QUEENSLAND
Family & Child
Commission

Queensland Government

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Committee Secretary
Joint Standing Committee on the
National Disability Insurance Scheme
Via email:

Dear Committee Secretary

Thank you for the opportunity to provide a submission to the Joint Standing Committee on the National Disability Insurance Scheme's (NDIS) inquiry into the integrity of the scheme.

The Queensland Family and Child Commission (the Commission) is Queensland's statutory authority for promoting the safety, wellbeing and rights of children and young people. The Commission's responsibilities include administration of the Child Safe Standards and the Reportable Conduct Scheme under the *Child Safe Organisations Act 2024* (Qld).

This submission builds on the Commission's earlier contribution to the parliamentary consideration of the National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2025. Our focus here is narrower: how NDIS integrity reforms can better protect children with disability.

This submission focuses particularly on cross-system risks at the intersection of disability services and child protection, including workforce screening, information sharing, organisational accountability, and relational safeguarding.

This submission presents the speeches of two young Queenslanders who have advocated for reform at the Queensland Youth Summit, and I would be happy to connect the Committee members to these young people should the opportunity arise.

If you would like to discuss this matter further, please don't hesitate to contact me directly on XXXX@qfcc.qld.gov.au

Yours sincerely

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Submission to the Joint Standing Committee on the National Disability Insurance Scheme

Principal Commissioner Luke Twyford

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This submission is made within the Commission's statutory remit as Queensland's child safety oversight body. It does not attempt to address all aspects of NDIS integrity. It focuses specifically on integrity risks as they affect children and young people with disability, particularly those whose circumstances mean that market-based safeguards cannot adequately protect them.

The Commission's central proposition is that for children with disability, integrity failures are often also safeguarding failures. The conditions that enable fraud, sharp practices, and poor provider behaviour are frequently the same conditions that enable abuse, grooming, neglect, and exploitation to go undetected.

This submission addresses four aspects of the inquiry:

1. The nature and structural drivers of non-compliance and sharp practices as they affect children.
2. The effectiveness of current worker screening and safeguarding arrangements.
3. Cross-system regulatory gaps between the NDIS and state child protection frameworks.
4. Priority reforms to strengthen integrity for children in high-risk cohorts.

1. Non-compliance and sharp practices: structural drivers, not anomalies

The nature and extent of non-compliance in the NDIS

The Commission submits that sharp practices in the NDIS are not primarily a product of individual misconduct. They are predictable outcomes of structural market conditions that reward volume over quality and place safeguarding responsibility on the participants least able to exercise it.

Across multiple human services systems, my work has consistently identified patterns of significant harm where governments have relied heavily on outsourced care models governed primarily through contracts, procurement settings, and regulatory compliance frameworks.

This failure to purchase ‘quality care’ is evident across early childhood education, aged care, residential care, and disability services.

While these systems differ in design and maturity, they reveal a common structural tension: the application of market logic to inherently relational work.

Contracting frameworks are, by necessity, designed to specify, measure and enforce deliverables. They privilege what can be counted - hours of service, staffing ratios, incident reporting, accreditation status, and procedural compliance. However, the core determinants of safety and wellbeing in care environments are often intangible and relational. They include trust, connection, continuity of relationships, emotional attunement, cultural safety, and the capacity of staff to exercise judgement in complex, dynamic situations. These are not easily codified, priced, or audited.

As a result, systems that rely predominantly on compliance risk creating a form of “procedural safety” without delivering actual safety. Services may meet required standards on paper while failing to provide the stable, responsive, and therapeutic relationships that underpin genuine care. In such environments, organisational attention can shift toward managing compliance risk - meeting reporting obligations, passing audits, and avoiding sanctions - rather than investing in the quality of relationships and practice.

Market dynamics can further exacerbate this problem. Competitive procurement processes, price pressures, and funding cycles may disincentivise long-term investment in workforce capability, supervision, and organisational culture. Providers operating under financial constraint may experience high staff turnover, reduced continuity of care, and an increased reliance on less experienced or casualised workers. These factors directly undermine the relational stability that is critical to safety, particularly for vulnerable populations such as children, people with a disability and those in State care.

Importantly, this is not an argument against the role of non-government providers. Many deliver high-quality, relationship-based care and are deeply embedded in their communities. Rather, it is an argument that current commissioning and regulatory approaches are insufficiently aligned with the nature of care itself. Where

governments act primarily as purchasers and regulators - rather than stewards of a care system - there is a risk that relational quality is crowded out by transactional imperatives.

