OVERVIEW REPORT OF REVIEW INTO SERVICES PROVIDED BY IRABINA AUTISM SERVICES TO NDIS PARTICPANTS

The Hon Jennifer Boland AM

15 February 2024

Introduction

1. Irabina Autism Services (Irabina) operated programs for children and young persons with a diagnosis of autism, including some children and young persons with extreme behaviour problems. Programs were provided from 3 sites in Victoria and included a program known as the Intensive Severe Behavioural Day Treatment and Intervention Program (the Severe Behaviours Program). This program was modelled on a program conducted in the USA by the Marcus Autism Center, Georgia and licensed to Irabina. It commenced in 2019.

2. On and from 1 July 2019, Irabina, as a transitional provider, was required to comply with specific practice standards prescribed under the National Disability Insurance Scheme (Provider Registration and Practice Standard) Rules, 2018. Those rules were made under the *National Disability Insurance Scheme Act* 2013 (Cth) (the Act). On 7 June 2021 the National Disability Insurance Scheme Quality and Safeguards Commissioner (the Commissioner) registered Irabina as a NDIS provider under s 73E of the Act.

3. Complaints about practices engaged in by Irabina in delivering services, particularly in the Severe Behaviours Program, were made to the Commission from October 2020. Earlier concerns about unauthorised restrictive practices adopted by Irabina came to the attention of the Commission in the first half of 2020.

4. Although Irabina's use of prohibited restrictive practices ceased in mid 2021, and the Severe Behaviours Program was discontinued in 2022, following further complaints and media attention, the Commissioner determined a review of Irabina's practices should occur. A Commission investigation into Irabina was initiated in late 2023 and remains open. This investigation may result in further regulatory action being taken against the provider.

5. I was tasked with conducting a review of how matters relating to Irabina were handled by the Commission. The review was designed to identify shortcomings, if any, in dealing with complaints, Irabina's conduct and any lessons which could lead to better outcomes in the future for NDIS participants.

6. I was also directed to provide an "overview" of my findings and recommendations to be made available to the Commission's staff internally as part of the continuous learning approach at the NDIS Commission.

7. In conducting the review, I was assisted by the co-operation of several of the present Commission staff members who have been involved with Irabina. I acknowledge with gratitude that co-operation. Many staff involved with Irabina are no longer with the Commission. The review has principally been conducted "on the papers" by my examination of the Commission's records supplied to me for this purpose.

Executive summary

8. [redacted] The Prohibited restrictive practices can cause death or serious injury and are to be avoided. [redacted]. Complainants report psychological and emotional damage has, or may have, been suffered by participants affected by prohibited and restrictive practices.

9. [redacted] completed an investigation plan, approved by [redacted] into Irabina's practices in 2021. Later, in October 2021, a draft Investigations Closure Report by [redacted] provided soundly based recommendations to [redacted] for the issue of an Infringement Notice to Irabina. However, for unknown reasons, the Infringement Notice was never actioned.

10. Notwithstanding attempts made by the Commission's Behaviour Support Officers to educate Irabina's senior executives about restrictive practices in and from 2019, it appears that [redacted] until at least late 2022 after the Severe Behaviours Program ceased. While Irabina states it did not engage in prohibited restraints (prone restraints and basket holds) from June 2021 after it conducted an internal investigation.

11. Several of the 13 identified complaints made to the Commission were not dealt with in a timely way. Some complainants were not informed, or not informed in a timely way, of the outcome of the complaint process. Of the 13 identified complaints, 4 raised concerns about the Severe Behaviours Program and/or concerns around prohibited or restrictive practices. The remaining complaints related to a range of other issues, including alleged overcharging. 5 of the complaints were lodged anonymously, which meant it was not possible for the Commission communicate with the complainant or inform them of the outcome.

12. The closing of a complaint by one team/branch within the Commission, when a referral or escalation is made to another team/branch has, in some instances, resulted in a lack of coherent record keeping, militated against a holistic approach to issues raised, led to duplication and diminished effective responses. This fragmentation was exacerbated by the Commission's inadequate information technology systems.

    I am informed that the current Commission Operating System (COS) comprises separate modules for each of the Commission's core functions (e.g.: complaints, reportable incidents, compliance and investigations). This means that when a complaint is referred or escalated to another team, it may be marked closed in the complaints module. That does not necessarily mean it is closed from a Commission perspective, as the information contained in the complaint may be acted on through an investigation or compliance action. In respect of the Irabina complaints, emails and file notes indicate that staff across complaints, behaviour support and compliance teams in the Victorian office had some liaison about how to coordinate regulatory responses.

