Victorian Parliamentary Inquiry into
Abuse in Disability Services – Submission 1

Submission S100
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Family and Community Development Committee

CONTACT DETAILS NOT FOR PUBLICATION

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[redacted]

Name of person with Disability: Deanna Lee Dixon

Relationship to person with Disability: Mother

Background:
My daughter Deanna is 41yrs old, has Down Syndrome and a moderate intellectual disability. Deanna dehydrates easily and has low blood pressure and a slow heart rate which resulted in her having a pacemaker implanted in 2002. If certain support measures are not followed, particularly adequate fluid intake and exercise she is prone to suffer severe dizzy/fainting spells or unconsciousness.

I have always encouraged Deanna to be proud of herself and to be confident and independent in making her own decisions in all areas of her life to the best of her ability and to speak up for herself however, when she is unsure and/or feels intimidated by anyone she asks for my support. eg. When she wanted to make a complaint about something she was concerned about at the house and was too frightened to raise it with house staff she would ask me to raise it with the Tipping coordinator, managers or the CEO.

Deanna lived at home with me for the first 30 years of her life when she then chose to move into EW Tipping Foundation (Tipping) shared supported accommodation (SSA) in [redacted] Victoria from March 2004 until June 2012 when at that time she chose to return to live with me (her mother) as a direct result of being bullied and intimidated by Tipping management, house staff, and a disability advocate employed by Victorian Advocacy League for Individuals with a Disability (VALID).

Whilst Deanna resided in Tipping SSA she regularly came home for sleepovers and I visited her. During the 8+ years Deanna resided in the SSA there were many incidents of abuse including physical assaults perpetrated by a male co-resident, ongoing duty of care/negligence failures where Deanna's health and wellbeing suffered as a result of Tipping management's failure to ensure all staff adhered to Deanna's health professionals instructions. Deanna also suffered psychological trauma as a direct result of the 3½ years of physical assaults and also due to management and particular staff intimidating/manipulating her into doing or saying what they wanted in order to shut me out so they could cover up their ongoing duty of care failures.

This submission lists only some of those incidents. Detailed documentation can be provided to the Inquiry if required.

Despite the Disability Act 2006 and mountain loads of policies and procedures, the Government Minister of the day, the legal system, DHHS Secretary, Disability Services Commissioner, Public Advocate, Tipping and VALID nothing protected my daughter from being abused. When I raised concerns with the relevant Minister, DHHS Secretary, and the Executive Director Disability Services (apparently no longer in existence) I was fobbed off and told to go back and work it out with Tipping or make a complaint to the Disability Services Commissioner.

Supposedly my daughter has rights yet all of the above failed to protect her right to live free from all forms of abuse. It certainly appears that the DHHS, the Disability Services Commissioner, the Public Advocate and funded service providers all have a cosy relationship with each other and their prime focus is to cover each other's backs.

Successive governments have failed dismally to protect people with disabilities and have been reluctant to address abuse in all its forms, their sole focus being to keep the abuse hidden at all costs. Tipping's focus is to keep the abuse hidden and protect all levels of staff. VALID's focus is to tread softly so they don't jeopardise their funding.

Since returning to live with me Deanna is again living the full, independent life she had prior to moving into SSA. There have been major improvements in her health and emotional well being, she is relaxed and happy and fully integrated back into our local community. What she has now is quality of life as opposed to existing in a mini institution and not having real freedom to make her own choices and do her own thing such as going to the supermarket on her own, developing friendships and interacting with our neighbours, choosing her own bedtime, deciding herself which day of the week to change her bed sheets, travelling independently on public transport to her day placement, having a full social calendar.

Deanna is no longer living in a regimented, mini institution. She is again living a *real* life, with *real* meaning. She has freedom, flexibility and control over her life. Isn't this what the average person aspires to?

[redacted]

Outcomes I seek from this investigation

1. CEO's, senior management and all staff down the line to direct care staff who fail in their duty of care must be held accountable for their failures and severe penalties must be applied.
2. Service providers who have failed in their duty of care must be publicly named and shamed.
3. Mandatory sacking of public servants, Chief Executive Officers and Boards of funded agencies when they fail to adequately address complaints and fail to sack abusive employees.
4. Former DHHS senior bureaucrats should be banned from being appointed to watchdog positions.
5. Senior public servants who hold disability positions should only be allowed to hold these positions for limited time periods.

