COMMONWEALTH OMBUDSMAN

Submission by the Commonwealth Ombudsman

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Submission in response to the Safeguards and Quality Issues Paper, November 2020

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Introduction and summary

The Office of the Commonwealth Ombudsman (the Office) welcomes the opportunity to respond to the Safeguards and Quality Issues Paper released in November 2020 by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

An effective complaint handling framework needs to be at the heart of any safeguards framework for people with disability. In this submission, we provide our insights on the National Disability Insurance Scheme (NDIS), including the existing complaint handling arrangements, from our experience in overseeing both the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission (the NDIS Commission).

However, effective safeguards also need to be tailored to the environment in which they will operate. For example, a safeguards framework predominantly based on individual complaints might be appropriate in a setting in which affected people are empowered to make complaints. In contrast, other mechanisms, such as more proactive oversight or positive reporting obligations on providers, might be more appropriate in circumstances where relying on individual complaints is not realistic.

Our Office has experience with many of these different safeguard mechanisms. Informed by this experience, this submission outlines the principles we suggest should underpin the safeguarding framework for people with disability. We have illustrated these principles with a detailed analysis of each of the following mechanisms:

- An effective complaints handling framework.
- Own motion investigation powers for the regulator.
- Proactive inspection and audit functions.
- Placing reporting obligations on service providers, illustrated through the reportable conduct scheme for child safety.
- Pre-emptive oversight with a focus on prevention, illustrated through the Optional Protocol on the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Background on our role

The purpose of the Office is to:

- provide assurance that the organisations we oversee act with integrity and treat people fairly, and
- influence systemic improvement in public administration in Australia and the region.

We seek to achieve our purpose through:

- correcting administrative deficiencies through independent review of complaints about Australian Government administrative action
- fostering good public administration that is accountable, lawful, fair, transparent and responsive
- assisting people to resolve complaints about government administrative action, and

- providing assurance that Commonwealth, State and Territory law enforcement, integrity and regulatory agencies are complying with statutory requirements and have sound administrative practices in relation to certain covert, intrusive and coercive powers.

The Office also has jurisdiction over ACT government agencies as the ACT Ombudsman. The ACT Ombudsman has a variety of specialist functions which it performs on behalf of the ACT Government, including:

- ACT Reportable Conduct Scheme
- freedom of information
- ACT Policing and oversight
- Inspector of the ACT Integrity Commission
- public interest disclosures.

Our insights on the NDIS

The Office has jurisdiction to consider and handle complaints, undertake investigations and make recommendations in relation to the administration of the NDIS.

We consider complaints about the NDIA and organisations contracted to deliver services on its behalf, including NDIS Local Area Coordinators and Early Childhood Early Intervention partners. We also consider complaints about the NDIS Commission's operations.

Generally, our focus is on administration rather than policy. In cases where we consider an agency's actions are deficient, we may make a suggestion or recommendation to the agency for it to revisit the matter or provide a remedy. However, we cannot require or direct an agency to take a specific action or make a specific decision; nor can we substitute our own decision.

Oversight of the NDIA

Since the creation and rollout of the NDIS up to 2019-20, complaints to the Office about the NDIA increased each year. This is unsurprising given the speed of the rollout and the increased numbers of NDIS participants each year.

In 2019-20, complaints to our Office about the NDIA decreased by 22 per cent compared with the previous financial year. While we noted an overall decline in all complaints to our Office during this period (10 per cent), the reduction in NDIA complaints exceeded this general decline. It is not clear the reasons for this decline, although we are aware that during the COVID-19 pandemic, the NDIA took a proactive approach to contacting vulnerable participants. This may have enabled any emerging issues to be dealt with by the NDIA more quickly and thus not require a complaint to our Office.