13. While permanent banning orders against two former executives are now in place, [redacted]

14. [redacted]

15. Some families have felt unsupported by the Commission because of difficulties in accessing officers, delays in responding to complaints, or because of no response. More timely responses and ease of accessibility for complainants should be explored including the possibility of a user advisory group and investigation of the feasibility of establishing a role of an Official Visitor to provide "on the ground" reporting to the Commission. Also noted are the recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission) and the NDIS Review.

16. I have been informed that since 2023, the Commission has been working with a Complaints Function Advisory Group which comprises people with lived experience and a range of disability representative organisations, including Women with Disabilities Australia, the National Ethnic Disability Alliance, First Peoples Disability Network and Children and Young People with Disability Australia. Many significant changes to the complaints model were implemented in February 2023, in consultation with the Advisory Group and other stakeholders. These changes include accessibility improvements and more timely communication with complainants.

17. Critical retrospective analysis of the Commission's actions, or lack thereof, must be tempered by a number of factors including, during the relevant periods, the lack of sufficient staff resources. This was exacerbated by staff resignations, staff reporting lines, inadequate information technology systems, and restrictions on site visits because of the COVID 19 pandemic.

18. Going forward, closer liaison with the National Disability Insurance Agency (NDIA) about quality and efficacy of providers' programs and providers' expertise should be explored particularly programs associated with Adaptive Behaviour Analysis (ABA). Ensuring quality and efficacy may require liaison with States and Territories and regulatory reform.

19. It is pleasing to observe that new delegations mean staff can now, if appropriate, more effectively prosecute actions independently or with assistance from the Legal Services Branch, that IT issues are being addressed, and that the *Disability Act* 2006 (Vic) has been amended to permit the Victorian Senior Practitioner to commence proceedings for an offence under Parts 6A, 7 and 8 of that Act (see s 218 (3)). Also noted are the recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission). Each of these developments is likely to enhance the safety of NDIS participants.

Terms of Reference

20. The review was based on Terms of Reference as amended on 10 December 2023. The Terms are as follows:

    1. The nature and types of supports and services provided by Irabina, particularly with regard to the Severe Behaviour Program offered in Melbourne, but encompassing any services that involve restrictive or prohibited practices.

    2. The NDIS Commission's receipt of information pertaining to Irabina operations and activities from 1 July 2019 including:
       a. How the information was received and the type of information received
       b. The risk or triage approach applied
       c. The flow of information including process arrangements between teams/functions within the Commission
       d. Resulting communication with the provider, participant, complainant
       e. The internal management and disclosure of information within the NDIS Commission.

    3. How the NDIS Commission carried out its regulatory response, as a result of the process and actions undertaken and described in 2 above.

    4. Whether the regulatory response was appropriate and proportionate, and whether the process and actions leading to the response were appropriate in the circumstances

       a. In undertaking a review of the regulatory response, both previous (point in time) and current arrangements should be examined.
       b. Whether alternative or additional actions could, or should now, be taken.
       c. Outline additional steps that could, or should now, be taken to ensure the safeguarding of NDIS participants.

    5. Any other matters the Reviewer thinks relevant for the Commissioner.

Findings Item 1 of Terms of Reference

21. The documents provided to me disclose that the Commission's officers, whilst initially accepting of information provided by Irabina, and in good faith endeavouring to educate Irabina's executives about prohibited and restrictive practices, had by mid 2021 become aware of unauthorised restrictive practices engaged in by Irabina on and from 2019. Also as discussed under Item 5 of the Terms of Reference, the National Disability Insurance Agency (NDIA) had significant concerns about Irabina's programs. These concerns included matters such as that programs were not tailored to individuals, were not focused on integrating participants back to school or other services and involved restrictive practices.

22. Going forward it is recommended that providers' programs for autistic children and young persons should be carefully evaluated for clinical efficacy and safety and the expertise of the provider scrutinised.

23. Because 4 of the 13 complaints related to prohibited and/or restrictive practices. Compliance and Investigation work involving Irabina focussed on the Severe Behaviours Program. However, it is probable inappropriate restrictive practices were engaged in by Irabina staff in other programs including environmental and mechanical restraints (in the mealtime management program).

24. Two reports, including a report of the Victorian Senior Practitioner, were available to the Commission from August 2022. Those reports were damning of conduct perpetrated at Irabina and supported regulatory action against the service provider and potentially banning orders against some executives. The responsible senior officer did not act on this information.

25. Regulatory action proposed by the [redacted] in [redacted] draft Investigation report to issue an Infringement Notice did not occur. The proposed action was within the time provided in s 103 of the *Regulatory Powers (Standard Provisions) Act* 2014 (Cth). For unknown reasons this did not occur. The failure may have been caused by workload pressures, temporary acting arrangements and /or staff turnover.