6. The current Disability Services Commissioner should be sacked immediately.
7. Current and former DHHS service managers must not be able apply for the position of the Disability Services Commissioner.
8. Community Visitors must be given the power to have direct contact with families/guardians when they have raised concerns about their person with a disability.
9. Family advocacy must be funded to ensure there is a level playing field when going up against service providers.
10. Compatibility of clients is critical and must be ensured.
11. As well as a rigorous police check prospective staff should be psychologically tested prior to employment.
12. Whistleblowers must be protected, not punished.
13. A Royal Commission into the abuse of people with disabilities in care is required.

Conclusion

Committed and caring staff are often bullied/intimidated by their managers and co-workers to the point they eventually burn out and leave or are pushed out. Increased pay rates for staff will not guarantee honest, responsible quality staff or quality service provision. Individuals know what is right and what is wrong. Decent morals cannot be bought; they are inherent in an individual's makeup.

Families are disempowered by many service providers and particular advocacy organisations. I have zero faith in the disability sector as a whole and despair that Deanna will again be at the mercy of these organisations when I can no longer support and care for her. The best I can hope for is that she predeceases me.

This Parliamentary Inquiry will have only touched the tip of the iceberg of abuse. Only a Royal Commission will expose just how endemic abuse is in the disability sector. I therefore strongly urge the parliamentary committee to take this into serious consideration when making its recommendations.

Barbara Dixon
26 November 2015

The following provides details of the submission

Section 1 -Physical Assaults

Example 1 – Client to Client

Deanna was physically assaulted on an ongoing basis for 3+ years by a particular male resident. For the first nine months of Deanna moving in I was totally unaware she was being abused. When she finally told me what was happening I asked why she hadn't told me sooner. She stated a particular staff person told her she wasn't allowed to tell me, it was gossip and she wasn't allowed to gossip or she would get into trouble with staff. Tipping management failed to inform me for 18 months when she was being abused. It was my understanding that original Incident Reports (IRs) had to be filed in the relevant residents folders but this had not been done.

Deanna was very often too frightened to stay at the house following assaults both on her and also when the other two male residents were assaulted and would choose to stay with me until she felt safe enough to return. Following one particular assault she was too frightened to return to the Tipping house for 6 weeks. In effect, she was forced out of what was supposed to be her home, there were no consequences for the abusive resident, Tipping continued to talk meaningless rhetoric and Deanna continued to be abused.

In 2006 Deanna and I met with Kevin Stone, Executive Officer of the Victorian Advocacy League for Individuals with an Intellectual Disability (VALID) which proved to be a complete waste of time. All he offered was to have a "friendly chat" with the Tipping CEO. Nothing changed and Deanna continued to be abused.

In desperation, to try and protect her from further assaults I applied for an interim intervention order in September 2006. The Magistrate didn't appear to be at all interested and curtly dismissed me. I left court that day in tears and despairing that no-one except me, her mother, was prepared to try and protect her and fight for her human rights. I then went to Legal Aid and was granted a Solicitor. Meanwhile, while waiting for a court date, Deanna continued to be abused.

At the first court date the Magistrate ordered mediation which proved to be a waste of time as Deanna continued to be assaulted. I note that prior to court mediation Tipping management had refused to provide me with copies of IR's however when I advised them Deanna had a right to them they were provided and copies filed in her folder. Following our first court attendance all IRs relating to Deanna being assaulted or her witnessing assaults on other residents mysteriously disappeared from her file. They were only returned following my formal complaint advising management it was illegal to remove them.

Management denied any knowledge of why or who had removed the IRs but they reappeared in Deanna's file just as mysteriously as they had disappeared.

There were numerous court dates and adjournments between 6 October 2006 and 14 November 2007 with no outcomes to protect Deanna. She continued to be assaulted. Eventually a preliminary hearing was set for 7/12/07. A week prior to this date the defendant threw his bowling bag at Deanna injuring her ankle. I took her to the local Police Station and demanded they do something. Initially the officer said it was a DHHS matter but I stood my ground and he eventually agreed someone would visit the Tipping house. Later that evening he advised they had been to the house and clearly something needed to be done. The following day

this police officer asked if it would help if they wrote to DHHS advising them of the situation at the Tipping house. As it turned out this didn't need to happen because on the night of this assault I emailed the Minister for Community Services, DHHS bureaucrats and Tipping CEO demanding the defendant be removed permanently from the house the following day and, if he wasn't removed a journalist from The Age was prepared to speak with Deanna and me the following day.

Tipping obviously did not want adverse media attention and the violent resident was quickly and permanently removed.

I did not lodge a complaint with the Disability Services Commissioner because his office only came into being in July 2007 and we were already involved with the legal system.

The legal system, Minister for Community Services, Community Visitors, DHHS Secretary and her staff, Tipping and VALID *all* failed dismally in protecting my daughter from ongoing abuse.

