



Policy and Practice Review

Lee-Anne Mackey

**Independent report
commissioned by Scope**

January 2025

Policy and Practice Review

Lee-Anne Mackey

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Table of Contents

1	Executive Summary.....	6
1.1	Review Context	6
1.2	Methodology	6
1.3	The sequence of events	7
1.4	Findings	7
1.5	Areas for improvement	8
2	Background.....	10
3	Review objectives, scope, and method	11
3.1	Objectives and scope	11
3.2	Methodology	11
4	Context – Services for people with disability in Australia	13
4.1	Human rights obligations	13
4.2	Funding and delivery of disability services	13
4.3	External oversight arrangements.....	15
4.4	NDIS standards	15
4.5	NDIS Practice Standards	15
4.6	NDIS Code of Conduct	16
4.7	Services offered by Scope	17
4.8	Residential services delivered by Scope.....	17
5	The chain of critical events affecting Lee-Anne Mackey from 2019	18
5.1	Safety concerns, complaints and incidents.....	20
5.2	Management responses.....	20
5.3	Staff qualifications and training and development history	22
5.4	Remedial actions by Scope.....	23
5.5	Relations with the Mackey family	24
5.6	Evidence from Lee-Anne	24
5.7	Disability Royal Commission	24
5.8	Re-emergence of the video footage in 2024	25

6	Safeguarding arrangements and developments at Scope	26
6.1	Safeguarding policies and practices	26
6.2	Taskforce activities and reforms underway	26
6.3	Client engagement reforms	28
6.3.1	Experience (CX) Tracker	28
6.3.2	Client Advisory Panel	28
6.4	Family engagement initiatives	28
6.5	Complex Care Project	28
6.6	Technology uplift and streamlining	28
7	Reflections	30
7.1	Attention to basic human rights of people with disabilities	30
7.2	Oversight of Supported Independent Living (SIL) services	31
7.3	Worker availability, skills and capability	32
7.4	The impact of COVID	33
7.5	Taskforce and transformation initiatives and Scope	33
7.6	Oversight relationships	34
7.7	Growth at Scope	34
8	Findings and Recommendations	35
8.1	Oversight, care and responses in relation to Lee-Anne Mackey and her family	35
8.2	Scope’s vision and mission	35
8.3	Relationship with external partners	36
8.4	Approaches to investigations	36
8.5	Managing client complexity	37
8.6	House leadership and oversight	38
8.7	Supporting and hearing clients and families	39
8.8	Workforce development and recruitment	40
8.9	Training, education and support	41
8.10	Relationship management	42
8.11	Record keeping and case management	43
8.12	Reporting concerns	43
8.13	Incident and complaint management	44

8.14	Data mining, intelligence gathering and risk mitigation	45
8.15	Governance and structural issues	46
9	Appendices	47

Policy and Practice Review – Lee-Anne Mackey

1 Executive Summary

1.1 Review Context

In May 2024, Scope commissioned an independent review of service delivery, practices and responses at defined stages of a case involving the services and supports provided to Lee-Anne Mackey (Lee-Anne) while in the care of Scope.

The need for the work arose, in part, as a result of complaints received by Lee-Anne and her family, and a video substantiating abusive treatment of Lee-Anne which aired on a 60 Minutes program in April 2024.

In undertaking the review, Scope sought advice on:

- the unfolding of critical events related to the care of Lee-Anne at Corio Street (from 2019);
- the responses and actions taken by Scope in relation to complaints received and the video footage provided by the Mackeys;
- recommendations for reforms to address the systemic issues including the power dynamic between clients, their families and Scope; and
- the line of sight into SDA homes and how Scope can ensure its staff behave in a manner that is consistent with Scope values.

1.2 Methodology

The review was primarily informed by a comprehensive review of documentation related to the experiences of Lee-Anne and her family, complemented by a series of interviews with a range of stakeholders, including: clients, frontline workers, managers, authors of previous investigative reports, executive team members, and current and former board members.

While efforts were made to obtain information about the chain of events, actions and decisions, many of those interviewed were relatively new to the organisation and generally relied on file notes and other records. Despite invitation, none of the previous Scope executive team members involved at the time of the allegations and subsequent investigations between 2019 and 2021 agreed to participate in the review process. As such, apart from information provided by Mr and Mrs Mackey (Lee-Anne's parents) and Lee-Anne herself, the vast majority of information about events, responses and actions was derived from the recollections of Scope staff, investigation reports and records.

1.3 The sequence of events

Lee-Anne, a long term Scope client, was living in a Supported Independent Living (SIL) house in Corio Street in 2019, when a series of complaints and incident reports were lodged, culminating in the provision of a video to Scope by Lee-Anne's parents, Robert and Lorraine Mackey in late 2020. This video substantiated significant abuses by staff of Lee-Anne over a period of time. This video and some additional footage was subsequently aired on a 60 Minutes program in April 2024.

1.4 Findings

The purpose of the review was to identify issues relevant to the responses, actions, and service delivery in relation to incidents and complaints concerning Lee-Anne and to identify opportunities for improvement in systems, policies, and processes.

It is clear that day-to-day care and treatment of Lee-Anne was compromised, primarily due to: poor house leadership and management; a lack of regular oversight (especially during the COVID period); limited access to meaningful activities and therapeutic support; poor staff cultures and attitudes; and a lack of skills to manage client complexity and changing health needs. This significantly contributed to the escalation in abusive behaviour by staff at Corio Street.

In sum, my review found the abusive behaviours displayed by staff was not due to failures of policies practices or process per se, but wider issues associated with a culture which did not prioritise client rights and dignity. The situation was exacerbated by a range of other factors endemic to the disability sector, including: a dearth of available workers (and, in particular, those with the capacity and skills to manage complex needs); a lack of housing suitable to meet individual needs; limited understanding of human rights; and a lack of effective leadership and transparency at a number of levels. In addition, the low levels of constructive engagement with Lee-Anne and her parents served only to prolong and normalise the culture of abuse at the house.

It should be noted that the circumstances around Lee-Anne occurred at the height of COVID restrictions, which generally limited the opportunity for activities, education, family time, supervision and oversight. The COVID environment and its aftermath also contributed to a significantly depleted workforce and had a negative impact on intra-agency relationships.

Certain staff acted in ways that were clearly at odds with policies and guidelines, and in contravention of basic human rights principles. In addition, there is evidence that actions or decisions by staff impacted negatively on the safety and welfare of clients, including Lee-Anne, and that earlier intervention by senior management was warranted.

Scope has in place solid policies, procedures, and documentation; however, these need to be integrated into a service wide practice framework. A reform program is underway at Scope which is likely to deliver much needed system and structural improvements.

However, there remains limited line of sight to house operations and cultures. Frontline workers interviewed for the purposes of this review demonstrated a mixed understanding of risk management and how policies and procedures were implemented in practice at the operational level. Formal supervisory arrangements and processes at the houses also appear to be somewhat ad hoc under the day to day pressure of getting things done. While

operational staff were confident in reporting serious safety concerns, they were not always clear about which escalation channels were most appropriate and were not always made aware of subsequent actions and decisions taken. They also lacked confidence in using both the paper-based and electronic incident and case management systems (Riskman/Lumary) in place. It would be prudent to test whether similar levels of risk management awareness and capability are replicated across the agency at the front line.

While the model of care represented by SILs has a legitimate place, it should be underpinned by the strongest quality assurance measures and be closely monitored given the inherent risks involved. These types of arrangements should also include a significant therapeutic component.

The review found that there are opportunities to improve the guidance and training available to staff in relation to: human rights; complaints and incidents; monitoring and supervision processes; and escalation processes where risks are present or concerns arise.

Reforms in areas such as independent oversight, workforce professionalisation, intra and inter-agency relationships, client voice and participation and family engagement, record keeping and case management should also be prioritised by Scope.

1.5 Areas for improvement

The review identified a number of opportunities for improvement to systems, policies, processes and procedures, and for enhanced oversight, training, training and development and information exchange.

The review made 49 recommendations, as detailed in Section 8 below. The recommendations span the following range of areas:

- Consistency of Scope's vision and mission
- Relationships with external partners such as the NDIS Quality and Safeguards Commission and other disability service providers
- Approaches to investigation
- Managing client complexity and supporting the psycho-therapeutic needs of clients/families
- House leadership and oversight
- Hearing and supporting the voices of clients and families
- Workforce development and recruitment
- Ongoing and more frequent staff training, education and support
- Management of relationships with families of clients
- Digital solutions and use of AI tools for record keeping and case management
- Options for anonymous reporting of concerns
- Incident and complaint management

- Data mining, intelligence gathering and risk mitigation
- Governance and structural issues.

Overall, the investments likely to make the most significant difference in terms of client safeguarding relate to: supporting the House Manger/Coordinator role and uplifting the level of oversight of house operations; promoting client and staff agency and feedback; improving and integrating record keeping into a fit for purpose case management system (and which delivers timely intelligence and insights); and finalising the development of an integrated Scope-wide practice framework.

2 Background

The need for the review arose, in part, as a result of footage which aired on a 60 Minutes program in April 2024 showing the abuse of a Scope client in 2020.

This case pointed to the need to explore potential system improvements in client safeguarding, including responding to complaints and critical incidents.

The Key Activities and Terms of Reference (ToR) specified for the Review were as follows:

The Key Activities of the review are to:

- investigate the approach Scope took to respond to Ms and Mrs Mackey and the Commission's complaints regarding the SIL services provided to Lee-Anne at Corio Street;
- investigate the approach Scope took to respond to the video footage provided by Mr and Mrs Mackey in October 2020; and
- provide recommendations as to reform which will address the systemic issues including the power dynamic between clients, their families and Scope; the line of sight into SDA homes and how Scope can ensure its staff behave in a manner that is consistent with our values.