26. Because Irabina has ceased to offer the Severe Behaviours program, and other programs, concerns which would otherwise rightly need to be raised about adherence to the objects of the Act (see s 3 (1) (ga)) and breaches of the Rules are historical and are now moot. But several safety concerns remain for other potential or actual participants under the Act. The Commission's Regulatory Approach and operating model recognises the need for site visits.

27. I have recommended:

[redacted]

Findings Items 2 and 3 of the Terms of Reference

28. The material reviewed discloses how the teams in the Commission obtained information from or about Irabina from June 2019.

29. Generally, the Commission received information about Irabina from four sources. First, it received information and policy documents provided from Irabina executives primarily in response to queries from the Commission's officers. Responses were not, on many occasions, factually accurate or complete. Secondly, it received information from complainants. Thirdly, detailed and highly relevant information was received when the Commission, in July 2022, received the Victorian Senior Practitioner's report (which annexed a report commissioned by Irabina post June 2021). Fourthly, up to date information was provided by the "new" Irabina executive team post 2022 supplemented by information from Aruma.

30. In dealing with the complaints about Irabina, several matters must be considered noting that they relate to the Commission structure that was operational at this time. First, the Victorian Behaviour Support Team comprised only three persons at the relevant time. Matters were escalated to [redacted] because of workload. Information provided indicated that [redacted] lacked adequate staff to deal with matters in a timely way. Secondly, these events, the subject of this review, took place during the COVID 19 Pandemic. This precluded face to face visits to Irabina by the Commission's teams. Thirdly, there was considerable staff turn-over during the relevant period and the reporting structure does not appear to have been effective in alerting senior management to relevant issues albeit the Victorian Senior Practitioner's report was provided to the Commission in July 2022. Fourthly, effective overall oversight of management of Irabina's [redacted] was hindered by the lack of appropriate IT systems within the Commission with either a lack of access by one team to another team's material, or at least a lack of knowledge about how to access this information with some material on COS and other data kept on ARC.

31. The approach adopted by [redacted] between late 2019 to at least June 2021 with Irabina was focussed on education delivered to Irabina executives and staff about their statutory obligations around behaviour support plans, prohibited practices, restrictive practices, and reporting obligations. It may be observed that NDIS Commission staff interacted with Irabina executives in good faith in carrying out their educative function and initially had no reason to challenge the bona fides of Irabina's executives or the information they provided. Only one site visit to the Bayswater Road site was conducted and the Commission relied on the accuracy of information provided by Irabina at least until July 2021. Irabina's response was to provide information to obfuscate and deny any wrongdoings.

32. Investigations conducted a thorough investigation of the significant complaints concerning prohibited restrictive practices, made soundly based recommendations in the [redacted] draft report for the issue of an Infringement Notice (having regard to the Commission's policies) and drafted all relevant documents. Why the proposed Infringement Notice was not processed in a timely way at the relevant time in accordance with the legislation is unknown. This failure or oversight may be attributable to work overload. The failure to issue the Infringement Notice resulted in an unfortunate shortcoming in appropriate regulatory response by the Commission.

33. It is noteworthy that, after the receipt of the Irabina commissioned report and the change of executives at Irabina, the Board and executive did co-operate with the Commission albeit that some use of restrictive practices continued in Irabina's programs. Irabina acknowledged shortcomings and attributed the ongoing use of restrictive practices, but not prohibited practices, to the difficulty in shifting the culture of some behaviour support practitioners.

34. In many instances, complainants have not received a response at all, or in a timely manner. It is noteworthy for example that one complainant made a complaint in October 2020 and received a "high level" advice of closure by telephone in April 2022.Of the 13 complaints, there was communication with the complainant in 6 of the matters. Five of the complaints were lodged anonymously so the Commission was unable to communicate with the complainant.

I am advised that, in respect of the remaining 2 complaints, these are being considered as part of an active investigation and communication has or will occur with the complainants.

35. It is also relevant to note that the carers who have contacted the Commission are frustrated at their lack of ability to communicate with the Commission pointing to telephone call delays and feeling of a lack of support. Relevance of this review has been questioned – i.e. the benefit of an historical examination rather than a focus on present protection of participants by ensuring only those suitable to work in the NDIS environment are accredited.

Conclusions – paras 2 and 3 of Terms of Reference

36. In the period 2019 to late 2021 the Commission's teams were impeded in their regulatory roles by insufficient staff to carry out necessary functions to ensure compliance with the Act and Rules and to institute appropriate regulatory penalties. Their task was difficult in the environment of COVID19 and the pandemic's restrictions. The teams' ability to act in an effective co-ordinated manner was further impeded by the dual IT system (COS and ARC) and knowledge, or lack thereof, about accessing material by key personnel. This resulted, in some cases, to a fragmented approach to Irabina's breaches of the Act and Rules, workflow blockages under the Registar and duplication of effort without any effective outcome for participants.