It is a damning indictment on all the above that if Deanna had not had her mother advocating for her she would have continued to be abused. My determination to protect her proved to be much more powerful than any legislation or organisation.

Example 2 – Staff to Parent
As a result of being physically assaulted twice by a Tipping staff person at Deanna's dietician appointment in April 2012 I went to the police and pressed charges. The police attempted to investigate the matter but because no witnesses came forward at the dietician's and because I only had tenderness in the areas I had been hit and no visible injuries the police weren't able to take the matter any further. At the time I was assaulted I said to the perpetrator "That is assault". The second staff person responded "I didn't see anything."

Section 2 - Duty of Care / Negligence

Dietary Requirements, Health & Weight Concerns
Example 1 – Failure to ensure adequate hydration - CRITICAL CARE ISSUE
2009 - Deanna was diagnosed with dehydrated kidneys twice and suffered a severe vasovagal collapse in 2009 as a direct result of staff failing in their duty of care to ensure she was adequately hydrated. Although I had provided detailed medical information on Deanna's condition the day she moved into the Tipping house and I had seen this document in her health file not long before she had the collapse a senior manager's response to my formal complaint was:

1. to deny the information was in Deanna's file.
2. to then falsely accuse me of not providing the information.
3. to download from the internet and place in Deanna's file generic information on dehydrated kidneys and Vasodepressive syncope that had the potential to cause Deanna serious harm.
4. to state staff may not have read the information because the information was not recorded on their official template and insinuated this was my fault. (This tactic was as a direct result of a long term staff person admitting having seen the information I had originally provided in Deanna's file.)

Tipping were left red-faced in that they had failed to comprehend that their poorly thought out excuses above, in reality, only pointed the finger at

themselves for failing to comply with mandatory procedures to develop a Plan when Deanna first moved in. They tried the blame game but it backfired.

Example 2 - Failure to adhere to GP, Dietician instructions
Deanna's weight increased substantially within a few months of moving into the Tipping house due to not being provided with healthy balanced meals and a lack of exercise. Although I constantly raised my concerns with Tipping management Deanna's weight continued to increase and she was diagnosed as being morbidly obese and borderline diabetic. Her GP prescribed a low fat, low sugar diet with plenty of exercise. Most house staff failed to follow these guidelines and Deanna kept gaining weight so I took her to a private dietician who implemented a food, fluid and exercise chart. The majority of staff consistently ignored the dietician's instructions. False recordings were frequently made on the charts – eg. the meals recorded were not the meals I witnessed Deanna eating, quantity of food was not as prescribed, food wasn't low fat/low sugar, fluids recorded on the chart but hadn't been consumed, exercise (walks) recorded that hadn't occurred.

One particular staff person seemed intent on sabotaging the dietician's efforts by suddenly including desserts that previously weren't provided.

Example 3 - Rotting food
On numerous occasions there was rotting food in the fridge or being prepared for the residents meals. I started taking photos so staff couldn't continue to deny it. Rather than address the problem management initially responded by trying to bully me by saying I was not allowed to take photos inside the house because I was breaching residents privacy. I continued to take photos, a staff person reported me to the coordinator however they knew they didn't have a leg to stand on because I was only taking photos of rotting food, not photos of the residents.

On one occasion there were 4 litres of sour milk in the fridge. Deanna had made us both a coffee and didn't notice the milk was off. The coordinator had earlier made herself a coffee and thought it tasted strange but she didn't bother to check to see if the milk was off. Fortunately I did. All the residents could have been ill if they had consumed it. I can only wonder how often these sorts of incident may have occurred.

Example 4 - Personal Care
Particular staff consistently failed to support Deanna in her personal care to the extent that it became necessary to develop a comprehensive personal care chart in the hope that it would make staff more accountable. This didn't work as staff simply made false entries on the chart.

Although Deanna is capable of doing most of her personal care independently she often needs reminding when she forgets or positive reinforcement when she doesn't want to do something however these same staff ignored their duty of care in that they neither prompted nor positively encouraged her to do these tasks for example:

- Numerous occasions when Deanna obviously hadn't cleaned her teeth for a number of days and on one occasion her teeth were coated in green muck.
- On two occasions a staff person cut 15cm x 4cm lengths off her hair due to staff not supporting her in checking whether knots had been brushed out.
- Overall skin was very dry and at times cracked due to staff failure to prompt her to apply moisturiser and assist where needed.

