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This is the written statement of:

1. Mr Robert Fitzgerald, AM, of [redacted] NSW. Since 1 July 2019, I have been the inaugural NSW Ageing and Disability Commissioner.

   My previous roles have included Commissioner at the Productivity Commission and the Royal Commission into Institutional Responses to Child Sexual Abuse; Deputy Ombudsman and Community and Disability Services Commissioner at the NSW Ombudsman's office and Commissioner and CEO of the NSW Community Services Commission.

   I hold a current NSW Solicitor's practising certificate having been admitted to the NSW Supreme Court in 1979. I have degrees in commerce and law from the University of NSW, an honorary doctorate from the Australian Catholic University and am currently an Adjunct Professor at the University of Western Australia.

   I have had more than forty years involvement in the human services areas, including care of older people in numerous paid and voluntary roles, including:

   - As State President of the NSW St Vincent de Paul Society in the late 1980s, which charity owned and operated over 25 facilities for older people including independent living units, aged hostels and nursing homes. Such facilities were almost exclusively available to low income/socially disadvantaged older people. The Society has since transferred most facilities to Catholic Healthcare.
   - As Deputy Chair Benevolent Society, which charity had previously conducted aged care residential services, but ceased to do so and transitioned into the provision of in-home care services for older people in the early 2000s.
   - Commissioner on the Productivity Commission's Inquiry into the Care of Older Australians – 2010/11.
   - NSW Community and Disability Services Commissioner that oversighted, in an ombudsman-type role, the delivery by government and non-government service providers of out-of-home care, child protection, disability services and home care in NSW.
   - My current role as NSW Ageing and Disability Commissioner, which seeks to prevent and respond to the abuse, neglect and exploitation of older people and adults with disability, especially within the family, home and community.

2. Ms Kathryn McKenzie, of [redacted] NSW 2000. Since 15 July 2019, I have been the Director, Operations at the NSW Ageing and Disability Commission (ADC).

   I transferred to the ADC from the NSW Ombudsman's office, where I had worked for 17 years in a range of roles, including Director Disability, Director Systemic Reviews, and across

investigations, complaints, death reviews, reportable incidents, projects and the Official Community Visitor scheme. I have previously held roles in the NSW Community Services Commission, NSW Independent Commission Against Corruption, NSW Public Guardian, and non-government disability services.

I hold a Bachelor of Education (Secondary – Humanities) from the University of Sydney.

I have over 25 years' experience working in the disability, ageing and community services sectors, including in regulation/oversight, guardianship, employment, and direct care provision.

The information provided in this statement is based on our work and experience in the ADC. As a result, the information has a particular focus on abuse, neglect and exploitation of older people in their family, home and community, and there are some questions that we have not addressed as they do not directly link to our work.

4) What are the objectives, strategies and mechanisms for safeguarding of people who receive care in their own homes? In doing so, comment on any special considerations that should apply to the safeguarding of older people.

a) Drawing on your experience in other sectors, can an effective line of sight be established into care provided in a private home? If so, how can this occur?

b) Is there a tension between continuity of care and safeguarding?

Appropriate safeguarding of people who receive care in their own homes relies on having a risk-based and proportionate approach that is underpinned by a clear focus on the rights of the care recipient. There is a need to ensure that an appropriate balance is struck between providing protections for individuals and supporting their autonomy, and that there is a range of safeguarding options. No one safeguarding option is fail safe; effective safeguarding requires multiple mechanisms that interrelate.

For older people, issues of safety relate not only to risks associated with engaged care workers and service providers but also in respect of informal carers , family members and others that interact in the lives of older persons. For residents living alone there is the added risk that there is little line of sight for interactions between carers/workers and the older person, unlike in aged care residential setting where there is a line of sight by multiple workers, visitors and health practitioners.

