

**Submitted by:** Sarah Barnbrook, Unpaid carer

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### **About the Author**

Sarah Barnbrook is an unpaid carer, human rights adviser, digital safety advocate, and rural and regional women's representative with extensive lived experience navigating the National Disability Insurance Scheme (NDIS).

Sarah supports multiple people in her household who rely on the NDIS, while living in a regional community where workforce shortages, limited provider choice, and service delays are part of daily reality. Her caring role involves managing high and complex care needs in the home, navigating NDIA planning, reassessment, and safeguarding processes, and filling critical gaps when systems are slow or local supports are unavailable. This lived experience underpins her contribution to this inquiry.

Sarah is the Founder of Away from Keyboard (AFK), a registered not-for-profit charity focused on digital safety, ethical technology, and the prevention of harm in online environments. All of Sarah's work through AFK is undertaken on an unpaid basis. This work enables her to contribute meaningfully to policy development, advocacy, and community education while balancing high-level caring responsibilities. It also provides an essential sense of identity, purpose, and belonging at a time when caring roles can otherwise be isolating and erode a person's sense of self.

Through AFK, Sarah advocates nationally and internationally on issues including digital inclusion, technology-facilitated harm, online safety, and the unintended consequences of automated and digital systems on vulnerable people. Her digital expertise informs her understanding of how administrative and technological systems can either protect people or quietly compound harm when accountability, accessibility, and human oversight are lacking.

In addition, Sarah serves as Human Rights Adviser, ICT and Social Media Adviser, and Rural and Regional Women Adviser with the National Council of Women of Victoria (NCWV), and as Programme and UN Liaison for Soroptimist International Melbourne. In these roles, she works to connect local lived experience with national and international human rights frameworks, including engagement with United Nations processes such as the Commission on the Status of Women.

Much of Sarah's advocacy, research, and writing is undertaken from her home. This allows her to remain an active and contributing member of society while providing high-level unpaid care. Her voluntary work includes policy submissions, advisory briefs, program development, and public education, all undertaken alongside her caring responsibilities.

Sarah's experience demonstrates the importance of systems that recognise unpaid carers not only as providers of support, but as people with expertise, insight, and the right to contribute, belong, and maintain a sense of self. She has chosen to make this submission not to seek individual remedy, but to provide lived-experience evidence that can strengthen the administration, integrity, and safeguarding of the NDIS, particularly for those who are injured, isolated, digitally excluded, or otherwise unable to speak for themselves.

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## **1. Introduction**

I am an unpaid carer supporting multiple people in my household who rely on the National Disability Insurance Scheme (NDIS). I make this submission in response to the Joint Committee's inquiry into the administration of the NDIS, to highlight systemic failures in how the Scheme is currently operating in practice.

I bring lived experience of navigating the NDIA's planning, reassessment, change of circumstances, and safeguarding processes over several years, in a regional context where workforce shortages and service gaps are persistent. I also draw on my roles as a Human Rights Adviser, ICT and Social Media Adviser, and Rural and Regional Women Adviser with the National Council of Women of Victoria, which inform my understanding of how these administrative issues affect carers, women, and families more broadly.

This submission is not a request for individual remedy. It is an evidence-based account of how administrative processes within the NDIS can acknowledge risk, document need, and complete procedural steps, while still failing to act in ways that prevent foreseeable harm.

In my experience, when NDIA systems do not function effectively, the consequences are not merely administrative. They result in unsafe care arrangements, physical injury to unpaid carers, inappropriate reliance on children, and the quiet transfer of risk from the Scheme into households. These outcomes undermine the fundamental objectives of the NDIS and raise serious human rights concerns relating to safety, dignity, equality, and accountability.

This submission examines how failures in administration, information handling, decision-making, and digital systems contribute to these harms, and questions whether current practices align with the Government's stated intent to place people with disability at the heart of the Scheme and to operate the NDIS with integrity and safeguarding at its core.

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## **2. Government intent and the test of administration**

In the Second Reading Speech for the *National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2025*, the Government states that it is committed to building an NDIS that is fair, consistent, empowering, and centred on the needs and safety of people with disability. The Bill is presented as a mechanism to strengthen integrity, prevent harm, and ensure the Scheme operates in a way that protects participants from abuse, neglect, and exploitation.

The measures contained in the Bill, including expanded enforcement powers, stronger penalties, enhanced information-gathering, and increased reliance on electronic and automated processes, are framed as necessary to safeguard participants and restore trust in the Scheme. These objectives are important and widely supported.

However, integrity and safeguarding are not achieved through legislation and regulatory powers alone. They are ultimately delivered through administration that functions effectively in real time, particularly when evidence of risk is known. A system can have strong enforcement tools on paper and still fail people if its day-to-day administrative processes do not act when harm is foreseeable.

From my lived experience, there is a significant gap between the Government's stated intent and the outcomes produced by current administrative practice. I have experienced situations where serious risk was identified, documented, discussed, and acknowledged within NDIA processes, yet no timely or adequate action followed. In these circumstances, the Scheme appears procedurally complete, forms are submitted, meetings are held, records are generated, but the underlying safety issue remains unresolved.

This gap matters because the NDIS does not operate in a vacuum. When administrative systems fail to respond to known risk, the consequences are displaced into households. Participants remain in unsafe care arrangements. Unpaid carers are expected to absorb additional physical and emotional labour to prevent immediate harm. Children are drawn into inappropriate caring roles when no alternative supports are available. These are not unintended side effects; they are predictable outcomes of administrative inaction.