Staff were required to apply prescribed ointments to Deanna's face and feet but particular staff failed to do so. This was evidenced not only by the ongoing tinea on her feet (which she did not have prior to moving in) but also because both the face and feet ointments did not need replacing as often as they would have needed to be if they had actually been applied as required.

The majority of staff consistently ignored their duty of care to Deanna and refused to provide the support, encouragement and prompting in making healthy food choices, to exercise and to keep her fluid levels up. Rather than provide positive reinforcement and explain the pros and cons of doing/not doing these tasks they used excuses such as *"it's Deanna's choice what she wants to eat and if she wants to exercise"* and "*She knows how to get herself a drink from the fridge."*

I had a lifetime's knowledge of Deanna but not only did particular staff frequently question/challenge me at times they also questioned Deanna's health professional's advice/instructions. These staff had an arrogant belief that they knew better than anyone else.

Section 3 – Inaccurate/False Incident Reports

Example 1
On one occasion my friend and I witnessed Deanna being assaulted by the violent resident however the direct care staff's version and my version of this incident were significantly different. Witnesses names had to be recorded on IRs however my friend and my names were not included. I asked the staff person who witnessed the assault and who wrote the incident report why her report wasn't factual and why our names weren't recorded as witnesses. She became very defensive stating her senior had told her she wasn't allowed to discuss anything with me.

Example 2
It was common practise for Tipping to 'water down' incidents when recording what had actually occurred so they could keep the IR 'in house' and it was extremely rare that Tipping contacted the police following an assault. This only seemed to occur when the general public or neighbours witnessed an assault.

Example 3
For the 5 years prior to 2012 I had automatically received copies of IRs. Tipping did not forward an IR pertaining to the staff person's assault on me. When I requested a copy initially the Coordinator advised it would be provided, however 5 days later she recanted. I then requested it from the Service Manager and he stated no incident report was submitted.

Clearly, either Tipping lied about the existence of the IR or the two house staff involved breached mandatory procedure by failing to submit an IR.

Example 4
Noting that category 3 incidents didn't have to be forwarded to DHHS it certainly appears Tipping tried to be deceitful by categorising Deanna's collapse in 2009 as a category 3. I challenged this as I believed it was a category 2 incident. Tipping refused to upgrade the IR to a category 2 so I lodged a complaint with the ODSC, the outcome being Tipping then agreed to submit the IR to DHHS as a category 2.

Section 4 - Tipping's devious tactics to try and shut me down

From the time the summons was served on the violent resident in 2006 Tipping management and most direct care staff became hostile towards me. Management made it very clear from the outset whose side they were taking. They supported the defendant and his mother at court appearances and at mediation yet at no time did they offer any support to Deanna and me. I was under no illusion this hostility towards me would only exacerbate and it did, almost immediately.

Example 1
2006 - Whenever I visited Deanna particular staff blatantly stalked me the whole time I was at the house, eavesdropped on my conversations with Deanna and the other residents and during telephone calls between us. (These calls were written up virtually verbatim in Deanna's file notes.) Even when on group outings particular staff would eavesdrop on my conversations with other people and on one occasion a staff person even followed Deanna and me into the toilets at a bowling alley. The intensity of this bullying, intimidating behaviour continued until I lodged a formal complaint with Tipping management however particular staff continued to 'monitor' me in what they perceived to be a less obvious manner right up until the time Deanna returned home to live with me.

Because I dared to speak up for my daughter's rights not only to be free from abuse but also in trying to ensure staff were made accountable for their day to day failures in service provision and the fact that I refused to be bullied/intimidated by Tipping management and staff into shutting up and going away I was now enemy no 1 as far as they were concerned.

I was yet to find out just how vindictive particular staff could be and the extraordinary lengths they would go to in order to try and shut me down.

Example 2
2007- The Tipping Regional Manager advised that staff had lodged a complaint against me and he requested a meeting with staff and management. I advised that I would not agree to meet until I had been provided with specific details of the allegations against me. In considering I heard nothing more about the matter I can only conclude the allegations against me were vexatious.

2008 –Particular staff lodged another complaint against me. Although I again requested specific details of the complaint from the State wide Manager this was not provided. Eventually she advised that their finding was that there were '*no grounds for, or substance to the claims made.'* Clearly, this second complaint against me was also vexatious.

These malicious complaints failed to achieve what particular staff had hoped for – to shut me down, so they tried another tactic in that they cunningly manipulated/coerced a co-resident into complaining about me.

Example 3
2008 - On two occasions the Residents Meeting Minutes recorded a co-resident had allegedly stated he didn't like me going to the house. It is noteworthy that one of the staff members who attended both of these meetings was party to the grievance against me earlier in the year.

