Response to the

Review of child restraint requirements in the Australian Road Rules

19 December 2025

Submitted by: Mobility and Accessibility for Children and Adults Ltd.

MACA

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19 December 2025
National Transport Commission
Level 3/600 Bourke Street
Melbourne VIC 3000

To whom it may concern,

Re: Review of child restraint requirements in the Australian Road Rules

Mobility and Accessibility for Children and Adults Ltd (MACA) welcomes the opportunity to respond to the preliminary regulatory options and early-stage questions outlined in the *Review of child restraint requirements in the Australian Road Rules* Issues Paper.

About MACA

MACA is a not-for-profit organisation dedicated to advancing the rights of people with disabilities and medical conditions to safe and equitable motor vehicle transport. Our work program includes the Australian Safety Assessment Program (AuSAP), the only independent assessment and crash testing program in the world for specialty vehicle restraint systems.

With funding support from the the Australian Government Department of Health, Disability and Ageing, we are leading national efforts to address systemic gaps in research, policy, and practice impacting the safe transport of children and adults with disabilities and medical conditions. Our work focuses on:

- Developing national information resources for parents, carers and allied health professionals.
- Building capacity and capability across organisations, allied health professionals and disability product suppliers, who play a key role in supporting children's transport needs.
- Strengthening policies and systems to ensure they are inclusive of, and responsive to, the transport needs of people with disabilities and their families.
- Advancing research and driving innovation to support safe and equitable transport outcomes.

Response to the Issues Paper

MACA commends the National Transport Commission (NTC) for its inclusive and considered approach to this review. We view this review as a significant step towards achieving equitable transport for Australian children with disabilities and medical conditions. The review's focus area on *Improving the level of protection for children with medical conditions and disabilities* aligns with MACA's vision that every person should have access to safe and equitable transport.

Our submission provides responses to relevant questions outlined in the Issues Paper, with a particular focus on Section 4 — *Children with medical conditions or disabilities.* As many children with disabilities and medical conditions can safely travel in Australian Standard child restraints, we have also addressed relevant questions in other sections of the paper.

We wish to draw attention to the critical role of occupational therapists and physiotherapists in assessing and prescribing for the motor vehicle transport needs of children with disabilities and medical conditions. MACA strongly supports the proposed regulatory framework to formally recognise suitably trained allied health professionals as approved prescribers of 'alternative restraints/methods of travel.'

Occupational therapists and physiotherapists apply an evidence-informed approach to assessing and prescribing for children's motor vehicle transport needs, consistent with their professional obligations and AHPRA regulation. Research shows that they are the **primary source of advice** for parents of children with disability seeking guidance on safe and appropriate transport options (Black et al., 2023). However, in 2020 these professionals reported significant challenges, including limited access to specialised training and professional supports (Black et al., 2024). They also reported challenges in understanding and navigating road rules, as highlighted in these comments from participants of MACA's specialist training course.

> *It would be great for all states to have the same road laws and vehicle standards to make it consistent across the board, it makes it more confusing and difficult for families when travelling between states as the requirements are different and you have to make sure you have i.e. the right paperwork completed as it can differ between states.*
>
> *A more nationally consistent approach would reduce stress for families when transporting their children particularly in the disability community when accessing essential care occurs across state borders.*

In response, MACA developed a specialist training course and accompanying prescribing resources to build workforce capability and support evidence-based practice. The resources include detailed information about the road rules in each state and territory.

We believe that recognising occupational therapists and physiotherapists, in addition to medical practitioners, within the regulatory framework would, for example:

- Reduce the cost and burden for families of obtaining a medical certificate from a medical practitioner where the child has been assessed by an occupational therapist or physiotherapist.
- Raise community awareness about the role of suitably trained allied health professionals in supporting families of children with disabilities and medical conditions with motor vehicle transport.
- Assist families to gain access to suitable alternative methods of travel, improving road safety and community participation.
- Enable harmonisation of road rules across jurisdictions, reducing confusion and burden for families, allied health professionals and organisations.

Further details on these benefits are provided in our submission.

