FEBRUARY 2014

Deception - The Illusion of Care, Protection and Rights in Victoria's Disability Accommodation Sector

AUTHORS: MARGARET RYAN AND MAX JACKSON

A JACKSONRYAN CHALLENGE PAPER

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Introduction

The Title – Deception - The Illusion of Care, Protection and Rights in Victoria’s Disability Accommodation Sector – did not come about by accident. It was created in order to convey the message that within the disability accommodation sector in the State of Victoria deception is taking place.

- It is a deception that seeks to create the illusion that the rights of all people with disabilities who reside in supported accommodation facilities are being upheld.
- It is a deception that seeks to create the illusion that all those charged with a duty of care to protect those in their care and to meet their support needs are fulfilling this mandated obligation.
- It is a deception that seeks to create the illusion that all who work in the sector are adhering to both the letter and intent of the Disability Act 2006 and are meeting both the objectives and principles of the Disability Act.
- It is a deception that seeks to create the illusion that “It’s OK to complain!” and that complaints will be dealt with judiciously, efficiently and where they need to be investigated, this will occur.
- It is also a deception that seeks to create the illusion that those who fail in meeting their duty of care obligations will face some type of remedial or discipline action.
- Yet, none of this is so - hence the title and this folio.

What this folio is about

This folio highlights in stark reality what is happening in various services within the disability accommodation sector. In effect it exposes the deception that is being perpetrated. Where, although care and protection and the practice of rights are promoted as the norm, the reality is that, in many instances, as evidenced by the cases depicted in this folio, the disability accommodation sector operates under a shroud of deception. These case studies are indicative of systemic practices in the disability sector.

Why a folio?

From time to time the plight of families and their family member with a disability receives some media and public and political attention. Nonetheless, this tends to be of fleeting interest and soon drifts from the consciousness of concern.

In some ways this is akin to what happened in terms of the sexual abuse of children. That is, the abuse drifted from consciousness until the realisation emerged that the abuse was far more widespread than ever contemplated. Also, that it was far more systemic than just a handful of individual cases. It was the ultimate acceptance of this realisation that finally led the Victorian Government to establish a Parliamentary Committee Inquiry in 2012 and the Federal Government to establish a Royal Commission in 2013 into the abuse of children. The reality for both governments was that the decades of abuse could no longer be countenanced.

The intention was, therefore, not just to expose systemic cover-ups and the abuse of power - but of equal significance, that real and demonstrable action will be taken to address the corruption; corruption created by unbounded power and a system more intent on protection of the already powerful.

The following extracts from the Victorian Committee's report into the handling of child abuse by religious and other non-government organisations are sobering and as such the power brokers in the disability sector must heed them.

> *"Evidence and information provided to the Inquiry showed that even today, leaders of some non-government organisations are reluctant to fully acknowledge that they adopted policies that gave first priority to protecting the interests of their organisation."*
>
> *"A challenge put by the Committee:*
> *How many complaints or established incidents of abuse would be necessary before it was acknowledged that a systemic problem existed within some organisations, and that their structures, processes and cultures required full investigation?"*
>
> *"Victims also had hopes and expectations that organisations they had trusted would acknowledge that they failed in their duty of care to protect them from the harm."*

The situation of there being people with disabilities where a duty of care is denied them, and the situation of their families being in effect shut out by the authorities, is also far more widespread than might ever be admitted.

This folio details a cross-section of case studies arising from actual events in the disability accommodation sector. These case studies illustrate how, despite the legislative protection for people with disabilities and their families, and the myriad of entities established to allow complaints to be made, the system is still failing these people.

They illustrate that despite the focus on rights and choice, and despite duty of care as a basic service principle and a basic expectation, many service providers deny service users this provision. Of equal concern, the case studies also illustrate how institutional protection occurring in the service and complaint entities, and the tactic of blanket protection of service institutions and their staff, are denying people with disabilities and their families a fair go.

The compilation of case studies and the analysis provides a non-fleeting account of the plight of families and their family member with a disability, and demands that action be taken to address and rectify concerns.

The Enduring Story

In essence, while the dominant story has been the headline-grabbing individual cases of abuse in care, the enduring story is about the more subtle failures in care. Issues like health management, activity based engagement, food services and dietary needs, and manipulative behaviours aimed at excluding families, are indicative of the failings. And of ever increasing concern, the failure of some staff to do what they get paid to do, and their protection by intransigent managers.

The cases depicted in this folio illustrate with frightening consequences current examples of the enduring story in the disability sector. In order to understand the real world of disability it is necessary to go beyond the gloss of the policy statements, to look behind the facade of the reform language such as choice, individual supports and self-direction, and to assess the real effectiveness of the support and protective mechanisms. It is necessary to listen to people with actual experience and to assess the actual effectiveness of the so-called reforms. Five case studies are included in this folio, but given the level of dissatisfaction among service users and their families, the number could have been multiplied many times.

In reading the case studies it is necessary to put aside your thoughts about what ought be happening, and, instead, appreciate the realities of what is actually happening to an increasing number of families and their family member with a disability.

Market Forces

While the concept of market forces may well be applicable to the commercial world, the expectation that decent services, offering real choice, will miraculously appear just because funding has been allocated to individuals who can exercise 'consumer choice' seems to ignore the realities that can influence availability, which is necessary if choice is to be exercised. Factors such as economies of scale, transport provision and proximity all come into play.

Action is called for

The folio, in Part B, identifies actions which must be undertaken, and if taken will go a long way to ensuring the rights of people with disabilities are upheld and greater accountability enforced.

The information and analysis contained in this folio should provide the impetus for all those concerned to add their voice to the call for a judicial inquiry into disability supported accommodation services in Victoria. It is only through such an inquiry that the deception occurring in disability accommodation management and service delivery, and the failure of the so-called safeguard protective mechanisms, will be fully exposed and addressed.

Max Jackson Margaret Ryan

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Part A: A Matrix of Fault, Ambivalence and Protectionism

The case studies which comprise this folio, although each an individual case, nonetheless reflect many similarities in terms of their core elements. These similarities have given rise to the title of this document in that the similarities, while reflecting the illusion of care and protection and rights, nonetheless are underpinned by deception, power plays and control.

The institutional approach - as in the bureaucracies of government, government departments, and the management of agencies - is one of ambivalence and self-protection. It is one of protection of the system. It is the type of protection that operates at the expense of the individual and families. It is one whereby what might be called the 'sentiments of concern', as expressed by the powerful, seek to deceive us into believing that duty of care is being practised and rights protected. Or, if not, justice will prevail and wrongs will be righted. Not so! The case studies depicted in this folio, supported by many more known to the writers, give lie to such sentiments of concern.

While there are a number of principal lessons to be taken from these case studies, of themselves the lessons are not enough. It is not enough to simply nod wisely and hope things will get better. It is not enough to pretend that the current institutional approaches and the way they are practised provide the answers. And, it is not enough to hope that things will improve with the introduction of the National Disability Insurance Scheme (NDIS).

Decisive action and government leadership are required to fix today's problems. At the same time the Federal Government must ensure that the NDIS does not go down the same path as Victoria's less than robust approach. Duty of care and the protection of rights for those people with disabilities who live in supported accommodation go well beyond platitudes and the illusion of care and protection.

As such, the following concerns must be addressed. If not, the list of systemic failures in supported accommodation will grow. At the same time the institutional mechanisms meant to protect will continue to deceive.

1. **A Need for Change to Renew and Strengthen Confidence**
   Public confidence in our institutional response, whether through the Department of Human Services (DHS), funded service providers, or indeed, the so-called institutionalised protective mechanism such as the Office of the Disability Services Commissioner (ODSC), continues to be shaken. While over the years there have been parliamentary and audit inquiries into supported accommodation and disability services, it is obvious something more is required as a platform for change. A judicial inquiry is a necessity.

2. **The Power of the Law - A Failure of a Duty of Care**
   Each service entity providing services to people with a disability has a legal obligation to meet their duty of care to those people to whom they provide services and supports. Those entities that fail to meet their duty of care must be deemed not only to be in breach of the Disability Act 2006, but also to have, in law, been negligent.

   Duty of care, in essence, is the platform on which services and supports must be provided. Thus, it is an assessment of an organisation's performance in terms of duty of care which provides the benchmark for determining whether the organisation is meeting its duty of care obligation to people with disabilities.

In the context of disability services and supports, duty of care is not a complex concept. It is really about whether organisations and individuals are doing their jobs in accordance with legislation, agreements and role responsibilities. In terms of direct care this embraces personal care, health and physical and psychological well-being, food services, and activities of daily living, as well as supporting social and family participation. Although not complex of itself, duty of care is, nonetheless, all pervasive. This is in the sense that each of the deficits, as depicted by the case studies, means that the actions, or in some instances the inactions, of particular entities or individuals has meant a failure to meet their duty of care to people with disabilities.

Duty of care also embraces the upholding of the rights of persons with disabilities. In terms of those in supervision and management roles, it is a matter of monitoring, guiding and ensuring direct care staff are doing their jobs; and, if not, either invoking remedial action or in some cases taking disciplinary action. In terms of the protectors, or those with responsibilities to check, enquire and investigate, it is a matter of them not being diverted, and instead having the courage to call it as it is.

3. A Lack of Adherence to the Disability Act

In each of the case studies there is evidence, or strong indicators, to show that someone in authority, be it staff or management, has at some time during the course of the individual case, failed to adhere to the mandated requirements of the Disability Act 2006. The Act represents the law and yet time and again the law is broken. But, unlike being fined for example, for going through a red light, or being given a bond or something more severe for, say, shoplifting, there is no evidence to show that there is ever any penalty imposed on those who breach the law in disability. Such inaction is, of course, unlike the high profile media-exposed cases where the powers that be are, in effect, forced into taking discipline action. Why the different approach?

There is no evidence to show that even in those cases where fault can be attributed any penalty has been imposed. This includes those cases where fault has been admitted, even though this is a rarity. As noted elsewhere in this report, despite the Disability Act 2006 having provision for the imposition of 'penalty units', again there is no evidence to show any such penalties have ever been imposed on anyone or any entity. This being over the seven years the Act has been operational.

While it is all very well to promote the notion of conciliated outcomes and to use the argument that communication can fix everything, or alternatively, to put up the barrier of privacy and confidentiality, the real issue is that if fault exists a penalty must be applied and must be publicly seen to have been applied. What essentially is a no-fault approach taken by the Office of the Disability Services Commissioner ODSC) is nonsense, and totally contradicts the concept of justice 'being seen to be done'. Not to apply the rules of justice sends the message that no matter what the level of fault, and no matter what transgression against the law, as in the Disability Act, there will not be any negative outcome. This is not the way transgressions of the law are meant to happen in our society.

Part 9 of the Disability Act has provision for penalties. When have penalties ever been invoked and with whom? Why does there appear to be no enforceable regime? And, if the Act is not going to be applied as it is written – What then is its purpose?

4. Intransigence - The Concept of Putting Staff Before Clients

In every case in this folio, the concept of intransigence has been demonstrated, principally by the Department of Human Services, but not limited to the department. The first two case studies demonstrate, in the starkest way possible, how staff needs were put before the clients and how the protectionism by the employer was at the forefront of management's response.

While of course industrial law and agreements do prevail and cannot obviously be ignored, nonetheless, the approach often taken by employers is to protect their staff at all costs. It is an approach that never admits fault.

5. A Matter of Clarification - The Questionable Role and Power of Advocates

What is the real status of advocacy agencies and what is the basis of their power? Regardless of the fact that either the Federal or the Victorian State Government, or both, fund some advocacy agencies, the fact remains that they seem to be a law unto themselves. They are selective in case selection, have in some cases been shown to not have had the best interests of the client at the forefront of their actions, and have actively acted against families.

Advocacy bodies, while having the potential to provide an effective service cannot be allowed to operate in isolation from legislative obligations. Client rights must not be ignored and family participation must occur.

Funded advocacy for persons with disabilities has now been in operation for over a quarter of a century. While advocacy for persons with disabilities is a highly desirable and necessary service, there is little evidence to suggest that any government in this state has ever undertaken real scrutiny of the accountability required of funded advocacy services. Indeed, the longevity of some of the funded advocacy agencies seems to have given them a status of being a "sacred cow" and therefore untouchable.

Despite the introduction of federal quality standards for funded advocacy agencies, there is no evidence to show that quality standards actually produce a better quality service. While recent amendments to the Disability Act 2006 now allow for complaints about advocacy organisations to be made to the Disability Services Commissioner, nonetheless the point as made further below as to the Commissioner not having any directive powers weakens this provision.

One of the cases clearly demonstrates that not only did the advocacy service involved, through one of its employees and then supported by its CEO, fail to uphold the rights of the client, but also their actions actually sought to undermine a positive family relationship and exclude not only the mother, but also the client, from being informed of the advocate's intention.

The time has now come whereby the government must introduce greater scrutiny and accountability for funded advocacy services, and ensure that funding rounds for the provision of such services are not a foregone conclusion simply by funding an agency because it has been funded before.

6. Amending the Disability Act 2006 and Addressing the Legislative Weakness

While the establishment of the Disability Services Commissioner position constituted a major step in reviewing complaints, the fact is that without the legislative authority to compel or direct, the role will simply remain dependent on conciliating outcomes. Although conciliation is a useful tool in dealing with disputes, it does not always provide the answer. Thus, as evidenced in particular case studies, where an agency refuses to abide by the outcomes of conciliation, the family and the person with a disability remain powerless.

