

REPORT OF AN INQUIRY
CONDUCTED BY
THE HONOURABLE D G STEWART
INTO ALLEGATIONS OF OFFICIAL MISCONDUCT
AT THE BASIL STAFFORD CENTRE

MARCH 1995

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CRIMINAL JUSTICE COMMISSION

Telephone: (07) 360 6060

Facsimile: (07) 360 6333

Your Ref.:

Our Ref.:

Contact Officer:

The Hon Dean Wells MLA
Minister for Justice and Attorney-General and
Minister for the Arts
Parliament House
George Street
BRISBANE Qld 4000

The Hon Jim Fouras MLA
Speaker of the Legislative Assembly
Parliament House
George Street
BRISBANE Qld 4000

Mr Ken Davies MLA
Chairman
Parliamentary Criminal Justice Committee
Parliament House
George Street
BRISBANE Qld 4000

Dear Sirs

In accordance with section 26 of the *Criminal Justice Act 1989*, the Commission hereby furnishes to each of you its report on an inquiry conducted by the Honourable D G Stewart into allegations of official misconduct at the Basil Stafford Centre.

Yours faithfully


R S O'REGAN QC
Chairperson

10 March 1995

Mr P M Le Grand
Director
Official Misconduct Division
Criminal Justice Commission
557 Coronation Drive
TOOWONG QLD 4066

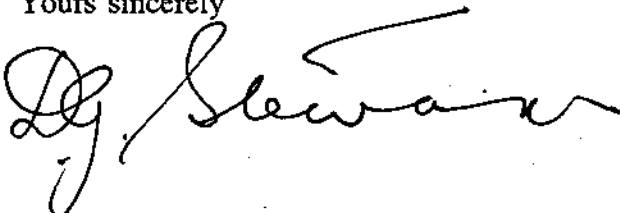
Dear Mr Le Grand

I refer to resolutions of the Commission dated 26 November 1993, 10 December 1993, and 10 January 1994 resolving to conduct an investigation into allegations of official misconduct concerning the Basil Stafford Centre and related matters, and further resolving to appoint me to conduct such an investigation.

I now present to you a report of my investigation in order that you may report to the Chairperson in the discharge of your responsibilities under the *Criminal Justice Act 1989*.

Two further confidential reports, as referred to in section 1.12 of the enclosed report, will be forwarded to you in due course under cover of separate correspondence.

Yours sincerely

A handwritten signature in cursive script, appearing to read 'D G Stewart', written in black ink.