We would like to express our thanks for the opportunity to provide input into this important review. MACA welcomes further discussion on the matters raised in our submission and looks forward to continued collaboration with the NTC to advance the rights of all Australian children to safe and equitable motor vehicle transport.

Yours sincerely,

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Question 5: Should national legislation address incorrect use and modifications and accessories to restraints more clearly?

No. We do not believe the Australian Road Rules (ARR) are the appropriate mechanism to address the full range of aftermarket accessories, vehicle- and child-restraint-specific modifications, or incorrect use.

Multiple standards, regulatory settings and legislative frameworks intersect in this area, including, for example:

- AS/NZS 1754 Child restraint systems for use in motor vehicles
- AS 8005:2020 Accessories for child restraints for use in motor vehicles
- AS 5384:2023 Accessories for seat belts for use in motor vehicles
- Vehicle standards, modification codes and jurisdictional approval schemes
- Australian Competition and Consumer Commission consumer law
- Jurisdictional processes, including child restraint fitting programs, equipment-approval pathways and medical-exemption mechanisms
- National disability frameworks, including the National Disability Insurance Scheme (NDIS), which influences prescribing practices, funding decisions and market supply of restraint-related assistive technology.

This broader environment is too complex for the ARR to address. Any changes to address modification, accessories and incorrect use will need to consider impacts in relation to the existing regulatory and legislative environment.

We therefore support a non-prescriptive approach in the ARR, combined with clear definitions and a nationally consistent prescriber role (as outlined in our response to Question 20). This would enable all jurisdictions to apply a consistent and evidence-based approach for passengers under 16 years, including children with disabilities and medical conditions.

Prescriber role

The current retail environment includes a wide range of accessories, readily available online and through shop-front retailers, which can create confusion for families and increase safety risks and non-compliance.

Research over the past seven years demonstrates that suitably trained allied health professionals (prescribers) play a critical role in ensuring safe and appropriate solutions (Black et al., 2024). Importantly preliminary research findings have found a reduction in prescribing of accessory products and modifications for children with disabilities and medical conditions, when compared to a baseline evaluation undertaken in 2020/21. This included, for example, reductions in prescribing additional padding (40% to 25%), head supports (37% to 25%), and specialty harnesses/vests (68% to 52%).

Recognising the prescriber role within the ARR provides an opportunity to strengthen community understanding that accessories and modifications should only be used when clinically appropriate, rather than purchased or applied independently. Prescriber recognition also has the potential to disincentivise the sale or promotion of inappropriate products, while creating a clear, forward-looking pathway that encourages manufacturers to develop accessories that comply with AS 8005 and AS 5384.

Question 7: Should the ARR allow for the use of transversely installed (for example, lie-flat) child restraints?

Yes. MACA strongly supports the inclusion of provisions within the ARR to allow the use of transversely-installed (lie-flat) child restraints, consistent with AS/NZS 1754 terminology.

AS/NZS 1754 defines 'transversely installed restraints' as those where the child lies approximately at right angles to forward direction of travel of the vehicle.

The ARR currently provides for definitions of **rearward facing** approved child restraints and **forward facing** approved child restraints, however, there is no definition for **transverse** approved child restraints.

Australian families have not had access to a transverse child restraint since the Steelcraft Swinger ceased production around 1987. The Steelcraft Swinger was designed as a lie-flat child restraint and was available for mainstream use. In contrast, Europe and the United States have lie-flat child restraints widely available for mainstream use. In addition, the US offers specialised lie-flat 'car beds' for infants with complex medical conditions.

Although AS/NZS 1754 continues to provide for transversely-installed restraints (Type A3), no manufacturer has developed a product in recent decades, likely due to the small market size and the need for two vehicle seating positions for installation. This lack of availability of AS/NZS 1754 transversely-installed lie-flat child restraints negatively impacts infants and young children, who for medical reasons are unable to be transported in an inclined, or semi-inclined position. Consequently, infants and young children requiring lie-flat transport have faced limited and often unsafe options, including travelling on a parent's lap or relying on ambulance day transport restricted to hospital appointments. These barriers significantly impact family mobility, community participation, and overall quality of life.

