A Case Study - Abuse of Power Through Threat and Intimidation - A Submission to the Victorian Parliamentary Inquiry into Abuse in Disability Services

Abstract
This submission is presented as a case study relating to how a Department of Health and Human Services middle manager perpetrated abuse by using his power by threatening to evict a person with an intellectual disability from her DHHS residential placement. The threat was issued despite the resident not having contravened any sections of the Disability Act 2006 that in any way gave legitimacy to the threat. The case study shows how direct bullying tactics constitute abuse. It shows, how abuse was used to intimidate and apply retribution against a complainant and how no one was prepared to do anything about this abuse.
A Case Study of the Abuse of Power Through Threat and Intimidation
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An overview
1. This submission addresses the Committee’s Stage 2 Terms of Reference and in particular Terms of Reference A (III), B (II) and (III) and C.

2. The case study, which is the subject of this submission, is evidence of how abuse can be activated in a variety of ways and, as in this case, by issuing a threat. The study emphasises that the abuse was neither warranted nor in accord with the abuser’s obligations associated with Victoria’s Charter of Human Rights and Responsibilities Act 2006 (the Charter) and principles enshrined in the Disability Act 2006 (the Act). The study further shows how individuals and entities can blatantly seek to divert attention from their own inappropriate actions or inactions and instead cast blame on a family.

3. While the case study stands as a single study, nonetheless, this does not deny the fact that a middle manager employed by the Department of Health and Human Services (DHHS or the Department) on more than one occasion blatantly and unambiguously abused a client and her mother by making a threat to evict the mother’s daughter who is a client of DHHS. Further, given the employee’s direct line manager, by her silence, failed to take her reportee to task, she must also be deemed to be party to the abuse and threat, by condoning it.

4. This case study serves to illustrate how individuals and service entities are able to act with impunity.

5. The study highlights the importance of calling people to account. As identified in the case study those to be called to account are the person who initially perpetrated the abuse, his line manager who condoned it and the Disability Services Commissioner (DSC) who refused to immediately initiate an investigation and instead sought to go through an unnecessary and elongated assessment process, which at the time of writing was still taking place.

The Principal Players
6. Notwithstanding the key role played by the Departmental representatives and the DSC representative, significantly the two people most affected by the abuse perpetrated by the threat to evict are the client and her mother. The following however, identifies the full list of key players:
   - The client
   - The mother – Ms Kerrie Lecluse
   - The stepfather
   - The sister
   - The family advocate – Mr Max Jackson
   - The DHHS employee who issued the threat – Manager, Residential Client Services, Bayside Peninsula Area, South Division Department of Health & Human Services (the Manager)
   - The DHHS senior manager who failed to intervene – Director, Bayside Peninsula, Department of Health & Human Services (the Director)
   - The Disability Services Commissioner – Represented by Acting Resolutions Manager
   - The Secretary, Department of Health and Human Services
   - The Victorian Public Sector Commission

The circumstances
7. The client has been a resident in a DHHS managed house for in excess of twenty years. She has a cognitive level that precludes her from representing and communicating on her own behalf. Additionally, the client is susceptible to significant health issues and hence the management of her health care is of prime importance and requires ongoing scrutiny and intervention.
8. The client’s family has maintained an ongoing positive and caring involvement with their daughter/sister. This is by way of frequently having the client home on weekends and during holiday periods as well as making frequent visits to her place of residence. The client’s sister has been appointed by VCAT as her financial administrator.

9. Given the client’s high level medical support needs in particular, including dietary, the mother has always been anxious to ensure her daughter receives the best of care and has sought to hold staff and managers to account for their duty of care responsibilities and obligations to her daughter.

10. As a result, particular managers and staff have resisted the mother’s involvement. Over recent years they have sought to limit it by creating roadblocks to her involvement.

11. Examples of roadblocks have included and in some instances continue to include:
   • Seeking to impose restrictions on communication by imposing a ban to communicate directly with house staff over a period of five years.
   • Seeking to restrict the mother’s attendance at her daughter’s place of residence.
   • Acing to invoke the Occupational Health and Safety Act 2004 by having a Provisional Improvement Notice imposed.
   • Diverting attention in Care Plan meetings to alleged issues associated with the mother, as opposed to the purpose of such meetings being required to address matters directly associated with care to the client.
   • ‘Stacking’ Care Plan meetings with senior staff who have no direct involvement with the client.
   • Applying a ‘go slow’ in dealing with issues and responding to requests.
   • Denying failures in duty of care have occurred despite the evidence showing otherwise and hence ignoring the mother’s protestations.

12. Additional to the above, particular staff including the House Supervisor as well as middle and senior managers, have sought to paint the mother as the ‘bad guy’ and thus by doing so avoiding having to address issues associated with the failure of staff to meet their duty of care.