The investigation required is to analyse what should have happened according to the relevant legislative requirements, NDIS Quality and Safeguards Commission requirements and Scope policy (together the relevant policy/ies) against what did happen in practice, with a focus on the following:

- In relation to the Key Activities, did Scope's practice align with the relevant policies, ie. was the relevant policy fully and correctly applied in the circumstances.
- If Scope's practice did not align with relevant policies, please:
 - describe the deviation from or noncompliance with the relevant policies in respect of each Key Activity; and
 - advise if there was any obvious reason for the deviation or noncompliance.
- Please highlight any examples of noncompliance with the relevant policies that has the potential to have a major impact on Scope.
- What changes should Scope implement to ensure that the deviation or noncompliance does not happen in the future.

3 Review objectives, scope, and method

3.1 Objectives and scope

In undertaking the review, advice was sought on the unfolding of critical events related to the care and treatment of Lee-Anne.

In addition, the consultant was to review Scope management, oversight, responses and actions in relation to the Mackey case; and identify potential system improvements to better safeguard Scope clients.

3.2 Methodology

The project method involved:

- Desktop review of relevant legislation, standards, and compliance requirements;
- Review of relevant Scope's policy and procedural documentation;
- Review of relevant case notes, care plans, correspondence, and other documents relating to Lee-Anne's treatment and care during the period in question;
- Review of relevant incident, complaints or concern reports;
- Review of complaints handling policies and procedures;
- Review of selected training resources;
- Interviews with key stakeholders;
- Preparation of a draft report; and
- Completion of a final report and accompanying Executive Summary.

In total **30** people were interviewed, and **87** documents (both generic and case related) reviewed. Interview participants included: Lee-Anne and her parents, relatives of former Corio Street clients, Disability Support Workers, House Managers/Coordinators, Regional and Operational Managers, members of Scope's Executive Team and CEO, External Investigators, and Board Members. At interview, participants were asked about their backgrounds and qualifications, their history at Scope, their involvement or understanding of the events and experiences of Lee-Anne and her parents, and perspectives on where safeguarding and other improvements might be made.

(See **Appendix A** for a list of document categories reviewed).

I wish to thank all those who participated in interviews for this review, who willingly gave up their time, were open, candid, and thoughtful, and provided me with invaluable information to help identify ways that Scope clients can be better supported. In particular, I wish to commend the commitment of all staff who so clearly care about the people they work for and with and want only the best outcomes for them. The circumstances surrounding Lee-Anne have been distressing for all concerned, and it is important that work to support and empower Lee-Anne and other residents, family members, and workers continue. I also wish to thank Leanne Dillon and Kathy Bodycoat in particular for their expert support and

guidance, and to CEO Kate MacRae for her courage and determination to be transparent and pursue excellence in service delivery for Scope clients.

While efforts were made to obtain information about the chain of events, many of those interviewed were relatively new to the organisation and primarily relied on file notes and other records. As such, the vast majority of information about events, actions and decisions was derived from staff and client recollections and records and do not necessarily reflect a complete picture of all that occurred in a coherent timeline.

Further, it has proved somewhat difficult to determine whether or not all policies (some of which have changed) were adhered to at the time, given the passage of time, the departure of some key people, people's varying memories, and operational and leadership changes that have occurred since. In this context, Scope's compliance with some of the Key Activities listed at 1 and 2 of the Terms of Reference are unable to be fully assessed, and that, as a result, the report primarily focuses on future proofing Scope's safeguarding architecture.

4 Context – Services for people with disability in Australia

4.1 Human rights obligations

The purpose of the United Nations Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. Australia ratified the Convention in 2008.

Article 19 of the Convention talks about the right of people with disability to live independently and be included in the community, referring to two types of support: personal support and community support. Community support acknowledges the extent to which the participation of people with disability is limited by societal barriers. As such, it articulates the need for mainstream services to be accessible to people with disability in order to facilitate their full and equal participation in the community.

Community supports could include things like structural modifications, accessible bathrooms and entrances and provision of sign language interpreters, braille and easy read versions of information. Personal support refers to individualised services or supports that a person with disability may require to overcome functional limitations with mobility, communication, daily living or self-care.

Historically, personal services and supports in Australia were provided to people with disability by a number of key service providers who received funding from federal and/or state governments. Informal supports or natural supports such as family, friends and carers also played, and continue to play, an important role in the care and support of people with disability.

4.2 Funding and delivery of disability services

In 2013 a new national program, the National Disability Insurance Scheme (NDIS), established under the *National Disability Insurance Scheme Act 2013* (Cth) began to rollout across several Australian launch sites. The NDIS is administered by a statutory authority called the National Disability Insurance Agency (NDIA). This represented a major milestone in Australia's implementation of the Convention on the Rights of Persons with Disabilities and allowed for lifetime care and support for people with disability.

Most specialist Australian disability support services are now provided through the NDIS. The NDIS is a 'market-based' approach underpinned by the principle that people with disability should be able to exercise maximum choice and control of the supports they access.

The NDIS aims to help people with significant and permanent disability and who need assistance with everyday activities. Applicants are assessed according to a set of criteria and participants receive a package of funding to buy the services identified in their individual support plan. Services are primarily delivered by non-government and government organisations.

The Australian, State and Territory governments have different but complementary roles and responsibilities under the Scheme:

- All governments share responsibility for NDIS policy, funding and governance;
- State and Territory governments are responsible for providing specialist disability services, except disability employment services;
- States and Territories have full financial and operational responsibility for Basic Community Care (BCC) services for people with disability aged under 65 years (and Aboriginal and Torres Strait Islander people aged under 50 years);
- The Australian Government is responsible for providing employment services for people with disability and income support.¹

The Disability Support Pension (DSP) is the primary income support payment for working-aged people aged 16 and over with disability who are unable to work more than 15 hours per week due to their impairment. People with disability may receive other income support payments, such as the Age Pension, Carer Payment, Parenting Payment, JobSeeker Payment.

Other specialised and mainstream services to support people with disability are also provided by government and non-government agencies.

Specialist disability accommodation (SDA) refers to a range of housing options for people with significant functional impairment or very high support needs funded under the NDIS. SDA dwellings have accessible features to help residents live more independently and allow other supports to be delivered better or more safely.

SDA funding is paid directly to SDA providers (private, non-government or government) to cover building and maintenance costs. Participants pay a rent contribution and other day to day living costs such as electricity bills.

¹ Productivity Commission, Report on Government Services 2023, Part F, Section 15, Services for People with Disability, 24 January 2024

4.3 External oversight arrangements

The NDIS Quality and Safeguards Commission (the Commission) is the key independent agency that works to improve the quality and safety of NDIS services and supports. The Commission's responsibilities include:

- monitoring providers' compliance with the NDIS Code of Conduct and Practice Standards;
- receiving and responding to complaints about the quality and safety of NDIS services and supports. This includes complaints about abuse and neglect of NDIS participants;
- investigating incidents that affect the rights and safety of people with disability;
- providing best practice information and guidance to NDIS providers;
- coordinating the national NDIS Worker Screening Check with States and Territories; and
- monitoring the use of restrictive practices within the NDIS.

The NDIA can also receive complaints relating to the NDIS. Complaints about state-funded specialist disability services operating outside the NDIS can be made to independent agencies across jurisdictions (for example, ombudsmen and disability services commissioners).

State and Territory Community Visitors also play a role in monitoring the quality of services in residential homes for children and adults. They visit accommodation facilities for people with disability and monitor and report on the adequacy of the services provided and, where possible, communicate with residents or patients to ensure they are being treated with dignity and respect.

4.4 NDIS standards

Prior to the introduction of the NDIS, service providers receiving funding from the Australian Government operated under the Disability Service Standards set out in the *Disability Services Act 1986* (Cth). Agencies receiving funding from state governments were subject to standards set out in state-based legislation.

Following the introduction of the NDIS revised national standards were introduced at the end of 2013. These included six core standards, as well as a number of performance indicators to help guide the work of service providers in meeting these standards. The National Standards for Disability Services were aimed at ensuring a nationally consistent approach to service quality across the disability sector.

4.5 NDIS Practice Standards

The NDIS Practice Standards are designed to assist providers to assess their performance and demonstrate how they provide high quality and safe supports and services to NDIS participants. Together with the NDIS Code of Conduct, the NDIS Practice Standards also assist NDIS participants to be aware of what quality service provision they should expect from NDIS providers. They are monitored by the Commission.

The NDIS Practice Standards are included within the National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018. The National Disability Insurance Scheme (Quality Indicators) Guidelines 2018 lists the outcomes of the NDIS Practice Standards and the associated quality indicators NDIS providers can use to demonstrate conformity with the outcomes. The NDIS Practice Standards consist of a core module and several supplementary modules that apply according to the types of supports and services NDIS providers deliver.

The **Core** module covers:

- rights and responsibility for participants
- governance and operational management
- the provision of supports, and
- the support provision environment.

The **supplementary** modules cover:

- High intensity daily personal activities
- Specialist behaviour support
- Implementing behaviour support plans
- Early childhood supports
- Specialised support co-ordination, and
 - Specialist disability accommodation.

Each module has:

- a series of high-level, participant-focused outcomes, and
- for each outcome, quality indicators that auditors will use to assess a provider's compliance with the Practice Standards.

4.6 NDIS Code of Conduct

The NDIS Code of Conduct requires people who deliver NDIS supports and services to:

- act with respect for individual rights to freedom of expression, self-determination, and decision-making in accordance with relevant laws and conventions
 - respect the privacy of people with disability
 - provide supports and services in a safe and competent manner with care and skill
 - act with integrity, honesty, and transparency
 - promptly take steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability

- take all reasonable steps to prevent and respond to all forms of violence against, exploitation, neglect, and abuse of people with disability
- take all reasonable steps to prevent and respond to sexual misconduct
- not charge or represent higher prices for the supply of goods for NDIS participants without a reasonable justification.