While a focus is often appropriately placed on the delivery of services, including the quality of the care being provided and worker screening and qualifications, in our experience there are additional key measures that are important in safeguarding people receiving care (or seeking to receive care) in their own homes, including:

Identifying and mitigating risks for vulnerable people through the assessment and planning process

It is important that steps are taken to identify high risks at an early point, via face-to-face assessment and regular review, and to provide a range of safeguarding options. Aside from enabling people to be linked to appropriate direct support, risk assessments provide opportunities to identify people who are at risk of (or subject to) abuse, neglect and exploitation due to particular factors – such as dependency on others, substantial cognitive impairment, complex support needs, challenging behaviours, communication problems, and social isolation – and to link them to key safeguards. For example, to identify individuals who would benefit from in-home visits; the involvement of a support coordinator; and communication support.

Maximising the decision-making and involvement of the person

The ADC often handles matters in which the views and wishes of the older person (or adult with disability) have not been sought, or they've been dismissed. We regularly identify matters where the person has decision-making capacity, but:

- service providers defer to the wishes of, or solely consult with, the person's family or spouse
- a family member has been recorded as the person's nominee or representative (for example, in relation to Centrelink or aged care supports).

While the above scenarios are concerning from a rights perspective, they are particularly problematic where the family member or spouse in question is the alleged perpetrator of abuse, neglect or exploitation of the person. The ADC does a considerable amount of work with service providers and agencies to re-focus them on engaging with the person in relation to supports and decisions, to uphold their rights and reduce abuse.

It is important that actions are taken to maximise the involvement of the person in decisions that affect them, including access to appropriate decision supports when required (such as advocacy assistance).

Empowering individuals and providing effective mechanisms and opportunities for them to speak up and be heard about concerns, risks and abuse

It is critical that active and ongoing efforts are made to maximise the ability of people receiving care in their own homes to be able to recognise and speak up about concerns, abuse, and increasing risk. This relies on:

- targeted work and accessible resources for individuals to understand their rights, the assistance available, and steps they can take – focused on prevention and safety measures as well as speaking up in relation to abuse, increasing risks, and adverse events
- providing effective mechanisms and opportunities for individuals to speak up or otherwise communicate concerns – including providing situations in which the person feels safe to do so (such as in the presence of trusted staff and in the absence of other parties)
- clear guidance for staff and other supporters to know what to do when they identify, or the person raises, issues relating to concerns, increasing risks and/or abuse.

On a related note, the ADC is undertaking community education and training activities that aim to heighten awareness of adults with disability and older people in private accommodation settings who may be subject to, at risk of, or living in circumstances that will result in abuse, neglect or exploitation, including (but not limited to):

- developing and implementing accessible training modules for frontline workers (including direct care staff and volunteers) and managers to better identify and respond to actual or potential abuse in the adult with disability's family, home or community
- working with government and non-government agencies to add to and support the existing Elder Abuse Collaboratives in NSW
- delivering community engagement sessions to key relevant staff, such as Local Area Coordinators, iCare, NSW Trustee and Guardian, and private trustees.

Ensuring community connection and social networks

Increasing individuals' social networks and circle of support are known protective measures, for multiple reasons. Among other things, the greater number of people who have line of sight of the person, the greater opportunity there is that potential issues or concerns will be picked up at an early point.

In the disability sector, the Information, Linkages and Capacity Building (ILC) program and Local Area Coordinators are key measures that are intended to link people with disability with community and mainstream services and activities. However, there are significant opportunities to develop and strengthen these connections and networks, particularly for people who have high and/or complex support needs. Among other things, there are existing community networks that could be more greatly engaged – including faith-based groups, and volunteer bases.

This is also a vital safeguard for older people. We recognise that there are some existing mechanisms in the aged care sector that are intended to support community connections, including through community visitors, the Commonwealth Home Support Programme, and aged care packages. However, and similar to the disability sector, there are considerable opportunities to strengthen the work to ensure good community connections and social networks for older people, particularly for those who are vulnerable.

Maximising community awareness and engagement

Effective safeguarding of vulnerable people relies on having mechanisms that are not solely reliant on regulation. In particular, it is important that there is ongoing education and work to maintain an active conversation with the community/ the general public about identifying concerns, increasing risks and abuse, to enable early identification and response to these matters. This work and key messages need to be complemented by an awareness of central, accessible, and easily identifiable point(s) for raising concerns, with a 'no wrong door' approach. In relation to the abuse of older people, we note that 1800ELDERHELP provides a useful mechanism for facilitating the connection of reporters to the appropriate State or Territory body that can assist.