13. At a Care Team Meeting in April 2015, Ms Lecluse, as the result of the failure of department staff to address the care issues raised by her and in relation to her daughter over a period of more than five years, expressed a high level of frustration. Despite the claims made by the Manager, Residential Client Services, some seven weeks later, alleging the mother had acted in a threatening way at the April meeting, no reference was made in the minutes of the April meeting and no issues were taken up with Ms Lecluse until a meeting involving the family on 28 May 2015.

14. This therefore raises the question of the Manager’s motivation in issuing the threat. Given the mother had raised concerns about the level of care provided to her daughter, on the balance of probabilities it seems reasonable to suggest that the Manager acted to shield the house staff from legitimate scrutiny by the mother. And, given previous attempts to ban the mother from the house, the eviction threat was used as a last resort by the Manager.

15. As noted in greater detail further below, the Manager’s actions represent a direct contravention of particular principles of the Act as relating to supporting families. The attempts to ban Ms Lecluse from visiting her daughter caused the writers of this submission to reflect on a story reported in *The Australian Newspaper* (28/8/2015 P. 8). As indicated in the article, this case will apparently be reported to the Senate Inquiry into violence, neglect and abuse against people with disabilities in care. This case related to a 91-year-old lady in an aged care facility. The lady’s daughter was banned from visiting the aged care facility for almost three months before her mother died. The ban was imposed because the daughter dared complain about the level of care provided to her mother.
The abuse by threat and intimidation

16. At a meeting dated 28 May 2015 attended by Ms Lecluse, the client’s step father and sister, Mr Jackson and the Manager, Residential Client Services and his line manager from DHHS, following some introductory discussion and without any warning, the Manager stated that Ms Lecluse would not be allowed to visit her daughter in her residential placement unless Ms Lecluse agreed to an independent person being present. Further, that should Ms Lecluse not agree to this or visit at any time without such a person being present, the Manager would take action to “evict” Ms Lecluse’s daughter, as in the client, from her place of residence.

17. When questioned in relation to his threat, the Manager advised that he had authority to do so under the Act. He agreed however, that the client had not done anything to cause her to be evicted. During the course of the meeting the Manager issued the threat to evict the client on at least five occasions. Never once did the Director, as the Manager’s line manager, challenge his threat or request him to withdraw it. As such, it is reasonable to assume that the Director agreed with it. This assumption is supported by the fact that although Ms Lecluse wrote to the Director on at least three occasions seeking her intervention, and although the Director responded, she failed to acknowledge that the Residential Client Services Manager had abused Ms Lecluse and her daughter by making the threat that he did.

18. A further failure of the Director was that although she assumed responsibility for taking minutes of the meeting of 28 May 2015, when provided, key elements of these minutes were wrong. Noting of course that minutes of meetings do not become confirmed until all parties to the meeting confirm them.

19. Significantly, the minutes not only wrongly attributed comments to the client’s step father alleging things that he did not actually say, but specifically in relation to the threat to evict as made by the Manager and his actual use of the word “evict” the minutes wrongly and manipulatively recorded his statement as him having used the word “relocate”. This is simply wrong. Further, no mention was ever made of “moving” the client “to a new group home.” The inclusion of both terms can only be considered to have been included in the minutes as an afterthought and attempt to ‘soften’ the blatancy of the threat to evict. Indeed, it is simply untrue and therefore raises the question of how far management will go in order to protect their backs.

20. In addition to the above, and as part of the DSC assessment of Ms Lecluse’s complaint, the Director provided the Acting Resolutions Officer with what was described as a “File Note” dated 28 May 2015. The contents of this note were presumably compiled either by the Manager, the Director or by those two parties jointly albeit the Director neither provided the other parties with a copy of the File Note nor did she discuss its contents with those parties.

21. To add to this slight, part of the broader contents of the Note were challengeable. However, worse still, the Note stated that the Manager “believed staff were seeking independent legal advice regarding how they can protect themselves from future exposure to behaviour they believe is bullying.” Regardless of the truth of this statement as in what staff may have allegedly expressed, the fact is that no such advice had been conveyed to Ms Lecluse between the period of the April meeting and the meeting of 28 May 2015. As such, the writers challenge the statement on the basis the Manager failed to substantiate it. Even more critically however, it showed no understanding that by the imposition of the long running ban on Ms Lecluse communicating with house staff and by making the threat that the Manager did, these actions constituted abuse against Ms Lecluse and her daughter.

22. Crucial to this case study and therefore this submission, the File Note, as for the meeting minutes, further stated that the Manager had “specifically advised that the department may be forced to consider options to relocate [the client – named] to a different group home ...
Further, that the Manager “explained that we hope that this could be done with the family’s consent but that if the family did not consent there were provisions within the Disability Act 2006 to issue a Notice To Vacate and to move [client named].” Again, the File Note, as for the Minutes, wrongly and blatantly used the word “relocate” when in fact the word “evict” was used by the Manager.