We have investigated and made recommendations to address systemic issues regarding the NDIA in the following reports and submissions which can be found on the Office's website (www.ombudsman.gov.au/publications):

- Administration of National Disability Insurance Scheme funded assistive technology (August 2020)
- Investigation into the actions of the National Disability Insurance Agency in relation to Mr C (February 2020)
- Submission to the Department of Social Services regarding the review of the *National Disability Insurance Scheme Act 2013* (November 2019)
- Submission to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into NDIS Planning (September 2019)

- Submission to the Joint Standing Committee on the National Disability Insurance Scheme's inquiry into assistive technology (September 2018)
- Administration of reviews under the *National Disability Insurance Scheme Act 2013* (May 2018).

Monitoring the NDIS Participant Service Guarantee

In 2019, the Australian Government committed $2 million across four years to enable the Office to monitor and report on the NDIA's performance against the Participant Service Guarantee (the PSG) and to support NDIS participants pursuing complaints about the timeframes for NDIA decision-making.

While the relevant legislation has been delayed, the NDIA agreed to commence operationalising the PSG and commence public reporting against its timeframes and service standards, as much as possible, from 1 July 2020, as set out in the NDIA's Participant Service Charter available on the NDIA's website.

We will assess and report on the NDIA's performance against the PSG engagement principles, service standards and timeframes, to determine whether the NDIA is in fact providing the participant experience to which it has committed, and to identify opportunities for improvement.

Oversight of the NDIS Commission

The NDIS Commission regulates NDIS providers and responds to concerns, complaints and reportable incidents regarding providers. The NDIS Commission is the frontline for issues of quality and safety under the NDIS.

A person can complain to us about how the NDIS Commission's activities. We can consider how it handles the complaints it receives about NDIS providers, but we will not separately oversee the conduct of the provider.

Since the NDIS Commission commenced operations in July 2018, the Office received 30 complaints in 2018-19 and 74 complaints in 2019-20. By way of comparison, we received 1,711 complaints in 2018-19 and 1,331 complaints in 2019-20 about the NDIA.

The complaints we receive about the NDIS Commission are mostly about how it handles complaints. To date, we are satisfied the Commission generally responds appropriately to complaints it receives.

As the NDIS Commission is relatively new, the Office has not yet looked more broadly into its administration. Following the death of Ms Ann-Marie Smith in April 2020, we considered whether to commence an investigation into the Commission's regulatory approach. At this stage, we have declined to do so in light of the numerous other inquiries which have been commenced, including the Independent review into the circumstances of Ms Smith's death by the Hon Alan Robertson SC and the Joint Standing Committee on the NDIS's inquiry into the NDIS Commission to which we made a submission. We are continuing to monitor the outcomes of these inquiries with a view to determining whether further activity is required by this Office.

We also acknowledge the NDIS Commission's broad remit and the large number of NDIS providers it covers. We recognise the challenge for oversight and regulatory agencies in taking a risk-based approach to prioritise limited resources across a broad range of responsibilities. In this context, we consider the additional funding made available to the

NDIS Commission as part of the 2020-21 Budget will greatly assist its vital oversight role, although we note risk-based prioritisation will continue to be necessary.

Principles for building upon existing safeguards

We have observed that the NDIS Commission has in place a robust framework which comprises regulation, accreditation, inspection, audits, monitoring and complaint handling which provides a sound basis for safeguarding people with disability.

That being said, no framework is flawless. To be effective, it needs to be supported by a range of practices and measures that take an integrated approach to safeguarding. This needs to include proper resourcing for regulatory activities, qualified and well trained regulatory staff, well-credentialed and high quality providers, and clear mechanisms and pathways for people to raise issues of risk or concern to the relevant agencies.

Based on our experience of various oversight and safeguarding frameworks, we consider formal safeguards in the disability sector should be guided by the following principles:

- an overriding objective of protecting the rights and safety of people with disability
- complementary measures, including individual complaints, proactive oversight and clear expectations on providers, to report concerns where something appears amiss
- independent and impartial oversight by a regulatory body that is well resourced and empowered to use its resources both flexibly and proportionately where it identifies a person or people with disability who might be in circumstances of greater risk or concern
- a proactive approach to inspections and monitoring, particularly in settings where people are less likely or able to complain
- education to providers, participants and the broader community about their rights and responsibilities, and how and where to complain if things goes wrong
- an integrated approach to safeguarding which encourages information sharing between relevant agencies where a person with disability might be at risk
- a 'no wrong door' approach to minimise the burden on complainants to identify which oversight body is the right one to approach in their particular circumstances.