From a human rights perspective, this represents a failure to protect the rights to safety, health, dignity, and equality. Safeguarding is not achieved by acknowledging risk in documents or summaries. It is achieved when systems intervene early enough to prevent harm. Where administration allows risk to persist despite evidence, responsibility is shifted away from the Scheme and onto individuals who are least resourced to carry it.

This section of my submission uses the Government's stated intent as a benchmark and examines whether current administrative practice meets that standard in reality. The issues that follow are not about disagreement with policy objectives. They are about whether the way the NDIS is administered is capable of delivering those objectives for people living inside the system every day.

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### **3. Failure to act on acknowledged evidence of risk**

One of the most serious administrative failures I have experienced within the NDIS is that the NDIA can receive and acknowledge evidence of risk without being required to respond to it in a way that prevents foreseeable harm.

This is not a minor inefficiency. It goes to the heart of what the Scheme is meant to do. The NDIS exists to enable people with disability to live with dignity and safety in the community. When evidence identifies that a person's current supports are unsafe, the system should not be able to remain administratively "complete" while that risk continues.

#### **Evidence can be on file, but safety still not protected**

In the case of a participant I support, professional assessments clearly documented that 1:1 support was unsafe and that 2:1 support was required to deliver care safely. That evidence was provided to the NDIA and was known within the system. Yet the plan continued to fund an arrangement that did not match what the evidence said was necessary.

The practical outcome of this is predictable. When funded supports do not meet actual need, the gap does not disappear. It is transferred into the household. It is filled by unpaid care. In a regional context where workforce shortages are constant and provider choice is limited, there is no quick fallback. The person with disability still needs to be showered, transferred, supported with continence, repositioned, and kept safe. If the funding and workforce don't cover those needs, the work still has to happen.

In my experience, the system's failure to act on known risk effectively treats unpaid carers as an assumed buffer, a hidden capacity that absorbs risk, prevents immediate crisis, and makes it appear as if the plan is functioning.

#### **Disability supports are safety-critical supports**

From a human rights perspective, this is not a technical planning dispute. Disability support decisions are safety-critical decisions. They determine whether essential care can be delivered without injury, neglect, or preventable deterioration.

When a professional assessment identifies foreseeable risks, such as unsafe transfers, manual handling dangers, continence and hygiene risks, and inadequate supervision, and those risks are not addressed, the system is no longer simply slow. It is failing to protect the rights of the person with disability to safety, health, and dignity.

It also fails to protect the rights of the unpaid carer, who is often expected to compensate for those gaps. Carers are not an infinite resource. When administrative settings effectively rely on unpaid labour to fill structural shortfalls, the Scheme shifts its burden onto bodies and households, most often women's bodies, without acknowledgement, compensation, or protection.

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### **My injury is evidence of foreseeable harm**

My experience illustrates what this looks like in real life, and why administrative delay and inaction must be treated as a safeguarding issue.

In 2018, I was diagnosed with a left hip labral tear. In February 2019, I underwent surgical repair. I have continued in a high-care caring role because there has been no safe alternative arrangement in the absence of adequate funded supports.

Over time, the physical demands of filling gaps, including manual handling, stabilisation, and stepping in when supports are insufficient or unavailable, have contributed to further degeneration. My labrum has torn again. I have been advised by my specialist that a second repair is not possible and that I now require a total hip replacement, as outlined in my carer statement.

This is not a one-off incident. It is the foreseeable outcome of sustained exposure to unsafe care conditions in the home when the system has evidence of risk but does not act.

I am able to articulate this, submit evidence, and speak to it in a public process. Many people cannot.

There are carers in every community who are exhausted, injured, isolated, and simply trying to get through each day. Some are caring for people with complex needs with no local workforce. Some are managing intimate and high-risk care tasks with limited training because the alternative is leaving a person unsafe. Some are navigating language barriers, low digital literacy, trauma histories, or cognitive demands that make repeated administrative processes impossible to sustain. Many fear that speaking up will make things harder, not easier.

When the system does not act on acknowledged risk, the people most likely to be harmed are often the least able to submit paperwork, advocate persistently, or challenge decisions. Their absence from consultation is not consent. It is capacity collapse.

### **The structural problem: procedural completion without safety outcomes**

What I have observed is a pattern where the NDIA can:

- receive evidence of unsafe arrangements
- record that evidence in notes or summaries
- proceed through reassessment or review steps
- and still leave the underlying safety gap unresolved

This is a fundamental integrity issue. It means the Scheme can appear to function administratively while failing in its core purpose: enabling safe, dignified living for people with disability.

Safeguarding is not achieved by acknowledging risk. Safeguarding is achieved when the system responds early enough to prevent harm.

This issue raises fundamental questions for the Committee about:

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- how the NDIA assesses and escalates safety-critical evidence
- what thresholds, if any, trigger urgent action when harm is foreseeable
- whether administrative processes prioritise procedural closure over safety outcomes
- how the Scheme measures the human cost of inaction, particularly the cost shifted onto unpaid carers and children
- how rural and regional constraints are accounted for when gaps cannot be filled by “choice” or “market options”

If the NDIA can acknowledge evidence that current supports are unsafe without taking timely corrective action, then the Scheme’s integrity and safeguarding framework is incomplete. People with disability remain at risk, and unpaid carers become the unrecognised mechanism through which the system continues to operate.