The personal impact of this lack of access is significant, as shared by Julie Cini, founder and former CEO of Spinal Muscular Atrophy Australia:

> *'As a parent who lost two daughters to Type 1 Spinal Muscular Atrophy (SMA), the devastation of not being able to go out with my family before my daughters died lives with me forever.'*

Since 2019, MACA has led a national initiative to enable access to transversely-installed lie-flat child restraints from overseas in Australia. This work included two global desktop reviews, stakeholder workshops, engagement with international manufacturers, and crash testing of three products. A transversely-installed lie flat child restraint from Europe, is now available in Australia as a special purpose car seat, with a pilot program underway at the Royal Children's Hospital.

Proposed regulatory solution

Inclusion of a definition for transverse child restraints would encourage industry investment and innovation to develop AS/NZS 1754 transversely-installed lie-flat child restraints for the Australian market. This would extend the choice of lie-flat child restraints to all families, consistent with availability in Europe and the United States. It would also reduce reliance on overseas products and ensure continued access for Australian children with medical vulnerabilities who require lie-flat child restraint systems.

Access to overseas transversely-installed lie-flat child restraints would continue to be managed appropriately under the proposed ARR framework - through prescribers and medical practitioners approved to support use of alternative methods of travel, ensuring safe and clinically justified use for children with complex medical needs.

Without these regulatory changes, Australia risks both the continued exclusion of families who need lie-flat child restraint options and the complete loss of access to these essential products as global production declines.

Question 15: Should the ARR be amended to allow for children aged four to seven years to travel in the front seat when rear seating is unavailable due to another passenger's disability or medical need?

Yes. MACA supports consideration of amendments to the ARR to enable a controlled and nationally consistent mechanism allowing a child aged four to under seven years to travel in the front seat when all rear seating positions are occupied by passengers with a disability or medical condition and a carer providing medical supervision. This would be appropriately managed through the proposed role of prescribers to authorise alternative methods of travel.

This approach aligns with Australia's obligations under the United Nations Convention on the Rights of the Child (Articles 3 and 23), which require that the best interests of the child and the rights of children with disabilities to community participation are considered in all policy decisions.

MACA acknowledges that the rear seat of a vehicle provides the highest level of protection for children and supports initiatives that encourage children to travel in rear seats for as long as practicable. However, strict application of this rule can unintentionally disadvantage some families where rear seats are required to accommodate children with disabilities and medical conditions, and a supervising parent or carer.

In 2021, MACA supported a family with twin children requiring medical monitoring in the rear seat, and a four-year-old sibling who consequently had no available rear seating position. MACA sought legal advice which confirmed the relevant jurisdiction's road rules did not clearly provide for such circumstances.

The legal advice identified uncertainty in the interpretation, specifically whether a medical certificate could be issued because of another person's disability or medical condition, rather than the front seat passenger's own condition.

Following this advice, MACA sought guidance from the relevant regulator. After several months of correspondence, the regulator confirmed that a registered medical practitioner could issue a medical certificate, permitting the four-year-old to travel in the front seat in an approved booster seat when no rear seating was available.

While this outcome was ultimately positive, the process took months to resolve, during which the family experienced significant isolation and distress, unable to travel together or attend family events at an already stressful time. The regulator also noted that its correspondence was only indicative of policy, not an exemption under the relevant road rules, and that enforcement discretion rested with police or the courts.

This case illustrates the inequity created by the current ARR which have provision to allow children aged four to under seven years to travel in the front seat when no rear position is available. However, the ARR do not provide an equivalent provision for families whose need for their child aged four to under seven years to travel in the front seat is due to another child's disability or medical need.

We also support improving clarity in the ARR regarding the type of vehicle restraint that a child aged four to under seven years must travel in when in the front passenger seat.

Question 17: Do you support updating the definitions of 'approved child restraint', 'approved booster seat' and 'approved child safety harness' in the ARR?

Yes. We support updating the definitions of approved child restraint, approved booster seat and approved child safety harness in the ARR.