Enabling independent checks with reporting responsibilities

In NSW, the Official Community Visitors (OCV) scheme provides independent Ministerial appointees who visit children in care and people with disability and additional needs living in full-time accommodation services and assisted boarding houses. A key focus of the role is on engaging with residents to identify any issues that are affecting them that need to be raised with the service providers and other appropriate bodies for resolution. The scheme is well supported by legislative powers and functions, and is administered by the ADC. The scope of the OCV scheme does not currently include people living in private residences.

The Community Visitor Scheme (CVS) in the aged care sector does include visits to private residences, but has a different approach – focused on providing companionship to older people and social connections.

There may be merit in a hybrid approach, in which Visitors visit people living in private premises, but with a role to identify and raise matters of concern with appropriate bodies in relevant circumstances (such as concerns about the person's living situation, or high/increasing risks). In our view, the option of having independent checks should be available to people who are receiving in-home supports as well as those who have been assessed as eligible but who are waiting for a service.

5) What are the key differences between the way that the aged care and the disability sectors operate in terms of safeguarding for people who are receiving care services in their homes or in non-institutional settings?

There are a number of key differences in relation to safeguarding elements between the aged care and disability sectors for people who are receiving supports in their homes or in non-institutional settings, including (but not limited to):

- There is greater scope in the reportable incidents scheme under the NDIS, including that it covers a broader range of incidents and applies to participants in a broader range of settings (including incidents that occur in connection with the provision of supports in their own home).
- A national worker screening system is being developed in relation to the NDIS (which will include, among other things, consideration of adverse findings from the reportable incidents scheme). There is not currently an equivalent worker screening system in relation to aged care, despite information that identifies workers of concern jumping across sectors involving vulnerable people, including moving from child-related employment to working in the disability sector to working in aged care.
- The Official Community Visitor (OCV) scheme in NSW provides independent Ministerial appointees who visit children in care and people with disability and additional needs living in full-time accommodation services and assisted boarding houses. A key focus of the role is on engaging with residents to identify any issues that are affecting them that need to be raised with the service providers and other appropriate bodies for resolution. The OCV scheme has substantial legislative functions and powers to enable independent checks on people in residential care, but does not extend to people living in private residences. While the community visitor program in aged care does not appear to have the same depth of functions and powers, it does provide some line of sight over care recipients living in private residences.
- The NDIS Quality and Safeguarding Framework includes the Information, Linkages and Capacity Building (ILC) program and Local Area Coordinators, which include a focus on linking people with disability with, and improving inclusion in, community and mainstream services and activities. While there is some focus on community connection under the Commonwealth Home Support Programme (CHSP), home care packages and the aged care community visitor scheme, there does not appear to be the same overarching focus on improving community and social inclusion of individuals.
- People with disability are able to access individual advocacy support regardless of whether they are NDIS participants or not. Advocates play an important role across the lifespan for people with disability, including assistance to have their views heard, gain appropriate and timely access to mainstream services, and support in relation to contact with the justice system. There are some effective individual advocacy supports in the aged care sector, but they rely on the older person either receiving, or seeking to receive, government-funded aged care services.
- NDIS support coordinators play an important role in relation to safeguards for NDIS participants, including facilitating connection to necessary supports; identifying and responding to changes in the participant's circumstances; providing assistance to navigate the system; and providing some line of sight over the delivery of supports to meet the participant's needs. It is not evident that there is an equivalent role in aged care. The older person would need to pay for case management out of their pool of funding, which is usually required to meet their support needs.

More broadly, access to in-home supports also provides an important safeguard – aside from delivering necessary practical assistance, it enables additional eyes on the person and their living circumstances. In our experience, access to supports under the NDIS, while not a perfect process, is substantially easier than access to aged care supports. Among other things, NDIS packages are not limited to a certain number; participants are typically not waiting years for vital in-home supports; and it is much easier to raise critical issues and address gaps in support (or the amount of support). The limited funding and hours of in-home support for older people is a significant issue in our handling of reports of alleged abuse, neglect and exploitation. We have noted that the significant difficulties and delays in obtaining assistance, and the inadequate levels of support, result in carer stress, increased risk of abuse, and serve to force older people into residential care.