As part of the Office's oversight role, we undertake a range of activities in a range of settings which reflect these principles, to provide assurance that the organisations we oversee act with integrity and treat people fairly. Some practical examples, including lessons learnt, are outlined below.

Effective complaint handling systems as safeguards

Effective complaint handling systems play an important role in providing safeguards when something goes wrong. They can assist to identify people who are potentially at risk and prevent harm to people with disability.

A good complaints system will allow people with disability, their families and carers to raise concerns regarding service delivery and administration. Complaints allow individual concerns to be assessed and if necessary, action to be taken. More broadly, analysis of complaints data can provide an indicator of systemic issues that may require policies or processes to be reviewed or updated.

For a complaint handling system to act as an effective safeguard, it should allow for the resolution of individual complaints, as well as the ability to draw high level organisational and systemic learnings.

There are a number of features of a good complaint handling system that allow for such outcomes to be achieved:

1. The complaint handling system would ideally involve an independent and impartial oversight body with broad statutory jurisdiction. It should have well-trained staff with adequate powers to assess and investigate complaints, take appropriate action to resolve individual matters and act on broader systemic concerns it might identify.

2. A complaint handling system needs to be accessible and trusted by people with disability. Complaint pathways should be actively promoted and explained to increase the likelihood of issues being raised. There should be clear guidance on how to make a complaint, the role and processes of the organisation to whom a complaint can be made, including to manage expectations of potential outcomes and likely timing, and the availability of services to address people's communication needs.

3. There should be a 'no wrong door' approach to support and assist people to raise their concerns with the agency best placed to assess and investigate the concerns raised.

4. A complaint handling system should be underpinned by a culture that values complaints. Staff should be curious and willing to inquire further when presented with limited information about a person in potentially vulnerable circumstances, or information that indicates something is amiss and should be further investigated.

5. There also should be a strong commitment to effective complaint resolution with a focus on the end outcome. Effective complaint handling should be focussed towards a suitable remedy for a complainant that will deal fully and finally with the problem.

6. Complaint analysis should be part of the continuous cycle of review and improvement in an agency and when done this way can act as an effective safeguarding measure.

7. A complaint handling system is most effective when complaints data is collected, analysed and reported on as a means to address systemic issues, as well as inform policy settings. This can involve highlighting increases in complaint numbers for particular communities, issues or programs, or particular causes of complaints that may affect other people. Identifying these trends can lead to targeted investigation of the causes of the problem and ways to address it, and provides an additional means to safeguard people in similar circumstances who might also be at risk.

   Complaint analysis can also help organisations think ahead to develop and implement responses to emerging risks and challenges. Complaints help an agency see what is needed and how to make systems work more effectively. Complaint information is a valuable resource for evaluating possible strengths and weaknesses in new programs and services.

Capability building and education

An effective safeguards framework supports good complaint handling within other organisations. A regulator can play a role in improving complaint handling within the organisations it oversees,

facilitating resolution of disputes at the lowest possible level. With this in mind, our Office has established an education program to help organisations to improve their complaints handling systems through education and training of front-line complaints handling staff.

Education is an essential part of safeguarding as it ensures a focus on continuous improvement, quality complaint management and the essential elements of a good complaint handling system. When providing training, the Office promotes a focus on accessibility, user-centred services and the use of data to identify issues with programs or policies. This training builds the capability of individual staff members and complements wider activities focussing on processes and systems.

Through providing training, the Office has identified that many complaint handlers seek advice and assistance on how to improve their communication and engagement with their clients, while remaining empathetic. This focus is critical for all complaint handlers, particularly those in the disability space, where people may face barriers to accessing complaint services and require a tailored communication approach.