It therefore seems reasonable to argue that if a complaint mechanism is to be absolutely effective, then the authority given to the person in charge must go beyond conciliation as its major tool. While there is no criticism of the intent of trying to work things through without necessarily having to go to the next level of imposition, nonetheless, there are those times when greater authority is required. The failure of the Disability Act to provide an enforceable regime is a significant weakness of the Act. Without this authority, agencies or staff who err have the ability to ignore the outcomes of actions initiated through the ODSC.

As noted in Case 2, there is also the case of the Occupational Health & Safety (OH&S) Act being used to avoid obligations imposed by the Disability Act. Such legislative weaknesses and inconsistencies must be fixed.

7. The Failure to Exert Powers

Notwithstanding 6 above, what the case studies show is that despite the inadequacies of the Disability Act, where the ODSC was involved it has failed to fully exert those powers that have been provided. As evidenced not only through the case studies but also through recent ODSC Annual Reports, the Commissioner shows a significant reluctance to investigate, even where such an action is evident as desirable. Powers not used, when available, and where the situation provides a strong case for using such powers, is tantamount to justice denied. While an investigation does not of itself give the authority to direct, it is argued that an investigation is more likely to place pressure on erring agencies for change to occur. This being particularly so if such cases are reported in the ODSC Annual Report and the offending agency named.

8. Balancing the Equation – Service Reform

Recent reports including the Shut Out report and the Productivity Commission Disability Care and Support report, which was the foundation for the NDIS, have made reference to the system being broken and people with disabilities being shut out. Despite the proliferation of initiatives to fix the broken system, including new legislation and protective mechanisms, Minister Woolridge, in Victoria, recently announced yet another "landmark" report, which is being hailed as a "Roadmap to improving lives of vulnerable Victorians".

This so-called **"**Service Sector Reform - A roadmap for community and human services reform" provides 25 recommendations. Among the report's recommendations are "better integration of services, a greater focus on measuring outcomes in people's lives, fostering a culture of collaboration, ensuring a capable workforce, simplifying regulation and improving productivity and accountability". A Community Sector Reform Council has been established.

But these are reforms that have been rolled out in one form or another over a period of more than a quarter of a century, albeit with language variations. What does this myriad of reforms actually tell us?

Primarily it tells us three things.

(i) When governments are under pressure they rollout yet another expert to undertake yet another review that largely say more of what has been already said in previous reviews. The only real difference is the creation and use of even more grandiose language.
(ii) The focus is generally on service enhancement, partnerships and yet even more planning.
(iii) Other than lip service, such reviews ignore the real issue of – What is to be done when services fail in their duty of care?

The time has long passed when we simply need to repeat the message of the past. The time is now well and truly here when the service side of the equation must be balanced with action against those in the service system who fail people with disabilities.

9. Breaking the Comfort Zone – Limiting Tenure

Despite the years of talking about the system failing, very little, if indeed anything, is ever said about who has been at the helm steering the system. The sad reality is that time and time again those who have been in charge are maintained in positions of power when a new wave of change is implemented. This applies to senior bureaucrats, members of committees and working parties and government appointees.

This must be reviewed and changed, the starting point being with the entity established to review complaints and ensure the protection of rights.

10. Power Plays and the Rise of the Articulate Ones

Of concern, since the rise of the focus on rights and individual needs and the creation of entities established to protect rights, is that the decision making power and influence has, over time, become more and more located in the hands of a select group of positions and entities. Perhaps unwittingly, or who knows as a self-preservation strategy, the locus of power has increased the power of the already powerful. In essence, power play has become the name of the game, whereby people with disabilities and their families have been relegated to the bottom of the table. Protection of positions and already established power is now the primary focus of the already powerful.

Also interesting, but also of concern, are the changes that have occurred in focus and power since the demise of the Intellectually Disabled Persons' Services Act 1986. What seems to be a reasonable conclusion is that since the introduction of the Disability Act 2006 there has been a power shift in terms of people with disabilities themselves. This power shift has been one whereby the voice for intellectually disabled persons has been muted, and has instead been replaced by the voice of what might be called the 'articulate ones'. These are people who have established a high profile, are often outspoken and very articulate, but whose disability is certainly not primarily an intellectual disability. Often this is to the detriment to people with intellectual disabilities and their families in terms of focus and understanding their needs.

11. Complaints Management on the Never-Never

On the basis of the cases detailed, it is reasonable to conclude that the process of dealing with complaints is far from efficient. If a matter is worth lodging a complaint about, and if accepted as a complaint, then the assumption is that someone has been disadvantaged. Given this, it therefore seems reasonable to expect that the process of dealing with the complaint and taking it through to a conclusion ought be efficient.

Unfortunately, the experiences of those involved in the case studies, and many more known to the writers, indicates that a review of a complaint can be drawn out with meetings and phone calls. This is an example of where the reviewing agency, albeit not responsible for direct care, is failing its duty of care to people with disabilities and their families.

12. Allowing Families into the Power Game and the Absence of Funded Family Advocacy

A tactic now used by some service providers, including the Department of Human Services, in dealing with complaints made by families who represent their family member with a disability, is to effectively freeze them out. Cases included in this folio clearly demonstrate how families, even where right is on their side, are painted as the 'bad guys'. This must change. Dealing with problem staff, rather than pushing families aside and casting families as the 'bad guys' must be the first step in allowing families into the power game.

Families have often been left to their own devices and are in effect thrown to the wolves in having to advocate and 'take on' the power of service providers. Funded advocacy services do not consider families' interests as a component of advocacy, though they may present as representing families.

Until, or unless, governments are willing to show real support for families of persons with disabilities by funding family advocacy, the principles in the Disability Act 2006, as concerning families, will simply remain empty sentiments. Yet, despite this obvious need, the current government as well as previous governments have studiously ignored calls for this to happen.

13. Guardianship – Dealing with the Victorian Civil and Administrative Tribunal (VCAT) and the Avoidance of Guardianship Approvals

The introduction of the guardianship legislation in 1986 gave hope to those families who had cared for their sons and daughters with a disability for many years, often decades, that they would be granted legal authority for the decision-making for their sons and daughters if sought. Alas, this hope has not been realised. The approach taken by the original Guardianship and Administration Board, and since maintained by VCAT, is to single-mindedly enforce what is termed the least restrictive alternative. Basically, what this has translated into has been that guardianship applications submitted by families, either parents or the siblings of the person for whom the application is made, are unlikely to be granted. The reason seems to be because the decision had been driven by a narrow application of what constitutes a least restrictive alternative.

A recent application for guardianship made by the sibling of a person with a disability, and in which one of the writers was involved, was denied on the grounds that to grant guardianship would breach the least restrictive alternative. This being despite the fact the subject of the application has no verbal language skills and is totally dependent. The Department of Human Services representatives who attended the hearing opposed the application for guardianship.

There is little doubt that this constituted another example of freezing families out from the decision-making process for their family member with a disability. It is also an example of how a principle can be blindly applied, no matter what the needs of the person with a disability; and despite the history of support provided by the family, and no matter how detrimental the decision might be to the person with the disability.

The formalisation of the concept of supported decision-making, as proposed by the Victorian Law Reform Commission's Final Report into Guardianship, can be considered a response to the shortcomings of the non-granting of guardianship because of the application of the least restrictive alternative.

14.The Case for Greater Scrutiny and Accountability of Funded Service Agencies

Despite the requirements detailed in Funding and Service Agreements with the Department of Human Services (DHS) and the relatively recent introduction of quality audits and accreditation, the reality is that time and time again situations arise in funded agencies whereby the agency has clearly failed to uphold both the letter and intent of legislation as well as their own documented intent. Yet, nothing happens.

What this highlights is the urgent need for even greater scrutiny and accountability to be imposed. In part, this requires the government, through DHS, to adopt a far more stringent approach to monitoring service agencies. In part it is also linked to the suggestion above that the Disability Act 2006 be amended to give real power to the Disability Services Commissioner, whereby through investigations undertaken by the Commissioner's office the Commissioner would then have the power of an enforceable regime.

Given the current system has failed to ensure that service providers live up to the intent and letter of the legislation, it is clear that unless, or until, such time that the results of the recently introduced quality audits are made public, then funded agencies will be able to continue to hide behind the veil of secrecy.

At the same time, it must be recognised that quality audits and certification of themselves are only indicative of an organisation having its house in order.

15. The Case for Modifying the Process of Vetting Applications for Guardianship

The current legislation and procedures relating to the operation of VCAT are restrictive. As evidenced by one of the case studies, VCAT is required to accept an application for guardianship just so long as the required "paperwork" has been provided. In one such case as reported, the applicant went beyond the requirement to provide medical certification of the client's intellectual disability and instead used coercive power with the client's doctor to gain supporting evidence for his case. Despite this, VCAT provided no advice to the subject of the application and denied her mother access as to what information had been provided, via the applicant, by the client's doctor.

The fact that the current legislation allows any person to submit a guardianship application opens the way for an abuse of this provision. Indeed, in this case this was what happened. As such, the writers support the recommendation in the Law Reform Commission's Final Report into Guardianship (Recommendation 348, page 486) and paragraph 21.11.0, that before accepting an application for guardianship "an analysis of the application to determine whether it should proceed directly to hearing or be referred to an alternative process" should be enacted.

Additionally, the writers support Recommendation 350, page 487, of the Law Reform Commission report, that it should be VCAT who makes "a preliminary determination of the potential parties to the proceedings and people entitled to notice.” The current arrangements provide for the applicant to notify potential parties. In one of the cases the applicant clearly chose not to notify all interested parties including a representative from the client’s day service.

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Part B: What Needs to Happen

Group One Actions – Government Actions

Action 1: A Judicial Inquiry
The Victorian Government establishes a judicial inquiry into (a) the capacity of service providers in the disability-funded accommodation system to meet their duty of care obligations to residents and their families; (b) the capacity of safeguards to uphold duty of care requirements; and for the inquiry to make recommendations as to any legislative, policy, administrative or structural reforms to entrench and improve duty of care practices.

Action 2: Strengthening the NDIS
The NDIS includes an enforceable regime that goes beyond the model currently operating in Victoria to deal with service failures and alleged service failures.

Action 3: Transparency
The Victorian Government publishes on an annual basis on the Web the results of quality audits of funded and contracted agencies.

Group Two Actions – Amendments to the Disability Act

That the Disability Act 2006 is amended by:

Action 4
Including in the Act the concept of duty of care - noting it is not currently mentioned in the Act. Further, that the failure of an individual or an organisation to meet their duty of care is listed as a punishable offence**.**

Action 5
Detailing a list of penalties to be applied to an individual or agency for a failure to meet their duty of care.

Action 6
Inserting a clause stating that where the head of an entity fails to take action where a breach of the Act is proven, such failure is deemed to also be a breach of the Act by that person.

Action 7
Making specific reference to funded advocacy bodies in which their responsibilities and limitations are detailed.

Action 8
Inserting a clause providing the Disability Services Commissioner with the authority to exercise directive power, thereby creating an enforceable regime.

Action 9
Inserting a clause requiring the Disability Services Commissioner to specifically report on all complaints where a fully agreed outcome has not been established, or where the complaint remains totally unresolved, or a conciliated solution to a complaint is not reached. Further, that unless the Disability Services Commissioner undertakes an investigation the Commissioner be required to direct such matters to VCAT.

Action 10
Altering the appointment of the Disability Services Commissioner to one term of five years only, with no provision for re-appointment.

Action 11
Amending Section 20 (6) of the Act to limit appointment to the Disability Services Board for three years, but in so doing establish a staggered appointment process.

Action 12
Amending the timelines set for the review of complaints and actions arising from such reviews to be of a period of no more than 45 days, with a mandated requirement for this to be met.

Action 13
Inserting a clause that specifically details the range of penalties that can be imposed on individuals and agencies that fail to meet their service obligations.

Action 14
Inserting a clause that specifically provides recurrent funding for the establishment of a dedicated statewide funded family advocacy organisation**.**

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Part C: Implications for the National Disability Insurance Scheme

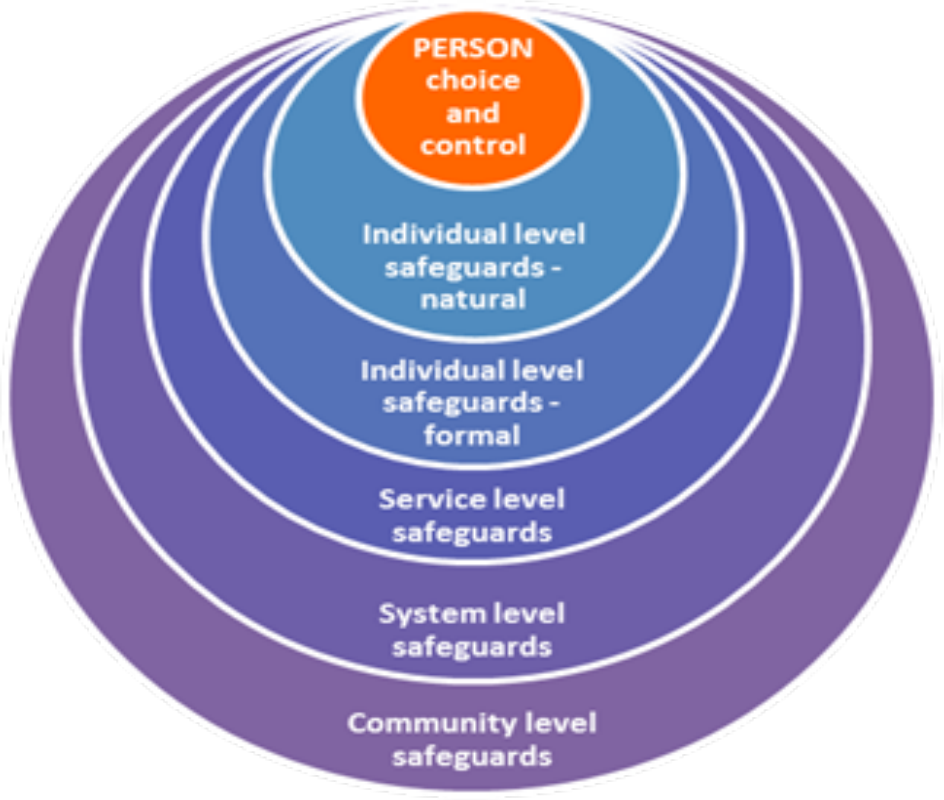
Much has been written and spoken about the National Disability Insurance Scheme (NDIS) and how it will reform and transform disability services – and by implication, transform the lives of people with disability, their families and carers. When the NDIS is being discussed there is emphasis on expressions such as "human rights", "choice", "control", "self-management", "capacity building", which reflects the language used in the NDIS legislation. It is as if the use of these expressions means that the disability system will by some form of osmosis be automatically transformed and reformed. When, in fact it is implementation which will determine whether the NDIS disability support arrangements will overcome the inequities, fragmentation and underfunding of the pre-NDIS arrangements.