MACA supports updating the definitions of *approved child restraint, approved booster seat and approved child safety harness* in the ARR to refer to products that comply with AS/NZS 1754:2013 or any subsequent versions of the Standard.

Consistent definitions across jurisdictions will support national harmonisation and provide improved clarity for Australian families, health professionals, and regulators.

Regarding variations to Australian standard child restraints to cater for specific disabilities (section 7 in AS/NZS 1754:2024), we support the proposal to exclude these from the definitions of *approved child restraint, approved booster seat* and *approved child safety harness*. These would be captured under *approved alternative methods of travel* instead (refer to Question 18), as this ensures they are assessed as suitable for the child's individual needs by a suitably trained prescriber. It also recognises that section 7 provides for limited variations, with alternative methods of travel much broader. Further it aligns with the AS/NZS 1754:2024 advisory information on labelling to include: "Advice that the contents are ONLY for use where professionally prescribed for a child with disability".

Question 18: Do you support introducing clearer legal definitions for approved alternative methods of travel in the ARR? What should these definitions be?

Yes. We support the proposed definition of alternative methods of travel as those *approved for use by a prescriber.*

As alternative methods of travel are varied and evolving in response to new research and innovation, it would not be possible to provide a prescriptive definition. This broad definition therefore provides the appropriate flexibility and adaptiveness for suitably trained prescribers to apply a best practice approach.

This definition also promotes a person-centred approach, recognising the individual needs of children with disabilities and medical conditions.

Question 20: Should prescribers be formally recognised in the ARR as approvers of alternative methods of travel? If so, who should be covered by the definition of prescribers?

Yes. MACA strongly supports formal recognition of prescribers in the ARR as approvers of alternative methods of travel.

This aligns with the role that some allied health professionals already undertake in providing clinical assessments and prescribing alternative methods of travel for children with disabilities and medical conditions.

The current ARR only has provision for medical practitioners to provide exemptions from the standard ARR requirements for children with disabilities and medical conditions. The lack of inclusion of allied health professionals in the ARR can result in unnecessary barriers, time and cost burdens for families impacting on road safety, community participation and wellbeing.

The Issues Paper provides a possible definition of prescriber:

> *'Prescriber': A person who is suitably trained and responsible for assessing a person's needs and prescribing the way in which a person with disability or a medical condition should be transported in a motor vehicle. This is an occupational therapist, physiotherapist, psychologist, medical practitioner or rehabilitation engineer/biomedical engineer.*

The professionals included in this definition are derived from the definition provided in the aged standard AS/NZS 4370:2013. The proposed definition differs from AS/NZS 4370:2013 in that it includes 'suitably trained'.

The inclusion of 'suitably trained' responds to recent research and practice which recognises the specialised knowledge and skills required to undertake clinical assessment to assess and prescribe for the motor vehicle transport needs of children with disabilities and medical conditions. For example, an Expert Group involved in a recent Austroads project investigating specialty harnesses/vests recommended that:

> *'the assessment of the need for a child (under 16 years) with a disability or medical condition to use a specialty harness/vest should be undertaken by **appropriately trained prescribers**'* (Austroads., 2025, p.33).

Who should be covered in the definition of prescriber?

The Australian Health Practitioner Regulation Agency (AHPRA) regulates Australia's registered health practitioners, including medical practitioners, occupational therapists, physiotherapists and psychologists, to ensure they practise safely, ethically and within their scope of practice.

Scope of practice refers to the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform.

Through National Boards, AHPRA sets and enforces professional standards, registration requirements, and codes of conduct, and requires practitioners to practise within their training and expertise and to refer when a task requires specialist skills outside their profession.

Occupational therapist and physiotherapist

We strongly support the inclusion of occupational therapist and physiotherapist in the definition of 'prescriber' in the ARR.

In Australia, the allied health professionals most involved in assessing and prescribing for motor vehicle transport needs of children with disabilities and medical conditions are occupational therapists, followed by physiotherapists. This is reflected in MACA's specialist training data, which shows participation of 89% occupational therapists and 11% physiotherapists.