That is not sustainable. It is not fair. And it is not consistent with the stated intent of putting people with disability at the heart of the NDIS.

The *National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2025* is framed as strengthening protections for participants by expanding enforcement powers, information gathering, and regulatory oversight. These measures assume that once risk is identified, systems will respond in a timely and effective way. My experience demonstrates that this assumption does not always hold in practice.

Safeguarding fails when evidence of harm is recognised but not acted upon. No amount of post-hoc enforcement, penalties, or regulatory power can compensate for administrative processes that allow unsafe care arrangements to persist despite clear warning signs. Integrity is not only about detecting wrongdoing; it is about ensuring that known risks trigger meaningful intervention before injury occurs. Where administration permits foreseeable harm to continue, safeguarding becomes reactive rather than preventative, and the burden of protection is shifted onto unpaid carers and families instead of being carried by the Scheme.

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#### **4. Unpaid carers as assumed infrastructure**

A persistent and deeply concerning feature of the NDIS, as it is currently administered, is the unspoken assumption that unpaid carers will continue to fill gaps when funded supports are insufficient, unavailable, or delayed. This assumption is not written into policy, but it is embedded in how the system functions day to day.

In practice, when supports do not meet need, when services cannot be sourced, or when reviews and reassessments take months to resolve, the Scheme continues to operate as though the gap will be absorbed elsewhere. That “elsewhere” is almost always the unpaid carer.

In my own case, the NDIA has continued to operate on the assumption that I will remain in the home providing high-level unpaid care, despite clear and documented indicators that this arrangement is unsafe and unsustainable. These include:

- permanent physical injury caused by the caring role
- the inability to earn a living wage due to the intensity and unpredictability of care demands
- escalating complexity and risk in the care required
- chronic workforce shortages in a regional area that limit alternative options

None of these factors are hidden. They are known to the system. Yet they have not triggered a fundamental reassessment of the reliance placed on unpaid care.

This assumption shows up in subtle but consistent ways. Plans are written that do not fully cover the hours or ratios required for safe care. Delays in reviews are treated as administrative inconvenience rather than risk escalation. When supports cannot be sourced locally, the lack of availability is treated as a market issue rather than a safeguarding failure.

At no point is there a clear administrative mechanism that asks the most important question: *who is absorbing the risk while the system waits?*

In reality, it is absorbed by carers’ bodies, time, income, and health. The Scheme continues to function because unpaid carers prevent immediate crisis. This creates a perverse outcome: the more a carer sacrifices to hold things together, the less visible the system’s failure becomes.

From a human rights perspective, this is not a neutral administrative design choice. It represents a failure to respect the rights of unpaid carers as rights-holders in their own right.

When unpaid carers are treated as an unlimited resource:

- bodily integrity is compromised
- health is sacrificed to maintain system stability
- economic security is eroded
- choice and consent are effectively removed

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Carers do not “choose” to absorb this burden in any meaningful sense. The alternative is leaving a person with disability unsafe. This is not free choice; it is coercion by circumstance.

The Scheme’s reliance on unpaid care therefore externalises risk and cost away from the NDIS and into private households. Harm does not disappear. It is displaced, quietly and unevenly, onto those least protected by formal safeguards.

### **Gendered and regional impacts**

This burden falls disproportionately on women, particularly in rural and regional areas. In these settings, limited provider availability, long travel distances, and workforce instability mean that unpaid carers are not a backup option; they are the primary means by which care continues.

Women in these contexts are more likely to:

- exit or reduce paid employment
- experience cumulative physical injury
- shoulder emotional and mental load across caring and parenting roles
- remain invisible in administrative decision-making

This is not the result of explicit discrimination. It is indirect discrimination created by administrative design, where systems assume a level of unpaid labour that is neither sustainable nor equitably distributed.

### **The unseen population**

I am able to articulate this experience and place it on the public record. Many cannot.

There are carers who are older, isolated, culturally marginalised, living with disability themselves, or lacking digital literacy. There are carers who do not have the language, time, or capacity to challenge decisions or persist through repeated administrative processes. There are carers who are already injured, exhausted, and afraid that speaking up will jeopardise what little support they have.

When the NDIS relies on unpaid carers as infrastructure, these people are not just overlooked, they are structurally erased. Their harm is not measured, reported, or mitigated. It is normalised.

A Scheme that depends on invisible, unpaid labour to function is not operating with integrity. It is masking its true costs and risks. Sustainability cannot be achieved by shifting harm onto households and hoping they hold.

If the NDIS is to meet its stated objectives, administration must stop assuming that unpaid carers will continue to fill gaps indefinitely. Instead, it must recognise unpaid care as a risk factor, not a solution, and respond accordingly.

Until this shift occurs, the Scheme will continue to function at the expense of carers’ health, women’s economic security, and children’s wellbeing, outcomes fundamentally at odds with the principles the NDIS claims to uphold.

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## **5. Fragmented information handling and lack of continuity**

A central issue for this inquiry is not whether information is collected by the NDIA, but how that information is held, understood, and acted upon over time. In my experience, the administration of the NDIS is characterised by fragmented information handling, where evidence can exist within the system without meaningfully shaping decisions.

Across planning, change of circumstances, reassessment, budget monitoring, and safeguarding interactions, I have experienced repeated breakdowns in continuity. Information is submitted, acknowledged, and sometimes even summarised in correspondence, yet subsequent planners or teams appear unaware of what has already been provided. As a result, carers are required to repeatedly restate complex, safety-critical information as if it were new.

