A CASE STUDY

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 on to 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, Mr Craig McDonnell, was instrumental in the sexual assaults being reported to police.

(ii) The Worker

Vinod "Johnny" Kumar was the staff member who sexually assaulted the clients. 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.) Kumar'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 and that the three women were at their most vulnerable.

Kumar, 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.

Kumar 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 behaviour, with one involving Kumar twisting the nipple of a male resident.

Kumar applied for a permanent job at Yooralla only months after being counselled and was unsuccessful because of rumours of inappropriate behaviour 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 Kumar'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". Kumar, 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, Kumar 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 her 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 raised that the consultant Brian Joyce has not spoken with her, Yooralla says police 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 Butler 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. It was chaired by Christine Nixon APM, former Chief Commissioner of Victoria. 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 Kumar and subsequent claims that they had insufficient information to sack him before his offences.

The parents of disabled Victorians exposed to the alleged offender were not told by Yooralla that he had been charged with rape in March. It was not until detectives sought to question residents in houses where Kumar 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 general manager Jennifer Boulton 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," Ms Boulton 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 Mr Kumar was charged by police 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 they had been raped by the carer. 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 causal 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 disabled 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 Mr McDonnell and other residents at his Box Hill North house over the transfer of a trusted carer elsewhere. Mr McDonnell said he and the other residents were not consulted about the move and felt it could compromise their safety. At the June meeting, Mr McDonnell 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 Craig, 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 Mr McDonnell 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. The first of these was carried out by Health & Disability Auditing Australia (HDAA) on site at Yooralla mid-August 2013. 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 is 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 general manager Jennifer Boulton 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 Ms Boulton 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 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 three weeks ago 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 any matter should be considered personally by the Minister.

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 it 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.

3. 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 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 resume its rightful place as a highly visible legally based platform for the provision of disability services.

(iii) An ineffective monitoring and compliance/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 monitoring and complaints mechanisms established for the NDIS must be robust, timely and effective.

4. 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 must, in the first instance, 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 brought to account.

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