I advised management that considering this resident frequently sought me out when I visited the house and would often sit outside with me he was obviously being coerced by particular staff into saying this and if staff lodged any more

vexatious complaints about me or coerced others into doing so I would take action against them. I heard nothing more from then in relation to these allegations.

Example 4
Occasionally I would arrive at the house unexpectedly. Most staff did not like this because they could be caught out. A senior manager suggested I make appointments prior to all my visits. I flatly refused and it wasn't raised again – at least not in this way.

Example 5
2009 – The same co-resident as in Example 3 inexplicitly became hostile toward me and would tell me to go home. He had allegedly told staff he didn't want me there. Again I told the coordinator that this resident had obviously been coerced/manipulated by particular staff into saying this and I believed staff 'worked' on him immediately prior to my visits to fire him up. Following my complaint to management the resident became friendly toward me again.

Example 6
2009 – When I was picking Deanna up for appointments particular staff started telling Deanna to wait for me at the front of the house and she would rush out before I had turned the car off. She said particular staff told her she had to wait at front door and hurry out when I arrived. I raised this with management and staff ceased using this ploy in an attempt to keep me out.

Example 7
2008 and 2009 – Mothers Day. On both occasions the same two staff were on duty. When Deanna and I returned to the house no-one was there. Although staff and management came up with excuses such as lack of communication between staff/staff and staff/me I had no doubt these 'lockouts' were deliberate. I requested Deanna be given her own key (which was done) in order to prevent staff being able to try this tactic again.

Example 8
March 2011 – Correspondence received from Tipping Area Manager in part vaguely referring to *"… appropriate visiting times to review files and staff concerns which have been raised."* Due to my submitting two sets of formal complaints in February and March I believe that particular staff did not like being held to account so again they attempted to shut me down by saying eg. my visiting the house stopped them from getting on with their job which proved to be absolute nonsense.

Example 9
November 2011 – Dietician asked if two particular prescribed foods were being purchased. Deanna said ***"Maybe, maybe not. I not know. I not say."*** I read between the lines and realised she was too frightened to tell the truth. On the drive back to the house I reminded her to show me what was in the fridge when we got back. She immediately became very anxious and was close to tears saying ***"No, no, I can't, I get into trouble with staff."*** I tried to reassure her however she kept repeating **"*You do it, I not do it. I get into trouble."*** After explaining that it was the residents fridge and you all have the right to check what is in it if you want to, she agreed but insisted that I check the fridge with her. On the drive back she kept repeating out loud to herself ***"Yep, I be strong, my rights, my choice, no, staff not allowed bully me, I not like that, yep, mum will help me."*** This self talk was very concerning. I had never before seen Deanna so anxious. It was obvious she expected repercussions from staff.

On arrival back at the house Deanna was very nervous and when I suggested checking the fridge she burst into tears and said **"*No, I can't, I get into trouble with staff.*"** I reinforced in her she had every right to check the fridge however she told me to do it, saying ***"I be scared of staff. "***

Both staff witnessed the above and neither of them uttered a single word to reassure Deanna that not only could she check the fridge but she would not get into trouble with them. After checking the fridge I spent quite some time talking privately with Deanna and reinforcing in her that staff weren't allowed to bully her and if she got into trouble after I left to ring me straight away.

Little did I know that from that moment on particular house staff and management started plotting a devious and despicable plan to shut me down completely.

Over the next few months Tipping, with VALID's involvement devised a despicable scenario to play out prior to Deanna's dietician appointment in April 2012. Particular Tipping employees and a VALID advocate, coerced/intimidated/bullied Deanna into saying she didn't want any contact with me.

It is my firm belief that Tipping bullied Deanna into saying she didn't want contact with me because:

(a) I dared to try to ensure management and house staff were held accountable for their failures in their duty of care to Deanna.
(b) Deanna had advised Tipping in 2011 that I was her advocate and they realised I wasn't going away.
(c) they did not like me discussing my concerns with Deanna's health professionals.

Up until a few days prior to this appointment Deanna had been quite happy about me taking her to her health professional appointments however when I arrived at her day placement I was advised house staff had arranged for her to be dropped off at the Tipping house early.

I went to the Dietician's and tried to speak with Deanna to try and ascertain why she had suddenly changed her mind about me being there but both staff kept blocking me by standing between us. When I asked both staff to leave so I could talk to Deanna without them influencing or intimidating her they refused to leave. Deanna looked completely bewildered and clearly didn't know who she should go with. A verbal altercation then ensued which escalated into me being physically assaulted twice by one particular staff person, once in the dietician's and again in the car park. I then rang the police and staff immediately and firmly hooked their arms in Deanna's, guided her to their car and sat in the car laughing at me while I was on the phone. The police weren't able to attend immediately and asked me to call in to the station either later that evening or the following day. In the meantime the house staff left with Deanna.