This is not a neutral inconvenience. It creates real risk.

When carers are required to retell the same information again and again, it is often interpreted as a communication problem. In reality, it is an information governance problem.

In my experience:

- professional assessments and reports are uploaded and acknowledged
- meetings are held in which risks are discussed
- autogenerated summaries record elements of those discussions
- yet later interactions proceed as though the information is not known

This repetition is exhausting, but more importantly, it is unsafe. Safety-critical information loses force when it must be re-argued each time. The burden of proof never ends, and risk is normalised through familiarity rather than resolved through action.

For carers already operating under physical strain, time pressure, and emotional load, repeated storytelling is not simply tiring, it erodes capacity to advocate at all.

### **Lack of a single point of accountability**

A key administrative failure underpinning this fragmentation is the absence of a clear point of accountability for integrating evidence into decision-making.

Different teams may:

- collect information
- record notes
- send correspondence
- or monitor budgets

But no single role appears responsible for ensuring that all known evidence of risk is synthesised, prioritised, and acted upon. This results in a system where information exists everywhere and responsibility exists nowhere.

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From a lived-experience perspective, this creates a situation where:

- carers do the work of coordination the system does not
- risk is identified multiple times without escalation
- and responsibility for safety quietly shifts away from the NDIA

### **Digital systems amplify fragmentation**

The increasing reliance on digital portals, automated correspondence, and electronic workflows has not resolved this problem. In some cases, it has made it worse.

Autogenerated emails and letters can acknowledge receipt of information or state that matters have been “actioned and closed,” even when the underlying risk remains unaddressed. For people with high digital literacy, time, and confidence, these inconsistencies can be challenged. For many others, they cannot.

For carers and participants with:

- low digital literacy
- limited internet access
- cognitive disability
- trauma histories
- language barriers
- or limited capacity to follow up repeatedly

these systems can entrench errors rather than correct them. Fragmentation becomes invisible because the system appears to function, while individuals quietly fall through the gaps.

From a human rights perspective, this undermines the right to an **effective remedy**. Errors are not resolved; they are reproduced across interactions.

### **Periods of highest vulnerability are least protected**

Fragmentation is most dangerous during periods when participants and carers are already under strain, such as:

- following injury or health deterioration
- during workforce shortages
- while awaiting reassessment or plan change
- or when caring arrangements are close to collapse

These are precisely the moments when continuity of information and decisive action matter most. Instead, the system often requires carers to expend additional energy re-establishing context, re-submitting evidence, and re-explaining risk.

From lived experience, this feels like being asked to prove an emergency repeatedly while it continues to unfold.

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From a human rights lens, fragmented information handling is not an administrative flaw; it is a barrier to justice.

When systems do not retain and act on what they already know:

- harm becomes foreseeable but unprevented
- accountability is diluted
- access to remedy is weakened
- and those with the least capacity to persist are most likely to be harmed

People who cannot continually advocate, because they are injured, exhausted, caring alone, digitally excluded, or afraid, are effectively silenced by process design.

Their absence from escalation pathways is not a sign that harm is absent. It is a sign that capacity has been exhausted.

The Committee is examining whether the NDIA operates effectively and whether current administrative arrangements safeguard participants. Fragmented information handling demonstrates a structural weakness in how risk is managed.

A system that requires carers to repeatedly restate known risk, without a clear mechanism for integration and action, is not operating with integrity. It is relying on persistence as a filter, and those who cannot persist are the ones most likely to suffer harm.

Until continuity, accountability, and corrective action are embedded into NDIA administration, the Scheme will continue to produce outcomes that are inconsistent with its stated purpose and its human rights obligations.

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## **6. Reassessment quality and procedural fairness**

Reassessments are presented as a key safeguard within the NDIS. They are the point at which changing circumstances, emerging risks, and new evidence are meant to be examined and responded to. For reassessments to fulfil this role, they must be conducted with care, preparation, and a full understanding of the participant's circumstances.

In January 2026, I participated in a scheduled plan reassessment. During that reassessment, the NDIA staff member asked questions that clearly indicated they had not read key professional assessments that had already been provided and were on file. The questions being asked were inconsistent with documented evidence regarding care needs, safety risks, and support requirements.

As a result, I was required to ask directly whether the documentation had been reviewed.

This moment is important. It illustrates not frustration, but a breakdown in procedural fairness. A reassessment cannot meaningfully test risk, need, or safety if it proceeds without engagement with the evidence that prompted the reassessment in the first place.

### **Reassessments without preparation shift risk onto carers**

When reassessments are conducted without adequate preparation, the burden of ensuring accuracy and safety is shifted away from the system and onto carers in real time. Instead of assessing need based on a complete evidentiary record, the process becomes an exercise in ad hoc explanation and correction.

For carers already under strain, this creates several risks:

- safety-critical information may be missed, minimised, or misunderstood
- carers may not have the capacity to restate complex information clearly under pressure
- power imbalances make it difficult to challenge incorrect assumptions
- the outcome of the reassessment may be shaped by what can be articulated in the moment rather than what is documented

This is particularly concerning where reassessments occur by phone, under time constraints, and in contexts where carers are managing competing demands or physical injury.