Safety in care settings is not produced through transactions alone. It emerges from consistent, trustworthy relationships; from environments where individuals feel known, valued, and secure; and from workforces that are supported to exercise professional judgement rather than simply comply with process. These conditions cannot be fully mandated through funding arrangements, nor assured through compliance activity alone.

Accordingly, there is a need to rebalance system design. This includes strengthening stewardship functions within government, embedding relational quality as a core objective of commissioning, investing in workforce capability and stability, and developing regulatory approaches that assess not only compliance, but the lived experience of care.

Central to this rebalancing is a clearer recognition that participant experience is the most meaningful measure of quality. Safety and wellbeing are ultimately realised—or not—at the point of interaction between a person receiving care and those providing it. Measures of quality must therefore move beyond organisational outputs and compliance indicators to capture whether individuals feel safe, respected, heard, and supported in ways that are responsive to their needs and identity. This requires systematic approaches to eliciting and acting on participant voice, including the experiences of those who may have limited capacity, confidence, or opportunity to articulate concerns through conventional feedback mechanisms.

It is also necessary to distinguish between market-based notions of choice and genuine participant empowerment. While policy settings often emphasise choice as a proxy for quality, the availability of multiple providers does not, in itself, ensure that individuals can exercise meaningful control over their care. Structural constraints—including information asymmetry, power imbalances, urgency of need, geographic limitations, and the vulnerability of many service users—can significantly limit a person's ability to make informed or safe choices. In some cases, the burden of navigating complex service systems is shifted onto those least equipped to carry it.

True empowerment is not simply the ability to choose between providers, but the capacity to influence the nature, quality, and continuity of care received. It requires services that are responsive and adaptable, systems that support advocacy and informed decision-making, and safeguards that do not rely solely on individual agency to mitigate risk. Without these conditions, an overreliance on market choice risks obscuring poor quality and entrenching inequities, rather than enhancing safety and outcomes.

In an inelastic market, the standard mechanisms of consumer discipline — choice, complaint, and switching — do not operate effectively as safeguards. Instead, structural conditions can produce:

- reduced incentives for quality and workforce capability
- provider reliance on volume-based revenue models, including over-servicing
- barriers to genuine competition and meaningful participant choice, and
- increased opportunity for exploitative or low-quality providers to enter and persist in the market.

For children, this structural vulnerability is compounded by the role of the state. Many children receiving NDIS supports are simultaneously in child protection or out-of-home care, where responsibility for exercising oversight and advocacy on their behalf is fragmented across multiple agencies, workers, carers, and systems. In the absence of a consistent adult who knows the child well, integrity risks can become child protection risks without any single actor being aware. The Commission is particularly concerned about the overlap between residential care providers and NDIS service provision. Where a provider or corporate group operates across both systems, poor practices in one setting can affect the other, and regulatory oversight may fall between jurisdictions.
Without such shifts, there remains a material risk that systems will continue to deliver the appearance of safety, while failing to prevent harm.

2. Worker screening and workforce oversight: a two-tiered system

The effectiveness of current safeguards and regulatory arrangements

The 2023 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*[1] identified a critical and unresolved gap in worker screening across the NDIS: while screening is mandatory for workers in registered provider settings, it is not required for unregistered providers, sole traders, and workers engaged by self-managed participants.

I submit that this gap has not been adequately closed and children and participants are at significant risk from unregistered and untrained sole providers.

After leading a year long review into System Responses to Child Sexual Abuse, I am particularly terrified by the number of parents posting photos of their children with disabilities on Facebook and social media seeking to engage independent support workers. This system has been generated by the structural design of the NDIS, the imbalance between demand and workforce capacity, and a lack of awareness of how those that seek to perpetrate harm against children will move between systems and present as trustworthy.

The current lack of protective factors within the scheme for independent providers creates a two-tiered safeguarding environment in which children may receive stronger protections in formally regulated settings and materially weaker protections in decentralised, market-based, or unregistered arrangements — despite the latter often involving equally intimate, high-trust, and high-frequency contact. This matters acutely because the NDIS workforce is increasingly mobile and diversified. Workers move between providers, sectors, and service models. Concerning conduct in one setting may not be visible to a subsequent employer, and sub-threshold behaviours — those that do not individually trigger criminal or employment sanctions — may accumulate across multiple engagements without any system detecting the pattern.