The structure of the NDIS is complex, involving as it does, for example, legislation in the National Disability Insurance Scheme Act 2013 and the suite of NDIS legislative rules; some decisions made by the Agency can be appealed to the Administrative Appeals Tribunal (AAT). The National Disability Insurance Agency (NDIA) established under the NDIS to implement the Scheme is a company under the Commonwealth Authorities and Companies Act 1997 (CAC Act). As well, there will be a "new" National Quality Framework and National Standards for Disability Services. At the time of writing this does not mean that the same standards will operate across Australia.

The Agency has stated that for the launch/trial they will use the existing quality and safeguard frameworks for specialist disability services that apply in the schemes launch/trial areas. As set out on its website (http://www.disabilitycareaustralia.gov.au/participants/safeguards, downloaded 28/10/2013) it considers that when the scheme is fully rolled out, safeguards will include:

- Individualised strategies built into participant plans to help the participant, their family and support network to reduce the risk of harm, through mechanisms such as advocates, guardians and nominees
- Arrangements that organisations put in place to protect participants, such as:
  - Staff supervision
  - Internal complaints processes
  - Quality frameworks
- System level safeguards such as:
  - External review of decisions and actions that directly impact on a person, such as access to relevant tribunals or commissions
  - Community visitors schemes
  - Police checks and working with children checks
- Community based safeguards that are available to all members of the community, such as:
  - Practitioner registration requirements
  - Ombudsman offices
  - Anti-discrimination, human rights and consumer protection law.

These safeguards are depicted as in the diagram below:



In effect, the Agency will pretty much continue how things are in Victoria, thus continuing the current inadequate safeguards. The question that arises is, "What happens when safeguards don't work?" It currently seems to be that the answer to this question is seen to lie in the power of the consumer dollar, so that if a person is not getting a satisfactory service, the answer is to go elsewhere. And further, if a satisfactory service is not available, then the individualised funding means a person could "innovate" and develop their own service. These answers of course avoid answering the question, "What happens when safeguards don't work?"

The actual power of the consumer dollar must be questioned, when there is a raft of independent complaints schemes in other sectors where the consumer holds the consumer dollar. For example, for phones and internet there is the Telecommunications Industry Ombudsman, and in the financial services sector there is the Financial Ombudsman, a Superannuation Complaints Tribunal, and a Credit Ombudsman Service.

The question must be answered, "What will the NDIS do when safeguards fail?"

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Part D: A Matrix of Failing Mechanisms

Never before in the history of disability have there been so many entities to which complaints can be made or heard. Yet, despite the proliferation of the protectors of rights, dissatisfaction among people with disabilities and their families is high.

Why is this so? There are probably many reasons. In part any of the following might apply either individually or severally. For example:

- Restricted legislative jurisdiction
- Protectionism
- Absence of motivation
- Particular ideology
- Financial shortcomings
- Lack of accountability
- Jurisdictional confusion
- Legislative conflict
- Government's failure to rectify legislative deficits

The matrix below identifies the principal entities in Victoria that can have some part to play in dealing with complaints, rectifying errors and services deficiencies, or imposing penalties. Whatever the reason for the dissatisfaction that prevails across the disability sector, the protective mechanisms are failing.

Entity	Principal Legislative Base
Department of Human Services	Disability Act 2006
Office of the Disability Services Commissioner	Disability Act 2006
Office of the Public Advocate	Guardianship & Administration Act 1986
Panel of Community Visitors	Guardianship & Administration Act 1986 and Disability Act 2006
Victorian Ombudsman	Ombudsman's Act 1973
The Police	The Crimes Act 1958 Evidence Act 2008
Health Services Commissioner	Health Services Act 1987 Health Records Act 2001 Freedom of Information Act 1982
Equal Opportunity & Human Rights Commission	Equal Opportunity Act 2010 Racial & Religious Tolerance Act 2001 Charter of Human Rights & Responsibilities Act 2006
Advocacy Organisations	Disability Act 2006

Guardians	Guardianship & Administration Act 1986
Financial Administrators	Guardianship & Administration Act 1986
Families	Disability Act 2006
Victorian Civil & Administrative Tribunal	Victorian Civil and Administrative Tribunal Act 1998

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Part E: The Case Studies – A Note on Confidentiality

The following case studies have been drawn from real events and real people. They represent just a few of the many similar cases known to the authors. The studies were written at various times, hence there are some variations in style.

With the exception of the Yooralla case study, which is based on information in the public domain, all other cases studies have preserved the confidentiality of the individuals involved and hence their real names have not been used.

While the Yooralla case study makes specific reference to some individuals or roles, such references have been taken from what has already been publicly reported and recorded.

Case Study 1

Control, Threats and Intimidation in Disability Services

Synopsis

This paper demonstrates how guardianship is being used as a tool in the disability sector to control, threaten and intimidate parents, and effectively abuse the rights of persons with a disability.

The Players

The case involves a single mum, her 37-year-old daughter with an intellectual disability, a funded residential service, a funded advocacy service, the Disability Services Commissioner (DSC), the Office of the Public Advocate (OPA) and the Victorian Civil and Administrative Tribunal (VCAT).

Setting the Scene

The daughter, who for the purpose of this paper we will call Emma, lived with and was supported by her mother for the first 30 years of her life. This situation was one of mutual respect and what might be described as a normal, loving mother-daughter relationship. In order to allow Emma the opportunity to live with other people of a similar age and effectively live in her "own" home, mother and daughter mutually agreed that Emma should move into a funded residential service. Thus, from 2004 until mid-2012 this is what occurred.

While generally Emma enjoyed the experience of shared supported accommodation, unfortunately particular staff in Emma's house failed to provide the level of care required. Thus, Emma's mum, who had been meticulous in the care of her daughter, and who had worked hard to develop Emma's social skills, and facilitate Emma's community inclusion, expressed her concern to the staff when issues arose in relation to her daughter's health care and other matters to do with her daughter's wellbeing.

Concerns which were expressed included the failure of the service provider to protect Emma from ongoing physical abuse from a former resident; non-compliance with prescribed dietary requirements; a failure to promote a recommended and prescribed exercise program; a lack of support in ensuring an adequate fluid intake to counter a significant medical condition; a failure to support necessary skin care; a lack of support to facilitate self-help skills such as clothes washing; and rotting food that had been prepared ready to be cooked and out-of-date sour milk being in the refrigerator.

Although Emma's mother showed a willingness to work with the staff in order to address the service and support deficiencies, and various remedial strategies were agreed, the failure of the support staff to meet their duty of care responsibilities continued. When the mother pushed harder for a fair deal for her daughter, the staff resistance increased. When Emma's mum continued to challenge and exhort the organisation to ensure improvement, staff then applied subtle pressure on Emma to challenge her mum's involvement.

The mother's willingness to work with senior management proved fruitless. Indeed mum was cast as the villain by the Chief Executive Officer (CEO), who demonstrated what might be described as "blind loyalty" to his staff, despite the evidence of some staff failing in their duty of care. It was also at this time that the CEO made a veiled threat that guardianship was an option. The rub finally came early in 2012 when a representative of the funded advocacy organisation became involved. While the advocate initially judged Emma as able to make her own decisions, Emma's decision to move back to her mum's home was the catalyst for a guardianship application being made by the advocate to VCAT.

From then, until the application was subsequently withdrawn in August 2012, the so-called support system became the enemy of both Emma and her mum. An enemy that was hell bent on splitting a loving family relationship. An enemy whose sense of righteousness and sense of self-importance caused the disability agency to ignore the deficits of their service and to use guardianship as a threat, and a paid advocate whose failure to understand the nuances of family relationships caused him to make a guardianship application that overrode the rights of a person with a disability and her mother.

The Dark Side of Disability Support and Advocacy

Despite the legislation, the myriad of principles, the promotion of rights and the ideal of self-directed decision-making and choice, this case demonstrates how power and intimidation can be unfairly wielded when the system is challenged.

Emma's mother rightly questioned staff about their failure to adhere to service improvement agreements, to follow health professionals' instructions, and their inconsistency in addressing Emma's needs. Initially, staff showed pretence of concern and suggested even more meetings. Then, when the deficits continued, they began to use the catch phrase that "Emma had exercised her choice". This meant, for example, that it was Emma's choice to not adhere to her diet, it was Emma's choice to not participate in her prescribed exercise program, and it was Emma's choice to not maintain good hygiene. However, despite more meetings, more plans and more checklists, the service and support deficits continued.

Emma's mother continued to exercise her right to advocate on behalf of Emma (who by the way had provided her authority for her mother to do so), and despite the advocacy being pursued over a period of some five or six years through a succession of meetings with various levels of management, the deficits continued.

In the first instance there was a group of staff that failed in their duty of care to Emma, but then sought to roadblock a mother who simply wanted to ensure the best for her daughter by manipulating the client into saying she did not want her mother involved. This was a completely contradictory position to one previously expressed by Emma and was inexplicable, unless through staff intervention and manipulation. This was an intervention aimed at diverting attention from the mother's challenges to the service deficits and thus seeking to effectively freeze the mother out. Inherent in this was the intended threat to Emma's mum that if her daughter didn't want her involved, the staff could "legitimately" stop the mother from visiting her daughter's home and her day placement.

The staff's manipulation went beyond this, however, in that they then deliberately changed Emma's medical appointment as an attempt to ensure that Emma's mother did not attend the appointment. This action was taken by the staff despite a previous agreement between the agency and Emma's mum that she would take Emma to her health professional appointments. Attending the appointments enabled Emma's mum to follow up on matters on her medical care, an area where there had been concerning deficits. Although Emma had stated that she did not want her mother involved, thus changing her mind from her previous position, this was not only an indication that Emma was confused, but further it demonstrated that the manipulation of Emma by staff was complete. In other words, surreptitiously the staff actions intimidated Emma and thus sought to control the mother.

There was then the involvement of successive levels of management, culminating with the involvement of the CEO. Each level of management not only failed to acknowledge the possibility that some staff may well have failed in their duty of care; but, just as concerning, if not more so, management failed to thoroughly investigate the claims made by Emma's mother.

It was at a meeting with the then CEO of the service organisation mid-2011 that the ugly side of disability support and advocacy really began. The CEO committed an even greater failure in that he not only demonstrated a condescending attitude towards the mother and challenged the attendance of a support person at a meeting, but he then sought to turn the mother's concerns into a blame game against her. The final ignominy committed by the CEO was his condescending suggestion that if the mother was not satisfied she could seek guardianship through VCAT - knowing full well that the history of guardianship applications by family members is that more often than not these have been met with refusal; and also knowing full well that guardianship provides no more power over an organisation than does a family member without the authority of guardianship.

In an attempt to have her concerns taken seriously, Emma's mother had taken the matter to the Disability Services Commissioner, and mediation was undertaken. The CEO was fully aware of mediated outcomes that had been negotiated between Emma's mother and representatives of the organisation through the Disability Services Commissioner. However, these outcomes had not been fully implemented by the organisation. It was this failure that had been the catalyst for seeking the meeting with the CEO. And yet the CEO at the meeting with Emma's mother effectively ignored the fact that the outcomes as agreed through the DSC had not been fully implemented.

Fast-forward 12 months. Out of the blue Emma says she does not want her mother involved. Enter a representative of the funded advocacy organisation. Without seeking to engage Emma's mother, after only three or four cursory meetings with Emma, without engaging Emma's day service, and without seeking to investigate why Emma would suddenly change her mind about her mother's involvement after a life-long loving and supporting relationship, a guardianship application was submitted to VCAT. Why? It can only be surmised that the advocate consulted the very staff who had been challenged by Emma's mother and it was the staffs' subjective and biased view, and their obvious intent on self-preservation, that was accepted by the advocate without question.

The fact that the advocate's application was ill-advised, lacked substance and was considered as wrong, is evidenced by the fact that as the result of an investigation by an OPA representative, OPA advised that they would challenge the application if it went ahead. The advocate did not of course stand alone in making the application as his CEO confirmed it as appropriate.

In making his application the advocate not only failed to speak with Emma about his intended action, but he then also failed to advise her of his intention to withdraw it. However, of even greater concern, was what can only be described as the use of 'bully-boy' type tactics by the advocate, in order to obtain information from Emma's doctor. These actions were taken without ever advising Emma or seeking her authority to do so. The advocate also ignored the principles enshrined in the Disability Act 2006 concerning the significance of family; and further he also ignored the principles as detailed in his own agency's policy and guidelines concerning individual advocacy.

In essence, the advocate allowed his ego and perceived authority to ride roughshod over Emma and her mother.