Australian parents report that allied health professionals are their most preferred source of information about safe transport for their child with disability or medical condition (Black et al., 2023). This is echoed by allied health professionals who report they are the best source of information for parents (Black et al., 2024).

Medical practitioner

We support the inclusion of medical practitioner in the definition of 'prescriber' in the ARR.

Whilst occupational therapists and physiotherapists are the primary prescribers in this field, the inclusion of medical practitioners recognises that some of these professionals may include prescribing for the motor vehicle transport needs of children with disabilities and medical conditions within their scope of practice.

Psychologist

We do not support the inclusion of psychologist in the definition of 'prescriber' in the ARR.

MACA is not aware of any data regarding psychologists assessing and prescribing for the motor vehicle transport needs of children with disabilities and medical conditions. However, we recognise the important role that psychologists provide in supporting children and families, often as part of a multi-disciplinary care team.

Rehabilitation engineer and biomedical engineer

We do not support including rehabilitation engineer and biomedical engineer in the definition of 'prescriber' in the ARR.

Rehabilitation engineers and biomedical engineers provide valuable technical expertise, for example in the design, adaptation and evaluation of assistive technology. However, they are not regulated by AHPRA and therefore do not have nationally consistent requirements relating to scope of practice, ongoing competency, or professional conduct.

These professionals may be members of *Engineers Australia,* which is a voluntary professional body and not a statutory regulator. Queensland is the only jurisdiction with a statutory registration framework for professional engineers, but this system is not specific to rehabilitation or biomedical engineering and does not provide national regulatory oversight.

Given the absence of a national regulatory framework and the clinical nature of prescriber responsibilities, we do not support including rehabilitation engineers or biomedical engineers in the definition of prescriber in the ARR.

Vehicle restraint fitter

We do not support including vehicle restraint fitter in the definition of 'prescriber' in the ARR.

People trained in fitting Australian standard child restraint systems and specialty vehicle restraints and accessories play an essential role in ensuring correct installation, user education and custom adjustments where required. These service providers work closely with prescribers to support families and their children's motor vehicle transport needs.

While they may have completed specialist fitment training, they typically do not hold tertiary qualifications in clinical assessment, such as evaluating a child's medical, behavioural, or postural needs. There is also no national regulatory framework that oversees these vehicle restraint fitters or defines a consistent scope of practice.

For these reasons, we do not support expanding the prescriber definition to include vehicle restraint fitter.

Revised proposed definition

We propose the following definition of prescriber in the ARR. We have removed the term 'suitably trained' as it is redundant; the training and competence of the included professions are already governed through AHPRA registration and relevant National Board standards:

'Prescriber' means an occupational therapist, physiotherapist or medical practitioner (as defined in these Rules) who assesses a person's needs and determines the appropriate method of transport for a person with disability or medical condition in a motor vehicle.

Note: All future references to 'prescriber' align with this revised proposed definition.

Alignment with other frameworks

The proposed definition directly aligns with the established roles and professional obligations of these prescribers across other national service systems such as the ational Disability Insurance Scheme (NDIS), hospitals, community health, and education settings. This ensures consistency across policy domains and minimises confusion for families, health professionals, regulators, and service providers.

For example, under the NDIS, the prescriber undertakes the role of a 'Professional Assistive Technology Assessor.'

Vehicle restraint systems and accessory products are classified by the NDIS as higher-risk AT, acknowledging both the inherent safety risks associated with motor vehicle travel and the importance of correct installation and use (NDIS, n.d.).

As Professional AT Assessors, prescribers undertake:

- clinical assessments
- evaluation of safety and functional risks
- prescription of appropriate AT
- preparation of formal evidence and documentation required by the NDIA for high-risk or complex AT

This demonstrates clear alignment between the proposed ARR definition and established national practice.

Roles and Responsibilities: A best practice framework for supporting motor vehicle transport for people with disabilities and medical conditions
(MACA., 2023)

This framework defines the roles and responsibilities of the broad range of stakeholders involved in supporting the motor vehicle transport needs of children with disabilities and medical conditions. This includes, for example, manufacturers, importers, clinicians, suppliers, service providers, funders, regulators and prescribers. It promotes coordinated, streamlined, and high-quality outcomes for people with disabilities and medical conditions in line with the scope of practice and expertise of professionals involved in supporting motor vehicle transport.

