Federal Court of Australia cases about harm to people with intellectual disabilities in service provision: Lessons for safe support

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Trigger warning

- Three deaths of people with intellectual disabilities
- Undoubted trauma for families and friends
- Undoubted trauma for the workers and managers

The cases

The first three decided cases

- *Commissioner of the NDIS Quality and Safeguards Commission v Australian Foundation for Disability* [2023] FCA 629 (Afford)
- *Commissioner of the NDIS Quality and Safeguards Commission v LiveBetter Services Ltd* [2024] FCA 374 (LiveBetter)
- *Commissioner of the NDIS Quality and Safeguards Commission v Valmar Support Services Ltd* [2025] FCA 11 (Valmar)

- Judgements and Agreed Facts
- For AFFORD, Royal Commission Hearing 23

Disclaimer

- Agreed Facts are agreed between the NDIS Commission and the provider. Not necessarily agreed by the workers involved.

AFFORD – The failures that led to the death of Merna Aprem

LiveBetter – The failures that led to the death of Kyah Lucas

Valmar

- The failures that led to the death of Mr H, and
- The risks to Messrs K and I

Analysis

- Within case, across case, and beyond case analysis

Comparison

- Hough, A. (2023b). Two scandals: the death of Ann Marie Smith in Australia and the Whorlton Hall scandal in Britain. *Research and Practice in Intellectual and Developmental Disabilities*, 10(1), 65-82. https://doi.org/10.1080/23297018.2022.2109194
- Hough, A., Bigby, C., & Marsh, D. (2023). Australian work health and safety enforcement regarding service provision to people with disabilities: Lessons for service providers. *Research and Practice in Intellectual and Developmental Disabilities*, 10(2), 91-112. https://doi.org/10.1080/23297018.2023.2210580
- Knaus, C. (2015, 18 November 2015). Systemic failings saw disabled woman choke to death after staff miss warnings. *The Canberra Times*. https://www.canberratimes.com.au/story/6060247/systemic-failings-saw-disabled-woman-choke-to-death-after-staff-miss-warnings/
- McCarthy, S., Hemsley, B., Given, F., et al. (2022). Death by choking or dysphagia: A review of Coronial Findings (Australia and Canada): A picture of preventable death, non-adherence to written recommendations, and lack of appropriate supervision. *Journal of Law and Medicine*, 29(2), 630.

Lessons for practice: The Devil is in the detail

1. **Risk assessment and management**

1.1 Ensure effective processes to assess and control risk

1.2 Assess and mitigate risks about new clients, or new services to existing clients

1.3 Ensure risks concerning the physical environment are assessed and controlled

1.4 Seek professional advice about risks where needed and ensure its currency

1.5 Ensure information flows to those who need it, and that it flows accurately

Lessons for practice cont.

2. Staff learning & development

2.1 Ensure quality staff learning & development, tailored to the needs of individual clients

2.2 Train staff in emergency response

2.3 Assure staff competency

Lessons for practice cont.