### **Procedural fairness is not a formality**

From a human rights perspective, procedural fairness is not a bureaucratic nicety. It is a safeguard that ensures decisions affecting safety, dignity, and bodily integrity are made on a sound basis.

A reassessment that proceeds without proper review of existing evidence undermines:

- the right to be heard meaningfully
- the right to decisions based on relevant information

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- the right to an effective remedy when circumstances have changed

When reassessments rely on carers to re-prove need verbally, rather than on the evidence already provided, those with the least capacity to advocate are placed at the greatest disadvantage. People who are injured, exhausted, digitally excluded, traumatised, or culturally marginalised are far less able to correct errors or challenge assumptions in real time.

Their silence is not consent. It is often a sign that the process itself has failed them.

### **Reassessments as risk points, not safeguards**

In theory, reassessments should reduce risk. In practice, when they are conducted without preparation or continuity, they can actually increase risk.

A poorly informed reassessment can:

- delay urgent action
- reinforce unsafe funding levels
- legitimise ongoing reliance on unpaid care
- create a false sense of review having occurred

From lived experience, there is a profound difference between a reassessment that meaningfully engages with evidence and one that merely completes a procedural step.

When reassessments function primarily as administrative checkpoints rather than genuine safety reviews, they fail in their safeguarding role.

### **Governance implications for the Scheme**

This is not an issue of individual staff conduct. It is a governance issue that reflects:

- insufficient time allocation for reassessments
- inadequate systems for ensuring planners review evidence
- lack of accountability for evidentiary engagement
- and performance measures that prioritise throughput over outcomes

If reassessments are to be relied upon as a core safeguard within the NDIS, there must be confidence that they are informed, deliberate, and grounded in the full evidentiary record. Without this, reassessments risk becoming procedural rituals that give the appearance of oversight while leaving unsafe arrangements unchanged.

I was able to recognise the problem, question it, and articulate its implications. Many cannot.

There are carers who do not feel able to challenge authority. There are participants with cognitive or communication impairments who cannot identify when their evidence has not been read. There are families who assume that if a reassessment has occurred, the system must now be responding appropriately.

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When reassessment quality is poor, these people are not protected by the process. They are exposed by it.

**What the Committee should consider**

For the purposes of this inquiry, reassessment quality should be examined as a key indicator of whether NDIA administration is capable of delivering integrity and safeguarding in practice.

If reassessments do not reliably engage with evidence, then:

- risk identification is weakened
- accountability is diluted
- and harm becomes more likely, not less

A system that treats reassessments as procedural tasks rather than safety-critical reviews cannot meet its stated intent of putting people with disability at the heart of the NDIS.

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## **7. Digital systems, automation, and exclusion**

The *National Disability Insurance Scheme Amendment (Integrity and Safeguarding) Bill 2025* expands the use of electronic processes, automated correspondence, and digital information-gathering powers, including electronic claim forms and system-generated communications. These measures are framed as efficiency improvements and integrity safeguards.

While efficiency is important, digital systems are not neutral. How they are designed, implemented, and corrected determines whether they protect people or expose them to harm. In my experience, the increasing reliance on automation within NDIA administration has introduced new risks, particularly for those least able to navigate complex digital environments.

### **Autogenerated systems can entrench error**

In my own interactions with the NDIA, autogenerated correspondence:

- contained incorrect personal information
- misclassified a scheduled plan reassessment as a “check-in”
- issued automated messages stating that matters had been “actioned and closed” while the underlying risk remained unresolved

In each case, I was later advised verbally that the correspondence was incorrect and autogenerated. However, the written record remained unchanged unless actively challenged.

This matters because administrative records are treated as authoritative. When errors exist in those records, they shape future interactions, decisions, and assumptions. If inaccuracies are not easily identifiable and correctable, they become embedded.

From lived experience, the system appears to prioritise generating outputs over ensuring accuracy. The burden of detecting and correcting mistakes is shifted onto participants and carers.

### **Digital systems shift responsibility onto users**

For someone with time, confidence, high digital literacy, and the capacity to follow up repeatedly, it may be possible to challenge these errors. For many others, it is not.

Participants and carers may be living with:

- low digital literacy
- cognitive disability
- trauma or stress that affects concentration and memory
- language barriers
- limited internet access, particularly in rural and regional areas
- exhaustion from caring responsibilities

In these contexts, automated messages stating that a matter is “closed” can be taken at face value, even when risk remains. Silence from the system is easily misinterpreted as resolution.

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Digital systems that rely on users to notice, question, and correct errors create unequal outcomes. Those with capacity are more likely to obtain correction. Those without capacity are more likely to carry the consequences.

### **Automation without correction pathways undermines safeguarding**

From a safeguarding perspective, this is deeply concerning.

When a system:

- acknowledges risk verbally
- generates written records that are inaccurate
- and provides no clear, accessible pathway to correct those records

it undermines accountability. Errors are not merely administrative; they affect safety planning, escalation decisions, and the credibility of evidence over time.

In my experience, automated correspondence created a false sense of closure. Matters were described as resolved when they were not. This is particularly dangerous in a system dealing with safety-critical supports, where delay or misunderstanding can result in injury or deterioration.

### **Digital exclusion is a human rights issue**

This is not simply a matter of improving user experience. It is a digital equity and human rights issue.

Administrative models that are “digital by default” assume:

- stable access to technology
- confidence navigating online systems
- the ability to interpret bureaucratic language
- and the capacity to persist when errors occur

For many people with disability, carers, and families, particularly in rural and regional areas, these assumptions do not hold.