4.7 Services offered by Scope

Scope was founded 75 years ago, by families who wanted better support for their children with cerebral palsy and was formerly known as the Spastic Society. The organisation is now known as the Scope Group and is one of the largest not-for-profit disability service providers in Australia, operating across Victoria and New South Wales through over 425 service locations.

Scope delivers a range of services to children and adults with disability, to people with complex intellectual, physical and multiple disabilities. Its services include therapy, communication support, employment options, accommodation, and social and skill-building programs.

Over recent years Scope significantly expanded its service reach, by incorporating Disability Services Australia (DSA) from NSW and entering an agreement with the then Victorian Department of Health and Human Services to provide SIL services at a number of homes. These latter services operate as Home@Scope, which transitioned to the NDIS in 2022.

A high-level organisational chart for Scope is at **Appendix C**.

Scope’s purpose, vision and values statements articulate that:

At Scope we create meaningful opportunities for people with disability to belong and thrive

Our clients and employees are empowered to live their dreams

We influence and push boundaries delivering positive change for people with disability.²

This replaced the “Scope Approach”, DSA Values and other prior mission statements, bringing Scope, Home@Scope and DSA together under a shared mission.

4.8 Residential services delivered by Scope

Scope’s service offerings include residential accommodation, generally known as Supported Independent Living (SIL) services. Such services are provided to between 3 and 6 people living in homes within the community. As well as having their own rooms and bathrooms, there are common kitchen, dining and lounge areas where people eat meals and socialise, and staff accommodation (for overnight shifts) and office areas. Day to day care supports vary depending on client need, and may include help with bathing, showering, lifting, mobility, eating, feeding and medication administration. Clients also have the opportunity to attend activities throughout the day and are supported to do this.

² Purpose, Vision and Values-Information and FAQs pamphlet, 2024S

As a result of its recent expansion, Scope has more than tripled its asset and resource base, with a current estimated portfolio of 347 homes, 5,214 clients supported by 6,796 staff and an annual income of over \$600 million, including revenue from Federal and State governments.

Scope houses are managed by a House Manager/Coordinator who manage one or two houses within a geographic area. They are employed on a full time basis, and expected to spend time at each house, hold team meetings and to provide supervision and support to staff. House Mangers/Coordinators can also take on direct care shifts.

Disability Support Workers (DSWs) report to the Manager/Coordinator and provide day to day personal care of residents.

5 The chain of critical events affecting Lee-Anne Mackey from 2019

Lee-Anne is a long term Scope client and had been a resident at Corio Street since 2017.

As can be seen in the table below, a series of escalating incidents and complaints were emerging at Corio Street in relation to Lee-Anne’s care and treatment from early 2019. In part these related to changes in Lee-Anne’s health conditions, in particular associated with her bone health. Lee-Anne was 48 years of age in 2019. She lives with severe cerebral palsy, is nonverbal and has other complex medical needs.

Table 1: Key events relating to care and treatment of Lee-Anne Mackey from 2019

YEAR	KEY EVENT/S
2019	<p>Incident reports recorded, related to Lee-Anne’s care and treatment:</p> <ul style="list-style-type: none"> - 25/3/2019 - 19/6/2019 - 17/8/2019 - 11/2/2019 - 17/5/2019 <p>Emails/phone calls received from Lorraine or Robert Mackey (Lee-Anne’s parents) regarding issues with Lee-Anne’s care:</p> <ul style="list-style-type: none"> - 2/5/2019 - 19/8/2019 - 10/9/2019 - 17/9/2019 <p>Complaints recorded:</p> <ul style="list-style-type: none"> - 22/2/2019

YEAR	KEY EVENT/S
	<ul style="list-style-type: none"> - 17/9/2019 <p>External Investigation Report dated 3/12/2019 regarding care of Lee-Anne received – with no findings of evidence of mistreatment or rough handling.</p>
2020	<p>Incident reports:</p> <ul style="list-style-type: none"> - 16/3/2020 - 18/4/2020 - 18/4/2020 - 17/6/2020 - 17/6/2020 - 12/10/2020 <p>On 1 May 2020 Robert and Lorraine Mackey speak with the House Manager/Coordinator, alleging emotional, psychological and other abuse by DSW at Corio Street.</p> <p>Complaint recorded:</p> <ul style="list-style-type: none"> - 12/10/2020 <p>Internal Investigation Report dated 5/6/2020 received following an internal review which found no evidence of neglect or poor treatment of Lee-Anne, but recommended communication improvements. The investigation dismissed most allegations due to lack of weight of evidence, but did conclude that the DSW may have refused to move Lee-Anne at her request.</p> <p>On 6 November 2020 Lorraine and Robert Mackay provide a video to Scope management substantiating abuse of Lee-Anne in her bedroom which had occurred on 5/4/2020, 19/10/2020, and 3/11/2020.</p> <p>Scope reports the incidents to Victoria Police, the NDIS Quality and Safeguarding Commission and launch an independent investigation. Staff were moved to other roles or stood down pending the investigation.</p> <p>External Investigation Report dated 1/12/2020 received by Scope into complaints against four Scope DSWs.</p> <p>The investigation substantiated the majority of the allegations and concluded that the actions of staff were against the employee code of conduct and contracts of employment. Staff members Moutsos and Paniczko are offered a transfer to a Scope Day Service. Wilson’s employment was terminated. Allegations against another DSW were not substantiated.</p>
2021	<p>After being charged by Police on 22/2/2021, letters are sent to Moutsos and Paniczko notifying them that their employment has been terminated.</p>

YEAR	KEY EVENT/S
	30 June 2021, Scope engages KPMG to undertake a Safeguarding Systems Review.
2022 to 2024	<p>KPMG Report - Safeguarding Systems Review delivered to Scope (February 2022)</p> <p>June 2022, Moutsos, Wilson, and Paniczko plead guilty in Broadmeadows Magistrates' Court, and are convicted of assault.</p> <p>After convictions were originally recorded against the DSWs, all three launch appeals. Moutsos and Wilson succeed in having their convictions not recorded. Paniczko is successful in withdrawing her guilty plea and has one charge dropped. Paniczko is fined, asked to apologise and banned by the NDIS for three years. Wilson is ordered to perform 175 hours of community work and banned by NDIS for five years. Moutsos is ordered to perform 80 hours of community work and banned for three years.</p> <p>On 14 April 2024, video footage is aired as part of a 60 Minutes program.</p>

5.1 Safety concerns, complaints and incidents

At interview Lorraine and Robert Mackey reported that they became increasingly concerned about incidents, primarily in the evenings and at night, involving Lee-Anne and other clients at Corio Street, and the attitudes and actions of workers there. They were also unsatisfied with the responses to incidents and complaints and did not feel that the issues raised by either themselves or Lee-Anne were taken seriously or believed. This is what they report motivated them to install a secret video recorder in Lee-Anne's room at the house, sometime early in 2020. They did not provide the video footage of the incidents between April and November 2020 to Scope until 6/11/2020, because they were concerned about the legality of the action they had taken, but felt compelled to do so at that point to ensure the reality of Lee-Anne's treatment and experiences was exposed, and to prompt more fulsome remedial action by Scope. To this day, they do not consider that they or their daughter have received an appropriate or genuine apology.

5.2 Management responses

In all, seven complaints were received between September 2019 and May 2021 in relation to incidents at Corio Street. Four related to the treatment of Lee-Anne. Two were investigated by an external investigator and five were managed internally.

In October 2019, Scope mounted an external investigation into complaints against a range of staff in relation to rough handling, neglect and emotional mistreatment of Lee-Anne, with no substantiated findings that rough handling had occurred or resulted in Lee-Anne's fractures. Following this investigation, Scope communicated (via a letter from the then General Manager North Division on 13 December 2019) the outcomes to Lorraine and Robert Mackey, acknowledging that Lee-Anne relayed to the investigator that "some carers hurt her while providing care due to being rushed...some did not talk to her to explain what they are doing while providing personal care...some carers spend too much time on their phones, some can be grumpy and at times say unkind things...some do not come straight

away or do not come at all when she calls them at night.” The investigator also determined that there was some evidence that clients were not given adequate choice around activities at the house.

An internal investigation into allegations against a DSW at Corio Street, primarily in relation to rough handling of Lee-Anne, was undertaken in mid-2020, with no allegations substantiated. Along with Lee-Anne, and Lorraine and Robert Mackey, this investigation included interviews with a number of DSWs and other staff, implicated in later events and incidents. The result of this investigation was relayed to Lee-Anne’s parents and to Lee-Anne (by letter from the then Customer Service Delivery Manager on 11 June 2020) indicating that the DSW would not be returning to work at Corio Street.

A further internal investigation was undertaken into allegations made in October 2020 that staff members (Wilson, Paniczko, Moutsos) had bullied Lee-Anne and spoken inappropriately to her. This investigation found that Wilson had spoken inappropriately to Lee-Anne, but there was no evidence against the other staff named. The results of this investigation were relayed to Lorraine and Robert Mackey by the Chief Operating Officer on 5 November 2020. It was at this meeting that Lee-Anne’s parents revealed that they had taken video footage over a 12 month period that substantiated additional abuse.

On 6 November 2020 video footage of three incidents which occurred in Lee-Anne’s bedroom at Corio Street between April and November 2020 was provided to Scope management by Lorraine and Robert Mackey. These incidents were as follows:

- On 5 April 2020, Paniczko blew into Lee-Anne’s mouth with words to the effect that she is giving Lee-Anne COVID
- On 19 October 2020, Wilson inserts two fingers down Lee-Anne’s throat, and then places a large tube down her throat with assistance from Paniczko. The voice of another worker at the house is also heard.
- On 3 November 2020, Wilson and Moutsos are seen dancing and singing in Lee-Anne’s room, Moutsos removes her top and is only wearing a bra and shorts, Wilson and Moutsos climb onto and swing from the ceiling hoist, Moutsos is swinging a large pole around the room, then holds the pole and inserts it into Lee-Anne’s mouth.