When I rang the house in the following days to speak with Deanna management and house staff stated Deanna allegedly didn't want to talk to me. Two days after this assault VALID's advocate rang me and said he was Deanna's advocate and she didn't want to have any contact with me. I asked him what was going on, this wasn't normal behaviour for Deanna. He was very curt and refused to discuss anything saying it was a privacy matter.

I knew Deanna would at some stage fret and miss me. I had to be patient and the following weeks were extremely stressful. In all her life we had never gone longer than a week without contact. I was extremely concerned about her health, safety and wellbeing and after around ten days I realised Tipping in particular would be bulling/manipulating her into not contacting me.

Example 10
Prior to Mothers Day 2012 I sent Deanna a registered letter asking if she would like to spend time with me on Mothers Day. I did not get a response so I went to the Post Office, and assured me a card advising the letter was being held at the Post Office would have been left in Tipping's letter box if no-one was home. Staff denied a card was left in their letterbox. I advised the Tipping coordinator that tampering with another person's mail was a very serious criminal offense. Her response was they had also checked with the Post Office and were told it was possible a card may not have been left and staff would take Deanna down to pick up the letter. Yet again, blame someone else rather than own up!

Example 11
When Deanna's aunt and uncle rang Deanna at the house during this time she was torn between wanting/not wanting to see me on Mother's Day and seemed depressed. They were highly suspicious that house staff had listened in on their conversations. A few days later the VALID advocate met with Deanna and the following day I received an email allegedly from her saying she didn't want to see me on Mother's Day.

I have no doubt that particular house staff, with the advocate's support, had bullied Deanna into saying she didn't want to see me on Mother's Day.

Around this time Deanna started saying to a number of people outside of Tipping - **"Staff tell me I be adult, I not need mum, make my own choice."**

Example 12
Five weeks after saying she didn't want any contact Deanna started ringing me from day placement, saying she was too scared to ring me from the Tipping house and that particular staff told her she wasn't allowed to talk to me or stay with me. We started meeting weekly and on the third week she decided to come back home with me, at least temporarily at that stage.

I advised the Tipping coordinator of Deanna's decision. The coordinator demanded to speak to Deanna. I advised her Deanna wasn't with me at the moment so it wasn't possible and she became angry, saying she needed to know it was Deanna's decision; they had a duty of care to know where she was and whether she felt safe.

The VALID advocate also rang, aggressively demanding to speak with Deanna and threatened if he didn't speak to her he would be requesting the police to do a welfare check and would also lodge an application for an independent guardian to be appointed through VCAT. Even though Deanna rang him later that afternoon he still went ahead with the VCAT application. Details of VCAT's actions are discussed in Max Jackson's Case Study – Control, Threats and Intimidation in Disability Services in Victoria which has already been submitted to the Inquiry.

Following the above phone call Deanna said ***"[VALID Advocate] talk fast, fast, fast, not listen to me. I tell him I happy, I be safe, him not listen. Give me***

headache. Him pain in neck sometimes." The extremely aggressive, interrogative manner in which he spoke to her was disrespectful and appalling.

Example 13
The following week, while Deanna was still staying with me, two Tipping staff turned up without Deanna's permission at her hospital appointment. I asked Deanna if she wanted to talk to them and she became frightened and said ***"No, I not like them. Tell them go away, I be scared. They nasty to me."*** I asked the staff to leave, they refused saying they had a duty of care to be there. I advised them that if they didn't leave I would contact security to have them removed. They then left.

Considering Tipping had never shown any interest in attending these appointments previously the conclusion can only be that this was a last ditch attempt by Tipping to try and control Deanna. I was thoroughly disgusted.

For the first three months of returning to live with me Deanna needed constant reassurance that she was safe. She said she was frightened house staff would come and take her back to the house so she preferred to watch television with me rather than in her own room.

Emotional abuse is insidious. It does not leave visible scars but it can be as damaging as, or indeed, more damaging than physical abuse.

The point of documenting the above at such length is to attempt to demonstrate the reprehensible lengths Tipping, with VALID's support, was prepared to go to in order to try and gain full control over Deanna.

In considering the despicable lengths Tipping went to, to try and control Deanna and me one has to wonder:

- What did Tipping have to hide, what were they so afraid of?
- Why was the VALID advocate so willing to be Tipping's conduit in doing their dirty work?
- Who would have genuinely been acting in Deanna's best interests?