The involvement of the OPA, at the request of VCAT, was a relief, in that the OPA investigator soon determined that the guardianship application was not based on any substantiation, that it ignored the strong bond between mother and daughter, and was in essence fallacious and ill-considered. And, it was clearly because of the OPA report that the advocate withdrew his application.

While the role and actions of VCAT were in accord with the published guidelines, nonetheless this case highlights a number of deficits, which have also been highlighted by the Law Reform Commission in their final Report into Guardianship.

The Abuse of Language and Intent in Disability

Five significant situations evident in this case highlight how the use of what might be termed 'the language of disability' and the power invested in particular individuals and entities can be misused, or constrained by inadequate legislation, leading to ineffective policy and processes.

The first situation relates to the way in which funded service providers monitor their service provision and what they do in the event of service deficits arising. In this case, significant service deficits arose over a period of some seven to eight years. They were brought to the attention of staff and management and the mother of the client did participate positively in seeking to have the problems rectified. Despite this, the problems persisted and staff continued to fail in their duty of care while management gave lip service to addressing the problems.

Essentially the organisation failed to fully acknowledge and put into practice the principles as contained in the legislation and the expressed values of their own organisation. Yet, when it suited them, the organisation espoused Emma's right to choose and in effect shifted the responsibility to Emma by suggesting that it was her actions that created the deficits, and not the failings of the staff.

The second situation relates to how the then CEO of the organisation not only failed to thoroughly investigate the mother's concerns and the failure of his staff to meet their duty of care to Emma, but then cast the mother as the villain in the story. When the challenge was put to him to fix up the service provision, he chose to espouse the option of guardianship. Additionally, the CEO also failed to ensure the implementation of the agreement arising from the mediation conducted by the Disability Service Commissioner's office 12 months prior. Further, the CEO then ignored the request of the mother to be interviewed by the auditors contracted to conduct a quality audit, using the excuse that this could not be done because those to be interviewed could only be randomly selected.

The third situation relates to the involvement of an advocate employed by a funded advocacy service. Like a bull in a china shop this person entered the fray. He failed to investigate and take full account of all of the facts, and ignored Emma's right to make a decision to return to the family home, despite the fact that the advocate had previously assessed Emma as being capable of making and understanding her own decisions. He then totally ignored Emma by not informing her of his intent to submit a guardianship application, by not seeking her approval to request information from her doctor, and not informing her that the guardianship application was subsequently withdrawn.

This advocate, while using the language of disability in terms of a client's right to self-determination and to be involved in decisions, acted contrary to these sentiments. He also ignored the principles of the Disability Act and the values expressed by his own organisation.

The fourth situation relates to the funded advocacy service. When the mother contacted the Executive Officer (EO) regarding his employees' actions, the EO gave scant attention to the issues and instead categorically supported the guardianship application. In so doing he also totally ignored the principles of the Disability Act and the values expressed by his organisation (which purports to have family advocacy), and instead displayed "blind loyalty" to the staff person. The organisation through its EO displayed little or no understanding how the rights and welfare of a person with a disability can be very much tied to the notion of family unity, as evidenced by the fact that Emma had made the decision to return to the family home before the application for guardianship was made. Logic therefore suggests that in a case such as this the responsibility of the organisation is to both the person with a disability and the family. In this case the organisation denied both Emma and her mother the right to maintain family unity.

The fifth situation relates to the role of VCAT. In this case clearly VCAT met the demands of the legislation which governs it and the processes arising from this legislation. However, what this case has demonstrated is how an entity such as VCAT can be constrained by inadequate legislation, which then leads to ineffective policy and processes. In other words, although there is no doubt that VCAT would wish to facilitate the principles as espoused in the Disability Act 2006, the fact that the guardianship legislation allows anyone to make a guardianship application, and the application to be heard without the requirement to assess its merits prior to listing for hearing, demonstrates that currently VCAT's hands are somewhat tied.

The issue arising out of this case is not a questioning of whether VCAT did its job but one that raises the issue of the importance of some of the Law Reform Commission's recommendations on guardianship.

A Need for Justice

This case highlights, without any ambiguity whatsoever, that the protections for persons with disabilities and their families, the same protections that were so enthusiastically promoted, are open to abuse and manipulation. This case also highlights the need to make changes that impose a greater responsibility on the many players who like to promote themselves as the flag-bearers for disability rights.

Concluding comment

This case study clearly demonstrates that despite the self-congratulatory rhetoric which abounds in Victoria concerning how we are leading the field in Australia in the disability sector, not all is well in this sector.

It is all very well to constantly make pronouncements about rights, sing the praises of standards and quality audits, establish a myriad of plans and promote the NDIS and individual funding as a panacea for the future. Nonetheless, even in a situation of individual funding, where it might be argued that if a person is dissatisfied with a service the person can take their money and seek to be supported through another service, this can hardly be considered as an argument for the status quo, where the status quo means an inferior service or one where deception or intimidation are allowed to blossom.

The real challenge arising from this case is to either force such services to change or refuse to approve them as disability service providers or to record them as non-approved service providers. It is time that a much stronger approach is taken, and rather than just mouth the words of quality, that the primary controller, as in the government, tackles the hard issues. The current situation of what might be described as a "buddy-buddy" system does not provide a sound basis for building quality services.

As long as individuals and entities within the system are allowed to continually bypass their responsibilities by using their power and position to threaten and intimidate, persons with disabilities and their families will continue to remain at the bottom of the pile in terms of the hierarchy of power and influence.

Case Study 2

Diversion and Control in Disability Services

Synopsis

This case study demonstrates how allegations of staff stress and the power of occupational health and safety legislation were used by Victoria's Department of Human Services (the department) to attack and cast blame on the family of a woman with an intellectual disability.

It explores how the department used control and threats as tactics in order to avoid confronting duty of care complaints and the department's obligations under the Victorian Disability Act 2006 (the Act).

The case represents a concerning study in how the blind protection of staff, the ignoring of legislated mandates and the protection of an institution itself, as in a government department, conspired to relegate the rights of a person with a disability and her family to a second order issue.

The case study presents five actions, which must be taken by government to correct the systemic flaws exposed in this instance.

1. The Principal Players

This case presents as an interplay involving four sets of players.

(i) The Client

The client is a woman in her mid-forties with an intellectual disability and associated conditions of kyphosis and high cholesterol. The client communicates through non-verbal means.

The client's health is of major concern to her family and issues such as her bowel regularly becoming compacted, along with dietary issues and the importance of daily exercise, have been ongoing. As a result, the client's mother has taken direct responsibility for visits to the client's health care providers.

The client has been in the care of the department in accommodation and support for in excess of 20 years. She attends a funded day service in close proximity to her accommodation five days a week, Monday through Friday.

(ii) The Family

The client's family, as in her mother, stepfather and sister, has continued to demonstrate significant support for her. Most weekends are spent in the family home. Her sister is her legally appointed administrator.

In effect the client's mother and sister, in particular, advocate on her behalf and take a keen interest in seeking to ensure the client's health and welfare.

(iii) Department of Human Services Representatives

The department's involvement in this case has been at three levels. The direct service level within the accommodation setting has involved in particular the House Supervisor and one other permanent staff member, as the protagonists and challengers to the family. The middle management level within the disability accommodation program, including all levels up to the Accommodation Manager, have been direct responders and represented the department in the conciliation conference. The department's legal officer has also been involved via responses to legal action initiated by the family. The department opposed a guardianship application in 2012.

(iv) The Disability Services Commissioner (DSC)

DSC officers became involved in this case in response to a formal complaint as lodged by the client's mother in November 2010. The DSC facilitated a number of actions over the course of almost three years including meetings with departmental representatives, a visit to the client's accommodation, and supporting an independent review. An attempt to conciliate the complaint in October 2013 was in part successful in terms of negotiating an outcome concerning communication protocols, albeit the family was told staff would have to be consulted and agree with the proposed changes. Nonetheless, the conference failed to address the core of the original complaint as in the care issues. Thus, in effect the original complaint could not be considered to have been resolved. The complaint was in effect 'parked'.

2. A Situational Analysis

This case highlights the significance of the principles listed in the Act and as applying to persons with a disability and their families. Essentially, the case brings to the fore how the failure of a service provider to acknowledge and apply mandated principles led to a situation where rights were denied. By ignoring the rights as inherent in the Act as applying to persons with a disability including sections 5 (2) (a), (b), (d), (g) and 5 (3) (b), (d) and (g), and as applying to families (sections 5 (3) (h), (i), (j) and (k)), the department failed to meet it statutory obligations as a service provider.

The family sought to support their daughter/sister by raising issues of care with the department and to express concern about the failure of staff to meet their duty of care obligations. The client's medical history supported the family's concerns that staff were not diligent in their observation of changes occurring in the client's health status and their failure to be proactive in giving attention to such matters.

As a result, and over time, the House Supervisor and one other staff person, in particular, responded by challenging the family and exerting pressure on them when they visited the house. Middle management gave no indication of any internal investigation being undertaken or any action having been taken in relation to the family's concerns. Instead, it can reasonably be concluded that management simply supported the House Supervisor without question. Or, in other words management denied the client and her family any right to have the matters investigated and to be informed of any management actions. The writers argue that what ought to have been a fair and reasonable expectation of the family was denied.

As a means of shifting blame, the department then promoted the notion of developing a Communication Guideline aimed at placing boundaries around the family's contact with their daughter/sister. In effect management sought to direct attention away from the issues associated with duty of care and health and welfare of the client by suggesting instead that the issues were about how the family communicated with staff. This was a classic case of blame shifting and painting the family members as the 'bad guys'.

To make matters worse the department submitted that the Guidelines were not only in response to a WorkSafe requirement, but were at the staffs' insistence and thus required their approval for any changes - clearly a case of the client and her family not having their rights considered. A frightening inclusion in the guidelines was the requirement the family could only visit the client in her bedroom, including having afternoon tea there. Further, any breach of the guidelines, or failure to adhere, would see the family being barred from the house for a predetermined period. This barring was subsequently actioned by the department. It is noteworthy that penalties could so easily be placed on the family and the person with a disability. Concurrently, the department argued that the action of restricted access did not contravene Section 58 (a) and (f) of the Act – ensuring the resident is treated with dignity and respect and not unreasonably interfering with the resident's enjoyment of the premises. The writers dismiss this as utter nonsense and submit it goes to show the spuriousness of the department's case.

As a result of the client's mother initiating a complaint to DSC, almost three years transpired before the DSC facilitated a conciliation conference. Despite the conference reaching a part agreement, the principal issues of the departments' obligation under the Act, and indeed attempts to raise the relationship of clauses in the Act to the department's failure to meet the duty of care provisions, were in effect ignored or glossed over.

3. The Issues

This case presented as a patchwork of interlocking issues. The following are identified, as issues the writers argue are the more critical ones, and in essence highlight the failure of the department and the DSC to support a person with a disability to have her rights protected. Further, these issues highlight the department's failure to acknowledge and respect the rights of the client's family.

(i) A Matter of Rights

The client**,** as a client of the department, is subject to the Disability Act 2006 (the Act) as indeed is the department.

The Act in its Purpose is unambiguous in reaffirming and strengthening the rights of persons with a disability. These rights are further emphasised in the Objectives of the Act (Section 4), the Principles (Section 5) and principles as specific to Persons with an intellectual disability (Section 6).

Section 57 of the Act makes reference to the requirement of a Residential Statement being provided to a person residing at a residential service and in particular specifying, as in section 57 (2) (e), any conditions which apply to the provision of the residential services. Further, and as per section 57 (4) (8) of the Act, there is the requirement of giving reasonable notice in writing of any changes to the original information provided. No such action as required in section 57 (4) (8) occurred, with the last statement being provided in 2012. The significant changes as proposed in the so-called Communication Agreement must therefore be deemed to be invalid.

Section 58 (1) (a) of the Act requires services providers providing residential services to, "take reasonable measures to ensure that residents are treated with dignity and respect …". Further, section 58 (f) of the Act requires a resident to be afforded the right to proper use and enjoyment of the premises. The department's attempt to restrict family visits to the house to the client's bedroom was restrictive and a clear breach of the Act. Particularly noting the department's demands that client take her afternoon tea in her bedroom when her family visited her, thus denying her access to the common areas of the house.

The department failed to adhere to particular clauses in sections 57 and 58 of the Act.

This case demonstrates that the department totally ignored the Disability Act, which of course was established to protect the rights of persons with disability, and in this case failed to uphold the client's rights.

(iii) The Matter of Duty of Care and the Law of Negligence

The concept and practice of duty of care is a requirement of service providers. The generally agreed understanding of the concept is that the standard of care is the way in which a person should act to make sure that they do not breach their duty of care by either placing a person in a situation of risk or by allowing a person to remain in a situation of risk.

Clearly, based on the medical evidence concerning the client's care within her accommodation setting, it is reasonable to conclude that particular staff have at times failed to meet their duty of care to her.

By failing to meet their duty of care, the department, and in particular some of the house staff, were negligent as defined in the Wrongs Act 1958.

(iv) Health and Safety Concerns - The Three-Card Trick and a Denial of Natural Justice

Despite the family having pursued their concerns about the failure of the department to meet its duty of care to the client, and having done so over several years, the department's response was to promote concerns about the health and safety of the staff. In effect they ignored the core issues as contained in the complaint to the DSC.

The department played the 'stress card' and in so doing sought to use it to argue that it was the family who was inappropriately placing the house staff under duress, which lead the staff to become stressed.

The way in which the department manipulated its approach was to claim that over a period of 12 months house staff had submitted nine Disease, Injury, and Near Miss Accident (DINMAs) reports. These forms are an internal document used to record and report injuries or near misses.