Following receipt of the video by Scope and complaints received, four staff members were stood down, and an external investigation commissioned into allegations against the workers who appear or are heard in the video. The investigation involved taking evidence from Lee-Anne in the presence of Lorraine Mackey. In parallel, Scope reported the matter to the Disability Worker Exclusion Unit, the Victoria Police, and the NDIS Quality and Safeguards Commission. Lorraine and Robert Mackey were not interviewed as part of the investigation.

An investigation report was delivered to Scope on 1 December 2020.

All but one of the allegations against Wilson were substantiated. All but one allegation against Paniczko were substantiated. All allegations against Moutsos were substantiated. No findings were made against the other worker whose voice can be heard on the video of the incident on 19 October 2020. The Investigator recalled that the staff members involved

generally downplayed their actions characterising them as ‘a bit of a lark’ and ‘a bit of fun’ and were convinced that Lee-Anne was ok to go along with it and having fun. The investigation further found that staff had acted in ways that were in breach of their employment contracts, and specifically the NDIS code of conduct to which the contracts refer. The Report did not recommend a particular course of disciplinary action in relation to the employees, but did suggest that Scope may consider reiterating to all staff policies regarding respecting residents and staff.

The result of this investigation was relayed to Lorraine and Robert Mackey on 18 December 2020, following a meeting on 14 December (via email/letter from Scope’s Chief Operating Officer).

It appears that only a few people within Scope Management viewed the video and although the then Board chair was notified of its existence, she did not view the video herself.

Wilson’s employment was terminated. However, despite the findings made against Paniczko and Moutsos, both were offered alternative employment with Scope at day services via letter/emails issued on 14/12/2020 by Scope’s Chief Operating Officer.

Following charges being laid against the three staff by Victoria Police, this decision was reversed and in February 2021, Moutsos and Paniczko received notification of their dismissal. Lee-Anne returned home to live with her parents for a period at this time.

A separate complaint was received in November 2020 regarding theft of monies from the client housekeeping fund at Corio Street. An internal investigation was mounted and the employment of the then House Manager/Coordinator was terminated. This additional complaint matter points to the fact there were significant cultural and leadership issues at the house beyond the actions of particular staff in isolated incidents. This was borne out by conversations with Lee-Anne, her parents, and another DSW who worked at the house over the period. This DSW reported witnessing poor physical and emotional treatment of Lee-Anne and other clients, sub-standard professional practices and experienced bullying by the staff member in question. The DSW interviewed also said they had reported the bullying and worrying staff behaviour towards clients to the then House Manager/ Coordinator but indicated that no action was taken. Lorraine and Robert Mackey also stated that leadership at the house was unstable and concerning.

5.3 Staff qualifications and training and development history

Moutsos had worked at Corio Street since 2017 on a casual basis and was completing a nursing degree at the time. Paniczko had worked at Corio Street since 2003 on a permanent part time basis and had cared for and known Lee-Anne for a number of years. She had certificate IV qualifications. Wilson had been employed on a permanent part time basis at Corio Street since 2017 and had certificate IV qualifications. All appear to have attended and completed relevant training at Scope, including in relation to safeguarding and preventing abuse.

5.4 Remedial actions by Scope

In response to the series of incidents and complaints in 2019 and 2020, a range of actions were subsequently taken by Scope. For example, in relation to the earlier complaints:

- Additional communication support to assist overnight staff was put in place
- The DSW investigated for rough handling was moved to another house.

In relation to the theft of client monies:

- The House Manager/Coordinator investigated was dismissed
- Client housekeeping funds were reimbursed
- Additional financial safeguarding strategies were put in place.

Following the investigation into the video footage:

- Wilson was dismissed, and Paniczko and Moutsos were offered alternate employment in a day service. Following charges laid, the remaining two staff members were dismissed
- A safeguarding review of Corio Street was conducted, and an action improvement plan developed
- Monitoring of Lee-Anne's health issues and complexities was upgraded and Lee-Anne's health management plans and charts refreshed
- Daily care records for pad change, food charting and stoma output were monitored to observe changing patterns and identify emerging health concerns
- New charts for food and fluid intake and stoma output were established based on medical and nutrition appointments attended by Lee-Anne and her parents
- A full review of Lee-Anne's file was undertaken at the time of her return to Scope
- Staff training modules involving family on nutrition and feeding for Lee-Anne were developed and implemented
- A weighing machine was purchased to better monitor weight changes.

Lee-Anne was also offered new accommodation at a different location.

While some measures to address issues at the house were introduced in response to earlier complaints and incidents, as can be seen, actions were elevated significantly after the receipt of the video footage in November 2020.

5.5 Relations with the Mackey family

Relations with Lorraine and Robert Mackey were increasingly strained over this period, given the number of concerns and complaints raised, culminating in the provision of the video footage. It is clear that interactions with the Mackeys, the House Manager, and the staff in question were hostile at times, and that this spilled over into their relations with Lee-Anne. Some staff felt the Mackeys were overly interventionist and present at the house and resented their professionalism being questioned.

5.6 Evidence from Lee-Anne

In her interview for the External investigation undertaken in 2020 following receipt of the video, it was reported that Lee-Anne was clear about the events that occurred, and indicated she was scared that she would be hurt. Further, she didn't find any of the actions of the staff funny or fun, that she was not asked whether she was ok for them to do those things, and that she was unable to make them stop.

Participants in this review noted that Lee-Anne frequently expressed to workers a view that she did not feel safe and had issues with certain workers. Frontline staff commented that they felt Lee-Anne's voice and experiences were 'lost' along the way. Lee-Anne herself reiterated this at interview. Lee-Anne's experience had caused her considerable trauma, mental and physical pain, and consequently, she has limited faith in the staff to manage her well or professionally. She did, however, indicate that she knew who to talk to if she needed to raise a concern or make a complaint. She has a good relationship, in particular, with the current House Manager/Coordinator, as do her parents.

It is also clear that rather than relying on Lee-Anne's Eyegaze communication device, short cuts were often taken when engaging with her, by using the yes/no eye clues or making assumptions about her wishes based on workers' past knowledge and relationship with her. In fact, at times the Eyegaze device was turned off by staff or not offered to Lee-Anne to support her communication. It should be noted that, at the time this reviewer interviewed Lee-Anne, the mechanism to attach her communication device to her wheelchair at the correct height had broken and so it wasn't being used to communicate with Lee-Anne as a matter of course. This demonstrates how easy it is to get out of the habit of doing things or create bad habits in ways that maximise client control and voice.

5.7 Disability Royal Commission

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ran from 2019 to 2023. During this time, it heard from thousands of individuals and families about discrimination and abuse of people with disabilities. Lorraine and Robert Mackey presented Lee-Anne's and their story to the Commission in a private session because the Court case was live at the time and publicity was not desirable.

In response to a formal request for information from the Commission, Scope established a special internal group to review past instances of abuse within its services and provided the Commission with information about critical cases and remedial action taken by Scope. The Mackey case was not one of these cases because it occurred outside the timeframe identified by the Commission.

5.8 Re-emergence of the video footage in 2024

After the Court case of the three individuals charged had concluded, Victoria Police's media unit made contact with the media more broadly. In turn the media contacted the Mackeys so that the media could learn more about Lee-Anne and the Mackey's side of the story.

The new CEO, who was on leave when the video footage re-emerged, had stepped into the role in early 2022, but had not been made fully aware of the chain of events, the court cases, or the existence of the video until the 60 Minutes program aired. Likewise, the extent and nature of the abuse recorded was a surprise to many board members and new executives at Scope who either had not been made aware of it, or had events described in a way that downplayed their seriousness.

Once Scope became aware that the program was going ahead (via a social media and general contact line message from the show's producer) an internal crisis management team was established and a media firm engaged to assist Scope with the process.

Scope's Chief Operating Officer, who was acting CEO at the time, appeared on the program. Following the program's airing, Scope made a public apology to Lee-Anne and her family, and instituted a significant and targeted program of work to lift the safeguarding capability of the agency. Part of the focus of this review is to build on that program of work in the context of Lee-Anne's case.

6 Safeguarding arrangements and developments at Scope

6.1 Safeguarding policies and practices

Scope has in place a range of policies and guidance, scaffolded by a regular training and development program that support client safety and wellbeing across its services. These include:

- Quality and Safeguarding Framework
- Code of Conduct policy
- Whistleblower policy
- Privacy policy
- Complaints policy
- Client Participation Framework
- Incident management and recording system (Riskman)
- Case management and rostering systems (Lumary and VisiCase).

However, at present different policies remain in place for different services and operating arrangements. A new integrated Scope quality and safeguarding framework is currently in development which will be applicable to all Scope service offerings. It is intended to build on contemporary clinical and practice governance thinking to ensure Scope offers safe high quality integrated and effective support to clients in line with the NDIS Quality and Safeguarding Framework and NDIS legislation. The framework will integrate activities that impact on clients across the agency under the four pillars of:

1. Client-led support
2. Practice effectiveness
3. Effective workforce
4. Safeguarding.

To be effective, this framework will need to articulate how all Scope policies, procedures, systems and practice work in concert to achieve a safeguarding culture.

6.2 Taskforce activities and reforms underway

In April 2024 Scope stood up a time limited Taskforce focused on identifying and addressing the key contributors to Lee-Anne's experiences. It is due to run to early 2025, with progress updates occurring to the CEO on a weekly basis, within existing Executive meetings on a monthly basis, and monthly CEO reports to Board.

The activities of the taskforce are guided by aspirational statements in five key areas, representing critical reforms in response to Lee-Anne's case.

Communications and Engagement

We will develop ways to actively communicate and engage with our key stakeholders to deepen relationships, create psychological safety, and support Scope to focus on our clients, client families and staff.