Section 5 - Family funded Advocacy

The Disability Act 2006 (The Act), particularly section 5(3) (h), (i), (j) and (k) clearly details the requirements of respecting, acknowledging and strengthening the capacity of families. Tipping and indeed VALID both totally ignored and disrespected the important role I had as Deanna's mother.

I was indeed very fortunate to have the invaluable support of JacksonRyan Partners throughout my dealings with Tipping, DSC and VALID however, too many families are suffering and being abused by service providers because they have no one to support them and/or they are too afraid to speak up due to fear of reprisal.

Although family abuse does at times occur, the vast majority of families are genuinely committed to supporting/advocating for their person with a disability and have their rights and best interests uppermost as their entire focus. The health, safety and wellbeing of their loved one is paramount.

Too often, DHHS, and particular funded service providers manipulate The Act and legislation in an attempt to try and cover up the abuse and shut families down and

advocacy agencies such as VALID support them believing they know the person with a disability better than the family.

Independently funded family advocacy is critical to ensuring families have a real voice in striving to protect their loved one from abuse.

Section 6 - Disability Services Commissioner

I gave up lodging complaints with the ODSC because there were no positive outcomes. Tipping continued to talk the talk while continuing to ignore their duty of care to Deanna.

Following lodgement of one particular complaint I refused to attend the pre-assessment conference as I believed it was a totally unnecessary part of the DSC's elongated process. As I result of my refusing to participate in the pre-assessment I was bluntly advised if I didn't participate the actual assessment conference would not proceed. I challenged this with the Disability Services Commissioner (DSC) and the conference went ahead without the pre-assessment.

The ODSC Learning from Complaints Occasional Paper No 2 can only be considered to be a load of meaningless drivel. I was so incensed after reading it I felt compelled to respond to the DSC. A copy of my response is attached.

Section 7 - Office of the Public Advocate and Community Visitors

History has shown that the OPA and Community Visitors (CV's) have failed to make any real inroads in protecting people with disabilities from abuse and ensuring service providers provide quality services. Apart from acknowledging receipt of my complaints I was virtually ignored by the OPA. Whether they fully investigated them I have no idea.

Example 1
On one occasion when I dropped Deanna off the CV's were in attendance. I asked one of them if they were aware that Deanna and 2 male residents were being physically assaulted by the third male resident. He said he wasn't aware. Clearly the CV's did not ask to see incident reports during their visits or they would have known.

Surely it would be reasonable to assume that it would have been a high priority for CVs to check incident reports.

Example 2
December 2011 – Deanna wrote to the OPA requesting they advise Tipping to respect her decision that she had nominated me as her advocate. The OPA responded that a CV would visit and talk to her about her wish for me to be her advocate and also suggested she consider contacting VALID. I have no idea whether a CV did indeed visit Deanna. If they did, I can only wonder whether the visit was held in private or in earshot of, or with Tipping in attendance.

Example 3
January 2012 - Deanna wrote to the OPA requesting a meeting with the CV's and advising she wanted me, as her advocate, in attendance. Noting she requested the OPA to contact me to make an appointment time, I have never heard from them.

SECTION 8 - VALID

VALID's advocate and indeed VALID's Executive Officer totally ignored The Disability Act and indeed its own policies when particular Tipping staff manipulated the advocate into supporting their aim – that being to shut me down. Not only did this advocate breach Deanna's privacy, he did not respect her rights and nor did he respect my role as her mother. [redacted]

[redacted]

Section 9 - Legal System / Law enforcement

1. Considering the amount of times we went to court over the physical abuse and left without any resolution or protection for Deanna it seemed to me the Magistrate did not take the assaults seriously. I felt we were just being fobbed off. Magistrates need to take these types of assaults much more seriously and protect victims.
2. The Police originally fobbed me off with comments such as *"nothing we can do, it's a DHS matter, the guy has an intellectual disability."* They had made it very clear they were not interested so I didn't bother going back to them until the final assault on her. The police also need to act to protect victims instead of fobbing off victims.
3. When a person with an intellectual disability turns 18 current law assumes the individual has legal capacity and can therefore make informed choices. Such 'one size fits all' legislation can only be considered to be ludicrous at best and dangerous at worst.
4. Rights come with responsibilities; decisions/choices have consequences. It has been my experience that when Deanna has participated in courses that teach people with disabilities about their rights the emphasis is focused on their rights/choices and very little or no emphasis put on responsibilities and consequences.
5. Too many disability and indeed advocacy organisations either distort or ignore The Disability Act and other legislation to suit their own agendas. They are not held accountable for breaches of the legislation and this is one reason why people with disabilities continue to be abused. This must be addressed.