Overall, we see greater flexibility and responsiveness in the NDIS to changing needs. In particular, in a range of matters where the person with disability has been identified as being subject to, or at risk of, abuse, neglect and exploitation, we have seen timely action to provide additional funding, and/or additional, flexible or different supports to meet their support needs and reduce or mitigate the abuse or risk. In relation to the aged care sector, while we have seen timely responses to assess or re-assess the older person's support needs in response to actual or reported abuse, neglect and exploitation, we do not tend to see timely access to, or adequate provision of, in-home support.

We have also noted a range of disability providers who have established safeguarding teams or positions – this does not appear to be a feature among aged care providers.

6) **In what ways and to what extent do assessment and planning processes, in the disability sector on the one hand and the aged care sector on the other, identify risks to a person receiving services that might be addressed by safeguarding arrangements? Further and in particular:**
   a) **What relevant rules or guidelines apply to assessors and planners in the disability sector, directed to ensuring that such risks are identified?**
   b) **How is such information used, and by whom, in order to ensure that people are not harmed?**
   c) **How does this contrast to your experience in the context of the aged care sector?**
   d) **What if any particular improvements should be made to the assessment and planning processes in the aged care context in this regard?**

The NDIA is best placed to provide information to the Royal Commission about its rules and guidelines. However, in our experience, there are opportunities for the NDIA to strengthen its processes for assessing risks to NDIS participants at their planning meetings and reviews, including:

- requiring face-to-face NDIS planning and review meetings to be the default option for participants – at a minimum, this would provide the opportunity for an external party to sight the participant
- undertaking a risk assessment as part of the NDIS planning process – to better identify participants who are at risk of (or subject to) abuse, neglect and exploitation due to particular factors and link them to key safeguards
- ensuring that the NDIS/planner is able to talk with the participant alone (or at least without parties that have a vested interest) – there is currently a heavy default to families (and providers) standing in the stead of participants, without adequate efforts to confirm that this is what the participant wants, and to provide supports to maximise the participant's ability to participate in the planning process and decisions that affect them.

In the aged care sector, we note that face-to-face assessments are the preferred approach, and the National Screening and Assessment Form includes specific items on personal safety and identifies complexity indicators that include where there is a risk of, suspected or confirmed abuse. However, in our experience there are also opportunities to strengthen the aged care assessment and planning process to identify risks, including:

- requiring the questions on personal safety to be mandatory to complete unless deemed unsafe to do so
- ensuring that service providers have a standardised reassessment form that includes screening for abuse and other specific areas of risk
- ensuring that assessments and planning are undertaken with the older person, not defaulted to carers or family members

- ensuring that abuse, neglect and exploitation of the older person is clearly articulated in assessment guidelines as a reason to prioritise the person for supports (and review the adequacy of supports).

Too often, older people experiencing abuse, neglect or exploitation in their own homes are placed into residential aged care as a safeguard. In our experience, very few older people want to go into residential aged care, and they tend to decline assistance, minimise abuse or decide not to report abuse due to fears that they will be placed into care. We have heard directly from older people that they would prefer the abuse than residential aged care.

7) Describe your experiences in raising and securing action on in-home care risks with the Aged Care Quality and Safety Commission (ACQSC) and the Department of Health/My Aged Care.

a) How often do you refer matters to the ACQSC?
b) What is the nature of those referrals?
c) Give a summary of those experiences, and particulars of examples.
d) Set out any knowledge you have, or your opinion (stating which) as to the reasons for any issues that have arisen.
e) How does this contrast to your experience interacting with the National Disability Insurance Agency and/or Local Area Coordinators?

Under section 13(8)(b) of the *Ageing and Disability Commissioner Act 2019* (NSW), if the ADC is of the opinion that a report, or part of a report, constitutes a complaint that may be made to the Aged Care Quality and Safety Commissioner, we must refer the information to the ACQSC.

Between 1 July 2019 and 30 June 2020, the ADC referred 40 matters across to the ACQSC. [Note: these referrals involve matters pertaining to people accessing in-home aged care support, as well as the broader range of matters about which complaints can be made to the ACQSC, such as residential aged care].