23. While Section 76 of the Act outlines ‘the rules’ associated with a Notice to Vacate, which is unequivocally simply another word for “evict”, nowhere in any part of this section of the Act is any mention made of “and to move” or linking the concept of moving or relocation with that of eviction or vacating.

24. By inclusion of the words “and to move” the client, they were clearly designed to seek to place a spin on the blatant eviction threat as made by the Manager. Never at any time during the course of the meeting of 28 May 2015 did the Manager state or even infer that the threat to evict would involve the client being ‘moved’ to another location. His threat to evict was simply that. For the File Note to suggest there would be the option of relocation is blatantly untrue. There was no ambiguity. However, regardless of this the threat to evict must be considered as standing alone.

25. Given the minutes were dated as at the date of the meeting as was the File Note, the question must be asked – Why did the Director consider it necessary to also compile a File Note, this being particularly given that the family was not privy to the File Note and had not even been made aware of it? As noted above for the meeting minutes, the only reasonable conclusion that can be drawn is that it was an act of ‘back covering’ by stating the threat to evict had been couched in the context of “moving” the client to another “group home”. This constitutes a terrible and blatant lie and must be considered as a subterfuge designed to deceive.

26. Despite the lie as contained in the Minutes and the File Note, nonetheless, in alleging that the eviction threat was couched in the context of “moving” the client to another “group home”, a number of immutable facts are evident.

27. The first is that the threat to evict was acknowledged by the Director.

28. The second is that even if it is intended, albeit it unstated, to relocate the client, this constitutes a transgression of S. 5 (2) (e) of the Act in that no consideration was given to allowing the client to “participate actively” in a decision affecting her.

29. The third is that given the Manager admitted the client had done nothing to warrant her eviction, and again re-emphasising that no mention was made of relocation, nonetheless, such an act would constitute a breach of S. 5 (2) (a) and (b) of the Act in that it does not “respect” the client’s “human worth and dignity”. Further, it does not allow the client to “live free from abuse … and exploitation” noting that the threat to evict and allegedly to relocate not only constitutes “abuse” but also constitutes “exploitation” in that the threat exploited the client to in effect provide a means for management to attack her mother.

30. The fourth is that by alleging mention was made of a move to another group home had been made, this would constitute a breach of S. 5. (3) (h), (i), (j) and (k) of the Act in that the requirement to acknowledge the “important role families have” is totally ignored.

31. The fifth is that the statement ignores S. 106C (c) of the Act in that it must be assessed as constituting an act that ignores taking “all reasonable steps to ensure” the client is not “adversely affected”.

32. The sixth is that “moving” the client would require consideration to be given to compatibly wherever the client might be ‘moved’. No mention was made of this.
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33. The seventh is that “moving” the client assumes a suitable vacancy in another location where the vacancy not only would need to take account of compatibility but also would require proximity to the client’s current day placement. No mention was made of this.

34. The eighth is that “moving” the client ignores who may be on the Disability Support Register or waiting list and whether this would require a manipulation of the list. No mention was made of this.

35. The ninth is that some 12 months or so ago, [redacted] had put forward the possibility of the client being moved to an alternative location. The family rejected this as being out of hand and stated their insistence that their daughter/sister stay in her current location. No mention was made of this.

36. The tenth is, whether the Manager’s actions translate to a case of “eviction”, “relocation” or being “moved” to another location, the Manager’s agreement that the client had done nothing to warrant any action being taken against her must again be noted. Additionally, the mother’s complaints about the failure of some staff to exercise their duty of care to her daughter must also again be noted. Yet despite this, the staff failures are ignored – no consequences or consideration of duty of care.

37. This is yet another case of a client being disadvantaged, and as in this case, her needs and those of her family being ignored, while staff and managers continue to act with impunity. This is a sad, sad reflection of where clients and their families truly sit in the disability sector and how the rhetoric of rights and choice are not matched by the actions of the Department.

38. Regardless however, of the above it must again be stated and put up in lights that never at any time during the course of the meeting of 28 May 2015 did [redacted] or [redacted] make mention of “relocation” or “moving.” What did state was his intention to “evict” the client if Ms Lecluse did not adhere to his requirement that she only visit her daughter’s residence if a third party was present.

39. Given the above, and the blatancy of what was stated in the minutes and the File Note, the actions and comments must not only be publicly condemned, but they should also be considered as ground for termination of the services of the Manager and the Director.

The people failures

40. This case highlights the failure of three individuals to have met their legislative obligations and to have acted in the best interests of the client and the person who lodged a complaint on the client’s behalf.