From a human rights lens, when systems become harder to navigate for those already marginalised, they reinforce inequality. Errors become more likely to affect people who cannot advocate effectively. Safeguards become less accessible to those who need them most.

The Committee is examining how the NDIA operates in practice and whether current systems protect participants. Digital systems that entrench error, obscure accountability, and shift responsibility onto users undermine those objectives.

If the NDIS is to operate with integrity and safeguarding at its core, digital systems must:

- prioritise accuracy over speed
- provide clear, accessible correction pathways

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- recognise digital literacy as a determinant of access
- and ensure that automation does not replace responsibility

Without these safeguards, digital efficiency risks becoming another way that harm is quietly displaced onto those least equipped to carry it.

## **8. Rural and regional impacts**

As the Rural and Regional Women Adviser with the National Council of Women of Victoria, and as someone living these systems daily, I see clearly that the administrative failures outlined above are not evenly distributed. They are significantly amplified in rural and regional contexts, where the assumptions underpinning the NDIS often do not match lived reality.

In metropolitan areas, administrative delay may be inconvenient. In regional areas, it can be dangerous.

In regional contexts:

- provider choice is limited or non-existent
- workforce gaps are frequent and unpredictable
- services are often unavailable at short notice
- travel distances and time compound delays
- unpaid carers are relied on as the primary continuity mechanism

When supports cannot be sourced locally, there is no meaningful “choice and control.” There is only what is available, or what can be absorbed privately by families.

### **Administrative delay becomes a risk multiplier**

Many NDIA administrative processes assume that delays can be managed because alternative supports can be arranged or care can be redistributed temporarily. In regional settings, this assumption collapses.

When a plan does not reflect actual need, or when a reassessment is delayed:

- there may be no alternative provider to trial
- no short-term capacity to increase hours
- no local workforce to fill gaps
- no nearby services to step in

In these circumstances, delay is not neutral. It actively increases risk. Every week that unsafe arrangements persist compounds physical strain, emotional exhaustion, and the likelihood of injury or system failure.

From lived experience, rural carers are not “holding the line” briefly while the system adjusts. They are sustaining unsafe arrangements indefinitely because there is nowhere else for the care to go.

**Submitted by:** Sarah Barnbrook, Unpaid carer

### **Unpaid care as the default rural response**

In regional areas, unpaid carers are not treated as supplementary supports. They are treated as the default infrastructure that allows the Scheme to function despite market failure.

This reliance is rarely acknowledged in planning conversations, yet it is foundational to how the NDIS operates outside metropolitan centres. Plans may be written as though provider availability is theoretical rather than real. When services cannot be sourced, responsibility quietly shifts to families, most often women.

For rural women carers, this results in:

- prolonged exposure to unsafe physical demands
- withdrawal from paid employment
- economic insecurity
- cumulative injury and chronic health issues
- increased isolation and reduced capacity to advocate

These outcomes are not accidental. They are the predictable result of administrative models that fail to account for geography.

### **Human rights and equality of access**

From a human rights perspective, equality of access means more than identical rules. It requires that administration respond to different conditions in ways that achieve equivalent outcomes.

When planning assumptions are based on metropolitan service density, rural and regional participants and carers are systematically disadvantaged. The result is indirect discrimination, where ostensibly neutral administrative practices produce unequal harm.

Women in rural and regional areas are particularly affected because they are more likely to:

- be primary carers
- have fewer employment alternatives
- face greater barriers to advocacy and services
- be isolated from peer and professional support

When the NDIS fails to account for these realities, it reinforces existing gender and geographic inequalities rather than alleviating them.

### **The absence of a safety net**

In metropolitan areas, there is often at least some buffer, additional providers, emergency services, or specialist support within reach. In regional areas, there is no such margin for error.

When administrative systems fail in regional settings:

- carers absorb the immediate risk

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- children are drawn into caring roles
- injuries accumulate quietly
- crises emerge suddenly and without warning

By the time harm becomes visible to the system, it is often already severe.

The Committee is examining whether the NDIS is administered effectively and equitably. Rural and regional contexts provide a clear test of this.

If the Scheme cannot respond safely where service options are limited, then its administrative design is incomplete. Equality of access cannot be achieved by applying metropolitan assumptions universally.

For the NDIS to operate with integrity and safeguarding at its core, administration must:

- recognise unpaid care as a risk factor, not a solution
- account explicitly for workforce scarcity
- prioritise early intervention in regional contexts
- and measure the true cost of delay where no buffer exists

Until rural and regional realities are embedded into administrative decision-making, the Scheme will continue to function at the expense of women's health, carers' safety, and family wellbeing, outcomes fundamentally inconsistent with its stated purpose.

**Submitted by:** Sarah Barnbrook, Unpaid carer

## **9. Safeguarding gaps and impact on children**

When the NDIS fails to provide adequate or timely supports, the consequences do not stop with the participant. The burden created by administrative delay, underfunding, or workforce gaps is transferred into households. In my experience, this transfer has resulted in dependent children being required, at times, to step in to support high-care needs when paid supports are unavailable.

This should never occur. It is not appropriate, safe, or consistent with the intent of the NDIS. It represents a safeguarding failure that is structural, not incidental.

### **How safeguarding fails silently**

Safeguarding within the NDIS is often framed in terms of preventing abuse by providers or responding to overt harm. Far less attention is given to systemic safeguarding failures, where harm arises not from misconduct, but from inaction.