Despite management initially saying that three of these forms related to concern about the client's sister and six related to her mother, when challenged the department stated that the forms did not include names. Apart from this the department refused to allow the mother and sister to access the forms and thus denied them any opportunity to defend themselves. Never was any advice provided as to times, dates, location and the staff allegedly affected by the mother and sister. Thus, the first card played by the department was the DINMA card or what might be more accurately described as the secret allegations card.

The next card played by the department was the Occupational Health and Safety Act (OH&S) card. That is, unnamed staff, and not all staff as advised by departmental management, made complaints under the OH&S Act. In essence while the department ignored their obligations under the Disability Act, it emphasised its responsibilities under the OH&S Act.

Associated with the OH&S Act, the department then used what is known as a Provisional Improvement Notice (PIN) as issued on the department by WorkSafe Victoria to rationalise the use of draconian restrictions on the family visiting the client in her home under the guise of Communication Guidelines drawn up by the department. The department then proceeded to document anything it considered a breach of these guidelines. Worse still, they then enacted a ban on the family visiting the house.

While the PIN was allegedly in relation to staff stress, noting the department also refused to provide a copy of the PIN to the family, the department's response was to simply apply restrictions on the family and thus abrogate its responsibility to consider other options to address the alleged stress of some staff. The department's approach ignored the rights of the client and the family as enshrined in the Disability Act. In effect, the department put the staff needs ahead of the client and family's needs without ever seeking to consider alternative responses to the PIN.

Three issues of concern are expressed in relation to this tactic by the department.

The first relates to the fact the OH&S Act does not apply to non-employees as in the case of the family – they are private citizens. Given this, it is argued that any requirements imposed by the OH&S Act on the department are not applicable to the family.

The second relates to the alleged nature of the PIN, noting a copy has not been provided to either the client's mother or sister. If, as alleged, the PIN relates to alleged stress being experienced by particular staff, then the obligation to deal directly with this is imposed on the department and not on private citizens as in the client's family. By seeking to impose a restrictive communication system, the department is in effect seeking to shift what is its responsibility to the family. It must again be noted that this response denies both the client and her family their rights under the Disability Act.

The third relates to the alleged complaint to WorkSafe and whether there were named respondents in the complaint. A DSC representative advised the family that a departmental manager had stated not all staff were signatories to the complaint. Further, that it was alleged to be about 50 per cent of the total of the staff in the client's home. It was also advised that no respondents were named in the complaint.

The above highlights two significant matters. Firstly, given not all staff were party to the complaint, and thus not party to the stress allegation, to then seek to impose a blanket solution denies those staff who have alleged being stressed the opportunity of being provided with an individually tailored solution to their stress allegation.

Secondly, the advice that no respondents were named, by implication means that to then seek to impose a supposed solution on the client's family is an invalid solution. It should again be noted that by refusing to give a copy of the PIN to the complainant, the department has contravened the principles of natural justice

If, as suggested, the PIN relates to allegation by some staff of being stressed, then the department's obligation is to those staff to implement a solution that does not compromise the department's obligations under the Disability Act. The proposed communication strategy seeks to subordinate the Disability Act to the authority of the OH&S Act. In so doing it also gives greater consideration to staff by subordinating the rights of the client and her family.

(v) The Family as Advocates

The Act is very clear in recognising the important role families can play in supporting their family member with a disability. Specifically sections 5 (3) (h), (i), (j) and (k) detail the requirements of respecting, acknowledging and strengthening the capacity of families. The family in this case have demonstrated, beyond any question of doubt, their commitment and support for their daughter/sister.

The family has at all times sought to ensure their daughter/sister's health, welfare and broader developmental needs have been at the forefront of their advocacy

In their attempt to pursue these matters the department sought to implement what were called Communication Guidelines.
Five specific clauses in these so-called guidelines contravened the principles of the Act as specifically relating to strengthening the role of the family.

(vi) A Review – Time Delays - No Investigation – A Denial of Rights

The department commissioned an independent review in mid 2013 of "aspects of care and support" provided to the client and included a term of reference related to family communication and support. While this review was intended to inform the matter of the complaint as made to DSC, the reality was that it was ill-conceived and simply constituted another case of diversion.

The problems with the review were five-fold.

i. It was only initiated some 20 months after the submission of the complaint.
ii. It was a review and not an investigation. Therefore, it lacked the rigor and authority of a full investigation.
iii. The outcome report was virtually ignored at the subsequent conciliation.
iv. The DSC ignored it legal authority to initiate an investigation and in effect abrogated its authority and responsibility to an independent review.
v. The time taken for the review added further to an already elongated time frame. As such, each month that passed added to the denial of the client's and the complainant's rights.

The writers are highly critical of what they reasonably conclude is a deliberate reluctance of the DSC to undertake investigations. This fact is borne about by the data provided in DSC's Annual Reports. The writers hold the view that the DSC is failing those complainants, and persons with disability, where there is clear evidence that an investigation is warranted. Clearly, this case warranted an investigation and this should have been initiated soon after the complaint was accepted.

4. Diversions and Control

This case provides a clear example of what the writers describe as 'diversion and control' and argue that this was evidenced in a number of ways.

(i) The Abuse of Power and Legislation

The department abused their power by refusing to acknowledge its responsibilities under the Act and their failure to meet their obligations. Yet, despite largely ignoring the Disability Act the department was quick to emphasise its responsibilities and obligations under the Occupational Health and Safety Act.

In effect, the department relegated the client and the complainant to second best and instead sought to protect their staff, despite the evidence of a failure to meet duty of care obligations.

(ii) A Legislative Conflict

This case brought into conflict the Occupational Health and Safety Act and the Disability Act. It is important to emphasise that the department obviously and knowingly elected to use the OH&S Act as a tool to impose restrictions on the family. Rather than address the requirements of the OH&S Act as the department's responsibility, they instead imposed the responsibility on the family.

(iii) Diversion – A blame the family tactic

An indication of the department's antagonism towards the family was evidenced by a comment made by one of the departmental managers where he suggested that the family has been a problem for over 20 years.

While it is true to suggest that the family's concerns about the level of care provided to the client do go back many years, significant documentation exists to show their concerns were valid. Indeed, in 1991 a staff member attached to the client's house left the department with 27 charges pending. Thus, the evidence in fact shows that concerns about the level of care provided to the client, expressed over more than the two decades the client has been in the care of the department, are still as relevant today as they were at that time, and indeed have continued to be.

For a departmental manager to therefore seek to characterise the current complaint as simply more of the same from the family is not only dismissive of the complaint but also sought to cast the family as the problem. This is a major concern and suggests that from the beginning the department seems to have had no intention to acknowledge the complaint as having any legitimacy. Further, that the department will do all within its powers to shield its staff from criticism and a possible finding of negligence

(iv) It's Not About Duty of Care – It's All About Communication – So Says the Department

This case saw the department using the tactic of emphasising the issues of the family's communication style and practices and ignoring the real issues of the complaint. The DSC in some way became seduced by the department's tactic rather than insist that the matter of the complaint was addressed from the beginning.

(v) The Relocate the Client Strategy

Another strategy used by the department, and also raised by the DSC, was that of the potential of relocating the client to another residential setting. This must be called for what it was – ignoring the client and saving the staff.

5. A Need for an End to Unequal Justice

If ever an individual case shone the light of despair on an absence of justice, it is this case. The case reflects a set of actions and inactions designed to avoid, redirect fault, and one where those responsible for the welfare, care and protection of a person with a disability refused to acknowledge and accept responsibility.

While the issues identified above characterise the flaws acted out by those responsible for enacting the principles of the Disability Act, the issues demonstrate that action is needed to correct the systemic flaws that, unless fixed, will see similar cases to this one arise in the future.

6. Concluding comment

Given the range and frequency of the department's breaches of the Disability Act, noting that this case is representative of many known by the writers, the current dysfunctional approach to the management and remediation of complaints represent a case of justice denied.

This case study stresses the necessity and the responsibility of both the DSC and the department to address, not divert, complaints. The department must ensure their duty of care to the client and their obligations under the Act are met.

> Client needs must not be allowed to come second to those of the staff and the department. Justice must not be allowed to continue to be unequal in relation to people with disability and their families.

Note:
At the time of publication this case was still not resolved. At the request of the ODSC, one of the authors of this Challenge Paper, who had been supporting the family, agreed to abide by the request not to publish any further outcomes of the conciliation meeting, simply as a demonstration of goodwill; not because, as suggested by the conciliator, that to do so would constitute a breach of confidentiality, noting no identifiers have been used in the case study.

Thus, while abiding by the agreement not to publish further information in relation to this case, the authors express concern at the sensitivity of the ODSC and its potential use of confidentiality to curtail discussion.

Case Study 3

The Rubik's Cube Case
- A Failure to Line Up Supports and Protections -

Synopsis

This case study demonstrates how, no matter the number of agencies involved in seeking to address a case that involves a client with high-level support needs, the service and protective systems failed. It presents as a clumsy attempt to line-up the colours on the six sides of a Rubik's cube, but where eventually the puzzle remained unsolved.

It explores how a funded agency failed to take account of the advice of a committed mother, knowledgeable about her son's needs, to the extent that the mother was forced to remove her son from the supported accommodation residence, and have him return to live with her. The case brings into stark relief as to how transparency is avoided at all costs.

The case also represents a concerning study as to how, despite the involvement of entities entrusted with protecting the rights of people with disabilities, these entities failed to address duty of care issues and failed the client and his mother.

1. The Principal Players
This case presents as an interplay involving seven sets of players.

(i) The Client
The client is a profoundly disabled man in his early twenties with a severe intellectual disability as well as having multiple physical disabilities. The client communicates through non-verbal means.

The client's health is of major concern and there is ongoing risk of hypoglycaemia precipitated by low blood glucose readings. He was born without a pituitary gland and as such if his food and drink intake, medication and general health is not managed adequately, his blood glucose level can drop to life-threatening lows.

Prior to his moving to live in a residential service in the care of a funded disability agency from early 2011, the client had attended overnight, weekend and week-long stays in respite with no issues – including multiple overnight stays with staff employed by the residential services.

(ii) The Family
The client's mother, who is in her mid-fifties, is now his sole family support. As a result, she has had to relinquish her employment and consequently has had to forgo a significant annual salary. This has placed a high degree of stress, including financial stress, on her. She was diagnosed and treated for cancer during this period.

(iii) The Funded Service Provider
Up until the time the client was placed in the care of the disability service provider, the family had not had any previous experience in

dealing with long-term supported accommodation. It is also of some significance that even though the client had experienced respite over a period of some ten years, and had experiences such as school camps, there had not been any incidents of the client suffering seizures or severe episodes of hypoglycaemia.

Although the client presented with significant complex issues the agency did not signal any concerns as to their ability to manage his needs. Indeed, the agency's website advised they manage over 30 shared supported accommodation houses. Hence, it was reasonable to assume that with the information provided by the mother as relating to her son's needs, the agency would be capable of providing a quality individual service. Indeed, agency management advised the mother that whatever supports her son required would be able to be provided, and he would be able to live safely and happily.

The mother was further advised that her input would be welcomed by staff and, given her knowledge of her son's needs, the staff were looking forward to learning from her.

(iv) **The Department of Human Services** (the Department or DHS)
The department's involvement in this case, while minimal in one sense, does have significance from three perspectives.

The first relates to the matter of the client's funding both in terms of his Individual Support Package (ISP) and the funding provided to the agency in the absence of the client being serviced by them. The second relates to the Minister's attitude to the matter of funding. The third relates to the department's current involvement.

Despite the client having been allocated an ISP to the amount of approximately $20,000 per annum and half of this money having been allocated to the agency for the purpose of the agency providing a 1:1 community access program, the community outings were not provided from September 2012 until the client returned to the family home in January 2013. The amount of ISP funds retained by the agency, but not used, amounted to approximately $8,000.

The department and the Minister sided with the agency in alleging the money for the 1:1 program was not part of an ISP but was part of the block funding allocated to the agency. The same argument was used when the mother challenged the inappropriateness of the money that would have been allocated for supporting her son as part of his general support and service within the house, being retained by the agency. Yet it was the agency which had refused to have the client return after some weeks at home with his mother.

In terms of the department's current involvement they have, some 14 months after the client returned to his home, allocated a new ISP with funding of approximately $60,000. An emergency care plan is also now in place and is to be invoked in the event of something untoward happening suddenly to the mother. The department also, under pressure of the mother's back injury becoming worse, provided $9,998 at 50% of the cost of second-hand wheelchair accessible bus so the client and his mother could safely go out of the house.

(v) **Office of the Public Advocate (OPA)**
The mother rang OPA and was advised that Community Visitors would visit the house. The mother was told that she would not be told when they visited or what they may find – but she should notice a definite improvement in the service soon. It was also mentioned by staff that they were very "aware" of that particular supported accommodation facility.

(vi) **The Office of the Disability Services Commissioner (ODSC)**
As the result of seeking advice from the ODSC the client's mother lodged a formal complaint with the office in June 2012. As a result of an illness suffered by the mother the ODSC did not undertake an Assessment Conference until November 2012. Following that conference, communication from the ODSC advised that the agency had advised that they had not "communicated any sense that your {the mother's} expectations are unreasonable."

An ODSC Conciliation Conference was held in early May 2013 as the ODSC had determined that "there are issues of substance that remain unresolved." While the outcome of this conference was that the agency was to prepare a plan to enable the return of the client to the residential service, in mid June the mother advised the agency that her son would not be returning.