It is usual that multiple forms of abuse or concerns are contained in a report to the ADC. The 40 reports referred by the ADC to the ACQSC involved allegations of:

- neglect (31)
- physical abuse (8)
- psychological abuse (7)
- sexual abuse (4)
- other concerns (4), and/or
- financial abuse (3).

In the main, the matters that we refer to the ACQSC relate to allegations against aged care providers and/or aged care staff. Where the report solely relates to matters under the jurisdiction of the ACQSC, we tend to close the report once we have referred the issues to the ACQSC and received advice back about acceptance of the referral and the outcome/initial actions.

In relation to our handling of reports about alleged abuse, neglect and exploitation of older people, we tend to have more contact with aged care assessment services and My Aged Care, as they are the mechanisms for assisting the person to gain access to, or increased levels of, support to meet their needs and improve their safety and wellbeing. In our experience, My Aged Care:

- is difficult to contact and navigate
- is bureaucratic and not adequately person-centred
- does not enable a flexible or adequately risk-based approach to assistance.

Below are a couple of examples of recent matters that have involved contact with My Aged Care, that help to illustrate the issues.

Example 1

The ADC was conducting an investigation into serious allegations of persistent physical abuse by a daughter towards her father, and contacted My Aged Care to make inquiries. The ADC was subsequently alerted by the Aged Care Assessment Team (ACAT) that My Aged Care had made a note on the file of the older person (which would be visible to his daughter), which identified the involvement of the ADC and our investigation. As this presented risks to our investigation, we contacted My Aged Care, who declined to remove the file note. The ADC made a formal complaint to My Aged Care, who responded in writing that it could not remove the note on the file as the ADC is not the older person or his representative (daughter). We contacted My Aged Care to explain that the older person was seriously unwell and did not have capacity to contact My Aged Care, and his daughter is the subject of allegation in our investigation. My Aged Care staff did not return the ADC's calls or our request to speak with a manager.

Example 2

The ADC spoke with an older person who was subject to psychological abuse by her family, which had resulted in police involvement and apprehended domestic violence orders. With the older person's consent, we made a referral to My Aged Care for assessment and services, noting our concerns about elder abuse and carer stress. We received advice from My Aged Care that its staff had tried to call the older person three times and, as they had not reached her, they had closed the referral. The ADC sought to confirm the number that My Aged Care had called, noting that the older person was answering the ADC's calls. My Aged Care refused to confirm the number, citing privacy reasons. The ADC noted that the referral and number My Aged Care had received had come from the ADC, so confirming the phone number would not breach privacy requirements, but My Aged Care would not change its position. The ADC then suggested that the ADC officer could read out the correct number to enable My Aged Care to record and use this number to reach the older person. My Aged Care told the ADC that it could not update its record without the consent of older person or their representative (regardless of the fact that the ADC was the source of the referral information). The ADC explained that the older person had no capacity to call My Aged Care herself, and was advised by My Aged Care that her representative would have to call. When the ADC asked who had been identified as the person's representative, My Aged Care refused to provide this advice. We were advised by My Aged Care that the only way to get services for the older person would be for the ADC to do a whole new referral.

In contrast, the ADC has regular contact with the NDIA in our handling of reports about alleged abuse, neglect and exploitation of adults with disability. We have an agreed process with the NDIA for bringing issues to the Agency's attention, obtaining information, and escalating matters for additional supports or other actions (such as review of the NDIS plan and/or removal of the NDIS plan nominee).

8) From your experience of complaints referred by the NSW Ageing and Disability Commissioner's office relating to aged care and the needs of older people, or of any other complaints known to the NSW Ageing and Disability Commissioner's office, does the ACQSC provide information obtained through its complaints function to the NSW Ageing and Disability Commissioner's office? If so, how does this occur?

a) Are you aware of whether the ACQSC provides information obtained through its complaints function to My Aged Care/ the Department of Health?