Capability Framework for Occupational Therapists Supporting People with Assistive Technology
(Occupational Therapy Australia., 2025)

This framework outlines the essential knowledge, skills, and attitudes required for occupational therapists supporting people with assistive technology (AT) across various career stages and across all relevant Australian service settings.

Section 4.12 outlines expectations across three levels of proficiencies in relation to assessing and recommending special purpose car seats, specialty vehicle restraints and accessory devices. This section refers to the need for occupational therapists working in this area to undertake 'specialist training'.

APA Physiotherapy Competence Framework
(Australian Physiotherapy Association., 2023)

The Australian Physiotherapy Association's Competence Framework provides explicit performance statements that emphasise:

- safety and quality in healthcare
- contemporary, evidence-based practice
- accountability within defined scope of practice

This supports physiotherapists' inclusion in the prescriber definition and reinforces alignment with established professional standards.

Benefits of formally recognising prescribers in the ARR

Formally recognising prescribers in the ARR as approvers of alternative methods of travel will deliver significant safety, equity, efficiency and system-wide benefits for families, clinicians and government.

Short term benefits

1. **Reduced time and cost burden on families**

   Removing the requirement for a medical certificate (often duplicating clinical assessment already completed by an allied health professional) reduces both:

   - out-of-pocket costs
   - unnecessary appointments and administrative delays.

2. **Faster access to safe and appropriate transport solutions**

   Families can obtain approval for alternative methods of travel more quickly, enabling timely access to health, education and community life.

3. **Improved road safety and safe participation in everyday life**

   Appropriate, timely prescription supports safer child restraint use, reduced misuse, and safer travel for children with disabilities or medical conditions.

4. **Improved national harmonisation of road rules**

   A consistent definition of prescriber across all states and territories reduces confusion, supports families travelling interstate or living in border regions, and streamlines administrative processes.

5. **Reduced delays in hospital discharge**

   Allied health professionals involved in hospital care can approve alternative travel methods as part of discharge planning, preventing unnecessary extended stays and freeing up hospital resources.

Longer term benefits

1. **Raised community awareness and improved public understanding**

   Clear prescriber roles promote better understanding of safe transport needs for children with disabilities.

2. **Improved government information and guidance**

   Government agencies can provide clearer, more consistent advice on their websites and in public materials.

3. **Stronger policy settings across the transport, disability and health sectors**

   A consistent, evidence-based definition enables policy alignment and reduces duplication of regulatory requirements.

4. **Increased investment in research and innovation**

   Formal recognition of prescribers and clearer national pathways support further investment in research, product development and safety innovation for transport of children with disabilities.

Question 21: Would removing the current age split and focusing on assessed needs better reflect real-world transport requirements for children with disabilities? How could this be achieved?

Yes. We support removing the current age split to recognise that children with disabilities and medical conditions who require alternative transport methods are assessed by prescribers based on individual needs, rather than age-based criteria.

The current differing requirements and conditions for children 'under seven years' and 'seven years to under 16 years' in the ARR create inconsistencies and unnecessary complexities, impacting safe transport and compliance. This is also exacerbated by jurisdictional differences.

The potential regulatory framework outlined in section 4.5 of the Issues Paper would remove the current age split and shift the primary focus to assessment based on individual needs when determining the suitability of alternative methods of travel.

Question 22: Are the current requirements for obtaining and using a medical certificate adequate, or do they create barriers to safe transport? What could be changed?

No. The current requirements for obtaining and using a medical certificate are not adequate and create barriers to safe transport for children with disabilities and medical conditions, impacting safety and community participation.

The current requirements limit the provision of medical certificate exemptions from the standard restraint rules to medical practitioners only.

In situations where an occupational therapist or physiotherapist has assessed and prescribed an alternative method of travel, the family is then required to seek the required medical certificate exemption from a medical practitioner.