The failure of the Manager, Residential Client Services to consider the rights of a client under his care

41. The Manager, as the person who made the threat, was clear and unambiguous in a meeting attended by five other people in making the threat to evict the client from her residential placement by citing his authority to do so using particular provisions of the Act. When it was put to him that the client had done nothing to cause her eviction, the Manager acknowledged this. Nonetheless, he proceeded to repeat his threat on at least four other occasions during the meeting.

42. He also openly stated that the threat would be activated if Ms Lecluse did not agree to have an independent third person present when visiting her daughter in her residential setting, even though this is the client’s home and she has a right to have her family visit her. The Manager also stated the threat had been made as the result of an alleged single outburst by Ms Lecluse at a meeting in April. The Manager did not provide any other rationale for his threat.
43. Notwithstanding the fact the Manager abused his power by issuing a threat, additionally the wrongness of the threat must be fully acknowledged and as such any attempt to direct blame to the mother must be totally rejected.

The failure of the Director to assert her authority and countermand Residential Client Services Manager’s threat

44. The Director was in attendance at the meeting of 28/5/2015 when the Residential Client Services Manager on more than one occasion made the threat to evict the client. As the Manager’s line manager and chair of the meeting, the Director had responsibility for controlling the meeting including the Manager’s contribution and behaviour. She failed to do so. Further, she also failed to acknowledge that the Manager’s threat was inappropriate and constituted abuse when Ms Lecluse raised concerns in writing, following the meeting. Given this, the Director should also be brought to account on the basis that she condoned the Manager’s abusive threat.

The failure of the DSC as represented by the Acting Resolutions Manager to initiate an immediate investigation and to also consider the VPS Code of Conduct and DHHS Vision and Values Statement

45. As a result of the Manager’s unequivocal threat to evict her daughter, Ms Lecluse submitted a formal complaint to the Disability Services Commissioner (DSC) and requested an immediate investigation. An Acting Resolutions Manager was assigned to deal with the complaint.

46. The complaint was submitted on 24/6/2015. At the time of writing the DSC was still undertaking its assessment phase. This being despite clear prima facie evidence that the Manager, Residential Client Services had committed an abuse by making a threat to evict a client under his responsibility.

47. In order to progress her complaint, the complainant Ms Lecluse along with Mr Jackson, acting as a family advocate, raised with the acting Resolutions Manager a number of queries and sought on a number of occasions for an investigation to be undertaken.

48. By way of example, the Acting Resolutions Manager was asked:
   • Do you consider there is a prima facie case indicating that the Manager, Residential Client Services actions and comments constituted a direct threat to the client and her mother?
   • Do you agree that the Manager, Residential Client Services threat constituted intimidation toward the mother, which can reasonably be assessed as representing retribution against her for raising concerns about the level of care to her daughter and her frustrations arising as a result of having her concerns diverted?
   • Do you agree the Manager, Residential Client Services threat constitutes a contravention of S. 1 and S. 5 (h), (i) and (j) and S. 76 and S. 106 of the Disability Act?
   • Do you agree that abuse by issuing a threat to evict is not appropriate either for an informal or conciliation resolution process?
   • Assuming you cannot deny the legitimacy of the above - Will the Commissioner initiate an investigation into the complaint?
   • If you do deny the legitimacy of any of the points above, it is requested you advise, in writing, as to which ones and why.

The Acting Resolutions Manager was further asked:
   • Does the DSC consider that a threat to evict a client from his or her residential placement, when the client has done no wrong, constitutes a major breach of the client’s rights and the values and principles listed in the DSC Summer Newsletter and those underpinning the Disability Act 2006, the VPS Code of Conduct and the DHHS Values/Vision statement (as applying to DHHS employees)?
   • Does the DSC consider that in assessing or investigating a complaint, and where there is prima facie evidence to indicate a major breach of the rights of a person
with a disability has occurred, that the DSC has an obligation and responsibility to consider all information and evidence that will “assist your assessment” and as per the advice in the DSC Information Sheet No. 5?

- Does the DSC consider that in accordance with point 3 of the DSC Information Sheet No. 5, the DSC can determine “what documents will be requested” and by association therefore, the VPS Code of Conduct and the DHHS Values-Mission statement must be taken into account?

- Does the DSC consider that in terms of the VPS Code of Conduct and the DHHS Values-Mission statement, the DSC has a legal, and moral obligation and responsibility to consult with the DHHS and the Victorian Public Sector Commission as provided for under per S. 17 (1) (a) of the Disability Act 2006, in order to seek their views as to whether Residential Client Services Manager’s threat to evict the client constitutes a serious breach of the Code of Conduct and the DHHS Values-Vision statement?

49. Rather than deal with the failure of the Manager to abide by the VPS Code of Conduct and the DHHS Values and Vision Statement in the context of Ms Lecluse’s complaint, the Acting Resolutions Manager advised Ms Lecluse that she should direct her concerns to DHHS by advising that, “The appropriate avenue for your complaint ... in regards to the VPS Code of Conduct is the Department of Health and Human Services (DHHS) Complaints, Integrity and Privacy Unit (CIPu).”