The Honourable D G Stewart

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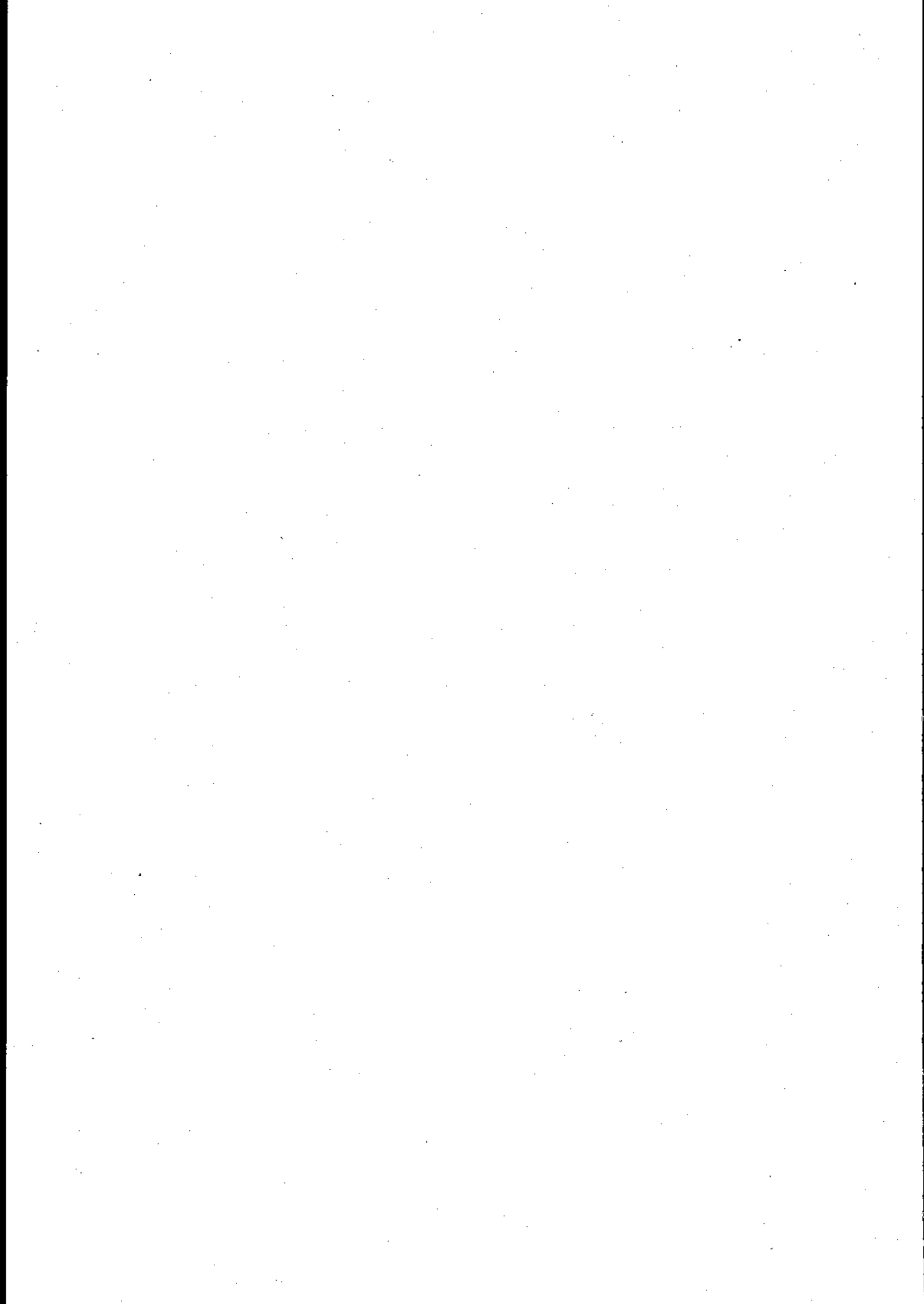
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ABBREVIATIONS

ALS	Alternative Living Service
AWU	Australian Workers' Union
Centre	Basil Stafford Centre
C Ex	Confidential exhibit
CT	Confidential transcript
Department	Department of Family Services and Aboriginal and Islander Affairs
Division	Division of Intellectual Disability Services
Ex	Exhibit
HEU	Health Employees' Union
IPP	Individual Personal Plan
ITEP	Individual Training and Environment Plan
JAB	Juvenile Aid Bureau
PRO	Principal Residential Officer
PSMC	Public Sector Management Commission
QAI	Queensland Advocacy Incorporated
QPOA	Queensland Professional Officers' Association
RCO	Residential Care Officer
RDO	Residential Duty Officer
RPO	Residential Program Officer
SCAN	Suspected Child Abuse and Neglect
SPSFQ	State Public Service Federation of Queensland
SSU	State Service Union
T	Transcript
TAFE	Technical and Further Education



SUMMARY OF MAJOR CONCLUSIONS AND RECOMMENDATIONS

Pursuant to resolutions dated 26 November 1993, 10 December 1993 and 10 January 1994, I was appointed by the Criminal Justice Commission to undertake an investigation into allegations of official misconduct involving staff of the Basil Stafford Centre. The Centre is a residential facility, administered by the Department of Family Services and Aboriginal and Islander Affairs, which provides services to individuals with severe or profound intellectual disabilities.