When funded supports do not meet actual need, and when administrative processes are slow to respond despite known risk, care does not simply pause. It is redistributed within the household. In families already under strain, this redistribution can result in children being drawn into caring roles that are inappropriate for their age, development, and wellbeing.

This transfer often occurs quietly. It is not formally recorded as a safeguarding incident. It is not captured in compliance data. It is normalised as “family support,” even when it involves exposure to medical care, physical strain, emotional stress, and ongoing vigilance.

From lived experience, this is one of the most hidden forms of harm produced by administrative failure.

### **Children as invisible risk absorbers**

Children do not choose to become carers. When systems fail, they become the **last buffer** between unsafe care arrangements and crisis.

In households where a parent or primary carer is already stretched, injured, or absent, children may step in to:

- provide physical assistance
- respond to urgent care needs
- monitor safety
- manage emotional distress within the household

This is not resilience. It is exposure to adult responsibility without protection.

From a safeguarding perspective, this represents a failure to protect children’s rights to safety, development, education, and emotional wellbeing. It also places children in situations where they may feel responsible for outcomes they cannot control.

**Submitted by:** Sarah Barnbrook, Unpaid carer

It is critical to understand that these situations do not arise from parental choice or family dysfunction. They arise from administrative conditions.

When the NDIA:

- acknowledges risk but does not act
- delays reassessment or plan adjustment
- assumes unpaid care will continue
- fails to account for workforce scarcity

it creates an environment where families must improvise to prevent immediate harm. Children are drawn into care not because it is appropriate, but because the alternative is leaving someone unsafe.

Safeguarding cannot be separated from administration. When systems fail to intervene early, they expose children to harm indirectly, but predictably.

### **Long-term consequences**

The impact of inappropriate caring roles on children does not end when the immediate situation stabilises.

From lived experience and advocacy work, these impacts can include:

- chronic stress and anxiety
- disrupted education and social development
- difficulty forming boundaries and relationships
- long-term emotional burden
- normalisation of crisis and instability

These outcomes are not measured by the NDIS, yet they are part of the real cost of administrative failure.

The Committee is examining whether the NDIS operates with integrity and safeguards those it is intended to protect. Safeguarding must include more than provider regulation and enforcement.

A system that allows children to quietly absorb the consequences of inadequate supports is not safeguarding families. It is shifting harm into spaces where it is least visible and least accountable.

Safeguarding must therefore include:

- recognising when administrative delay creates family-level risk
- preventing reliance on children as informal care providers
- treating unpaid care and household strain as indicators of system failure, not coping

If the NDIS is to meet its stated intent, it must prevent harm before it reaches children, not rely on families to absorb it silently.

**Submitted by:** Sarah Barnbrook, Unpaid carer

## **10. Integrity, sustainability, and human rights**

The Government has emphasised integrity and sustainability as central to current NDIS reform. These goals are repeatedly referenced as justification for tighter controls, increased enforcement powers, and more efficient administrative processes. In principle, these objectives are sound. A scheme of this scale must be sustainable, and it must operate with integrity.

However, sustainability cannot be achieved by shifting cost and risk out of the Scheme and into private households. When administrative systems rely on invisible labour and absorbed harm to continue functioning, they do not reduce cost, they displace it.

In my experience, this displacement is not accidental. It is a predictable outcome of administrative settings that allow risk to be acknowledged without action, delays to persist without escalation, and unpaid care to be treated as a stabilising force rather than a warning sign.

### **Displacement is not efficiency**

When the NDIS does not fund adequate supports in real time, the immediate consequences are not reflected on a balance sheet. Instead, they appear as:

- physical injury to unpaid carers
- withdrawal from paid employment
- increased reliance on family members, including children
- deterioration in household wellbeing
- long-term health costs transferred to other systems

From an administrative perspective, the Scheme may appear to be operating within budget parameters. From a lived-experience perspective, the cost has not disappeared, it has simply been relocated.

This is not integrity. It is accounting invisibility.

True integrity requires that the Scheme be honest about where its costs land and who is carrying them.

### **Sustainability built on harm is not sustainable**

A system that remains viable only because unpaid carers continue to sacrifice their health, income, and safety is not sustainable. It is fragile.

In my case, the continued reliance on unpaid care has resulted in permanent physical injury. As outlined earlier in this submission, my left hip labral tear was surgically repaired in 2019 following injury caused by caring. The condition has since deteriorated, and I have been advised that a total hip replacement is now required. When carers' bodies fail, and they eventually will, the system does not gradually adapt. It collapses suddenly, often into crisis care, hospitalisation, or emergency placements.

**Submitted by:** Sarah Barnbrook, Unpaid carer

This pattern creates precisely the kind of instability and cost escalation the Government says it is trying to avoid.

From lived experience, early action costs less than late crisis. Yet current administrative practices frequently delay intervention until carers' capacity has already been exhausted.

### **Human rights are measured in outcomes, not intent**

Human rights are not upheld by stating principles or completing processes. They are upheld by outcomes that protect people's safety, dignity, and bodily integrity.

When administrative systems:

- acknowledge risk but allow it to persist
- rely on unpaid carers to absorb harm
- draw children into inappropriate caring roles
- and treat these outcomes as outside the Scheme's responsibility

they fail to meet the standard of rights-respecting governance.

