A CASE STUDY

POWER PLAY
- 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 Victoria's 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, and in effect covered up duty of care failures.

The case study presents six actions that must be taken by government to correct the significant systemic flaws exposed in this instance.

1. The Principal Players

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

(i) The Client

Is a woman in her mid-forties with an intellectual disability and associated conditions of kyphosis (over curvature of the upper back) 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 more than 20 years. She attends a funded day service in close proximity to her home, 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 ensuring 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 particularly has involved 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 only in part successful, in terms negotiating an outcome concerning communication protocols, albeit the family was told staff would have to be consulted and agree with the proposed changes, this of course raising the question of - Who actually manages the service? The conference failed to address the core of the original complaint as in the care issues. Thus, the original complaint could not be considered to have been resolved and the complaint was, in effect, 'parked'.

2. A Situational Analysis

This case highlights the significance of the principles listed in the Disability Act 2006 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 (section 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 that staff were failing 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 to address their concerns. The writers argue that what ought to have been a fair and reasonable expectation by the family was denied.

As a means of shifting blame, the department then promoted the notion of developing Communication Guidelines 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 development of the Guidelines was not only in response to a WorkSafe requirement, but was at the staffs' insistence and required their approval for any changes. Thus, it is readily apparent that this is a clear 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 was an action that was subsequently taken by the department. Concurrently, the department denied that the action of restricted access did not contravene Section 58 (a) and (f) of the Act, that is, 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 facile 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 department's 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 the more critical ones, and in essence highlight the failure of the department and the DSC to fully 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.

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 demanded that the 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 led 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 of what are known as 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 concerns 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, 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 Australia 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 in 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's and family 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 was not 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. Noting again of course that this system 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 rights, 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 its legal authority to initiate an investigation and in effect abrogated its authority and responsibility to act as the independent reviewer.
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 the deliberate reluctance of the DSC to undertake investigations. This is borne out 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's staff abused their power by refusing to acknowledge their 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 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 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 a 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 had 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 effect became seduced by the department's tactic rather than insisting that the issues of the complaint were addressed from the beginning.

(v) The Relocate the Client Strategy

Another strategy used by the department, and also raised by the department and 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. The 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 power play with a set of actions and inactions designed to avoid, manipulate and redirect fault, 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 identified below detail actions to correct the systemic flaws that, unless fixed, will see similar cases to this one arise in the future.

(i) The provision of funded family advocacy

Although called for over many years, successive governments have ignored the need for funded family advocacy. Despite funds having been allocated to other forms of advocacy since the mid 1980s, families have been pushed to the sidelines. This case highlights how the department in effect bullied the client's family with their repeated attempts to divert attention from the family's complaints. Families must have the support of a dedicated funded advocacy body to ensure that individual and systemic issues are identified and addressed. Rather than being relegated to a position of disempowerment, families must be empowered through funded advocacy resources.

(ii) The case for real authority to be legislated to the Disability Services Commissioner

While the establishment of the Disability Services Commissioner position constituted a major step in handling 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. As evidenced in this case study, where the department refused to acknowledge it failure to meet it duty of care and the DSC had no power to direct, the family and the person with a disability remained powerless.

(iii) The case for complainants having the authority to demand a DSC investigation

The Disability Act must be amended to allow for a complainant to demand an investigation by the DSC in the event of a conciliated outcome not being forthcoming.

(iv) The case for an automatic redirection to VCAT

In the event of the DSC failing to facilitate an acceptable solution to a complaint, a legislative option of the matter being directed to the Victorian Civil and Administrative Tribunal (VCAT) should be activated.

(v) The application of penalties

The Act in Part 9 – General Provisions, provides for penalty units to be imposed for particular indiscretions, for example, making false and misleading statements. This section of the Act must be strengthened and linked to the Public Administration Act 2004 whereby public sector employees, as in the staff involved in this case, when shown to have transgressed their roles or failed to meet their obligations as public sector employees, are penalised through fines or some other form of discipline.

(vi) Address the conflict existing between the Disability Act 2006 and the OH&S Act 2004

This case demonstrates how the provisions of the OH&S Act overrode the provisions of the Disability Act, with frightening consequences. People with disabilities and non-employees must be protected to ensure they have their rights preserved as provided for under the Disability Act. As such the Government must take action to amend both pieces of legislation in order to ensure that never again can a PIN be misused, by any service provider, including the department, to unfairly and unjustly exert control and power.

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. The actual practice of rights must again be put front and centre, and the inappropriate protection of those who fail clients must not be allowed to continue.

The protection of those in care must be paramount. Institutional protectionism of staff, government departments and funded agencies cannot be allowed to flourish. Readers only have to remind themselves of the reasons why the Royal Commission into child abuse in organisations came into being. It was because abuse had been allowed to flourish for decades even with the knowledge of the authorities. Nothing effective was done and children suffered.

Rights and protection in disability can only become a reality when the protection of staff and organisations do not take precedence over clients and families, and the convenience of the institutional response is locked away forever.

About the Authors
Margaret Ryan and Max Jackson operate a boutique consultancy – JacksonRyan Partners - that specialises in workplace relations as well as policy and practices in the disability sector.

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