50. Ms Lecluse again followed up with the DSC. This time the Acting Resolutions Manager responded by stating, “As previously advised, all relevant information regarding the complaint issues will be considered in our assessment. As you are aware you can refer your concerns regarding the VPS Code of Conduct to the Department of Health and Human Services (DHHS) Complaints, Integrity and Privacy Unit (CIPu). Our assessment will consider the VPS Code of Conduct.”

51. What is noted in terms of the above two pieces of advice is that despite the second one stating, “Our assessment will consider the VPS Code of Conduct” No such advice had been conveyed in the first set of advice. The other matter to note is that the Acting Resolutions Manager ignored the request to also consider the DHHS Values and Vision statement. As a result, this matter was again followed up with a request to include the Values and Vision statement. At the time of writing, the Acting Resolutions Manager had failed to respond to this query.

52. As a result of the original advice from the Acting Resolutions Manager, Ms Lecluse directed her complaint regarding the breaches of the VPS Code of Conduct to the Victorian Public Sector Commission as well as directing her concerns about the breaches of both the VPS Code of Conduct and the DHHS Values-Vision statement to the Secretary of the DHHS.

The failure of the VPS Commission to take up the breaches of the VPS Code of Conduct and instead referred the complainant back to the department about whom the complaint was made

53. Two weeks after requesting the Public Sector Commission to consider the breaches of the VPS Code of Conduct, Ms Lecluse was advised by a Senior Advisor in the Commission that “As the employer, the Department is best placed to address any concerns regarding the behaviour of its staff in the first instance.” And therefore, the Commissioner would not take any action but would “record her concerns”.

54. Ms Lecluse followed up on this advice asking the Commission to directly address the breaches of the Code of Conduct. The Commission again responded by stating that they did “not consider further action is warranted at this stage.”
The failure of the Secretary of DHHS to intervene and instead referred the complaisant back to the Senior Manager who was one of the people about whom the complaint was made

55. The complainant sent her complaint concerning the failure of the Manager, Residential Client Services and his Director to abide by the VPS Code of Conduct and the DHHS Values and Vision Statement to the Secretary of DHHS and sough his intervention. At the time of making this submission, and some three weeks after making the request, no response had been received from the Secretary.

56. Ms Lecluse and Mr Jackson also challenged the DSC to stop expending so much energy on avoiding establishing an investigation and rationalising their behaviour by an elongated and unnecessary assessment process and by also seeking to divest responsibly to someone else. They called on the DSC to put the protection of the client’s rights front and centre and investigate. This was to no avail.

57. Three months after Ms Lecluse’s complaint was lodged, the DSC was still undertaking an “assessment”. While the DSC promotes the catchcry “It’s OK to complain!” The fact is that as this case study shows, while it might be OK to complain, it is how the complaint is addressed that is of even greater importance. Significantly, this raises the question of whether the complaint is dealt with judiciously and in accordance with the legislation. Also, whether the complaint is dealt with in a way that ensures the protection of the rights of the client about whom the complaint relates. As the old adage states – “Justice delayed is justice denied.”

58. This case study shows the DSC had, at least up until the time of writing this submission and some three months after the complaint was lodged, failed both the client and the complainant. The DSC was not only making the complainant ‘jump through hoops’ by seeking to focus on the history of the relationships between her and the Department, but more significantly by refusing to focus on the core of the complaint.

59. The core of the complaint was, and continues to be, that abuse had been perpetrated and there was no contradiction that the Residential Client Services Manager had issued a threat to evict the client.

60. On the Manager’s own admission, this was not because the client had erred in any way, but because the Manager was seeking to use the threat of eviction as the vehicle to punish the client’s mother. On the balance of probabilities it is reasonable to conclude this was because the mother had dared to challenge staff on their failure to meet their duty of care.

A failure to meet the requirements of the Disability Act, the Charter of Human Rights, the Code of Conduct for Victoria Public Sector Employees and the DHHS Values and Vision Statement

61. The following is significant in highlighting how each of the above was breached.

Sections of the Disability Act 2006 were breached

62. In relation to eviction, the only section in the Act applying is S. 76. However, although there are 13 sub-sections, only S. 76 (m) could be applied in this case, that being “no reason is to be specified” this being because the client has not transgressed any of the other clauses, or alternatively, they did not apply. Therefore, given only S. 76 (1) (m) could be applied this meant that S76 (4) had to then be considered whereby no less than 120 days notice of termination must be given.

63. However, despite S. 76 (1) (m) saying that “no reason is to be specified”, S. 76 (6) counters this by stating that the “notice to vacate must specify the grounds on which the notice is given.” Further, the disability service provider must sign the notice and thus in this case it is reasonable to assume that this would be someone in a position higher than that held by the Residential Client Services Manager. This would more than likely have
to be at a minimum his line manager, as in the Director, or probably the Secretary of the Department.