Clients and families

We will build mechanisms to ensure our clients, and their families are supported and have ways to contribute ideas and raise concerns.

Governance Risk and Legal

We will build the data, systems and processes required to identify, mitigate and manage future crises.

Quality and safeguarding

We will have the quality and safeguarding understanding of past failures to inform future best practice.

Workforce and wellbeing

We will continue our culture program to ensure our workforce will know that they are safe and can speak up, and our clients will be able to trust that our staff are developing the capabilities required to deliver on Scope's quality and safeguarding commitments.

Table 2: Current Taskforce initiatives

Taskforce Program – Current initiatives



Stream	Communications and Engagement	Clients and their Families	Governance, Risk and Legal	Quality and Safeguarding	Workforce and Wellbeing
Owner	CS&RO	COO'S	GC & CIO	CQ&SO	CPO
Purpose	<p>Family and Supporters Advisory Panel</p> <p>We are Unity – Your Difference Matters survey (Frontline Staff Engagement)</p> <p>Transformation communications</p> <p>Brand health check done – <i>no actions required</i></p>	<p>Client Wellbeing Support Pilot</p> <p>Trauma Informed Practice and Active Support Management</p> <p>CX Tracker (paused until October pilot finished)</p> <p>Creating a culture of communications</p>	<p>External Review</p> <p>Internal Review</p> <p>Client safeguarding indicators and risk appetite</p> <p>Information Management & Focus Houses (paused until after reviews)</p>	<p>Audit support</p> <p>Many pipeline initiatives, dependent on Incident Ecosystem being presented to Board late this month, as well as output from reviews and other initiatives.</p>	<p>Your difference Matter's Survey (co sponsor with CS&RO)</p>
					<p><i>Underway</i></p> <p><i>Complete</i></p> <p><i>Commencing</i></p>

6.3 Client engagement reforms

6.3.1 Experience (CX) Tracker

Over the last six months Scope has piloted a new program to understand and measure client experiences – Client Experience (CX) Tracker. The main purpose of the CX Tracker is to understand the client experience directly from clients and their families and is a key feature of Scope’s Client Participation Framework. The program uses a touch screen device to capture data by surveying clients about how they feel about their service experience. They can also use a QR code to download the program on their own device. For some clients the program has relied on the staff at houses and other services to support and encourage take-up. It is understood that while Lee-Anne was made aware of the CX-tracker program as part of the pilot she has chosen not to engage with it thus far. As another avenue for unfiltered client voice and perspectives it would be good to explore the barriers for different clients in engaging with the program.

6.3.2 Client Advisory Panel

Scope established a Client Advisory Panel (CAP) in 2023 to represent the voice of Scope clients. CAP members help shape decision-making at Scope and influence change. Through this forum they have the opportunity to have a say about what matters to them and others who use Scope services. This is an important initiative in elevating client voice. However, it is only one way to do this and not all clients will want to be or can be involved, depending on their situation and what is going on for them at the time.

6.4 Family engagement initiatives

Scope is also establishing a regionally based Family and Supporters Advisory Panel to help Scope to understand issues, trends, and feedback identified by families; and advise Scope on specific issues, improvement plans, and decisions. The Family and Supporters Advisory Panel will work alongside the CAP to provide advice on a range of topics. Again, while an important initiative, not all families will choose to be involved, and additional ways to gain feedback from families should be explored.

6.5 Complex Care Project

Scope has embarked on a project that recognises the complex care needs of many of its clients, especially those living in residential facilities. The project involves recruiting a team of nurse visitors to attend Scope houses and review the health and welfare needs of clients. The aim is to ensure that knowledge about client health is up to date and that staff are equipped to manage changing health needs. This is particularly important given the ageing profile of many of the residents in Scope houses.

6.6 Technology uplift and streamlining

Currently services are delivered differently across Scope, depending on their history and genesis. Victoria currently uses two different versions of Lumary to manage clients and support rostering activity, while New South Wales uses VisiCase. To address this, Scope is focusing on simplifying processes and technology by working with Lumary to build one system to help staff deliver all core services.

The new Lumary will be rolled out in a phased approach from the end of 2024 and into 2025. It is envisaged that the new system will be piloted in New South Wales, then Victoria before rolling out in full. The rollout will be underpinned by a robust program of staff training and support.

7 Reflections

7.1 Attention to basic human rights of people with disabilities

Article 16 of the UN Convention on the Rights of Persons with Disabilities sets out the provisions of the right to freedom from exploitation, violence and abuse and stipulates that:

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.
5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 17 relates to the right of the protection of the integrity of the person and states that every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

While the Convention is agreed to by National governments it is incumbent on civil society to ensure these conventions are implemented in action, especially when they are the recipients of Government funds. As such, these rights and others should be clearly embedded into the DNA of organisations and people who work with and for people with disability.

There is clear evidence the staff involved did not perform according to policies and procedures during 2019 and 2020 and did not respect the human rights of those they were caring for. They also acted in contravention of a code of conduct that they had ostensibly agreed to uphold and were in breach of their employment contracts. This is despite the fact

that some workers had been with Scope for a number of years, had relevant qualifications and had participated in relevant training and development.

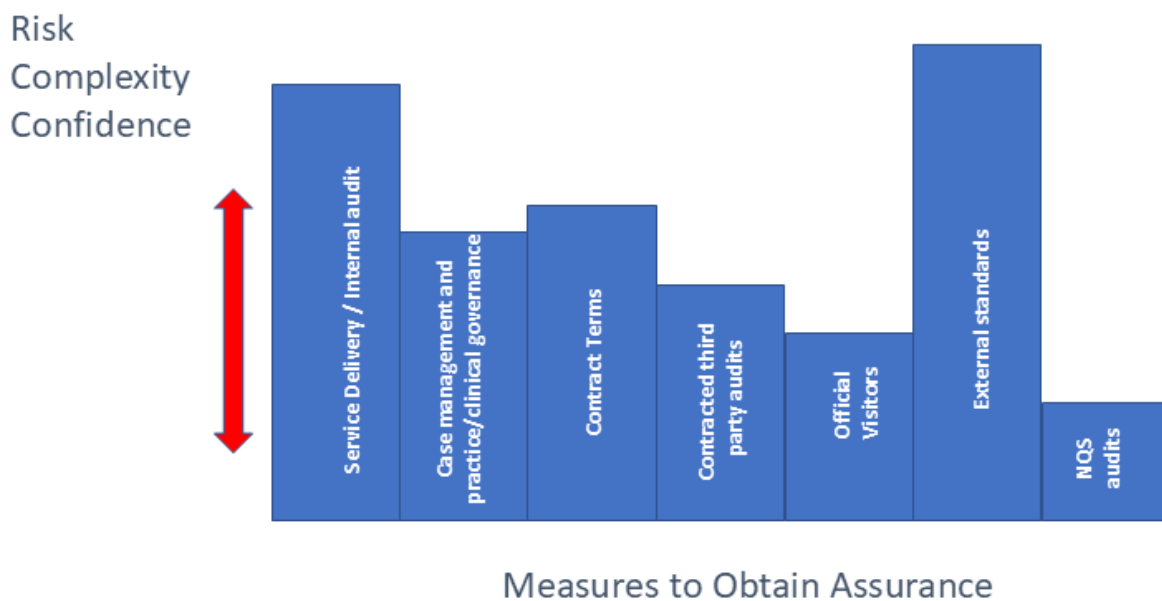
It needs to be noted that additional efforts were made to bolster supervision and support at the time which translated to increased visits to the house, regular meetings, improvement planning and the coordination, procurement and provision of various services and supports. Middle and senior management operational staff in particular did what they could to escalate concerns and ramp up remedial actions but the tight rein on information and transparency about the Mackey case at the top of the organisation limited their capacity to influence decision makers at the time. They also found themselves relatively unsupported in the subsequent court cases involving the staff involved.

7.2 Oversight of Supported Independent Living (SIL) services

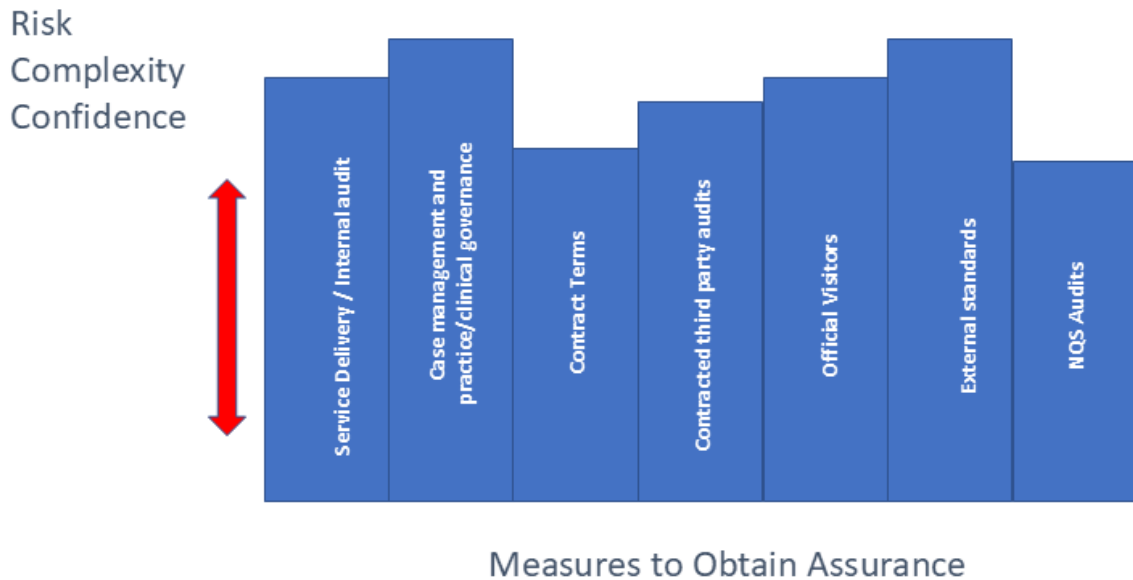
Accommodation models for people with disability, especially those with complex needs, hold inherent risks, and in particular in relation to the power and control over residents. In this context, additional measures need to be put in place to ensure the best quality care and case management is in place. This means, every effort needs to be made to ensure that: the highest quality of suitable care staff are available; the environment is as home-like and stable as possible; there are strict monitoring and oversight arrangements in place; that clients are safe, informed, heard and have optimal control over their arrangements; and, that the home is supported by experienced and skilled managers dedicated to empowering clients and keeping them connected to family, friends and the local community.