(vii) **Villamanta Disability Legal Services**
The mother in mid-February 2013 contacted this service. In response to the mother feeling forced to have her son approved for nursing home placement, Villamanta advised the mother that her son should not have to be consigned to a lifetime in a nursing home because of the agency's failings, particularly given the fact of him only being in his early 20s. Villamanta also asked the mother as to where her son's support plan was, or indeed whether one existed.

2. A Situational Analysis

Since the end of January 2013 the client has been living with his mother in country Victoria. He is reported as being very happy. It is also reported that he eats all his meals and his blood glucose is stable – so stable that in fact, it is no longer required to be taken every day. Immediately prior to this the client had been living in his own home for almost two years, in a funded residential service.

The client does not attend a funded day service, however, two workers attend the family home three times a week in order to shower him. He also receives five hours of 1:1 activities with another worker.

The mother has been forced to give up a well-paid employment position and is struggling financially and has recently put her house up for sale.

While some may say the mother "chose" to have her son return to her home, the fact is that this was not the mother's first choice. She went to great lengths to have the funded agency provide a level of care which did not put her son's life at risk. However, the duty of care failures of the funded non-government organisation, and their failure to address care issues, meant the mother could no longer contemplate the real possibility of her son dying because of a lack of care.

3. The Issues

This case presents as a case where, although a number of agencies were involved, the presenting issues were not dealt with and the mother was forced to take her son back to her home from his own home, the supported accommodation facility in which he had been living. Associated with this, the case also highlights a number of significant deficits. In the first instance these were deficits perpetrated by the accommodation support service. It also, however, exposes how those agencies from which the mother sought support failed her and her son.

(i) No Support Plan and Failing Duty of Care

The Disability Act 2006, Section 54, is unambiguous in requiring a disability service provider to ensure a support plan is prepared within 60 days of the person commencing to regularly access the disability service. In this case, the client entered the service in early 2011. A support plan had not been prepared at July 2013, a period of well in excess of two years.

The failure of the agency was highlighted even more starkly when taking account of the fact that the client's mother provided staff with a range of written material concerning her son's care needs, including records of his medical history, prior to him taking up the placement. Additionally, the mother also provided staff with a short DVD showing her undertaking particular care activities with her son.

While the lack of a formal support plan is a breach of the Disability Services Act, what is really highlighted is the lack of duty of care – plenty of information had been provided to the agency as to the client's needs and how to meet them, so in effect there was an informal support plan which the agency failed to put into practice.

Regardless of the Disability Act, which makes no mention of duty of care, service providers are subject to the Wrongs Act 1958 and its duty of care provisions.

(ii) Staff Training and Development

Despite the agency promoting itself as being able to provide the services required by the client, it soon became evident that, either through a lack of competency or alternatively a lack of training, the agency's staff were unable to provide the level of service to a high needs client, as this client was. The question then became one of - Did or did not the staff have the necessary skills, and, if not, why was this not addressed by management?

There was also an issue as to whether there was enough funding for enough staff – which of itself is something of a red herring diversion by the agency, who sought to diminish their duty of care obligations. The agency did not address the critical issues of staff competence and any necessary training.

(iv) Incident Reports – A Matter of the Run Around

Following a request by the mother in February 2013 for particular reports for incidents that occurred in August 2012 and January 2013, the agency directed the mother to DHS. When the mother again pursued her request with the agency, arguing her son had the right to access them, the agency again directed her to DHS.

When the mother contacted DHS she was told she would have to make an FOI application, but to also try the ODSC. Which she did, and was told by the ODSC that she would have to make application through Freedom of Information (FOI) to access their information – but that the client had a right to have the agency provide them. After a protracted argument with the agency on behalf of her son, the mother finally received ten edited Incident Reports, while others were withheld. The agency incorrectly told the mother she should request the Incident Reports under FOI despite the fact that FOI does not apply to the agency because it is a non government organisation.

Making client's and their families run around and jump through hoops represents another example of where agencies refuse to be transparent.

(v) Dealing with Complaints – The Office of the Disability Services Commissioner (ODSC)

The ODSC came into being through the Disability Act 2006; as such it has been established for seven years. Yet, despite this, the DSC in a letter to the mother advised, "Please be assured we have taken and applied the learnings for our practice from all you have shared with us."

All people with a disability, and their families, who refer complaints to the ODSC, must shudder at this statement and ask – How long does it take a legislated complaints' authority to get its act together?

(vi) The Service Response to a High Needs Clients

This case highlights the increased pressure that can be brought to bear on the family of a high-needs son or daughter. It also highlights the importance of support agencies not only being equipped to provide a quality service, but just as importantly, not adding to the pressure by intransigence and power plays.

In this case, the mother was desperate for her son to be able to access a supported accommodation service. Yet, once having accessed such a service, the provider failed her and her son. This was principally through an inability to attend to day-to-day support needs, a lack of responsiveness to complaints, and casting the mother as a problem, when all she was seeking to do was to ensure her son received a quality service commensurate with his high needs.

(vii) The System's Failure

Despite the mother, in the first instance, seeking to work with the support agency by providing them with significant information about her son, by the agency's failure she was then forced to seek to engage other agencies she thought would be prepared to prosecute her case. Yet, a legal entity, a legislated complaint's body, the department and finally the Minister, all to some degree failed her and her son.

This case reflects a frightening example of how the system does not always work to protect the rights of people with disabilities. It shows how, either by deliberate actions or by incompetence or intransigence, those charged with the responsibility to protect and who have the power to do so, in effect engage in a trade in duplicity, despite the adverse outcomes for people with disabilities and their families.

(viii) Terminating a Service

A few days after a health scare when the mother had taken her son to her home, the agency telephoned the mother to ask if the client had been withdrawn from the service. The mother advised that no formal notice had been given of her son being withdrawn from the service. Around two weeks later the mother did give formal notice of withdrawal, but a few days later she formally withdrew this notice and her son continued to stay with her. Approximately six weeks later the agency barred the client from returning to the service.

The Disability Act in sections 75 to 82 sets down what is required if a client intends to leave a residential service or if the service provider intends to remove a client from a service. Section 74 also allows the service provider to give a notice of temporary relocation. In this case, the agency did not appear to follow the requirements of the Act, in that the advocate working with the family was only verbally informed the client was to be barred from the service. Essentially, by barring the client from the service, it seems reasonable to conclude that the agency was engaging in a power play and in effect used the threat of barring her son against the mother.

Given, however, that a service provider may give notice to vacate and not have to specify a reason, the resident is not actually in an empowered living situation. Thus, while the Act provides for an appeal to VCAT regarding a notice to vacate, this appeal is not about the merits of the notice to vacate, it is about the technicalities.

4. Concluding comment

Time and time again cases are directed to the writers which highlight that despite the rhetoric of rights and the oft-repeated messages of the ideologues seeking more of this and more of that, the system still continues to fail people with disabilities and their families.

While each of these cases is an individual case in its own right, nonetheless, there is a significant similarity in many aspects of all the cases. Although the writers acknowledge the importance of promoting the notion of, for example, individual supports, partnerships, engagements and inclusion, they express significant concern that only one side of the equation is ever promoted.

The side of the equation, almost totally ignored is that of the question – What happens when the safeguards fail? In every case reported to the writers, the safeguards have failed at least at one level, or as highlighted by this case, at all levels of the system.

Case Study 4

Yooralla -
A Sad Story of Systemic Failure

Synopsis

This case study is mainly based on documents available in the public domain, which identify people and organisations. It demonstrates how a large and long-established government funded registered service provider, Yooralla, failed to safeguard its clients in a residential service. Clients were sexually abused. The study also highlights the organisation's response to the abuse.

The media paid attention to events, and in particular The Age newspaper published a series of articles as the story unfolded.

The case also represents a concerning study as to how duty of care does not rate a mention, despite it being a legal responsibility. As well, the exposure of systemic failures brings to the fore the shortcomings of existing regulatory and protective mechanisms.

1. The Principal Players

This case presents as an interplay involving four sets of players.

(i) The Clients

Two wheel-chair bound women who had cerebral palsy were raped and a third woman was sexually assaulted in their Box Hill home where residential support was provided by Yooralla. The pants of another resident, a disabled man who walks with the aid of a walking frame, were also repeatedly pulled down in front of other residents.

The three disabled women were assaulted in their bedrooms and their bathrooms over several weeks. The women were dependent upon care for toileting, or at least for assistance onto and off the toilet, and in their bedrooms were again dependent because they could not move without assistance. They were threatened about what would happen if they told anyone.

One of the women who was raped has expressed that Yooralla's failure to act on early warning signs and its attempts to protect itself from scrutiny later on cannot be forgiven.

A fellow Box Hill resident and friend was instrumental in the sexual assaults being reported to police.

(ii) The Worker

The staff member who sexually assaulted the clients was named in the media. He had arrived from India in 2007 on a student visa. (The nationality becomes a consideration as there were no international police checks undertaken, though it is not known if such a check would have revealed anything.) This person's offending was not opportunistic or spontaneous as he was careful to choose the time and place when committing the offences. He made sure he was the only person on duty when the three women were at their most vulnerable.

The offender, who pleaded guilty to eight counts of rape, two counts of sexual penetration, one count of committing an indecent act relating to a person with a cognitive impairment committed by a worker at a facility designed to meet her needs, and one charge of indecent assault, was jailed for 18 years with a non-parole period of 15 years.

The offender began working on a casual basis at Yooralla in March 2009 as a disability support worker and was counselled in August 2011 after two reported instances of inappropriate behavior, with one involving the person twisting the nipple of a male resident.

This person applied for a permanent job at Yooralla only months after being counselled and was unsuccessful because of rumors of inappropriate behavior with residents and staff. Nonetheless, Yooralla continued to engage him on a part-time basis, so he was working practically full time hours, and was often rostered on at times when he would be the only support worker at a residence.

(iii) The Organisation - Yooralla

Yooralla is one of Australia's largest organisations working to support people with disability. It is long established – since 1918 – and is a registered service provider under the Disability Act 2006. It is a reasonable expectation that Yooralla would provide services in accordance with the Act, and that its policies, procedures and practices accord with the legislation, and reduce the risks of accident, injury, abuse, neglect and exploitation.

The judge said one of the offender's victims had wanted to swear at him and tell him to "f--- off" but it was "a measure of her level of cognitive functioning that she felt unable to say that because there is a rule against swearing in the residence". The offender, believing there was a risk the woman would complain, left a note for the team leader at the residence who was due on duty the following morning. In the note the offender admitted he had said something rude to the woman and had apologised to her, but she had sworn at him, which had so upset him that he was unable to concentrate at work.

"The team leader appeared to accept your story and immediately went and remonstrated with [the woman] for swearing in breach of the house rules," Judge Hampel said. "[The woman] was crying when she went into her room, but the team leader did not ask why before she remonstrated with her, telling the client that her behaviour was inappropriate with the staff member." "Unfortunately for the woman the Yooralla response was less than adequate."

This summing up by the judge perhaps best expresses the "Yooralla response": less than adequate.

The organisation has responded to various queries by pointing to police responsibility. For example, when one of the victims allegedly raised that the consultant Brian Joyce has not spoken with her, Yooralla says police allegedly asked Yooralla's consultant Brian Joyce not to talk to victims for fear of compromising the integrity of their evidence. And, when asked about a staff member who had leaked reports and emails, a Yooralla spokeswoman said the organisation's email system had been hacked and confidential information ''unlawfully emailed to a third party''. Although Yooralla reported it to police, the decision to charge that staff person was made by detectives, she said.

In June 2012 Yooralla drew together senior members of the DHS, Victoria Police, people with disability and the Victorian Government and disability sector to identify and develop models of best practice around responding to allegations of assault. Christine Nixon APM, former Chief Commissioner of Victoria, chaired it. It is hard to believe that Yooralla did not already have in place such models.

(iv) The Families

The family members of Yooralla residents are baffled that neither the Victorian Ombudsman nor the Disability Services Commissioner will act on their requests to investigate Yooralla management's failure to respond to initial complaints about the offender and subsequent claims that they had insufficient information to sack him before his offences.

Yooralla did not tell the parents of disabled Victorians exposed to the alleged offender that he had been charged with rape in March. It was not until detectives sought to question residents in houses where the offender had worked as part of their investigation that some parents learnt the former Yooralla employee was facing charges. When The Age reported on the rape allegations, in June 2012, as well as complaints from two families of disabled men who were cared for by the accused man, the families said they were ''disgusted'' Yooralla had told them of the carer's alleged activities weeks after he had been charged.

At the end of June 2012 the mother of one of the residents (but not one of the victims) received a phone call from a Yooralla manager advising her that police were interviewing her son. This was the first the mother had heard of the allegations, though for some years she had been raising concerns with Yooralla about the services being provided. Six weeks after the Yooralla carer had been charged but a month before she was informed of the police probe, the mother had written again to Yooralla warning that, ''My son now lives in a house where vulnerable clients and staff are unsupervised by an on-site team leader/house manager, and this I believe compromises his safety.''

Yooralla's General Manager defended the agency's failure to tell all parents of children potentially exposed to the accused man's offending. She said Yooralla had decided instead to immediately inform and work closely with the families of its disabled clients who had made specific complaints of abuse. "Our main focus was on working with those who had made allegations," the General Manager told The Age.

Families and friends have continued to actively raise issues about Yooralla's management and Yooralla's response to the events since the allegations became public.

2. A Situational Perspective

The sexual assaults took place between October 2011 and January 2012, and police charged the offender in March 2012. He first appeared in court in June 2012. In November 2013 he was sentenced and jailed.

In June 2012 The Age reported the Yooralla rape allegations, as well as complaints from two families of disabled men who were cared for by the accused man.

