence in the Melbourne house;*
    - *whether staff were adequately trained and supported by LWB, particularly in dealing with a mix of clients, each with their own high support needs and behaviours of concern;*
    - *whether LWB's communication with families of the residents was deficient;*
    - *whether LWB responded appropriately to complaints made by family members and advocates;*
    - *whether there were deficiencies in documentation and record-keeping, and in responding to incidents of resident-to-resident violence and other reportable incidents; and,*
    - *more generally, what LWB did (or failed to do) to support the residents of the Melbourne house, in particular, in supporting each of the residents to live together safely in a way that met their needs both individually and together and respected their rights to 'choice and control'.*
- Further, in relation to the funding of disability support services and the NDIS, NDIA and NDIS QSC, the Royal Commission considered:
    - whether sufficient information about the NDIS, NDIA and NDIS QSC was available to people with disabilities, their families and their advocates;
    - whether the funding provided to residents in the Lismore and Melbourne houses was adequate;
    - the effects of inadequate funding upon residents; and
    - complaints made to the NDIA and NDIS QSC on behalf of residents, the failure of those bodies to resolve the complaints and the effects of significant delay in responding to complaints.

Other relevant public hearings

Issues considered at other public hearings conducted by the Royal Commission overlap with those examined at Public Hearing 20. The previous public hearings of particular relevance are:

- Public Hearing 3 which examined the experience of living in a group home for people with disability;
- Public Hearing 6 which addressed the issue of responding appropriately to behaviours of concern; and
- Public Hearing 17 which involved the consideration of the sexual and reproductive rights of women and girls with disability as well as ableism which can lead to the perception of women and girls with disability as infants or as asexual and to the assumption that they do not desire sexual experiences and intimate relationships.

Further hearing dates

At the end of day 6 of Public Hearing 20, the Royal Commission made directions which, amongst other things, require

Counsel Assisting to provide written submissions about the evidence heard during the case studies by 18 March 2022 and any responses to those written submissions to be provided to Counsel Assisting by 1 April 2022. After 1 April 2022, the Royal Commission will schedule a short hearing for oral submissions.