The investigation ("the Inquiry") largely proceeded by way of public hearings. The Inquiry sat on 63 separate days and heard evidence from over 70 witnesses. Approximately 6,000 pages of transcript were generated, and 430 exhibits (including attachments), comprising many thousands of pages, were admitted into evidence. Oral submissions were concluded on 19 August 1994 and a final written volume of submissions, of Counsel for the State of Queensland, was received by the Commission on 15 September 1994.

The proceedings of the Inquiry, including the preparation of this report, have taken a considerable time. The reasons for this are many: while some are set out in the relevant sections of this report, for present purposes, it suffices to note that the Inquiry's terms of reference called for an investigation of many issues of a most important and wide-ranging nature. The state of affairs of the Centre, as revealed by the evidence, demands that substantial reforms and improvements be undertaken so that the welfare of the intellectually disabled residents, whose interests are the paramount concern, may adequately be protected in the future. It was therefore necessary to give full and detailed consideration to the host of complex and serious issues that arose, so that informed and useful recommendations, rather than hasty and ill-advised suggestions, could be made. It must be borne in mind that other bodies, such as the Department and the Police Service, have previously attempted to investigate and resolve the problems at the Centre. For the most part, they were unsuccessful. In many respects, this Inquiry represented the last opportunity for those problems to be exposed and redressed.

Within the body of this report I have at times expressed opinions, outlined considerations, made recommendations and otherwise addressed the various issues that arose during the Inquiry's hearings. In some individual Chapters, where applicable, I have specifically set out my conclusions and recommendations apropos the particular matters of relevance therein, generally at the end of the Chapter or the relevant section. Included below is a summary of the major conclusions that I have reached, and the corresponding major recommendations that I make. These lists are not exhaustive, nor are their contents expressed in any order of preference, with the exception of a recommendation that the Basil Stafford Centre should be closed, as soon as possible, which is my primary recommendation.

While a perusal of the table of contents will disclose where in the report my findings and recommendations are discussed in detail, the relevant references are noted after each recommendation for ease of understanding.

CONCLUSIONS

In the period from 1 January 1985 to 31 December 1993, I am satisfied, to the standard of proof as set out in this report, that:

1. A number of unlawful assaults were perpetrated by staff at the Basil Stafford Centre upon severely and profoundly intellectually disabled persons residing there (clients). Additionally,

there were instances of clients being neglected by their care-givers; on occasions, that negligence was gross.

2. While a proportion of staff at the Centre were caring and committed in their endeavours, a not insignificant number of staff members were ignorant of their responsibilities, had an attitude of indifference, and in some cases were unwilling to act decently, toward the intellectually disabled persons placed in their supposed care.
3. An insidious institutional culture existed at the Centre. This culture promoted the occurrence of client abuse and gross neglect, and the harassment or intimidation of staff members who reported or could have reported such occurrences, by other staff members. This culture provided the climate, and thus the opportunity, for acts of official misconduct to take place and minimised the likelihood of both the act and the offender being detected. The situation existing at the Centre had the effect of discouraging, to the point of stifling, the reporting of such acts of official misconduct. The situation cannot be explained away as arising from the actions of a few individual "rotten apples".
4. The various instances of client abuse and gross neglect that were brought to my attention during the Inquiry were not isolated occurrences, but rather, were indicative of a pattern and represented instances that came to light in spite of the system existing at the Centre, that system being one where acts of client abuse or gross neglect would, more probably than not, remain undetected or unreported.
5. A number of both past and present staff, from all employment levels, were subjected to serious and distressing campaigns of harassment as a result of their employment at the Centre. Some officers were harassed, or at best thereafter shunned and distrusted, as a result of reporting incidents of client abuse or gross neglect, while others were harassed because of their perceived role in either assisting with investigations of such matters, or attempting to administer the Centre's operations in a manner most beneficial to the intellectually disabled clients in accordance with their duty as employees and decent human beings. That decent men and women should have been so subjected to such behaviour, merely as a result of attempting to do their duty, in accordance with the Department's aims and procedures, and as caring human beings, is a situation which can only be described as abhorrent, disgraceful and intolerable.
6. Management at the Centre, and in the Department, has been unable to effectively counter the problems presented by the insidious culture existing at the Centre; in particular, the problems of staff harassment and intimidation.
7. A feature of the culture was a deep division between staff holding managerial positions, and other staff (in particular the Residential Care Officers) at the Centre. At the time of the hearings, staff morale was for the most part low.
8. In many cases, there has been a wide divergence between the noble and enlightened aims, practices and procedures promoted and adopted by the Department, on paper, and the day to day realities of the lives of some of the Centre's clients, and the level of care afforded to them.
9. The Department's own attempts at investigating suspected incidents of client abuse or gross neglect have been marked by a lack of success. It is inappropriate, for a variety of reasons, for such "internal" investigations to be carried out.