An Age article in August 2012 revealed that a confidential internal inquiry commissioned by Yooralla had found a team leader saw the male carer on a bed with a disabled client but failed to report it. This was before residents alleged the carer had raped them. The inquiry's report accused the team leader of "poor performance" and recommended he should be disciplined for breaching rules requiring him to report serious incidents. The inquiry report by consultancy Lifeworks, along with confidential internal emails obtained by The Age, reveal that:

- A Yooralla area manager advised another senior staff member "to fill in a feedback form rather than make a formal complaint" about "inappropriate sexual comments" made by the carer before he was accused by residents of rape.
- A Yooralla team leader reacted with "scepticism" when the abuse allegations were first reported to him by a resident.
- Yooralla staff have detailed "a litany of stories about lack of back-up, poor management, being left without a manager and being 'kept in the dark' about important matters", including Yooralla's handling of rape allegations

The Age also reported that internal Yooralla emails reveal that staff and residents raised serious concerns after the carer was charged with rape.

An email from a consultant hired by Yooralla to interview residents and staff from one of the facilities in which the alleged rapist worked states: "Residents were unhappy about the large numbers of casuals and especially when all staff on are casuals. They get anxious wondering 'who will be on today/tonight'." "Staff are angry that there are no regular staff meetings to discuss important matters to do with the house. Staff felt that attempts to support them were few and those that were offered were thinly veiled attempts to silence them. They felt 'patted' and then encouraged to 'move on'," the email reads.

In June 2013 a meeting was called because of concerns expressed by one of the residents along with other residents at his Box Hill North house over the transfer of a trusted carer elsewhere. The complainant said he and the other residents were not consulted about the move and felt it could compromise their safety. At the June meeting the complainant also asked what had happened to the Yooralla worker who in 2000 had photographed him without his permission when he was in a state of undress. He alleges that a senior Yooralla manager responded in a ''very humiliating' way, saying, ''Oh, (person named) that was such a long time ago.'' The manager conceded the carer was not sacked but moved to another house. While the CEO of Yooralla has appointed an external investigator to probe the treatment of the complainant by two senior Yooralla managers at the June

2013 meeting, nonetheless being dismissive of concerns seems to continue to be a cultural practice within Yooralla.

Yooralla issued a statement to say that when allegations were made by Yooralla clients (which would have been around March 2012), "Extensive steps were immediately taken by the Yooralla Board and management to review client safety and wellbeing. These included commissioning Mr Brian Joyce, a former Regional Director with DHS, to conduct an external independent report into the circumstances of these events and to identify recommendations to enhance client safety."

The Yooralla Board has accepted all 20 recommendations contained in the Joyce Report 2012. The Joyce Report also recommended that Yooralla appoint an independent auditor to audit the progress of implementation after six months and twelve months, in line with the timeline for completion of strategies within the plan. Health & Disability Auditing Australia (HDAA) on site at Yooralla mid-August 2013 carried out the first of these. Thus one assumes the report was accepted around February 2013 – almost a year since the allegations were taken to the police - though no dates have been mentioned as to when Mr Joyce's commission took place. High compliance has been reported for the August audit.

The fact is that there is scant information available as to what lessons have come out of this for Yooralla, other than assurances that there is an ongoing overhaul of Yooralla's policies and procedures plus the establishment of a dedicated division to strengthen quality, innovation and safeguards. The audit report is little more than a "tick" against some general overall boxes. While Yooralla's website states that a Client Wellbeing & Safeguards Action Plan was established in response to the Joyce Report, this Action Plan was not published on the website when searched for in early December.

Interestingly, the head of this division has been critical of The Age for naming a Yooralla service and its location and showing a photograph of the home's exterior in its reporting "on a series of complaints". He has suggested this raises questions about protecting the privacy of people with disabilities, though he has not indicated whether or not Yooralla has or will take this up with the Privacy Commissioner. Also, he has been critical of The Age saying that the service was home to "some of Victoria's most severely intellectually disabled people," intimating that this was "a stereotyped description" which would "add to the negative social discourse on disability." These criticisms can be readily considered a diversion and a disparaging response, a "shooting the messenger" action, more indicative of an intent to lay claim to Yooralla staking the moral high ground than anything else.

In February 2013 Yooralla's general manager was reported as saying a taskforce similar to South Australia's Care Concern Investigations Unit should be set up by the State government to probe suspected abuse and negligent care in the disability sector. It should be noted that this Unit is only set up to investigate serious care concerns, and those assessed as minor or moderate must be handled by the service provider. Also, this in some ways is a diversion from looking at what the Secretary can already do under the Disability Act 2006.
In June 2012 the general manager was reported as saying that Yooralla was leading efforts in the sector to improve background screening of all staff

and in late March had introduced international criminal checks - which the accused man had not been subject to - for all employees. Nonetheless, a recent position vacancy advertised on the Yooralla website for a Direct Support Worker in Residential Support Services contained no notice about international criminal checks, and only noted that a current (i.e. less than six months old) Victorian Police Records Check was required.

While newspaper reports reveal there were indicators that there were deficits in service provision, which eventually led to a staff member being jailed for 18 years, the question must be asked: What was inadequate in this service provider organisation, one of the largest in Australia with significant management infrastructure, that this was able to happen?

In late July 2013 The Age reported on another home "in crisis" where serious issues include:
- The house being without an appointed manager for more than 12 months.
- Incidents involving residents not being adequately recorded or reported to families.
- No permanent full-time staff, leading to an over-reliance on casual staff.
- Inappropriate, or lack of supervision of residents, with at least one staff member accused of regularly falling asleep on the job.
- Reports of residents, including one with the mental ability of a six-year-old, found wandering unsupervised in the community after having been missing for hours.
- Failure by Yooralla management to comply with their policy that requires all new staff at the house to be ''shadow shifted'' by experienced staff for at least two weeks.

The Age stated that documents show that Yooralla has brought in the Department of Human Services and external consultants to help re-establish ''safety and security'' and to ''work with staff to know what they should and can do to prevent violence''. One wonders about the models of best practice supposedly under consideration since June 2012. Also, Yooralla stated that the plan for this house promises disciplinary action against staff who fail to properly document incidents, and the provision of medication and assures greater ''attention to household cleanliness and preparation of healthy and attractive meals''.

It must be considered doubtful that the Joyce recommendations and their implementation actually get to the heart of Yooralla's failures.

3. A Contextual Perspective

To have an appreciation that Yooralla does not operate in a vacuum, the context in which Yooralla operates must be considered. Given this, the question which has not been answered is: How was it that such a serious crime could be committed within what ought to have been a well-managed and monitored service?

As a registered service provider under the Disability Act 2006, Yooralla has funding and service agreements with the Department of Human Services. The Secretary of the Department of Human Services has functions and powers under the Act, in particular those under Part 6, Rights and Accountability. Under section 99, the Secretary has the power to give directions to the service provider if the Secretary considers that a disability service provider has breached or failed to comply with the Act or any other requirement made in accordance with the Act or any condition subject to which funding is provided by the Secretary. And, as per section 8, "to monitor, evaluate and review disability services" is a function of the Secretary.

At the very least, it appears that the Secretary has taken a very soft approach to requiring compliance with the Disability Act 2006. The acceptability of this approach must be questioned. Further, while one may appreciate that Yooralla can be seen to be responding to the situation, it is unacceptable that no explanatory public statement has been forthcoming from the Secretary as to compliance with the Disability Act. A rapist working for a registered disability services provider has been jailed for 18 years – yet not a word has been heard from the funder and regulator as to the deficits of the service provider.

As well as the Secretary of the Department, there are other statutory bodies that have a role in the protection of people with disabilities and upholding their rights. Specifically mentioned in the Disability Act 2006 are the Community Visitors and the Community Visitors Board, which operate as part of the Office of the Public Advocate. The Community Visitors are able to visit residential services and inquire into, amongst other things, any case of suspected abuse or neglect and any failure to comply with provisions of the Act; as well as whether the service are being provided within the principles of the Act, which includes the principle that people with disabilities have the right to live free from abuse, neglect and exploitation. Also, the Community Visitors Board is able to refer matters reported by the Community Visitors to the Secretary of the Department and the Disability Services Commissioner; and at any time submit a report to the Minister if the Community Visitors Board considers that the Minister should consider any matter personally.

There was no indication in either the 2013 Community Visitors Annual Report or the Public Advocate's report of matters being referred to the Secretary or the Minister, or for that matter to the Disability Services Commissioner. Why is it that statutory bodies do not appear to use the powers they do have? In its 2013 Annual Report the Community Visitors reported that "This year Community Visitors reported serious concerns with three major CSOs {community services organisations}" of which Yooralla was one, and further reported that "The Community Visitors met with the Board of Yooralla which was largely unaware of the issues Community Visitors had previously raised." It is noteworthy that Yooralla has advised that since the Joyce Report there have been regular meetings with community visitors to listen to and respond to their important feedback. One wonders why community visitors have not apparently met with Boards of the other two organisations, which they named.

The Office of the Public Advocate has recently promoted a new guideline to help prevent and address allegations of violence, neglect or abuse in services for people with a disability, and is encouraging services to sign up to this. It is noteworthy, however, that this guideline does not carry any legal authority and there is no apparent monitoring of the effectiveness of its implementation in an organisation's services. It is also noteworthy, however, that the guideline states, "This guideline does not address the significant duty of care organisations also have for their staff in these circumstances, which should be addressed by the organisations' human resources policies." It also states that an investigation must be established by the organisation with the relevant duty of care to the person who is affected. Whilst this initiative has the potential to better address the issues of violence, neglect or abuse, nonetheless the writers argue that unless the guideline is established not as a guideline but as mandated requirement, it has no real authority. It is merely a good intention.

The Disability Services Commissioner is established under the Disability Act 2006. Under the Act, as is required of all disability service providers, Yooralla must provide an annual report on complaints to the Disability Services Commissioner, including information about the number and type of complaints and the outcome of the complaints. Also, Yooralla is required to institute and operate a system to receive and resolve complaints received by it in respect of disability services provided by Yooralla; and has a duty to take all reasonable steps to prevent people being adversely affected because a complaint has been made. It is noteworthy that when Yooralla's website was searched in early December 2013 for information about making a complaint, this only revealed that its Life Skills program for clients covered making a complaint and being heard. There was no facility to submit complaints electronically. Also noteworthy is that there is no mention of the Disability Services Commissioner, not even on its Legal Rights & Safeguards page. It seems probable that the Joyce Report made no recommendations regarding complaints. Given that almost half of the complaints made to the Disability Services Commissioner relate to supported accommodation, it is a reasonable expectation that the Commissioner monitor how organisations measure up against standards for complaint mechanisms, but this does not appear to be done.

The Yooralla website promotes its Quality, Innovation & Safeguards team as providing an avenue for clients and their families to voice their concerns if they feel they are not being heard by the management of individual services within Yooralla. The team is also responsible for establishing and embedding quality procedures across the organisation to enhance client safety and wellbeing. This makes it all the more inexplicable that information about complaints is not apparently available on the Yooralla website. Given that websites are a good way of making information accessible, it is also inexplicable that Yooralla does not use its website to ensure that people using their service know how a complaint can be made to it as a disability service provider and to the Disability Services Commissioner. Such information must be provided to service users under section 89 of the Disability Act. Yooralla's effective compliance with the Disability Act is very questionable.

4. The Issues

This case highlights the failure of an organisation's systems to prevent criminal activities. Issues consequently arise out of the organisation's response to the criminal activity. Issues also arise because of the doubt cast on the effectiveness of the monitoring and compliance/enforcement regime for disability services.

(i) Systems failure

The systemic failure of staff to identify, report on and follow up incidents goes to the heart of the sexual assaults on residents. This put the supervisory and management practices of service providers under the spotlight. This case highlights the failure of Yooralla's operational managers and supervisors, to have either taken note of the indicators or, alternatively, to report them up the line. Equally, the case highlights how senior management, including the CEO, were apparently oblivious to the failures occurring in the service, and thus they also can be deemed to have failed in their duty of care to the clients.

No one would suggest that the provision of 24-hour residential services to dependent clients, in small stand-alone homes, is a simple undertaking. This means that there should be heightened attention by management to issues, which may have their basis in inappropriate behaviour by staff. Providing residential services is something Yooralla has been doing for many years, and has won tenders to do so. If nothing else, these tenders should have put Yooralla's management and systems under the spotlight of the Department of Human Services.

This particular systemic failure at all levels demonstrates how the level of risk of something untoward happening is heightened when inappropriate behaviour by staff goes unchecked. In this case it resulted in criminal behaviour.

(ii) The need for a visible platform for the provision of disability services

The rights of people with disabilities have been at the forefront of disability legislation and policy making for over 25 years. While translating these rights into practice and their implementation is the real undertaking, the fact cannot be ignored that rights are enshrined in legislation. While rights are the foundation, at issue is the fact that sight has been lost of duty of care as the essential platform to ensure rights are upheld. Duty of care is the basis for enabling the right to live free from abuse, neglect and exploitation; it is an enabling protection, not a restrictive protection.

In this case, there has been a failure to meet duty of care responsibilities and obligations. Of equal importance, the case also highlights the failure of the Disability Act 2006 to explicitly require service providers to meet their duty of care obligations. It is imperative that duty of care resumes its rightful place as a highly visible legally based platform for the provision of disability services.

(iii) An ineffective monitoring and compliance and enforcement regime

While publicity has been given to Yooralla's failings in the provision of residential care and support, thought must be given to what changes need to be made to strengthen the legislative and/or regulatory basis for the protection of people with disabilities.