3. Staff role and task clarity

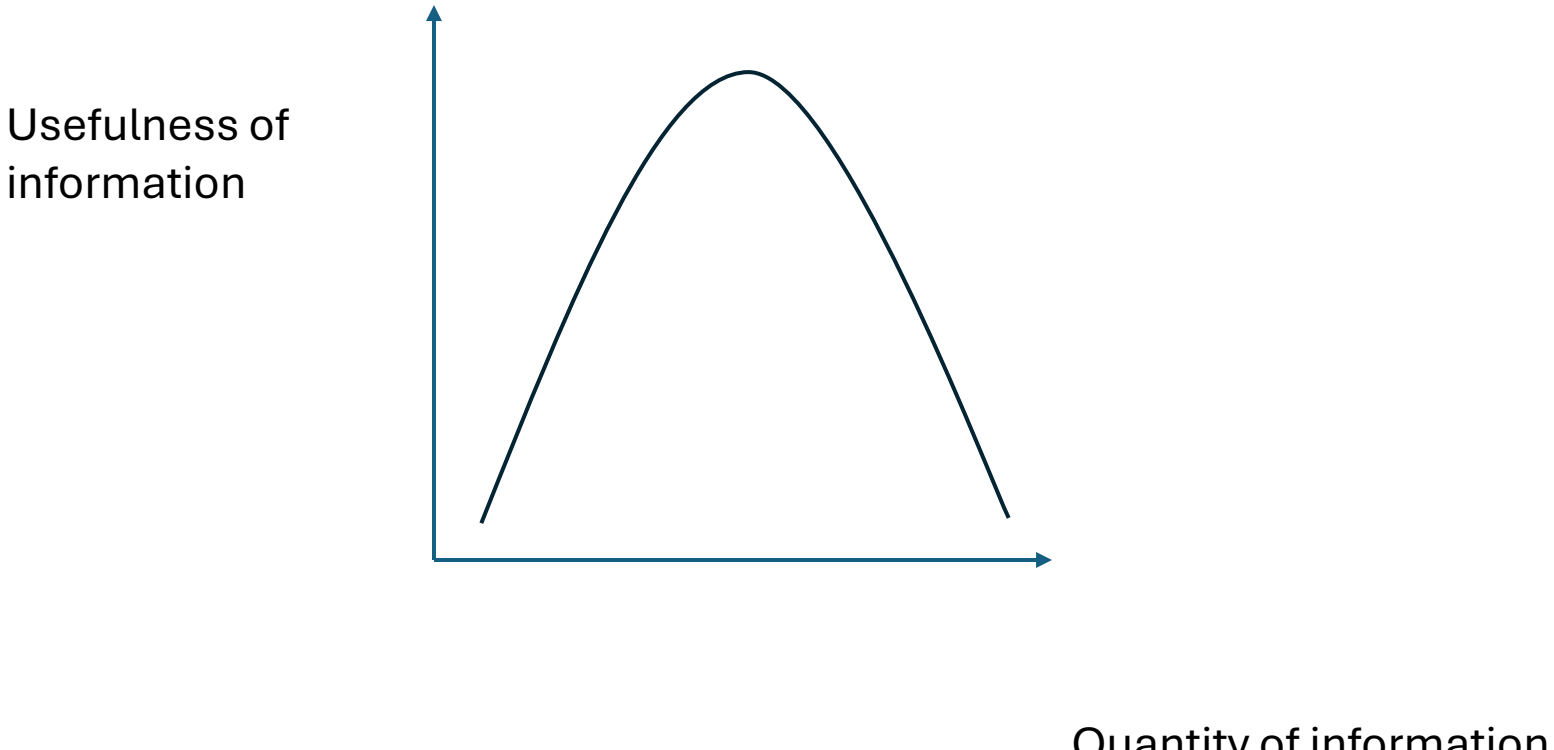
3.1 Ensure staff role and task clarity

3.2 Support and supervise staff, especially those supporting a person for the first time

4. Implement policies and procedures

4.1 Have suitable policies and procedures, which are implemented

Likely relationship between amount of information and usefulness of information to frontline workers



Lessons for practice cont.

5. Leadership focus

5.1 Ensure leadership focus on quality and safeguarding and not just growth

5.2 Ensure the leadership and management of quality and safeguarding

Limitations

- Three cases only
- Need ‘thick description’ (Geertz 1973)

Implications for theory and research

- Active Support and Practice Leadership need to incorporate risk explicitly
- Need a concept of ‘organisational practice leadership’
- Need deeper systemic analysis (e.g., Waterson’s Accimaps)
- Need to integrate lessons about harm *and* lessons about good practice
- Better understand frontline work and frontline workers’ experiences

Conclusion

- Our discomfort
- But the lessons must be learnt … the Devil is in the detail