10. All of the above compels a conclusion that it is more probable than not that further acts of official misconduct will continue to occur at the Centre until such time as it is closed. However, further safeguards and reforms can be instituted and undertaken to protect the rights of the clients pending the closure of the Centre.
11. In relation to the six specific and representative allegations of client abuse and/or gross neglect examined during the Inquiry's hearings:
 - (a) In relation to one incident, a report should be made by the Director of the Official Misconduct Division, pursuant to Section 33 of the *Criminal Justice Act 1989* to the Chairperson of the Commission for consideration as to whether it is desirable and appropriate that a report be forwarded to the Director of Public Prosecutions with a view to such prosecution proceedings, as the Director considers warranted, against a Residential Care Officer.
 - (b) In relation to one incident, a report should be made by the Director of the Official Misconduct Division, pursuant to Section 33 of the *Criminal Justice Act 1989* to the Chairperson of the Commission for consideration with a view to determining whether a Misconduct Tribunal should exercise jurisdiction in respect of a Residential Care Officer.
 - (c) The evidence has not established how the first head wound was sustained by Client 1; however, there is no evidence to support any suggestion of official misconduct against any staff member. The evidence establishes that the second head injury sustained by Client 1 occurred accidentally, and that there was no official misconduct on the part of any staff member.
 - (d) In relation to the allegation of unlawful assault on Client 7 by a Residential Care Officer, that complaint cannot be substantiated on the available evidence.
 - (e) In relation to Client 4:
 - i) Client 4 suffered an extensive and totally unacceptable series of injuries in October 1990, with at least some of those injuries arising as a result of an unlawful assault committed upon him by a person or persons unknown. My task in attempting to identify the perpetrator in that regard was hampered by the failure of the relevant staff members to accurately observe and record, and consequently investigate, the aforementioned injuries at the relevant time.
 - ii) Client 4 suffered a serious and lengthy history of gastrointestinal infections during part of his period of residence at the Centre; however, there was no gross neglect by any staff member in that regard.
 - iii) The teeth fractures suffered by Client 4 in November 1991 were sustained as a result of some unknown traumatic incident. Two Residential Care Officers failed to properly perform their duties in terms of detecting and reporting this injury.
 - (f) In relation to the death of Client 8 at the Centre in April 1991:

- i) Two senior officers were unable to respond appropriately to the emergency situation presented by Client 8's distress; in this regard their inadequate first aid training was a factor, although their failure to so respond was not ultimately a contributing factor to Client 8's death.
- ii) There was no official misconduct on the part of the house Acting Senior Residential Officer concerning the question of Client 8's access to the kitchen in his house, which led to his death. The evidence did not establish the identity of the officer who left open the kitchen door on the day in question, thus allowing Client 8 to gain access to food in the refrigerator, the ingestion of which killed him.
- iii) Although Client 8 was unsupervised for a brief period prior to his death there was no official misconduct on the part of any staff officer, in all the circumstances.
- iv) The listing of "epilepsy" as a contributing factor on Client 8's death certificate, by the Centre doctor, was not supported by the evidence, but was not made with any intent to deceive or conceal any of the relevant facts.
- v) The decision not to undertake a post mortem examination of Client 8's body was understandable in the circumstances, but the holding of a post mortem examination, and a coronial inquest, would have been preferable and helpful in establishing the cause of death.
- vi) Residential Care Officer AC was not subject to any improper attempts by senior officers to alter her report about the circumstances relating to Client 8's death, nor was the interviewing of her, by senior officers, about an associated disciplinary matter, inappropriate.