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FEEDBACK

Disability Services Commissioner

Occasional Paper No. 2

Families and service providers working together

Feedback on Occasional Paper No. 2, 'Families and service providers working together', can be provided, **until Friday 28 March 2014**, in the following ways.

Email: contact@odsc.vic.gov.au with the subject line 'Feedback on Occasional Paper No. 2'

Mail: Disability Services Commissioner
Level 30, 570 Bourke St
Melbourne, 3000.

Facebook: www.facebook.com/DSCVic

Fax: 03 8608 5765

Contact details in the event we need to clarify your feedback (optional)

Name	Organisation
Barbara Dixon	Parent
Email	Phone
[redacted]	[redacted]

Considering there are already reams of mandated legislation that service providers are required to adhere to one questions why there is a need for the Learning from Complaints Occasional Paper No 2.

History clearly highlights that some service providers ignore their legal obligations and indeed their own policies and processes. How will more policies/strategies fix the problems when service providers, including the Department of Human Services are not being held accountable now?

The Learning from Complaints Occasional Paper No. 2. can only be considered to be a distraction from the fact that the Disability Services Commissioner is failing dismally by

not using the powers available to him to make service providers accountable for their failure to meet their mandatory obligations to people with disabilities and their families as defined in the Disability Act 2006.

If service providers invested as much time and energy on genuinely addressing their poor management and service provision, their negative attitudes towards families, and their duty of care failures as they spend on trying to shut families down I have no doubt complaints would drop dramatically.

The Disability Services Commissioner appears to cling tenaciously to a belief that communication/mediation is the magical fix to what is wrong in the disability sector when, in reality, all that is required is for him to enact the powers invested in him to make agencies accountable for their failures.

Families do not want to be burdened by more meetings, more plans, more strategies. We have enough to deal with as it is and we know only too well that far too often they are a waste of time and are only a tactic that some service providers use and will continue to use no matter how many policies, plans, strategies are put in place in an attempt to be perceived as addressing/resolving issues.

To suggest that to 'talk openly and respectfully over a number of conversations' will solve the issue of 'differing expectations' is almost laughable. Been there, did that for 8 years and nothing changed. Families, at least in the large network that I am involved in who have a son/daughter in supported accommodation consider health, safety and welfare to be of the highest priority and these are the issues most complained about and are the very same issues that some service providers refuse to acknowledge and resolve and indeed attempt to hide.

Conciliation is more that meeting ad infinitum. Unless service providers are held accountable and penalties applied for their wrongdoings they will continue ignoring their mandated obligations knowing full well the Disability Services Commissioner won't take them to task.

My personal experience is that it is not "OK to Complain." The strategies listed in the Occasional Paper No 2 to reinforce people's right to speak up or make a complaint will not alleviate the fear of retribution to the person with a disability or their family. Some agencies and their staff are very creative in devising ways to 'punish' the person with a disability and/or their family and do coerce or bully people with disabilities into shutting their families out.

Severe mandatory penalties must be applied when intimidation, bullying and abuse of any kind occurs if people with disabilities and their families are to ever have the confidence there will be no repercussions for making a complaint.

It is very disappointing to note that it appears the Family Engagement Reference Group didn't include a family member representative independent of any organisation/agency. It therefore seems reasonable to conclude that members of the Reference Group have not had direct experience as a family member meeting with a service provider and have not had to suffer the arrogance, intimidation, frustration and extreme levels of stress that families have to go through when dealing with particular agencies. It therefore can only be concluded that the reference group could only represent an organisational

perspective and influence the content of this Occasional Paper from their own perspective. That is, have more meetings, more plans etc which is only a copout for pretending to fix problems – it is merely a cover up process.

One can only wonder why at least one independent family member was not included on the reference group.

First and foremost I am the mother, the parent of my daughter yet I am given the label 'carer' by service providers. Being my daughter's carer is secondary and I detest being referred to as such. The word 'families' is an all encompassing word for a relative and legislation needs to include the words such as mother, father, brother, sister, aunty etc.

In conclusion, while the Office of the Disability Services Commissioner continues to employ staff recycled from the Department of Human Services one must question whether this is a fair and balanced approach as I have no doubt there would be a sense of these employees not wanting to upset their former DHS co-workers. Perhaps this is why the Disability Services Commissioner refuses to do investigations or at the very least take action and apply penalties to those service providers who fail to meet their mandatory obligations under the law. Wishy-washy roundtable discussions with mates – aka- service providers will never result in positive outcomes for people with disabilities and their families.

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