The Child Death Review Board's *In Plain Sight*[2] report reinforced this concern, finding that offenders often exploit fragmented accountability and weak organisational cultures to persist across settings. A central finding of the report is that borders do not stop perpetrators; when safeguards are strengthened in one sector without addressing adjacent systems, harm may be displaced, rather than prevented.

For the NDIS, this means that it needs to deeply consider the protections put in place in the early child education and care sector in 2025 and 2026 including:

- *mandatory child safety training*
- *employee registers*
- *corporate accountability and liability*
- *awareness of grooming and child sexual abuse disclosures*

with the view to considering how risk may be transferring from that system to children with a disability.

The Commission submits that the Committee should recommend mandatory interoperability between the NDIS Worker Screening Database and all state and territory Working with Children Check systems and residential care worker registers, so that an adverse finding or exclusion in one system is visible and actionable across all relevant child-facing settings.

3. Cross-system regulatory gaps: where NDIS integrity reform falls short for children

Regulatory gaps and opportunities to strengthen the scheme

Since the Disability Royal Commission, Queensland has introduced the Reportable Conduct Scheme (RCS) under the *Child Safe Organisations Act 2024*, which commences on 1 July 2026. The RCS represents a significant

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[1] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. 2023, *Final Report – Volume 11*

[2] Child Death Review Board. 2025, *In Plain Sight – Review into System Responses to Child Sexual Abuse*

advancement in child safeguarding — shifting focus from individual compliance to organisational accountability and enabling the capture of sub-threshold behaviours and patterns of concern before serious harm occurs.

However, the RCS applies to prescribed child-facing organisations under state law. It does not map consistently onto the diversity of NDIS service arrangements, particularly for independent workers and unregistered providers. This creates a regulatory gap that current NDIS integrity reforms have not resolved.

The practical consequence is a system where the same child may be better protected in one service setting than another, based solely on the registration status or business model of their provider — not the nature of the contact or the level of risk involved. The Commission submits that NDIS integrity reform presents a direct opportunity to align Commonwealth and state safeguarding frameworks and close this gap. Specifically, the Commission recommends that the Committee consider:

- extending equivalent reportable conduct obligations — or closely aligned obligations — to NDIS service delivery settings not currently covered by state schemes, particularly for services delivered to children
- establishing a cross-jurisdictional information-sharing mechanism to enable detection of patterns of concern across both NDIS and state child protection systems
- creating clear accountability for NDIS providers to report, investigate, and escalate child safeguarding concerns, regardless of registration status.

This alignment would strengthen both NDIS integrity and child protection outcomes and would reflect the principle — confirmed by *In Plain Sight* — that effective safeguarding must operate across system borders, not within them.

4. The intelligence gap: from compliance to pattern detection

The adequacy of current detection and enforcement mechanisms

Current NDIS integrity arrangements are largely reactive and threshold based. They are oriented toward identifying and responding to conduct that has already crossed a legal or regulatory line. This approach has significant limitations for children, whose safety depends on the detection of cumulative risk — patterns of behaviour that may not individually trigger intervention but collectively indicate serious concern.

The Auditor-General's 2025 findings about NDIA claims compliance confirm that even financial integrity has relied too heavily on post-hoc detection. Specifically this report identified that only a very small proportion of claims were reviewed by dollar value and that basic prevention controls were absent before 2024. For child safeguarding, the consequences of reactive-only systems are more serious. By the time concerning conduct reaches a criminal or disciplinary threshold, significant harm has typically already occurred.

The Commission advocates for the establishment of an intelligence-led safeguarding capability to identify and act on sub-threshold indicators of risk across the NDIS and adjacent child-facing systems. Such a function should be capable of:

- aggregating patterns of complaint, concern, or adverse conduct across providers and service models
- identifying workforce mobility patterns that may indicate regulatory avoidance
- flagging provider practices (including over-servicing, high staff turnover, and weak reporting) that may signal governance failure or exploitation risk
- sharing intelligence with state and territory child safety regulators.

This represents a shift from compliance-based integrity to prevention-oriented integrity - consistent with the approach taken in effective workplace safety, financial regulation, and child protection systems.