Figure 1: Strengths of quality controls based on service risk profile

Low Risk Service



High Risk Service



As SILs represent high-risk service models, they require the dialling up of non-static controls such as case management and practice governance, oversight, independent audits and visits.³

7.3 Worker availability, skills and capability

For many years commentators have warned about the declining availability of disability workers. This has occurred at the same time as family and client needs have grown in complexity.

Unemployment is near record lows across many industries, and people previously working in or who may have been considering a career in disability, are likely to opt to pursue less stressful work and/or better pay and conditions. This continues to place considerable strain on the sector.

³ Sparrow, M.K. (2000). *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*.

7.4 The impact of COVID

The main abuses occurred in the acute periods of COVID infections and lockdowns, the legacy of which lingers to this day.

The consequences were unacceptable but explicable in the particular context that characterised the impact of COVID on residential service models. Apart from lockdowns, there were service closures, vaccination requirements, infection spread and a consequent lack of skilled and available staff. In addition, COVID lockdowns and restrictions had a direct impact on: inter and intra agency relationships (with most meetings taking place by video link); the capacity to visit residents in houses; the mental health of staff and residents; and the ability for residents to take part in activities outside the house, including with family members.

7.5 Taskforce and transformation initiatives and Scope

The taskforce and other transformation initiatives Scope has in train appear to be heading in the right direction, in particular:

- improving capacity for information mining and triangulation to highlight organisational pain points
- seeking to reduce and streamline the complex, multilayered and somewhat siloed operational structure
- recruitment based on values, more rigorous reference checking, scenario testing and possible psychometric testing, rather than basic screening only
- introducing a regional accommodation model, with an increased focus on operational management presence in homes
- strengthening independent oversight of homes and acknowledging client complexity
- moving towards digital client/case management systems
- introducing innovative client feedback systems
- establishing client and family reference/consultation groups.

Scope is a leader in the field of communications access for people with disability, operating a Communications Access accreditation scheme for businesses. Scope's Communications Access team, which includes people with lived experience of communication difficulties, deliver customised training, communication tools and resources to help businesses become more communication accessible. This is an important arm of the organisation's business that could be also directed inwardly, and especially in residential settings.

7.6 Oversight relationships

As has been discussed, a range of agencies and mechanisms play a role in regulation, quality assurance and oversight of disability services. These include:

- NDIS through standard setting, accreditation, audits, and maintenance of carer and residential care registers
- Commission through audit, complaints handling and investigations
- Community Visitors through monitoring visits to services
- Scope through policies, procedures, internal standards, audits, spot visits, performance reviews, incident reports and complaints management.

The NDIS and its parts can still be described as immature, and this immaturity is also reflected in the workforce and the disability service providing sector. Many services remain institutional in character, and are only just beginning to embrace and model a genuine commitment to human rights in practice and delivery terms. In this context, it is imperative that agencies are cognisant of their distinct but interrelated and sometimes overlapping roles and that effective protocols and systems are in place to foster cooperative working relationships, in ways that maximise and focus resources in areas and situations where they can add most value and have the greatest impact on service quality.

7.7 Growth at Scope

The rapid growth of the Scope portfolio brings many opportunities and challenges, and with that comes risks. These risks primarily relate to customer insight and responsiveness, workforce capacity and agility and consistency in practice.

A key challenge for Scope's residential services is to effectively integrate three different operating systems, service and industrial cultures. Without effective integration it will not be possible to embed common cultures, practices, and communication channels in ways that deliver optimal care and safety for clients.

At the same time Scope is a significant and potentially powerful advocate for policy change, sector reform, cooperation, transparency and mutual learning. It also has the capacity to contribute to evaluation and research to advance the safety and wellbeing of people with disability.

8 Findings and Recommendations

8.1 Oversight, care and responses in relation to Lee-Anne Mackey and her family

SIL services have a legitimate place in the current care environment. However, they must be underpinned by strong quality assurance measures and be closely monitored given the inherent risks and power imbalances involved.

Supervision of staff and monitoring of emerging cultural issues at Corio Street at the time that the key events occurred was plainly inadequate. In addition, there is clear evidence that staff failed to perform to expected standards, they did not follow policies and procedures, they did not respect Lee-Anne's basic human rights and were dismissive of her and her parents' concerns. While the staff involved had signed documents indicating an understanding of the code of conduct and employee contractual obligations this had clearly not been embedded as part of staff cultures, attitudes and behaviours. This is despite records showing that the staff in question had attended regular and up-to-date training, including in relation to client abuse and harm, managing health conditions and handling techniques.

8.2 Scope's vision and mission

To date, a clear service wide Scope vision, strategy and framework is not well understood, defined or documented, limiting commitment and understanding and implementation across the organisation, from top down to bottom up, from workers at the front line, to families and clients. This is particularly the case in relation to both a comprehensive quality and safeguarding framework and a practice governance framework for staff. It is noted that these are under development and will be important tools in embedding the cultural shifts needed.

This sentiment was articulated by a number of executive members and board members. In addition, a review of promotional material pointed to a lack of messaging consistency and in particular very few references to client safety and human rights. A total brand refresh is probably required.

RECOMMENDATIONS:

1. Continue to work on organisational reset, cultural uplift, and strengthening reporting capabilities through the Taskforce and other transformation initiatives, with regular progress reporting to the CEO and Board.
2. Develop a comprehensive integrated Scope practice governance framework, including elements related to supervision, KPIs, training and trauma informed practice.
3. Review promotional material to ensure consistency of messaging once organisation wide practice and quality and safeguarding frameworks are established.

8.3 Relationship with external partners

Understanding of expectations, standards, and reporting obligations could be enhanced by establishing a closer working relationship with external partners, such as other disability service providers and the Commission. Scope is also in a unique position to be a sector leader in the safeguarding space.

RECOMMENDATIONS:

4. Establish regular meetings between the Scope CEO and the NDIS Quality and Safeguards Commissioner to exchange information on safeguarding priorities and initiatives.
5. Explore joint information sessions with the Commission and the Scope Executive on reporting and reportable conduct obligations.
6. Explore sponsoring, with the Commission and other NDIS partners, a regular joint NGO practice insights conference or forum, primarily driven by DSWs and practitioners.
7. Consider sponsoring, with NGO and Government partners, a national forum on safeguarding, including lessons from the Royal Commission into Violence, Abuse and Exploitation of People with Disability.

8.4 Approaches to investigations

In reviewing the circumstances around the incidents and complaints in relation to Lee-Anne's treatment, the investigations instigated by Scope primarily related to employment and disciplinary matters. While a legitimate focus of inquiry, where serious matters are in play, a parallel cultural review should occur. It also emerged that the primary concerns of executive management at the time was union pushback, threats related to reputation, legal and monetary risks, and reprisals from the Fair Work Ombudsman, rather than client experiences and outcomes.

In addition, until recently, safeguarding responses at Scope have been skewed towards the reactive end. What is clearly now in train is the development of a proactive approach supported by defined inputs and outcomes.

Root cause analysis (RCA) is a structured method for identifying the underlying causes of problems and implementing solutions. It is used in many industries, including healthcare, manufacturing, child protection and IT operations. Examples of RCA tools include the fishbone and five whys method.⁴

- RCA is based on the idea that it is more effective to address the root causes of a problem than to just treat the symptoms. The goal of RCA is to determine what happened, why it happened, and how to prevent similar events in the future. Conducting an RCA can help to identify effective and sustainable solutions.

⁴ Bukhman, I. (2021). Root-Cause Analysis. In: Technology for Innovation. Management for Professionals. Springer, Singapore. https://doi.org/10.1007/978-981-16-1041-7_15

Such an approach should be routinely applied as an analytical tool to facilitate deep dives into complex or serious matters.

RECOMMENDATIONS:

8. Routinely employ an RCA approach to serious or cumulative incidents, and socialise results to the relevant board committees. To facilitate this relevant Scope staff should be trained in RCA methods.
9. Develop a criteria to determine whether an incident or series of incidents should be internally or externally assessed.

8.5 Managing client complexity

There is increasing recognition within Scope that some clients have or acquire increasing mental and physical complexity over time. In addition, many clients are ageing and this is contributing to the complexity of their conditions and health issues. The Complex Care nurse project was instituted in recognition of this. It comprises visits and assessment by nurses for clients in SIL. This project not only assesses changes in health conditions, but also adds extra eyes and ears to SIL environments and has the potential to identify skills and capability gaps. While appreciated by staff, clients and families, there was some evidence that the exercise was primarily record based.

People whose needs and circumstances are such that they require a supported residential placement, will necessarily have therapeutic needs. It is clear in this case that Lee-Anne had experienced significant trauma and had limited external support, apart from her parents. Further, she had minimal control over her residential arrangements, and her primary relationships at the house were with rostered staff.

Therapeutic support should be considered a component of any residential arrangement and Scope should ensure any behaviour management plans are regularly reviewed and updated and that all staff with day-to-day care responsibilities are aware of duties and responsibilities as part of the therapeutic team.

House Managers/Coordinators and families are keen for the next round of nurse visits as part of the ongoing work of the Complex Care Project team. A comprehensive person centred assessment would have been helpful for Lee-Anne and her parents (and will continue to be), as it is clear that her medical conditions have changed over time, and, along with what happened to her, this has affected her ongoing state of mind and comfort levels. Further, in general staff reported feeling poorly equipped to manage client complexity and changes in health needs for some clients, and this is an area that requires specific attention in terms of ongoing support, training and education.