[Note: The evidence before the Inquiry concerning the six specific incidents investigated, revealed a considerable number of instances where staff members had failed to observe applicable standards and procedures, particularly concerning the reporting of client injuries and suspected abuse. Although that conduct in all but two cases fell short of that required to amount to official misconduct, arguably, such omissions might reasonably expose the relevant officers to disciplinary action. With the exception of the aforementioned charge of official misconduct, I have not, within this report, recommended that the Chief Executive Officer of the Department consider bringing disciplinary action against any staff member. My reasons for not recommending such action are expressed in Chapter 10 of this report, and include the fact that in many cases the facts constituting the possible disciplinary breach were brought to the attention of supervising officers who failed, at that time, to take action upon them.]

12. Mrs A, while employed as a Residential Care Officer at the Centre, witnessed, or became aware of, a number of instances of clients being mistreated by her colleagues. While in some respects Mrs A's evidence was exaggerated and somewhat unreliable, and failed to establish any connection between some of the more dramatic incidents of harassment complained of by her, and staff at the Centre, it is clear that she became unpopular with some staff members as a result of her activist stance in reporting improper treatment of clients. In context, her continued

reporting was courageous and is to be commended. The Department did not act opportunistically or inappropriately in accepting Mrs A's resignation, although it was unable to respond adequately to the problems presented by her situation.

13. There is no evidence to directly link Mr F with any act of harassment of any staff member, concerning the reporting of client abuse or gross neglect, nor is there any evidence to directly link Mr F with any act of client abuse or gross neglect. However, the evidence does establish that Mr F had attitudes unsuited to the duties of a person entrusted with the care of people with intellectual disabilities.
14. The broad issue of the funding and resources available at the Centre was within the Inquiry's jurisdiction insofar as it was related to the detection, prevention and occurrence of official misconduct. Many factors relevant to the occurrence of official misconduct at the Centre are related to funding issues.
15. Steps must be taken in an attempt to attract more suitable applicants for Residential Care Officer positions. It is a matter of concern that applicants for positions within the Division of Intellectual Disability Services are only required by law to disclose their criminal histories, where relevant, in relation to limited classes of offences.
16. Although improvements have been made in recent years, in many respects the training given to the Residential Care Officers at the Centre has been inadequate, particularly in regard to the provision of ongoing training.
17. The ratio of staff to clients at the Centre is the poorest in Australia, is inadequate, and inextricably linked to the prevalence of official misconduct. It is not only desirable that two staff members should be allocated to work with client groups in the circumstances outlined in section 20.5, but is necessary to ensure that an acceptable standard of care is afforded to them.
18. There is a degree of ignorance or misunderstanding amongst Centre staff about the right to obtain outside medical opinions for clients.
19. Some staff have participated in absurdly unhygienic practices which expose the clients, and themselves, to health risks.
20. The trade unions associated with the Centre have not gone beyond the limits imposed by law in their provision of assistance to union members accused of matters such as client abuse, although a perception to that effect has arisen in the minds of some staff. There was some degree of over-sensitivity on the part of management to possible union influence in such matters, and some officers were placed in a position where a conflict of interest arose by virtue of simultaneously holding managerial roles and union representative positions. There was a substantial degree of mutual support between the ranks of union representatives and the ranks of those officers involved in the preservation of the insidious institutional culture at the Centre.
21. There is no need for a further independent investigative body to be established for the purposes of inquiring into allegations of client abuse, as the Criminal Justice Commission and the Queensland Police Service are adequately equipped to carry out this role. The existence of a number of other agencies and mechanisms suggested in evidence as constituting "checks or balances" in terms of preventing, detecting or satisfactorily investigating acts of client abuse do not in fact constitute adequate safeguards. The only involvement of such bodies has been retrospective and ineffective.