64. Also S. 76 (6) (d) (ii) requires the Notice to vacate to be provided to the resident’s administrator, which in this case is the client’s sister. Notwithstanding this however, and a Notice to Vacate has not actually been issued, but a threat to do so has been made, the Manager still sought to contact the client’s sister in her capacity as financial administrator. This suggests that the Manager has a naïve understanding of the Act in relation matters associated with eviction, which in itself is a major concern or that he sought to manipulate disharmony between the client’s sister and her mother.

65. Further, S. 76 (7) requires the Secretary and the Public Advocate to be notified. In relation to notifying the Secretary, while it is unclear whether the Secretary would have to sign the notice, nonetheless, in relation to this case this could only be done by invoking S. 76 (1) (m) of the Act. While no specific authority is subscribed to the Public Advocate under S 76 (7) of the Act, it seems reasonable to conclude that the Public Advocate would, or indeed should challenge DHHS, given the client has done nothing to cause her to be evicted.

66. Given the above, it is clear that in making the threat that he did and as such abusing both the client and her mother, the Residential Client Services Manager transgressed S. 76 of the Act.

67. Of equal importance however, is the indisputable fact that the Manager also transgressed particular clauses of S. 5 of the Act. Particularly, these include S. 5. (h), (i), (j) and (k) in that his by his abuse of the family, and in particular Ms Lecluse, he failed to respect the role of the family, he failed to acknowledge the role of the family and he failed to strengthen and build capacity of the family.

68. Significantly, the Manager also failed to consider the rights of the client as defined in S. 5 (1) and (2) of the Act in that he failed to respect her human rights and dignity. Instead, he abused her by issuing a threat to evict her even though she had not done anything to warrant such a threat.

69. In terms of S. 106 of the Act, both the Residential Client Services Manager and his Director failed to take all “reasonable steps to prevent adverse effects” because a complaint has been made and as such they ignored as S. 106 (a) and (b) and S. 106 (c).

Victoria’s Charter of Human Rights

70. Associated with the above legislative imperatives is Victoria’s Charter of Human Rights and Responsibilities. This has been set in law as The Charter of Human Rights and Responsibilities Act 2006. It sets out the basic rights, freedoms and responsibilities of all people in Victoria. It is about the relationship between government and the people it serves.

71. The Charter requires public authorities including government departments and public servants, to act consistently with the human rights in the Charter. Twenty fundamental human rights are protected in the Charter. Significantly in terms of this case study the charter demands that people are not abused.

72. Specifically, “The Charter requires the Victorian Government, public servants, local councils, Victoria Police and other public authorities to act compatibly with human rights, and to consider human rights when developing policies, making laws, delivering services and making decisions. So no matter which state or local government agency the community is dealing with, the same human rights apply.” (Victorian Equal Opportunity and Human Rights Commission website.)
73. Given the above, the Manager and his Director, as public servants have a responsibility to ensure the services under their control are delivered in accord with the Charter. In making the threat the Manager did and in the Director not withdrawing it, neither considered the client's or the family's human rights. As such, the threat must be deemed to be an act of abuse.

The VPS Code of Conduct

74. The VPS Code of Conduct mandates clearly stated requirements that are "binding" on all public sector employees. From a legal perspective the Code has its roots in the Public Administration Act 2004.

75. Specifically by making the threat that he did, the Residential Client Services Manager breached the following sections of the VPS Code of Conduct:

**Demonstrating Responsiveness** – As by clause 2.3 the Residential Client Services Manager disregarded his responsibility to provide "services to the community" and further his behaviour did not constitute a "professional manner"

**Demonstrating integrity** – As per clause 3.2 in making his threat, the Residential Client Services Manager did not "exercise power in a way that is fair and reasonable." Also as per clause 3.9, Residential Client Services Manager's threat did not "build and maintain a high level of trust".

**Demonstrating impartiality** - As per clause 4.1 in that in making the threat he did, Residential Client Services Manager failed to make a decision "based on sound judgment." Also as per clause 4.3 the Residential Client Services Manager did not act "fairly."

**Demonstrating accountability** - As per clause 5.2 the Residential Client Services Manager's threat was not within the "the scope of his "authority" and as such was not "lawful." Also as per clause 5.6 the Residential Client Services Manager's threat did not comply "with all legalisation relevant to the performance of" his duties.

**Demonstrating respect** – As per clause 6.1 in making the threat to evict, the Residential Client Services Manager did not "encourage respect" nor was he "fair, objective and courteous." Also as per clause 6.5, in making the threat that he did, the Residential Client Services Manager failed to consider "service outcomes."

**Demonstrating leadership** – As per clause 7.1, the Residential Client Services Manager failed to encourage "best practice" and to demonstrate "responsiveness."