5. Relational safeguarding: the integrity dimension of stability and trust

The broader integrity architecture and its effectiveness for children

The Committee's inquiry is primarily focused on fraud, sharp practices, and regulatory effectiveness. The Commission submits that for children with disability, one additional factor is integral to any effective integrity system: the presence or absence of stable, trusted adult relationships.

Safeguarding for children is not delivered by compliance mechanisms alone. It is also delivered by adults who know the child well enough to notice change, interpret behaviour, support communication, and act protectively when needed. Where those relationships are absent (because care is fragmented, workers are transient, or no single adult consistently holds responsibility) children may adapt to unsafe environments rather than disclose harm.

The Commission draws the Committee's attention to lived experience evidence presented at the Youth Summit, which illustrates this risk directly. We encourage you to watch Magenta's and Poppy's speech on You Tube.

Magenta – 2025 Queensland Family and Child Commission Youth Summit[3]

At the 2025 Youth Summit, youth advocate Magenta (who grew up in foster care and left the care of Child Safety at 21) described what fragmented relational care produces in practice. She described the experience of growing up in care as requiring children to become chameleons, adapting their behaviour, personality and responses to different environments in order to feel safe.

Her experience of the care system left her without a clear sense of identity, values or preferences and she had to develop those independently in early adulthood. Her insights highlight a critical risk in safeguarding, that safety is not only protection from harm but also the presence of stability, identity and consistent relational support. Where that is absent, children may prioritise adaptation over expression, suppressing preferences or concerns and avoiding behaviours that may destabilise placements or relationships.

Magenta's experience highlights the need for NDIS integrity reforms to prioritise continuity of relationships, communication and identity development alongside regulatory safeguards.

Magenta's evidence confirms that the absence of complaint or disclosure cannot be treated as evidence of safety. For children managing the instability of fragmented care systems, silence is often a survival strategy, not a signal that safeguards are working.

Poppy – 2026 Queensland Family and Child Commission Youth Summit

At the 2026 Youth Summit, youth advocate Poppy drew the Committee's attention to how ambiguous legislative thresholds and limited workforce capability compound safeguarding risk for children with disability. Poppy illustrated this risk through a case study of a young person with significant communication needs, where behaviours of concern were initially managed through restrictive responses. However, when appropriate communication supports were introduced, the behaviours reduced significantly.

Poppy's evidence illustrates that behaviour is often communication, and that where workforce capability is insufficient to recognise this, children with disability may be subject to restrictive or harmful responses rather than the support they need. Workforce capability is itself a safeguarding mechanism, and its absence is an integrity failure.

The Commission submits that NDIS integrity reforms should explicitly recognise continuity of care, stable relationships, communication supports, and capable, consistent workforces as protective integrity settings for children. In practical terms, this could include:

- continuity of support requirements in provider registration conditions or commissioning arrangements for high-risk cohorts

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[3] Youth Summit 2025 speaker Magenta: **https://www.youtube.com/watch?v=iSJocHI_COw**

- mandatory communication support planning for children with complex needs
- safeguarding risk flags for children in high-turnover or multi-provider arrangements
- strengthened case coordination where children interact with both NDIS and child protection systems.

6. Corporate accountability for systemic safeguarding failures

Provider accountability and governance arrangements

The Commission submits that current accountability settings place too much responsibility on frontline workers and too little on provider boards and senior leaders. Where systemic safeguarding failures occur through weak governance, inadequate supervision, poor organisational culture, or failure to report and respond to concerns accountability should not rest solely with the individuals closest to the harm. Organisational leadership must be answerable for the systems, cultures, and decisions that create the conditions for failure.

The Commission recommends that NDIS integrity reforms include clear and enforceable corporate duties on provider entities and senior leaders in relation to child safety. This should include positive duties to prevent and respond to safeguarding risks, not merely to comply with registration conditions after the fact. Accountability should be meaningful where systemic governance failure contributes to serious harm.

Conclusion

For children with disability, NDIS integrity is not only a question of financial accountability. It is also a question of whether the Scheme's design, market settings, workforce arrangements, and regulatory architecture create environments in which children are safe, heard, and protected from exploitation.

A compliance-focused, single-system response will not be sufficient for children whose vulnerability arises precisely from the fragmentation and complexity of the systems around them.

I welcome the opportunity to provide further evidence if that would assist the inquiry.