22. There is a clear need for advocacy to be undertaken, by suitable persons and groups, on behalf of the Centre's clients, on individual and group bases.
23. Many of the conclusions expressed by the then Senior Constable Angel, of the Queensland Police Service, in his report dated June 1991 about investigations conducted at the Centre by the Juvenile Aid Bureau, were correct and have been validated by the evidence adduced at this Inquiry.
24. There is a need for periodic reviews of the Centre's operation to be undertaken in the future in order to ensure that the recommendations contained herein are implemented, and that appropriate standards are being maintained.
25. I reject without reservation the submissions made by Mr Plunkett of Counsel, who was granted leave to appear at the Inquiry's hearings on behalf of the Crown in right of the State of Queensland, first, to the effect that there has been a denial of procedural fairness by the Commission in the conduct of this Inquiry, and secondly, that the reporting of the Inquiry's proceedings by the media has been other than generally fair and accurate.

[Note: It is regrettable that in this report I have found it necessary to refer, at length, to a number of the submissions made by Counsel for the State of Queensland which, even after the granting of an extended time in which to deliver those submissions, were often without foundation and expressed in intemperate terms. In light of the Commission's statutory obligations to act independently, impartially, fairly and in the public interest, it is necessary to deal in detail with some of the more serious of those submissions in this report.]

RECOMMENDATIONS

1. The primary recommendation of this report, foreshadowed by me during the hearings, was to be that the problems at the Centre, including the instances of official misconduct as revealed by the evidence, were of such a nature that the only practicable solution was to close the Centre at the earliest possible opportunity. On 19 October 1994, prior to the release of this report, the Director-General of the Department informed the Chairperson of the Criminal Justice Commission that the Government had announced that it intended to close the Centre within the next three to four years. This decision is in accordance with the Government's long-term policy of deinstitutionalising people with intellectual disabilities, and the stated recognition that there exist more appropriate models of care than that provided by institutions such as the Centre. I endorse that decision, and recommend that all possible steps be undertaken to expedite the process of the Centre's closure. I also recommend, as set out below, that a number of safeguards and reforms be instituted and undertaken in the period prior to that closure so that the rights of the intellectually disabled clients are protected to the greatest possible extent. I note that deinstitutionalisation does not mean abandonment; happily, abandonment of clients is not on the Government's agenda. [Section 13.8]

In addition to the above, I recommend:

2. In relation to one incident, a report be made by the Director of the Official Misconduct Division, pursuant to Section 33 of the *Criminal Justice Act 1989* to the Chairperson of the Commission for consideration as to whether it is desirable and appropriate that a report be forwarded to the Director of Public Prosecutions with a view to such prosecution proceedings, as the Director considers warranted, against a Residential Care Officer. [Section 1.12]