The Office provides training and education through online and face-to-face workshops and seminars, along with an annual Complaints Handling Forum.

Own motion investigations

In addition to receiving and investigating individual complaints, effective regulators have 'own motion' or 'own initiative' powers, which enables them to consider broader systemic issues that impact on multiple people, not just an individual complainant.

Own motion investigations provide an opportunity to conduct thorough reviews of organisational actions or processes at a system or program level, which can result in widespread improvements to service delivery. Our governing legislation provides a broad own motion power, which allows flexibility in determining when to commence an investigation and its scope.

We use a variety of sources to identify when to undertake an own motion investigation, including systemic and trend data from the individual complaints we receive, feedback from stakeholder engagement and regular liaison with the agencies we oversee. For example, we commenced an own motion investigation into the NDIA's administration of assistive technology after noting an increase in complaints relating to assistive technology in 2018-19 compared with the previous financial year.

Own motion investigation powers allow us to obtain a broad amount of information from agencies, including information regarding internal complaint handling, policies and procedures, data sets, and operational guidelines. These sources provide valuable information to analyse systemic issues and suggest improvements.

We have found the own motion investigation power an effective tool in seeking to influence systemic improvement in public administration. It is a useful safeguarding measure for a formal independent oversight body to have when investigating matters relating to mistreatment of people with disability.

In our experience, this safeguard is most effective when it ensures the following:

- **Maintaining relevance**—when scoping own motion investigation work, resources should be directed to completing the work within timeframes which ensure timely outcomes relevant to the administration of the issues, systems or policies under investigation.

- **Well-crafted recommendations**—to produce recommendations that are both practical and effective at addressing systemic issues, recommendations should be 'SMART': Specific, Measurable, Achievable, Results-oriented and Time-bound.
- **Liaison and procedural fairness**—ongoing liaison with agencies and providing them with the opportunity to comment on recommendations are effective mechanisms to ensure recommendations have the best chance of being supported by agencies, and that they will address and contribute to improvement of issues identified. This is important to ensuring that agencies responsible for administration are committed to implementing measures to address systemic issues.
- **Follow up**—recommendations should be followed up to ensure that intended improvements are realised. In 2020, we published a report titled, 'Did they do what they said they would? Reviewing our recommendations'. The report contained the results of our investigation to follow-up on recommendations made in seven investigation reports published by the Office over a two year period from July 2017 to June 2019. We found that agencies had implemented, in whole or in part, nearly all of the recommendations which they had accepted. We have also published a factsheet for agencies on how we make and follow up on recommendations.

Inspections and audit

The ability to make a complaint will not of itself be an effective safeguard where people may not be aware of activities that are occurring and thus have no opportunity to complain. In the context of the NDIS, this could arise where people are not aware that what is happening is wrong, due to a lack of awareness of their rights or the expectations on their provider.

In these circumstances, proactive inspections and/or audit by regulators and oversight bodies are required as an effective safeguard.

One example of this is the Office's role in performing compliance inspections of law enforcement, integrity and regulatory agencies' use of covert, intrusive and coercive powers. The covert nature of these activities means that a person is usually unaware they are the subject of these powers and, as a result, cannot make a complaint about or question an agency's actions. This may be similar to the experience of some people living with disability—they may, due to various reasons, be unaware of the activities of the agencies providing care or unable to complain.

In the absence of this visibility, the Office's inspections serve as an important safeguard by assessing and reporting on an agency's legislative compliance. Our inspections provide public assurance that agencies are applying these powers as intended by Parliament. We also improve agencies' compliance by providing recommendations and better practice suggestions.

Essential elements to the effectiveness of our work include:

- clear and adaptive inspection methodologies, policies and processes that the Office can apply regardless of agency
- a commitment from agencies to full and free access to records that we need to inspect
- adequate resourcing and expertise to meet the demands of the oversight role
- strong stakeholder relations to ensure that agencies are co-operative, responsive and engaged with our findings.