This requirement can create duplication of cost and effort for families, and barriers to safe transport. For example, some medical practitioners advise families that they are unable to provide a medical certificate due to lack of knowledge in this specialised area. This situation can cause stress, additional cost and time burdens for families, and delays in access to necessary transport (including for hospital discharge).

What could be changed?

As outlined in our response to Question 20, the recognition of 'approved prescriber' would reduce the need for occupational therapists and physiotherapists to refer to medical practitioners, whilst also retaining the ability for a medical practitioner to provide a medical certificate, where appropriate.

The recognition of 'approved prescriber' will also promote a harmonised approach. It will enable the development of nationally consistent information and resources to support families in accessing safe and suitable transport for children with disabilities and medical conditions requiring alternative methods of transport.

Case study

A four-year-old child with autism spectrum disorder repeatedly unbuckles their child restraint, climbs out of their car seat, and moves around the vehicle. Following a comprehensive assessment, the child's occupational therapist prescribes a child-restraint buckle cover. The OT completes a Transport Safety Advice Form and advises the parent that a medical certificate is required to legally use the buckle cover.

The parent books an appointment with their family doctor, with a one-week wait. During this time, the family limits their car travel to essential trips only, as the child continues to get out of their child restraint and remains at ongoing risk.

Question 23: What additional changes (legislative or non-legislative) do you believe are needed to improve the safe and consistent transport of children with disabilities and medical conditions?

We support the potential regulatory framework as outlined in section 4.5 of the Issues Paper. This proposed approach will significantly contribute to improved access to suitable and safe transport for children with disabilities and medical conditions, when they are unable to travel in line with the ARR for child restraints and vehicle seatbelts.

These changes can be realised today due to significant advancements in research, specialist training and practice. There is also increased community awareness of the rights of all people to safe and equitable transport.

However, further work, research and investment is needed to continue to advance the evidence-base and practice. Some examples of additional legislative and non-legislative changes are outlined below.

Legislative changes

Review ARR requirements for people aged 16 years and over

Following the review of child restraint requirements, the ARR provisions for people with disabilities and medical conditions aged 16 years and over should be reviewed for consistency.

Non-legislative changes

Operational funding for the Australian Safety Assessment Program (AuSAP)

MACA established AuSAP in 2020 with funding from the Victorian Transport Accident Commission. The program receives significant in-kind contributions from Neuroscience Research Australia (NeuRA), Britax Childcare Pty Ltd, and Transport for NSW (Safer Vehicles and Crashlab).

AuSAP has been instrumental in stimulating research, product innovations, and delivering unprecedented access to the safest specialty vehicle restraint systems for Australian children and adults from around the world.

However, MACA's coordination and management of this critical program is currently unfunded. Ongoing operational funding is essential to maintain this nationally significant program.

Further research investment

Additional research is needed to address ongoing gaps. For example, a recent Austroads report (Austroads., 2025) identified future research needs relating to specialty harnesses/vests, including:

- investigating their selection and use in school buses, and the continued need for products that convert lap-sash seatbelts to lap-only, or rely on lap-only belts
- investigating their use with modern seatbelt technologies such as pretensioners and load-limiters
- reviewing specialty harnesses/vests available in Australia and New Zealand against the criteria in AS 5384 Section 9 *Posture supports for occupants with disabilities,* and conducting selected crash testing following the desktop review and NeuRA research.

Inclusive information on government websites

Comprehensive information about transporting children with disabilities and medical conditions, including relevant road rules, should be included on mainstream government websites, such as state and territory transport agency sites.

Access to specialist training

As outlined in our response to Question 20, recent research, frameworks and practice recognise the specialised knowledge and skills required to assess and prescribe for the motor vehicle transport needs of children with disabilities and medical conditions.

The cost of accessing training can be a barrier, particularly for allied health professionals working in community, school and not-for-profit settings. MACA has secured grants in some jurisdictions to offer fully funded training places, but sustained funding is required to ensure ongoing equitable access.

Community education

To support implementation of any new ARR, a comprehensive communications plan is needed to ensure allied health professionals, organisations, and parents/carers understand the changes and what they mean in practice.

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