RECOMMENDATIONS:

10. Develop tools to support comprehensive assessments of clients' experiences of trauma and related psycho-therapeutic or counselling needs. Psycho-therapeutic support options should include both individual and family therapy.
11. Continue to explore options for strengthening allied health support for clients with specialised needs, such as occupational therapists and physiotherapists periodically rotating through houses.
12. Continue to implement and evaluate the Complex Care Nurse Project across Scope residential services. Evaluation findings could be used to advocate for government funding to support this as a standard service offering in organisations that care for clients with complex care needs in residential settings.

8.6 House leadership and oversight

House Managers/Coordinators are pivotal positions that require significant attention and prioritisation by Scope, including continued investment in supervision and peer support.

The lack of effective or consistent House leadership was a major issue between 2019 and 2021, when the core series of incidents occurred, and no doubt, along with COVID, contributed to the escalation of incidents and breakdown of trust. Staff raised issues with the House Manager/Coordinator at the time about the behaviour of the staff in question, but no action was taken.

At the time, House Manager/Coordinators frequently took on direct care shifts, substantively diluting their focus on leadership. In addition, the lack of external scrutiny during COVID, meant staff behaviour crossed boundaries, and some policies were clearly not followed - for example, the use of PPE, gaining the consent of clients for certain activities, use of communication devices, and generally treating clients with respect.

The role of House Manager/Coordinator is critical in the development and maintenance of house cultures practices and behaviours. Despite recent initiatives, the line of sight into individual homes and cultures continues to be compromised. Close relationships form with staff and clients and there are benefits to this. However, over time professional boundaries can become blurred and client needs and wishes diminished.

RECOMMENDATIONS:

13. Develop options for strengthening internal and external oversight of individual residential units. This could include supporting additional visits by community visitors, other independent advocates or mentors, nurse visitors, spot visits by executive management and Board member visits.
14. Conduct periodic cultural audits of houses to gauge staff and client attitudes and perspectives (e.g. one house every three years).
15. Consider basing Regional Operational managers within houses (at least part time) and institute a KPI that involves regular rounds of house visits within their area.
16. Consider periodic rotation of House Managers/Coordinators among houses (for example every three years).

8.7 Supporting and hearing clients and families

Scope has a clear emphasis on empowering clients. This includes establishing the Client Advisory Panel and Family and Supporters Advisory Panel. However, as many participants to this review have said, there needs to be multiple ways to hear client voice. In this context, there is a clear need to intensify efforts to amplify client and family voices in feedback and expressing themselves, including when incidents occur.

This, however, requires sound skills and capabilities in engaging with parents and families, and mediating conflicts and concerns. The review also found that there was ad hoc and inconsistent use of client communication devices.

A number of participants considered that Scope's Speak Up and Be Safe program (or a refreshed version of it) should be revisited. This program comprised a communication toolkit and resources for people with communication difficulties, to assist individuals to identify and report abuse.

RECOMMENDATIONS:

17. Invest in Disability Support Worker and House Manager/Coordinator training in family engagement.
18. Consider updating Speak Up and Be Safe training resources and program.
19. Conduct an audit of availability and use of communication devices in houses.
20. Utilise the expertise in the Communications Access Accreditation team to evaluate and support the staff and management of residential houses, both in Scope and in other disability services.
21. In evaluating the CX tracker pilot, conduct individual or group discussions about barriers to its take-up or use. The Client Advisory Panel could also be engaged in this exercise.
22. Consider developing a standard approach to supporting clients moving into residential accommodation at Scope, involving clients, families and advocates and staff in transition planning and information exchange. This should include establishing communication, relationship and behavioural protocols.

8.8 Workforce development and recruitment

The majority of the disability workforce, especially at the frontline, has no basic qualification requirements. The disability services workforce in Australia faces a number of challenges, including low pay, shortages, high turnover, and burnout. To meet the needs of the community, the disability sector needs to grow its workforce to improve the quality of services. A key workforce development need relates to attracting workers with the right skills, values, and experience to meet the needs of participants. This includes: recruiting workers from culturally and linguistically diverse, and Aboriginal and Torres Strait Islander backgrounds; and building positive cultures with capable leadership; opportunities for learning; and clear career pathways.

RECOMMENDATIONS:

23. Continue to support work on a national skills passport for disability workers through Ability First Australia.
24. Advocate for better pay and recognition for disability workers.
25. Explore increasing certification requirements for certain roles, including for those working with more complex clients.
26. Provide routine debriefing and support of staff impacted by traumatic incidents, for example, access to external counselling.
27. Explore scheduling team building activities to strengthen relationships between staff working different shifts.
28. Explore options for establishment of collaborating communities of practice across all Scope's residential services (at House Manager/Coordinator and Regional Manager levels).

29. Consider periodic DSW rotations across houses to prevent unprofessional relationships forming between clients, staff and families.

8.9 Training, education and support

Scope appears to have a strong suite of training and education resources, and a high level of commitment to staff training and development. Some participants, however, suggest that training materials should be reviewed to ensure more content is live and scenario based (including in relation to residential services), rights focused and delivered over a period of time rather than in one block.

A bystander is someone who witnesses something or is aware of something but doesn't take part in it. Lee-Anne's story demonstrates that people who were aware of what was happening (such as DSWs and other staff, the House Manager/Coordinator, other clients, families, and visitors) had limited power, motivation or capacity to intervene. This lack of bystander empowerment is a typical feature of poor safeguarding environments. Being an active bystander means being aware of when someone's behaviour is inappropriate or threatening and choosing to challenge it.

RECOMMENDATIONS:

30. Ensure all staff, including bystanders, feel supported to report any issues and will be protected from retaliation. Review training resources to ensure they adequately emphasise safety, bystander responsibilities, human rights and have a high level of interactive content.
31. Provide more frequent refresher training for all DSWs on topics like manual handling, duty of care and reporting processes. Review the training calendar to ensure training is scheduled to occur at least every two months. Ensure training resources emphasise that recording of staff/client interactions by client/families is a potential contemporary reality.
32. Consider implementing a practice model with frontline supervisors as practice coaches focusing on safe service delivery.
33. Consider utilising video recordings, with staff and client consent, for training or monitoring purposes.

8.10 Relationship management

Communication issues between staff and senior management and between Scope staff and the Mackey family were evident throughout the period covered by this review. In part, this related to a lack of regular supervision, and workforce and skills shortages. Some of this tension is inevitable and can be managed by timely reviews and supervision, good communication processes and a common focus on clients and their needs.

However, these kinds of tensions are of substantive concern when it results in a lack of timely information exchange and action critical to quality of care. This not only occurred throughout the review period but in relation to the gathering of evidence for the Courts.

A range of issues have been raised in connection with 'managing' parents at shared homes:

- visits can feel invasive to other residents, so there is a need to reinforce the need to respect the privacy and personal space of all residents. In addition, training of staff in handling parental concerns and feedback would be beneficial
- some parents are in constant contact with staff. One option might be to have a mobile phone dedicated to house for parents to contact staff rather than calling individual contact numbers or the house landline (which can be disruptive, especially at night)
- there is an ongoing fear that hidden cameras are being used, to the extent that some staff will not work in some houses or have left.

RECOMMENDATIONS:

34. Support House Manager/Coordinators to play a more consistent and proactive role in supporting DSWs to navigate relationships with family members.
35. Support staff within Scope (outside houses) to train as mediators when disputes or concerns arise between family members and agency staff, and/or bring in external mediators.
36. Reinforce protocols to ensure house visitors are aware of and respectful of client privacy. The protocol could be revisited by the Family and Supporters Advisory Panels.

8.11 Record keeping and case management

The current paper-based system of daily client recording at house level is a significant issue:

frontline workers are frustrated at the lack of digital systems (many also work at other services with superior systems). The result is poor record keeping, for e.g., a DSW who works overnight, sleeps, wakes up and makes a handwritten note in 'the book' before finishing their shift. This means there may not be real time recording which inevitably leads to omissions and inaccuracies, something the Mackeys recorded on video.

The fact that many staff are from non-English speaking backgrounds is a further argument to move to digital record keeping (for example, utilising voice activation or pull down screens rather than having to make entries in a book). Riskman has similar issues for front line staff.

RECOMMENDATIONS:

37. Consider introducing a mobile app for workers at houses to more easily record interactions and incidents as they occur to eliminate retrospective paperwork.
38. Trial AI tools like co-pilot to identify opportunities to reduce administrative burden on staff, including for activities like case note summaries. In doing this Scope should explore AI and other case based recording systems in place and working well for other providers.
39. Ensure the new Lumary is user friendly by engaging frontline staff in design and testing.
40. Staff training and development records should be digitally recorded and analysed on a regular basis by management, to provide assurance that all staff are up-to-date in all competency areas relevant to their roles.

8.12 Reporting concerns

It is clear that the main way frontline workers, parents and clients would raise an issue or concern was with the House Manager/Coordinator. If they had an issue with the House Manager themselves, they were less clear about their options. One suggestion is consideration of an anonymous concerns line (email, phone, or webchat) – for eg. '*Safe at Scope*' for staff and clients/families which avoids the need to identify as a whistle blower.

RECOMMENDATION:

41. Establish a protocol and systems for referral of anonymous concerns.

8.13 Incident and complaint management

In general, there is a widely held view that the Mackey case was poorly handled and lacked transparency from the outset, from initial complaints through to the provision of the video to Scope, and its subsequent airing in the media. In particular, information was held very tightly at the top of the organisation and few people were privy to what was in the video. When content was described to others, the actions of the staff involved appear to have been somewhat trivialised, and characterised as one-off events by a few bad actors.