**Demonstrating commitment to human rights** – As per clause 8.1 the Residential Client Services Manager failed to demonstrate an understanding of "human rights" and how they "apply" to his work. Also as per clause 8.2, the Residential Client Services Manager failed to consider the human rights set out in the Charter, and respect the human rights of the client and Ms Lecluse. Further, as per clause 8.3, the Residential Client Services Manager failed to "act in a manner that is consistent with the Charter." And as per clause 8.4, in issuing the threat, the Residential Client Services Manager failed to "protect the human rights of" the client and Ms Lecluse as "members of the Victorian community."

The DHHS Values and Vision Statement

76. DHHS recently launched a new set of organisational values. The values guide the behaviour and work practices of employees and how they are required interact with colleagues, partner organisations, clients, patients and the community - Link [http://www.dhs.vic.gov.au/about-the-department/our-organisation/our-values](http://www.dhs.vic.gov.au/about-the-department/our-organisation/our-values)

77. The Department states that its vision is to support and enhance the wellbeing of all Victorians. Further, they aspire to be an organisation where everyone is committed to achieving the Department’s vision and demonstrate the values in all that they do.

78. The values are detailed below and those in *italics* were highlighted to the DSC as being those transgressed by the Manager, Residential Client Services in issuing his threat.
1. We are respectful
   (a) We treat people with fairness, objectivity and courtesy.
   (b) We listen and communicate honestly and clearly.
   (c) We seek to understand others’ perspectives, experiences and contributions.
   (d) We recognise and value people’s diversity, equality and human rights.

2. We have integrity:
   (a) We are trustworthy, and we do what we say we will do.
   (b) We are professional in all our dealings with others.
   (c) We stay true to our values when it’s easy and when it’s difficult.

3. We collaborate:
   (a) We help each other as colleagues.
   (b) We generously share our knowledge, expertise and skills.
   (c) We work in partnership with people and organisations to find the best approach.
   (d) We are inclusive and seek people’s input and involvement.

4. We care for people, families and communities:
   (a) We involve people in decisions that affect their lives.
   (b) We value our colleagues, and we develop and support them to be resilient and effective.
   (c) We have empathy for people and seek to understand their perspectives.
   (d) We support and empower people through our work.

5. We are accountable:
   (a) We each take ownership of the quality and demonstrable impacts of our work.
   (b) We ensure that our decisions and actions are evidence based and outcomes-focused.
   (c) We are careful about and transparent in how we use public resources.

6. We are innovative:
   (a) We are flexible, creative and responsive to changing needs.
   (b) We have the courage to take informed risks and try something new.
   (c) We are reflective and seek feedback to inform and shape our work.

The consequences on the client and her family
79. In no way should the consequences and the impact on the client and her family arising from the Residential Client Services Manager’s abusive threat, be ignored. They have been significant.

80. For the client, it has meant that the stability that she requires to make sense of her world has been thrown into confusion. As a person with a disability who has limited capacity and who cannot express her needs in any formal way, stability is essential. Part of that stability has been the regular visits by her family and her mother in particular to her place of residence. Part of her stability has been her mother giving her the attention she needs. Part of that stability has also been taking the client home to the family home every second weekend but living in her residential placement with the other residents.

81. The Manager’s abusive threat has changed the above. The family is now divided as to whether they should buckle to the Manager’s demands, or whether they should challenge his threat and refuse to be intimidated or accept the retribution meted out by him because the mother dared complain about the quality of care being provided to her daughter.

82. The family has had their daughter/sister home on a far more frequent basis than ever before. In part this has been because of the failure of staff to adequately address her health care needs and in part because the mother is fearful that if she seeks to visit her daughter in her residential placement the Residential Client Services Manager will enact...
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his threat. In addition, the client is still required to pay rent and utilities and charges from her Disability Support Pension, even though in she is living at home for significant periods of time.

The absence of consequences for the departmental staff
83. Specifically in relation to the Manager's threat and his Director's refusal to withdraw the threat, no consequences have been applied to either person.

84. In terms of the Manager's responsibility to ensure his reportees, as in the staff in client's house, meet their duty of care and the responsibilities of the staff to do so, and yet not having done so has resulted in 'business as usual'. The threat of eviction has essentially translated into staff being now immune from any scrutiny by the client's family.

The Merry-Go-Round – A refusal to accept ownership
85. This case study is a classic demonstration of how no one is prepared to own a complaint. It demonstrates how a complainant can be placed on the Merry-Go-Round of referral and avoidance that represents a - Do nothing culture.

86. It shows how the refusal to accept the facts and how an unnecessary elongated process in dealing with a complaint can lead to frustration, stress and a total loss of faith in those responsible for the process.

87. It also shows how perpetrators of abuse are not brought to account and this is one of the main reasons why abuse continues.