37. The key regulatory failure of the Commission was the failure to proceed with the issue of an Infringement Notice in October 2021 following the preparation of the draft investigation report into Irabina's practices. If issued, an Infringement Notice may have resulted in the earlier cessation of the Severe Behaviours Program.

38. Delays in communicating with complainants and participants' parents have, in some cases, been unacceptable.

39. Although steps have now been taken to issue banning orders in respect of two Irabina executives, so far as I am aware, no investigation to date has been instituted in respect of any other Irabina staff including behaviour support practitioners who may still be working in the disability sector to assess their suitability to do so.

Findings Item 4 of the Terms of Reference

40. Many of the structural and other impediments which led to the delays and failures to act against Irabina for the implementation of prohibited and restrictive practices no longer exist.

41. It is relevant that:

    (a) Irabina ceased using prohibited restraints after its internal review in June 2021 and management changes occurred after receipt of its commissioned Report;
    (b) Irabina ceased the Severe Behaviours Program in about April 2022 following receipt of the Victorian Senior Practitioner's audit report;
    (c) the Victorian Senior Practitioner's audit report provided evidence of Irabina's breaches of its registration conditions.

The report, albeit indirectly, led to the effective cessation of the Severe Behaviours Program, and transfer of participants to Aruma;

(d) the Commission has received additional funding to employ additional staff and is progressing a new policy proposal that will enable a fit for purpose IT system to be implemented;
(e) Banning orders have been executed against two Irabina executives;
(f) Behaviour Support and other staff now have an active role in following up and or instituting infringement or compliance notices where appropriate;
(g) Victorian legislation now makes engaging in a prohibited restraint a criminal offence and gives the Senior Practitioner authority to bring proceedings for breach of the provisions of the *Disability Act* relating to prohibited practices; and
(h) The Disability Royal Commission investigated and made a number of recommendations relevant to restrictive practices which should lead to safer outcomes in the future for NDIS participants.

42. I am of the view that there are a number of steps, which can now and should be taken to protect NDIS participants.

43. It is apparent that the Severe Behaviours Program, as applied by Irabina using SABR training, placed participants at risk of death or serious harm and infringed human rights (see Attachment 1 to the Victorian Senior Practitioner's Physical Restraint Direction Paper, September 2019).

44. As discussed later under Item 5, there did not appear to be any rigorous investigation of either the efficacy of the program, or the experience or expertise of those implementing the program when Irabina commenced the Severe Behaviours program. The behaviour support plans formulated to obtain funding did not focus on the individual participant's needs and were at exorbitant cost.

    There should be closer liaison with the NDIA about novel programs, providers' expertise and plans to ensure the safety of participants and/or liaison with States and Territories about appropriate regulation to ensure participants' safety.

45. Families of children and young persons with a severe disability such as those who participated in the Severe Behaviours Program, were faced with enormous physical, financial and emotional challenges in sourcing suitable programs for their children and ensuring their best interests were met. Better access to the Commission when an issue about a program arises is a priority for them. Faster telephone access, and responses to participant's parents will indirectly benefit participants. Consideration should be given to a parent/carers user group to facilitate communication between parents and the Commission and the feasibility of establishment of a role of an Official Visitor.

46. Complainants should receive timely follow up and that appropriate action is taken when necessary. I note that the Commission's web site limits (in very small font) complaints to 1,000 characters. There should be information on the web site about how additional information can be provided by a complainant.

Findings Item 5 of the Terms of Reference

47. In the material provided for this review, I noted the involvement of the NDIA with the Commission (Behaviour Support Team) about Irabina's programs in 2020.

48. Shortly after commencement of the Severe Behaviours Program, the NDIA, the Victorian Senior Practitioner, and Behaviour Support officers had concerns about Irabina and its programs. In the future, participants may be prevented from enrolment in unsuitable programs, or programs being administered by persons lacking appropriate qualifications and expertise, if programs and providers are subject to appropriate empirical evidence-based assessment before funding by the NDIS.

49. In the case of the participants in the Severe Behaviours Program their carers were desperate for assistance for their child or young person. The carers were not likely to be in a position where they could make a truly informed choice about a program or a provider. To me, the "gap", or lack of effective regulation around the efficacy of a program or its providers, particularly if the provider's practitioners are not registered health practitioners and subject to regulation by the Australian Health Practitioners Regulation Agency, is a matter that should be addressed.

The Hon Jennifer Boland AM