Investigations at the time were primarily focused on assisting the agency to make decisions about staff employment and disciplinary action rather than dealing with any systemic abuse or cultural issues. Lee-Anne's voice was also not adequately amplified through these processes. An opportunity exists to apply a RCA approach (or similar) when major incidents or accumulation of lower level incidents occur.

Some Scope staff continue to carry trauma connected with past incidents. This presents lessons for when events happen in the future – by providing early and ongoing opportunities for all staff to debrief in a non-judgemental way. The Incident Management Team process in particular has felt uncomfortable and exclusionary for some staff. Further, some staff members have expressed the view that Scope is not as concerned with the welfare and views of its staff as it could be, and privilege client voice over staff.

RECOMMENDATIONS:

42. Test the current complaints and feedback process with clients, staff and families with a view to making it as simple as possible, especially for clients who are nonverbal. This could include surveying staff, clients and families to identify current barriers to voicing and escalating concerns.
43. Develop clear internal guidance at all levels on processes for timely escalation of serious or cumulative concerns in residential units, including nominating particular receiving positions or personnel, information about how concerns will be handled, and feedback mechanisms with timelines, and Board reporting requirements.

8.14 Data mining, intelligence gathering and risk mitigation

It is clear from the records, including in Riskman, that a pattern of incidents and associated complaints by Lee-Anne and her parents (and others at the house) was emerging, however there did not seem to be a process to analyse this if matters were not recorded at the highest threshold severity levels (4/5). Work underway to mine data systems should continue to be prioritised. However, it needs to be acknowledged that Riskman emanated from a health/hospital environment that is incident based and not a bespoke product designed to record or understand risk for people living in residential environments. It would be helpful for the sector to collaborate as a whole around finding a better option for clients in long term residential settings. In addition, any developments in relation to technology related risk management or client and staff records need to interface with the work of the Quality and Safeguarding team within Scope.

RECOMMENDATIONS:

44. Refine triangulation of risk data across to better identify houses requiring focus or intervention. As part of this work consider implementing a formal escalation process for repeated incidents or complaints (at any risk rating) about the same staff and/or houses over time.
45. Populate a client risk matrix using data from the nursing assessments emerging from the complex care project activities, to identify locations where clients have additional needs, and where more intensive monitoring and staff capability uplift is required.
46. Ensure Scope's client record management system (new Lumary) can support integrated safeguarding, risk identification, complaint management and audit functions. Ensure all relevant teams are involved in design and development, including quality and safeguarding personnel.

8.15 Governance and structural issues

Reflecting back, Board members felt that in the past not all information that should come to them has, that their capacity to question was overly managed and that they frequently did not see 'loops' closed on matters.

Safeguarding has become more of a feature of board duties through the Customer Experience and Outcomes Sub Committee, but could be raised to routine board agenda status, at least at a high level.

Many participants noted that there were numerous layers of bureaucracy between the CEO and on the ground management that had potential for streamlining, importantly in relation to effective transfer of critical and timely information. The reviewer notes that this is a current focus of attention.

RECOMMENDATIONS:

47. Ensure there is clear delineation and lines of accountability between the Audit and Risk Committee and Client Experience and Outcomes Committee, including a review of respective charters and role clarity on safeguarding matters.
48. Review management structures with a view to streamlining layers between the CEO, executive and operational management.
49. Make safeguarding a regular Board agenda item, where a deep dive on critical incidents, the systemic issues engaged and actions taken are explored and progress monitored by the Client Experience and Outcomes Committee.

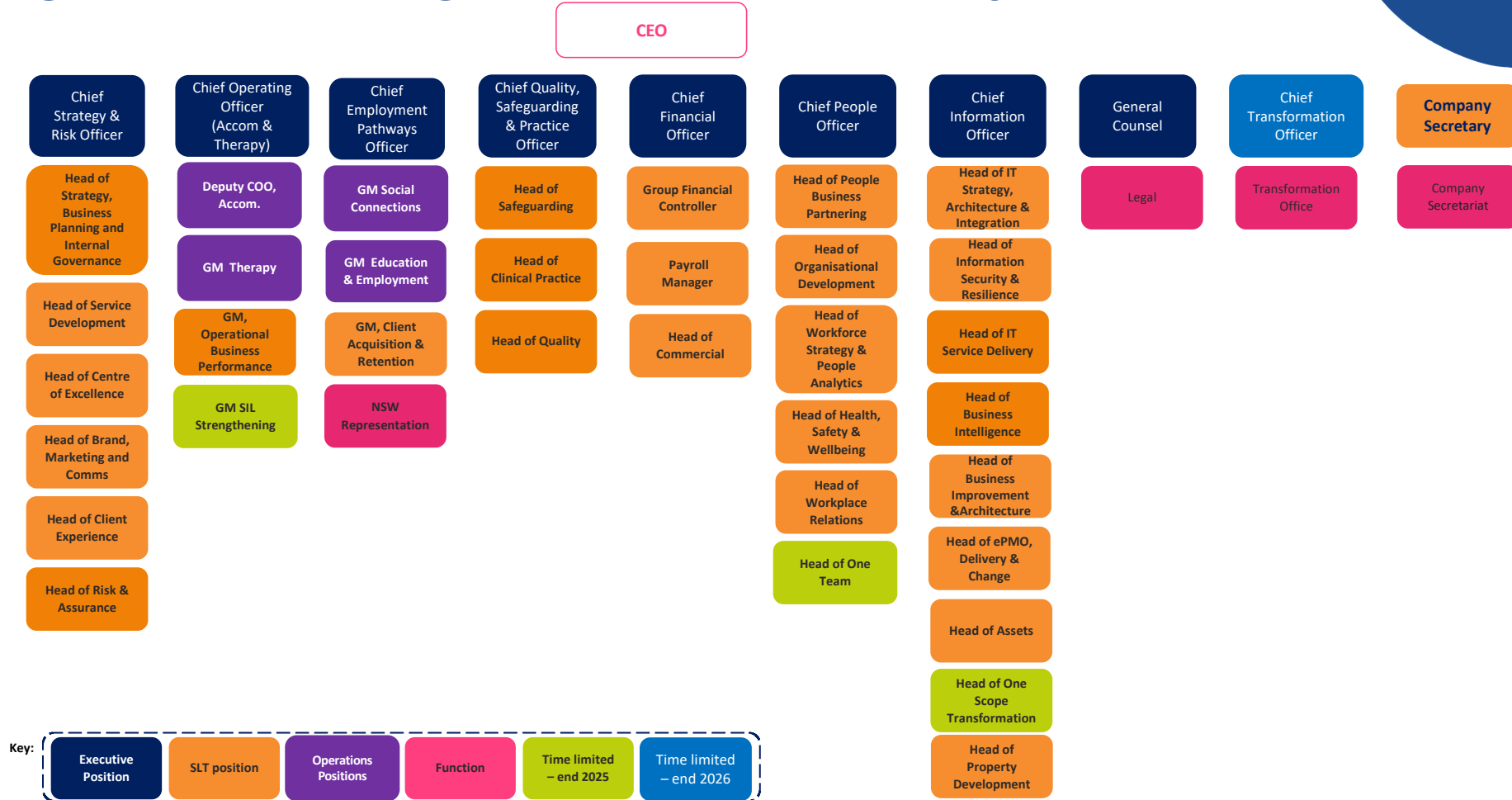
9 Appendices

Appendix A: Documents categories reviewed

	DOCUMENT NAME/TYPE
Key Legislation	National Disability Insurance Act Scheme Act 2013
	NDIS (Code of Conduct) Rules 2018
	NDIS (Provider Registration and Practice Standards) Rules 2018
	NDIS (Specialist Disability Accommodation Conditions) Rule 2018
Governmental Standards, Policies, Procedures, Guidance	NDIS (Quality Indicators for NDIS Practice Standards) Guidelines 2018
	NDIS Practice Standards and Quality Indicators 2021
	The NDIS Code of Conduct: Guidance for NDIS providers 2024
	New NDIS practice Standards and Quality Indicators 2021
	Zero Tolerance Initiative (NDIS)
	National Standards for Disability Services 2013
Scope Standards, Policies, Procedures, Guidance, internal and external communications	Scope Group Quality and Safeguarding framework 2022
	Various Scope information and communications material
	Scope Risk Register
	Scope Group Whistle-blower Policy 2023
	Scope Group Privacy Policy 2023
	Scope Client Incident categorisation table 2019
	Scope Group Code of Conduct Policy 2023
	Scope Disability Action Plan 2023-2026
	Scope terms and conditions of employment – Disability Support Workers
Investigation and Review Reports	Internal and External Investigation reports (2019-2022)
Complaints, Incident reports and responses	Incident reports and complaints (2019-2020)
	Risman entries (2019 -2020)
	House Quality Improvement Plan 2020
Emails, letters, meeting notes	Meeting minutes/letters/emails re results of investigations, NDISQSC correspondence (2019-2020)
Other	Scope media release April 2024
	60 Minutes video footage
	Various Scope staff training resources

Appendix B: Draft high level organisational chart

Organisational Design – Structure from 1 July 2024



Appendix C: Acronyms & Glossary

KEY ACRONYMS	
CEO	Chief Executive Officer
COO	Chief Operating Officer
The Commission	The NDIS Quality and Safeguards Commission
Corio Street	Corio Street, Glenroy – Lee-Anne Mackey’s residence from 2017 to 2021
CX Tracker	An e-program introduced to directly capture client experiences
DSA	Disability Services Australia -services formerly operated by DSA in NSW
DSW	Disability Support Worker
Home@Scope	Residential Services formerly operated by the Victorian State Government
NDIS	National Disability Insurance Scheme
RCA	Root Cause Analysis
Scope	Scope (Aust) Ltd. Established in 1948 and originally called the Spastic Children's Society of Victoria
SDA	Supported Disability Accommodation
SIL	Supported Independent Living