As indicated in (ii) above, an essential amendment that must be made to the Disability Act 2006 is to insert into the Act the requirement of service providers to meet their duty of care responsibilities. While these responsibilities are articulated in the Wrongs Act 1958, it is necessary to bring duty of care to the forefront of disability legislation as a core requirement, with real penalties if there are failures in duty of care.

Additionally, the Disability Act should also be amended so one of the functions of the Disability Services Commissioner is to assess the adequacy of duty of care as applying to any complaint referred to him, and to report on this. Likewise, the Act should also be amended under section 30 so one of the functions of Community

Visitors must be to monitor and report on the adequacy of the provision of duty of care to those clients in services visited by Community Visitors.

Of itself, however, legislation does not mean that the required actions and compliance will occur. Given this, the onus must therefore be placed on all parties, including the Department, the service provider, and the monitoring agents to meet their obligations under the Act. If failures are identified whereby any of these parties have failed in their duty then penalties must also be imposed on those who have not met their obligations under the Act. In this case there is no evidence to suggest that, apart from the perpetrator of the rapes and sexual assault and the whistle blower who leaked documents to The Age, any other party has been called to account.

(iv) Implications for the National Disability Insurance Scheme (NDIS)

While this case has no direct relation to the NDIS at this stage, nonetheless it does have significant implications for the registration of service providers, service monitoring and complaints management to be established under the NDIS. Given that Yooralla is a registered service provider under the NDIS, those responsible for the management and implementation of the NDIS must give consideration to this and any other case in order to ensure that the NDIS does not replicate identified mistakes and shortcomings.

In essence, the service monitoring and complaints mechanisms established for the NDIS must be robust, timely and effective.

5. Concluding comment

The sentencing of the sexual offender to 18 years jail with a non-parole period of 15 years, while a strong response to the horrific nature of the crimes, must nonetheless be considered as only part of this terrible saga. The organisational response of the service provider to allegations does not inspire confidence that protection of staff and the organisation is not its overriding concern. While it is important to ensure that staff who do the right thing are not placed under a cloud, nonetheless the overriding issue must be the delivery of duty of care. As such, there can be little confidence that Yooralla's future response to complaints will be satisfactory to the degree that the lessons learnt from this case will be effectively practised.

This case has highlighted that there are questions to be asked about the monitoring and compliance regime which operates under the Disability Act 2006. In particular, the case highlights the lack of adequate response by the Secretary of the Department of Human Services, the Disability Services Commissioner, and the Community Visitors. The public needs to know that protective mechanisms are in fact effective in ensuring that all parties, not just those providing direct care and support, understand and meet their duty of care responsibilities.

And while there is a need for the public to have confidence in care and support services for dependent people, it is absolutely essential that the people themselves and their families have unconditional confidence that the services are free from neglect, abuse and exploitation. Families, in the first instance, must have unconditional confidence that duty of care will be the priority of all service providers. And should there be any failure in duty of care, such failures will be swiftly and properly remedied, and those responsible transparently brought to account.

Case Study 5

The Meeting Treadmill

Synopsis

This case demonstrates how bureaucratic processes can work to frustrate rather than facilitate when families seek to improve the provision of services for their family member with a disability. Worse still, the case shows how the weight of bureaucracy, the slowness of those in power to act and to ensure direct staff did what had been agreed, finally proved too much, and the battle-weary family "retired". It is a case of treadmill management where the illusion of activity is formed, but nothing real eventuates.

1. The Principal Players

This case presents as an interplay involving five sets of players.

(i) The Client

The man in question, let us call him Peter, is middle-aged, and has a profound intellectual disability. Because of his disabilities he must be supported with communication - he is non-verbal and communicates with gestures, body language and vocalisation- and self-care. Also, monitoring is required for his epilepsy, which can be well managed with medication, and foot care. He is a social and outgoing man, who enjoys walking, music, attending social activities and groups, and he can interact well with others, and is very observant about things happening around him. Peter has been in residential care for many years.

(ii) DHS House Staff

The house staff workers are important in that they are the people who provide the direct care, who are at the coalface, so to speak, on a daily basis. While Peter's house was staffed 24-hours, there was only one House Supervisor, and this person worked standard hours. The house also worked on the Key Worker model, with one support worker designated as taking the lead on a particular resident's care and support. In keeping with DHS organisation for the region, there was also a manager with oversight of the house as one of a number of houses that person managed, based on geographic proximity. This manager attended meetings the family had with the house staff. It was apparent that the House Supervisor was essentially the only staff member in the house with designated authority, and there was no person with delegated authority when the House Supervisor was not on duty.

(iii) The Organisation – The Department of Human Services

As well as at the house level, the Department was involved through the Disability Accommodation Services (DAS) Manager for the region and through the Disability Client Services (DCS) Case Manager who had been appointed for Peter.

(iv) The Family

The client's family, including his siblings, had always maintained close contact with him, and he visited with family some time almost every weekend. A brother and sister were his financial administrators and they ensured that their brother was financially well provided for. This brother had taken an active role in liaising with staff regarding Peter's care and support, attending health appointments when possible, taking him shopping for clothes, visiting with him and involving him in family occasions. He took the lead for following up on Peter's move to a new place.

(v) The Disability Services Commissioner

Some 12 months after a person centred plan had been completed for Peter, the family sought the assistance of the Disability Services Commissioner to, amongst other things, resolve the impasse which had arisen from the Department's failure to take timely action to implement the plan to achieve identified outcomes. During these 12 months the family had been involved in nine meetings with managers, case management and house staff, in attempting to implement the support plan and actions agreed to at meetings or in other communication, so that Peter was not disadvantaged and his rights were upheld.

2. A Situational Perspective

The difficulties with Peter's care and support became apparent when he moved into a new home and there appeared to be little emphasis on developmental opportunities or activity generally. The family's concerns about this led to a DHS Disability Client Services planner developing an agreed plan, and a case manager being appointed to ensure the plan was implemented.

Meetings were held which focussed on the outcomes listed in Peter's Person Centred Plan, to ensure that the tasks identified relating to his social and community access, living skills, health, communication and safety were being addressed. In these meetings the house staff indicated their 'nodding agreement' with the plan, but its implementation became fraught with difficulties, as no work practices or routines in the house were changed or modified. Some changes or modifications were necessary to implement the plan.

The manager who attended these meetings demonstrated support for the plan as she sought to instruct staff on performance improvement. At the same time, this manager indicated she was making efforts to implement a common system for the houses she for which she was responsible. It was apparent that the House Supervisor was given considerable flexibility in running the house, in implementing policies and procedures, and in this instance a fairly rigid structure had been developed which Peter was expected to fit into, regardless of his needs. It was apparent that the house staff had little or no regard for the Case Manager position, and it was notable that this person was not a proactive case manager.

When monitoring tools were put in place, the information provided by staff invariably was incomplete or questionable as to its accuracy.

The family's complaint to the Disability Services Commissioner (DSC) meant they embarked on yet another round of meetings with Department staff and the DSC. The responses provided by the Department to the inquiries of the DSC were disputed by the family, and it was apparent that DHS management merely asked questions of staff "down the line" and accepted responses at face value, with no attempt to validate, investigate or clarify the information being provided – and then simply passed these responses on to the DSC.

When matters were raised with the DAS Manager, this led to more meetings, plus attempts to resolve matters using written communication. At times the family were almost stunned by the questionable information being provided by the DAS Manager. A number of meetings organised with the DAS manager were called off at the last minute because the manager was unable to attend. There was no recognition of the inconvenience and cost of this to the family, who had organised their own work schedules to attend such meetings.

Eventually agreement was reached at the Disability Services Commissioner as to how events would move forward to ensure the good outcomes planned for Peter, and his plan outcomes were updated and new monitoring tools agreed upon. The family believed a good platform acknowledging and respecting the important role of Peter's family had been built, with shared understanding and goodwill.

However, this confidence was undermined by the failure of the house staff to adhere to the agreed actions. Apart from health issues, DAS management failed to respond to other concerns raised by the family.

Finally, having been on the meeting treadmill for over three years, having attended meeting after meeting and having actively follow up on issues which arose, the family members were worn out. They recognised that despite the rhetoric of rights and person centredness, active support, recognition of families, complaints resolution, there were no mechanisms to ensure that staff undertook agreed actions, as management was not prepared to discipline or direct house staff. Consequently, the family stepped off the treadmill and directed their energies to their providing their brother with meaningful activities as much as they were able. As well, the family made an application for their brother to be relocated to another home in another region – noting that where their brother lived was virtually on a regional boundary. Interestingly enough, requesting another region uncovered another mountain of bureaucratic processes to be surmounted.

No family members were in the position to provide their brother with an alternative home, and they have no expectation that having their brother on the relocation register will result in his being able to move to another service provider – which of itself is no guarantee that his life would improve.

3. A Contextual Perspective

The Department of Human Services has years of experience in managing residential services for people with disabilities, particularly intellectual disability, and has well-established policies and procedures. The planning services for people with intellectual disabilities has long been a feature of the service system, with General Service Plans (GSPs) and Individual Service Plans (ISPs) having been in operation since the 1986 Intellectually Disabled Persons' Services Act. The Disability Services Act 2006 essentially maintained this planning regime, though not mentioning General Service Plans and Individual Service Plans as such.

The creation of the Disability Services Commissioner in the Disability Act 2006 included, in particular, the functions of investigating complaints relating to disability services, reviewing and identifying the causes of complaints, and determining what action should be taken by a disability service provider where a complaint has been found to be justified. Also, service providers – and the Department is considered a service provider – have to have a system for resolving complaints and make an annual report to the Commissioner about complaints received.

4. The Issues

This case highlighted why people conclude that the disability service system fails to focus on individual needs and outcomes and does not work well. It also highlighted the failure of managers to address complaints in a timely and effective way.

(i) Process more important than people

While there was much activity in terms of meetings and people sitting down to talk about the services being provided, and the talk resulting in agreement about what should happen, when the agreed actions did not happen the talking process was re-invigorated.

There is no doubt that the service provider failed to ensure the optimum well-being of their client – who after all is the reason they have a job and were getting paid – and improve the services being provided.

(ii) Conciliation cannot resolve the presentation of differences of fact

It was apparent that the disability service provider was not properly investigating the complaints being made by the family. "Differences of fact" is a euphemism for saying that the service provider had no qualms in responding to questions in ways that were less than truthful. The half-truth is a powerful tool of deception, and the lack of agreement on the reality of what was happening in the house meant the house staff, and the House Supervisor in particular, knew they did not have to change their activities and practices.

(iii) Management competency

There is little doubt that the competency of the service provider's managers to manage house staff is questionable. The staff at this house were dedicated to provide care and support for six people, none of whom could be considered as highly complex. The actions required to implement Peter's plan highlighted deficiencies in how the house was run – deficiencies which were not apparent on the surface, but as the planning process scratched below the surface, so to speak, the deficiencies were uncovered. Whether managers were unwilling or unable to correct the deficiencies is debatable.

(iv) The safeguards in action

The functions of the Disability Services Commission essentially are part of the system of safeguards to uphold the rights of persons with disabilities. The emphasis by the Commissioner on communication, on people meeting and talking, is a reminder of the movie "Cool Hand Luke" where the phrase *"What we've got here is (a) failure to communicate"* is spoken at different points in the movie, first by Strother Martin (as the Captain, a prison warden) and later Paul Newman (as Luke, a young prisoner). The context of the delivery of the line is:

Captain*: You gonna get used to wearing them chains after a while, Luke. Don't you never stop listening to them clinking, 'cause they gonna remind you what I been saying for your own good.*
Luke*: I wish you'd stop being so good to me, Cap'n.*
Captain*: Don't you ever talk that way to me. (pause, then hitting him) NEVER! NEVER! (Luke rolls down hill; to other prisoners) What we've got here is failure to communicate. Some men you just can't reach. So you get what we had here last week, which is the way he wants it. Well, he gets it. I don't like it any more than you men*.

Whether or not the Commissioner can be effective in having service providers (the captains) do what they agree to do is debatable. As described in the Explanatory Memorandum for the Disability Act 2006, the Commissioner can inquire into what action the disability service provider has taken upon a complaint, where the "inquire" relates to asking for information to be provided, though this is something of an arduous undertaking under the Disability Act 2006. The Commissioner also has the power to conduct an inquiry into the action taken by the provider upon a complaint. From information provided in the past two annual reports it does not appear that the Commissioner has conducted any such inquiries or any investigations in those years.

5. Concluding comment

For the writers, involvement with this family was a stark reminder of how change requires determined leadership and attention to reality. In this case, to bring about improvements in the life and well-being of a person with disabilities, change was required in the actions and practices at a house level. This did not happen.

Much time and effort was put into developing plans, with objectives and outcomes and strategies and actions required – the equivalent of "high level" thinking and action. Yet the implementation of the plan, on what might be considered a low level as in "on the ground", did not happen.

While the writers have formed the view that what happens "on the ground" needs to be at the forefront of anyone making decisions about what happens in the disability system, this case highlights how this will not happen just so long as the core issues are not rectified. Meeting after meeting must not be allowed to be the norm, meetings must generate unambiguous actions. Managers must ensure direct care staff implement agreed actions. Managers must monitor more and rationalise less. Those accountable for implementation must be taken to task if they do not do their job. The Disability Services Commissioner must act more decisively and investigate where it is clear that the problem goes beyond communication.

The treadmill of deception must be stopped.

JacksonRyan Partners
A Business Unit of
Max Jackson & Associates

ABN 50 086 394 676

Head Office
1/98 Wells Street
Southbank VIC 3006
Telephone: (61-3) 9077 4152

Max Jackson
Mobile 0413 040 654
Email: max@jacksonryan.com.au

Margaret Ryan
Mobile 0412 409 610
Email: margaret@jacksonryan.com.au