Our lessons learnt in this space are as follows:

- **A positive relationship**—a positive relationship between agencies is vital not only to complete our inspections but also to effect change. To nurture the relationships with agencies, we engage at multiple levels, provide clear information about how we conduct our inspections, invite agencies to provide input on our inspection schedule, provide an opportunity for an agency to correct information and craft realistic and solutions-focussed recommendations that take into account its circumstances. Agencies must also have confidence in our independence before they place trust in us to assess their compliance. This is applicable to the disability setting as it is important that all organisations working with people with disability take an integrated approach to safeguarding.
- **Scope may change**—as the powers used by agencies, the processes in place to administer those powers or the need to use them change, our work also has to adjust.
- **Ability to conduct remote and in person inspections**—both remote and in person inspections have advantages. Remote inspections can reduce the cost and need to travel and enable oversight of a broader range of activities, while in person inspections allow officers to collect incidental information and speak with staff.
- **Legislative requirements to inspect should not be prescriptive**—as long as the aim of the legislation is clear, the activities that are undertaken should not be too prescriptive. Within a broad mandate, oversight agencies and regulators are most effective when given a flexible legislative framework, as those bodies are best placed to determine how to prioritise resources to achieve the mandate. Legislative prescription on the mandatory nature or frequency of inspections can affect this flexibility.

The last point is particularly relevant to the disability setting. It is critical that the oversight body has flexibility to use its resources based on risks it has identified and proportionately to the issue it is aiming to oversee.

Safeguarding through obligations on providers: reportable conduct scheme

Another model for safeguarding, particularly in an environment where multiple service providers are operating, is to set high standards and reporting obligations on those providers, in turn overseen by a regulatory body. An example of this is reportable conduct schemes to protect child safety, such as the scheme in operation in the ACT and overseen by our Office in our role as the ACT Ombudsman.

The ACT Reportable Conduct Scheme (RCS) was introduced on 1 July 2017 to improve organisation-related child protection in the ACT. Under the RCS, the ACT Ombudsman has a central role in overseeing and promoting good practice by designated entities' in the prevention of and response to reportable conduct allegations. Designated entities covered by the scheme must report to the Ombudsman any allegations, offences and/or convictions relating to reportable conduct by an employee or volunteer, such as child abuse or misconduct. The scheme covers conduct that occurs in the employee's professional capacity and private life involving children, regardless of the child or young person's willingness to participate or consent to the conduct.

The definition of reportable conduct set out in s 17E of the *Ombudsman Act 1989* (ACT) and expanded on in the Office's Practice Guide No. 2, published on the ACT Ombudsman website, reflects the definitions of violence, abuse and neglect provided by the *Royal Commission into*

Violence, Abuse, Neglect and Exploitation of People with Disability. The RCS applies to services accessed by people with disability across various stages of their life, from birth, early childhood, schooling and adolescence.

The RCS demonstrates the importance and value of an integrated safeguarding approach which encourages appropriate information sharing in specific circumstances. The RCS is an important safeguard because it places an obligation on, and supports, designated entities to develop and implement practices and procedures to identify, investigate, respond to and prevent allegations of reportable conduct and reportable convictions. Under the RCS, the Office actively promotes public awareness of the scheme's requirements and builds the organisational capacity of designated entities to increase the likelihood of reportable conduct being identified, reported and responded to effectively.

In order to effectively contribute to the safeguarding of children and young people in the ACT, the RCS depends on the following elements:

- **Independence**—independent oversight of responses to allegations of reportable conduct helps to address the possibility (or perception) of conflicts of interest that may be present with internal investigations and can improve the competency, transparency and accountability of designated entities.
- **A clear description of jurisdiction**—a clearly defined jurisdiction promotes effective and efficient oversight by facilitating targeted engagement, a reduction in duplication and the development of clear and agreed referral processes.
- **Information sharing and working collaboratively with other oversight bodies**—with the introduction of the RCS, there are at least eight bodies within the ACT that have legislated oversight and reporting responsibilities in relation to child abuse. In order for these bodies to provide effective safeguards, robust information sharing processes and agreed methods of collaboration are essential.
- **Building the capacity of designated entities**—within the ACT there are more than 800 designated entities covered by the RCS. By implementing strategies that actively improve an entity's capacity to effectively identify and respond to allegations of reportable conduct, we are able to reduce entity dependence on the Office and expand the safeguarding effects of the RCS.
- **Flexibility of engagement with designated entities**—our work with designated entities includes case management of individual matters, broader engagement with entities to address identified systemic issues, considering and providing feedback on entities' practices and procedures and conducting investigations into allegations of reportable conduct. As a result of this flexibility, the Office is able to tailor its engagement with designated entities to maximise safeguarding outcomes.
- **Raising public awareness through education and data based publications and reporting**—the effectiveness of a scheme such as the RCS is directly related to the level of awareness of its existence and requirements. The Office seeks to maximise public awareness of the RCS by posting relevant information on social media platforms, publishing quarterly reports and public statements where appropriate.

Since the commencement of the RCS, the Office has collected data based on the notifications and reports it has received from designated entities. While the Office's experience under the RCS does not specifically relate to people with disability, a number of lessons learnt are relevant to the development of safeguards within the disability space. These include:

- **Facilitating positive outcomes following an allegation**—when it is identified that an allegation of reportable conduct has occurred, better outcomes can be achieved and the

detrimental impact on involved parties minimised, when inquiries are commenced promptly and scoped appropriately.

- **Maintaining the integrity of intersecting frameworks**—when allegations of reportable conduct are raised, a designated entity may be required to respond in line with a number of regulatory frameworks. In a public statement in October 2018, the ACT Ombudsman acknowledged that a single process, done well, can fulfil multiple purposes. However, it is important that the focus of each of these frameworks is reflected when the process is finalised and outcomes are recorded.
- **Formal risk assessment processes**—a designated entity's ability to prevent allegations of reportable conduct is enhanced by the identification and implementation of risk management strategies that are tailored to the employment setting and the individual vulnerabilities of the employees of the entity, and the children or young people accessing the services of the entity.
- **Functional practices and procedures**—like many safeguarding schemes and programs, the RCS requires designated entities to have practices and procedures in place for preventing and responding to allegations of reportable conduct. In our experience, organisations having practices and procedures in place is a good start, but is not itself enough. In order to be effective, these practices and procedures must reflect the unique needs of the environment they are being implemented in and staff should be well versed in their application.
- **Training and codes of conduct**—in order to provide consistent high quality services, it is beneficial for a designated entity to actively ensure its staff are aware of what is expected of them and have strategies they can use to manage difficult situations that may arise. The availability of readily accessible training material and codes of conduct assist designated entities to clearly communicate its expectations to staff.

Under the RCS, the Office engages with designated entities and ACT Directorates that provide services to people with disability, and is able to share information related to the safety, health and wellbeing of children and young people with these organisations. The Office also liaises regularly with the following regulators who are responsible for implementing formal safeguards for people with disability:

- Australian Federal Police (ACT Policing)
- Access Canberra
- Childhood Education and Care Assurance
- Public Advocate
- Office of the Senior Practitioner
- Teacher Quality Institute
- Child and Youth Protection Services
- ACT Human Rights Commission.

Examples of the Office's collaboration with these regulators includes:

- regular information sharing with Access Canberra regarding the status of Working With Vulnerable People registrations of individuals who have had reportable conduct allegations raised against them, and
- liaising with the ACT Human Rights Commission regarding the implementation of the Child Safe Standards Scheme within the ACT.

Pre-emptive oversight with a focus on prevention: OPCAT

A final model of safeguarding relates to that of pre-emptive or preventative oversight – seeking to address potential issues of concern before they arise. The Office plays this type of role in relation to our role under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT is an international treaty designed to strengthen protections for people in situations where they are deprived of their liberty and potentially vulnerable to mistreatment or abuse. This includes people with disability who are in detention.