3. In relation to one incident, a report be made by the Director of the Official Misconduct Division, pursuant to Section 33 of the *Criminal Justice Act 1989* to the Chairperson of the Commission for consideration with a view to determining whether a Misconduct Tribunal should exercise jurisdiction in respect of a Residential Care Officer. [Section 1.12]
4. The Department review and update its procedures relating to the treatment of gastrointestinal infections amongst the client population, and in so doing heed the advices, given in evidence, of Dr Cleghorn. [Section 10.6(E)]
5. The Department review its present first aid training procedures, with a view to ensuring that *all* officers at the Centre, whether working directly with people with intellectual disabilities or not, including those holding managerial positions, receive instruction in the application of appropriate first aid techniques. As part of this review, the Department should ensure that all officers working with people with intellectual disabilities receive continuing first aid training on a regular basis. [Section 11.11]
6. The *Queensland Coroners Act 1958* be amended to provide that the Coroner be required to hold an inquest into any case of the sudden death of an intellectually disabled person, where that person has died in a residential institutional facility operated and administered by the State, or other privately operated facility. [Section 11.15]
7. The Department take all steps that are open to it, in a thorough and conscientious effort, to ensure that Mr AJ is not further prejudiced or inconvenienced, as a result of being exposed to serious and disgraceful harassment by other staff members as a consequence of diligently performing his duties. [Section 15.3]
8. The Department endeavour to attract more suitable applicants for Residential Care Officer positions. The selection criteria for the Residential Care Officer position must be upgraded, with the imposition of a basic educational qualification, and improvements in salary and working conditions. [Section 19.2]
9. The *Criminal Law (Rehabilitation of Offenders) Act 1986* be amended so that applicants for positions, within the Division of Intellectual Disability Services, are required to disclose any and all contraventions of or failures to comply with any provision of law, whether committed in Queensland or elsewhere. [Section 19.4]
10. The Department adopt rigorous, fair and realistic standards of performance appraisal for staff, in order to lessen the occurrence of official misconduct at the Centre. [Section 23.2(C)]
11. Further improvements be made to the training provided to Residential Care Officers. In particular, an initial training period must be provided which, in all the circumstances, adequately prepares newly-appointed Residential Care Officers for their duties. Those officers must also receive appropriate formal instruction to ensure, as far as possible, that they hold the correct values and attitudes towards the intellectually disabled. The critical importance of the observance of the Department's procedures relating to the reporting of client injuries must be stressed in any training program. A realistic career pathway for Residential Care Officers must be created in order to attract more suitable applicants. All staff should receive continuing training, with attendance by Residential Care Officers at such training being compulsory. [Section 19.6]

12. The staff/client ratio be improved. The Department must take all steps open to it to ensure that two staff are allocated to work with the clients in each house at the Centre at all possible times, particularly during the morning and afternoon shifts. More stringent supervision of Residential Care Officers, by an increased number of direct line managers, is required. [Section 20.5]
13. As a matter of urgency, the Department take whatever steps are necessary in order to upgrade the facilities at the Centre's medical premises to an acceptable level. [Section 21.3]
14. The Department immediately take steps to improve the knowledge and practices of staff concerning basic hygiene matters. [Section 21.3]
15. The Department, or any other body charged with the duty of investigating allegations of staff misconduct, not be influenced or deterred in any way in the pursuit of necessary inquiries by considerations of possible industrial unrest or difficulties relating to the various trade unions associated with the Centre. [Section 22.3]
16. Disciplinary action be taken, as a matter of course, in each and every case where a staff member does not comply with the Department's procedures concerning the reporting of client injuries, or other suspicious occurrences. The recording of client injuries, by staff, must be improved. The Department must actually enforce, rather than simply implement, procedures and policies in this area. [Section 23.2(B)]
17. The investigation of allegations of client abuse or gross neglect at the Centre be carried out, to the greatest possible extent, by the appropriate bodies, namely, the Criminal Justice Commission and the Queensland Police Service. Injuries and other suspicious circumstances, when detected, must be reported immediately to management, and to those investigative bodies. Consultation and continual liaison must take place between the Department, the Commission and the police in order to ensure that more matters are investigated as satisfactorily as possible. No further independent investigative body is required. [Section 23.3]
18. The Department consult with concerned and reputable advocacy organisations in the field of intellectual disability, such as Queensland Advocacy Incorporated, with a view to ascertaining how the resources and abilities of such organisations can best be deployed for the benefit of clients. [Section 23.8]
19. The benefits of strong individual advocacy, for each client at the Centre, be recognised, and steps be taken to promote the achievement of that objective. [Section 23.8]
20. The Department liaise with this Commission with a view to implementing methodology allowing the undertaking of periodic reviews of the Centre's operations in order to ensure that the recommendations contained herein are implemented, and that appropriate standards are being maintained. As part of this liaison the aforementioned bodies are to determine, and consult with other bodies if necessary, as to the appropriate entity or entities to undertake such periodic reviews. [Section 23.10]