Under section 25(3) of the ADC Act, the ADC is required to report to NSW Parliament on the number of referrals it has made under section 13 and the outcome of each referral. In relation to the 40 matters referred by the ADC to the ACQSC in the 2019/20 financial year, we recorded the outcomes as:

- agency advised that it accepted the referral (23)
- agency advised it will act on the matter (9)
- agency made inquiries and advised that it was taking/had taken further action (6)
- agency investigated and advised that it was taking/had taken further action (1)
- other (1).

Advice about the outcomes/ actions are provided by the ACQSC via email, in response to an email request from the ADC. The information obtained by the ADC regarding the outcome of our referrals has improved over time, as we have implemented an agreed referral and feedback process with the ACQSC. The ADC and ACQSC also now meet on a quarterly basis to discuss the referral process and common issues.

In September 2019, the ADC provided the ACQSC with a draft information sharing agreement (MOU), which incorporates details of the referral processes, and communication between our agencies. We understand that the draft MOU is with the Aged Care Quality and Safety Commissioner for review; we have not been provided with a timeframe for finalising the MOU. As noted above, the absence of a signed MOU has not prevented the ADC and ACQSC staff from developing and implementing an agreed referral process.

The ADC does not have information in relation to whether the ACQSC provides information from complaints to My Aged Care/ Department of Health.

9) Should all service providers who are providing care in the home have a safeguarding regime? If yes, what should this regime look like and how could this be implemented?

Yes, in our view all providers of in-home supports should have a safeguarding regime. In addition to the suite of safeguards that should apply across the aged care sector in relation to the provision of supports, including worker screening, complaint-handling and incident reporting systems, and self-assessment and compliance with quality standards, we consider that the following areas should be included:

- face-to-face re-assessment of support needs and risks at the commencement of service, and regular review (that includes screening for abuse and other specific areas of risk) – identifying people who are vulnerable/ at higher risk, and implementing a risk and person-centred monitoring system
- provision of guidance, training and ongoing support for staff to identify and respond to concerns, increasing risks to the person, and abuse
- provision of guidance, accessible information and ongoing support for care recipients to understand their rights, options for raising concerns, and the supports available
- proactively seeking and providing multiple (safe) opportunities and mechanisms to obtain feedback and information from care recipients about provision of support and any issues
- clear policies and procedures on preventing, identifying and responding to abuse, neglect and exploitation of care recipients – including reporting and escalation processes.

Such a regime should explicitly acknowledge the fact that workers may well observe conduct or circumstances that may indicate an older person is, or may be, subject to abuse, neglect or exploitation by another person. Workers should be provided with guidance as to such issues, signs of such abuse, and processes for reporting of such matters within the agency or to external authorities, such as the NSW Ageing and Disability Commission.

10) Who is responsible for safeguarding a person receiving care at home when there is one service provider or multiple service providers for different aspects of their care? In responding to this question, comment on the role of:

a) the provider
b) the system regulator
c) the Australian Government
d) the community.

In our experience, the involvement of multiple service providers affords some additional oversight of the person, but effective safeguarding in this scenario also relies on access to support coordination and effective information sharing arrangements. However, the NDIS Commission should be well placed to provide information to the Royal Commission on this topic, based on its experience with these different scenarios in the disability sector.

11) What lessons can the aged care sector learn from other sectors in relation to managing the rapid expansion of providers in the sector, from a safeguarding perspective?

While the ADC has some experience with the rapid expansion of providers in the disability sector through our role in administering the Official Community Visitor scheme, the NDIS Commission will be best placed to provide information to the Royal Commission on this topic.

Nevertheless, there are risks associated with an overly rapid open market approach to the provision of human services, including aged care. Any market is likely to attract the competent, the incompetent, and the exploitative. Regulators and system owners must be attentive to ensure systems for vetting, accrediting, oversighting and responding are designed with such anticipatory knowledge. The expansion of the vocational training market, the early childhood development/childcare market, and the new NDIS disability services market all provide informative examples.

It is noteworthy that new regulations in relation to retirement villages in NSW, introduced in July 2019, require all operators to have an Elder Abuse Prevention Strategy, including making the residents aware of the NSW Ageing and Disability Commission.

Robert Fitzgerald, AM

Date: 3/08/2020

Kathryn McKenzie

Date: 3/8/20