88. Essentially, the 'prancing horses' while having so much power and liking to convey the illusion of providing an active response, simply go up and down on the one spot, while the complainant is sent on a circular farce - A merry-go-round that goes nowhere.

89. This nonsense and avoidance of ownership is a common fault and represents a major reason why people with disabilities and families give up. So, when the Committee addresses Question 1.1 of Stage 2 of the inquiry - What experiences have people with disability, families and carers had when disclosing or reporting abuse? - The writers urge the members to have this case study upper most in their deliberations.

The implications for the Parliamentary Inquiry
90. The writers acknowledge that the Committee is required to undertake its work in accord with the Terms of Reference defined for it. As such, the following Terms of Reference are considered in the context of this case study.

Term of Reference A (III)
91. The threat to evict was the opposite of representing a measure to support the person with the disability and her family. Further, in reporting the abuse to the DSC, the Commissioner's response to the complaint of the abuse was not only inadequate but it also could be considered to constitute negligence.

Term of Reference B (II)
Neither Residential Client Services Manager nor his Director took any action or initiated any strategy when dealing with the family to "prevent" the “abuse occurring”.

Term of Reference B (III)
The Manager, his Director and the DSC failed to take into consideration the needs specific to the client and her family.
Term of Reference C
The Committee has a responsibility to assess the role of the DSC, as an oversight body, in relation to this case.

What should happen and implications of the Parliamentary Committee?
92. The Committee should not simply just read this submission and then consign it to the ‘interesting’ case study folder. The case study must be accepted as being much more than this.

93. Next to sexual abuse and other forms of violent physical abuse, the threat to evict a person from his or her residential placement particularly when the client has done nothing to warrant such a draconian action, cannot be characterised in any way other than detestable.

94. The case study however, goes beyond the abusive threat. It is a very real example of how those in positions of power and control are capable of abusing their power.

95. The case study also shows how those in positions of power can act with impunity.

96. Further, it also shows how those responsible for ensuring the protection of people with disabilities and for bringing those who perpetrate abuse to account, whether by way of a threat of direct action, can be ineffective. Therefore, in their ineffectiveness they can be accused as condoning the abuse.

The Committee must therefore ask – What do we do in relation to this case study? The writers submit five standout ‘must do’ actions to be taken by the Committee:

97. The Committee must require the Residential Client Services Manager and his Director to appear in person before the Committee in a public hearing whereby they are called to account regarding their particular actions associated with the abusive threat to evict a client from her residential placement.

98. The Committee must require the Disability Services Commissioner to appear in person before the Committee in a public hearing whereby the Commissioner is called to account regarding the particular actions of how his staff failed to investigate the complaint concerning the abusive threat to evict a client from her residential placement.

99. The Committee must require the Secretary of the Department of Health and Human Services to appear in person before the Committee in a public hearing, whereby the Secretary is requested to advise on consequences imposed on an employee who blatantly abuses his or her responsibility as a public sector employee and as applying to abuse against a person with a disability, by specifically focusing on this case.

100. The Committee must be willing to detail the facts of this case study in their final report. In so doing, the Committee must use the case study as being illustrative of how those in positions of power and responsibilities and particularly as associated with this case, failed to meet their duty of care and other legislative responsibilities.

101. The Committee must be willing to state in their final report that the case study is not about a systems failure but is symbolic of the way in which people in positions of power and authority can perpetrate abuse and get away with it.

102. The Committee must be willing to emphasise that respect must be shown to people with disabilities and their families at all times.

103. Given the above, the Committee must emphasise that the rhetoric of respect alone, as in talking the talk - is not sufficient. Action is what is required. The writers of this submission urge the Committee to take the actions as detailed in 98 to 103 above.
A Concluding Comment
While acknowledging this submission has detailed a single case study only, nonetheless, it cannot and must not be ignored, in that it does represent a significant and far more widespread ‘cover-up’ of the abuse and neglect occurring in the disability sector than is currently acknowledged.

104. As long as watchdogs, and senior and middle managers and the entities they represent continue to abrogate their responsibilities by refusing to take ownership of complaints and refusing to acknowledge they are part of the problem, abuse and neglect will continue.

105. As long as those who perpetrate abuse and neglect and those responsible for ensuring the application of unequivocal safeguards continue to ignore their duty of care, abuse and neglect will continue.

106. As long as watchdogs and bureaucrats continue to play games with words, abuse and neglect will continue

107. As long as watchdogs and bureaucrats continue to procrastinate and play games with processes, abuse and neglect will continue.

108. As long as perpetrators, middle and senior managers and entities are allowed to act with impunity, abuse and neglect will continue.

109. As long as governments continue to ignore the matters of responsibility, ownership and people being allowed to act with impunity, the abuse and neglect of people with disabilities will continue.

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End of Case Study