To strengthen the protections for people deprived of their liberty, OPCAT requires Australia to establish a system of regular preventive visits by independent bodies, known as National Preventive Mechanisms (NPMs), and accept visits from the international oversight body, the UN Subcommittee on the Prevention of Torture.

The Office has two roles under OPCAT:

1. We are the NPM body for places of detention under the control of the Commonwealth (Commonwealth NPM), with effect from 1 July 2018. This means that we conduct inspections of places of detention and report on our findings.
2. We are the NPM Coordinator. As NPM Coordinator, we will facilitate the network of NPM bodies once they are designated in other jurisdictions. We also have a policy and research role to promote improvements and share experiences between bodies in strengthening oversight in places of detention.

One of the unique features of the OPCAT framework is that it includes preventive visits to pre-emptively examine systems in places of detention rather than simply reacting and responding to complaints or specific incidents after the fact.

This could be applied to the disability setting especially in circumstances where people are not likely to complain or have access or awareness of complaint pathways. Proactive inspection and monitoring would also provide assurance that these settings are being properly run and are safe for people with disability.

The core requirements for NPMs highlight the need for independence and access to information and facilities. The core requirements include:

- a preventive visiting mandate
- independence—financial and functional, including no perceived conflicts of interest
- composition—gender-balanced and representative
- unrestricted access to places of detention
- unfettered access to information
- unrestricted access to persons, including staff
- the ability to make public reports and recommendations
- privileges, immunities and protections from reprisals.

Our lessons learnt in this space include:

- **The role of civil society (stakeholder organisations and interest groups)**—international experience shows that civil society plays an important part in OPCAT implementation and that early engagement enhances the credibility and visibility of the NPM. The work of the NPM network should be informed by the views of civil society and by those with lived experiences of detention, including those with a disability. NPMs may seek to leverage civil society's knowledge and expertise. Effective ways to encourage the participation of civil society include through the establishment of formal advisory committees, informal ad hoc requests for advice or the call for submissions. Similarly, it is critical that people with disability and groups that represent them, have an active and central role in developing the safeguarding framework. This is critical in committing to addressing systemic issues.
- **Resourcing**—appropriate funding should be provided to inspection roles that create new and expanded functions for bodies.

The Commonwealth Government's approach is that initial priorities for NPMs are primary places of detention. Primary places of detention include closed forensic disability facilities or units where people may be involuntarily detained by law for care. They also include:

- adult prisons
- juvenile detention facilities (excluding residential secure facilities)
- police lock-up or police stations
- closed facilities or units where people may be involuntarily detained by law for mental health assessment or treatment
- immigration detention centres
- military detention facilities.

The list does not currently include aged care facilities and community based disability accommodation. The inclusion of these facilities is expected to be the subject of ongoing discussion between the Commonwealth, State and Territory governments as OPCAT is implemented in the coming years.

OPCAT does not create new rights for detained people, but it seeks to reduce the likelihood of mistreatment. The mechanisms to be established in accordance with OPCAT are designed to ensure that conditions and treatment within places of detention are respectful, safe and humane.

Conclusion

In our experience, safeguarding measures can take many different forms. The most effective frameworks will involve multiple complementary components, as we have outlined above. Those individual components themselves must be well-designed. We have shared some of our insights from our experience with a number of these different components.

Effective safeguards also involve multiple players, all of whom recognise safeguarding as being a core part of their responsibilities, with overall responsibility sitting with a central regulator or oversight body, with broad powers, adequate resources and sufficient flexibility.

We also recognise the importance of *informal* safeguards as essential elements to complement formal measures in the effective delivery of formal safeguards. For example, a consistent theme across all of the functions outlined in this submission is the importance of education of government agencies, the community and individual participants. Such education builds increased understanding, capacity and good practice for both regulators and those whose rights the system is designed to enhance and protect.

Informal safeguarding measures also include advocacy groups, support networks for people with disability in the community and communication supports. Regular engagement with these groups provides another avenue for safeguarding people with disability.

Together, both the formal and informal safeguarding measures provide a solid foundation to identifying and monitoring issues to help and protect people with disability.