This failure affects not only people with disability, but also the carers, predominantly women, whose unpaid labour sustains the system, and the children whose wellbeing is compromised in the process.

If integrity and sustainability are to mean more than cost containment, they must include:

- honest accounting of where harm and effort are displaced
- recognition of unpaid care as a risk indicator, not a solution
- administrative triggers that respond before capacity collapses
- measurement of outcomes, not just throughput

A sustainable NDIS is not one that functions on paper while families break quietly in the background. It is one that intervenes early enough to prevent harm, protects those carrying the load, and distributes responsibility where it belongs.

Until administrative systems are designed to prevent displacement rather than depend on it, the goals of integrity and sustainability will remain unmet, not because the intent is wrong, but because the outcomes do not match it.

**Submitted by:** Sarah Barnbrook, Unpaid carer

## **11. Recommendations**

In light of the issues outlined in this submission, I respectfully recommend that the Committee consider the following measures to strengthen the administration, integrity, and safeguarding of the NDIS in practice.

These recommendations are grounded in lived experience of how current administrative settings operate, and in the human rights principle that harm should be prevented where it is foreseeable.

### **1. Require reporting on evidence-to-outcome alignment for safety-critical decisions**

The NDIA should be required to demonstrate how submitted professional evidence is reflected in plan outcomes where safety-critical risk is identified.

This should include:

- clear documentation of whether and how evidence has been accepted, modified, or rejected
- reasons provided where plan funding does not align with identified risk
- specific reporting on cases involving manual handling risk, high-care needs, and unsafe support ratios

This would shift the focus from procedural completion to outcome accountability, and ensure that acknowledged risk cannot be left unaddressed without explanation.

### **2. Establish clear escalation pathways when foreseeable harm is identified**

The NDIA should implement explicit escalation pathways that are triggered when evidence indicates foreseeable harm to a participant or carer.

These pathways should:

- prioritise safety-critical risks for urgent review
- allow for interim safeguards while reassessment is underway
- recognise unpaid carer injury and capacity collapse as escalation triggers
- ensure responsibility for action is clearly assigned

Foreseeable harm should never sit in a queue. Early escalation prevents crisis and reduces long-term cost.

### **3. Strengthen requirements for planner preparation prior to reassessment**

Reassessments should be recognised as safety-critical decision points and treated accordingly.

The NDIA should require that:

- planners confirm review of all relevant evidence prior to reassessment
- reassessments cannot proceed without documented engagement with key reports
- time allocation reflects the complexity and risk involved

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- quality assurance mechanisms assess preparedness, not just throughput

This would improve procedural fairness and reduce the likelihood of unsafe decisions being made under pressure.

#### **4. Improve accountability and correction mechanisms for automated records and correspondence**

As automation and digital systems expand, so must safeguards for accuracy and correction.

The NDIA should:

- provide clear, accessible pathways to correct autogenerated errors
- ensure that verbal acknowledgements of error are reflected in written records
- prevent automated “actioned and closed” messages from being issued where risk remains unresolved
- treat record accuracy as a safeguarding issue, not a clerical one

Administrative records shape future decisions. Errors must not be allowed to persist by default.

#### **5. Incorporate unpaid carer impact into NDIA performance and sustainability metrics**

Unpaid care should be recognised as a key indicator of system strain, not an invisible resource.

The NDIA’s performance and sustainability reporting should include:

- reliance on unpaid care to fill funded support gaps
- evidence of carer injury, burnout, or withdrawal from employment
- household-level risk indicators, including impacts on children

Without measuring where unpaid labour is propping up the system, the true cost of administration remains hidden.

#### **6. Ensure digital systems do not entrench exclusion or inequality**

Digital administration must be assessed not only for efficiency, but for equity.

The NDIA should ensure that:

- digital systems are designed with low digital literacy in mind
- correction pathways do not rely on repeated user persistence
- alternatives to digital-only processes are accessible and effective
- automation does not replace human responsibility for safeguarding

Digital systems should reduce burden, not shift it onto those least equipped to carry it.

#### **7. Embed rural and regional realities into planning and administrative assumptions**

Administrative models must account explicitly for geographic reality.

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The NDIA should:

- adjust planning assumptions where provider markets are thin or unstable
- recognise workforce scarcity as a risk factor, not an external issue
- prioritise early intervention in regional contexts where no buffer exists
- ensure equality of access is measured by outcomes, not uniform rules

Without this, rural and regional participants and carers will continue to experience disproportionate harm.

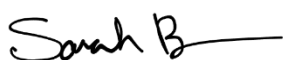
## 12. Closing

I am making this submission not to seek redress for my own circumstances, but to give voice to carers, families, and participants whose harm is quietly absorbed, normalised, and rendered invisible by administrative design.

Across this submission, I have outlined how failures in administration, not intent, allow foreseeable harm to persist. When systems acknowledge risk without acting on it, rely on unpaid carers to sustain unsafe arrangements, and displace cost and responsibility into households, the NDIS falls short of its stated purpose.

Integrity and safeguarding cannot be measured by the existence of powers, penalties, or processes alone. They must be measured by outcomes, by whether systems intervene early enough to prevent harm, protect bodily integrity, and uphold dignity for people with disability and those who support them.

I thank the Committee for the opportunity to contribute to this inquiry and urge it to consider how administrative practice can be strengthened so that integrity and safeguarding are realised in lived experience, not just in policy intent.



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