The Basil Stafford Centre Inquiry Report:

Review of the Implementation of the Recommendations

KEY FINDINGS

W J Carter QC

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CJC Mission: To promote integrity in the Queensland Public Sector and an effective, fair and accessible criminal justice system.

Acknowledgments

This paper summarises the key findings of a review by The Honourable W J Carter QC of the implementation of the recommendations of the 1995 Basil Stafford Centre Inquiry Report ('the Stewart Report'). In conducting the review, Mr Carter was assisted by Ms Margot Legosz and Mr Gary Adams of the Research and Prevention Division of the Criminal Justice Commission with Ms Lisa Evans providing administrative support.

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Abbreviations

ALS	Alternative Living Service
AWU	Australian Workers Union
BSC	Basil Stafford Centre
CBPA	Competency Based Performance Assessment
CJC	Criminal Justice Commission
DFYCC	Department of Families, Youth and Community Care
DSQ	Disability Services Queensland
MPU	Misconduct Prevention Unit
PFA	Parents and Friends Association
QAI	Queensland Advocacy Incorporated
QPS	Queensland Police Service
QPSU	Queensland Public Sector Union
RCO	Residential Care Officer
RDO	Residential Duty Officer

Introduction

In the early 1990s, the Basil Stafford Centre (BSC) — a government-run facility providing accommodation and care for intellectually disabled people (including children) — came under fire in the media for alleged abuse and neglect of its clients. A Criminal Justice Commission (CJC) investigation into the allegations uncovered evidence of serious wrongdoing and the subsequent report by The Honourable D G Stewart (published March 1995) recommended the Centre's closure 'at the earliest possible opportunity'.

During the course of the lengthy investigation into this matter, these facts emerged:

- staff of the Centre were directly or indirectly implicated in allegations of assault, client abuse and neglect
- conventional methods of investigation undertaken by the State Government, the QPS, and the CJC itself, had experienced difficulty in identifying wrongdoers or in stemming the tide of allegations of abuse and neglect
- the alleged occurrences of assault and client abuse were seen to be linked to what the Stewart Report called an 'insidious institutional culture' characterised by a regime of non-reporting of such behaviour and the fear of reprisals and harassment being visited upon those who 'broke ranks'.

At the time of the Inquiry, the BSC provided accommodation and associated care services for approximately 122 people who were intellectually disabled, all of whom had severe or profound levels of intellectual disability. Seventeen of these clients were children aged 16 years and under.

The Centre was located administratively within the Division of Intellectual Disability Services of the Department of Family Services and Aboriginal and Islander Affairs. The Department has since been restructured and the Centre is now (since December 1999) administered within Disability Services Queensland (DSQ), which is an independent body within the Department of Families, Youth and Community Care (DFYCC). At the time of writing this review, the BSC had 69 residents.

The recommendations

The Stewart Report made 20 recommendations, the primary one being that the problems at the BSC disclosed by the evidence at the Inquiry, including instances of official misconduct, were of such a nature that the only practical solution was to close the Centre at the earliest possible opportunity. (See the appendix to this review for a full transcript of Stewart's 20 recommendations.)

Recommendations 2, 3 and 7 — which relate to the institution of criminal prosecution proceedings, an investigation by the Misconduct Tribunal, and departmental action against certain Residential Care Officers (RCOs) — are of historical interest only as they have all been complied with.

Recommendations 6 and 9 sought amendments to legislation:

- No. 6 recommended that the *Coroners Act 1958* be amended to require the Coroner to hold an inquest into the death of a person with intellectual disability where that person had died in a residential institutional facility operated by the State or in any other privately operated facility.
- No. 9 recommended that the *Criminal Law (Rehabilitation of Offenders) Act 1986* be amended to require job applicants to the then-named Division of Intellectual Disability Services to disclose all contraventions or failures to comply with any provisions of the law, whether committed in Queensland or elsewhere.

The recommended amendments to legislation have not been effected.

Both pieces of legislation appear to be within the portfolio of the Attorney-General and Minister for Justice. Queensland Advocacy Incorporated (QAI) has, in correspondence with the Minister, raised the issue of amending the legislation not only on account of the matters raised by the Stewart Report, but also because of other recorded deaths that have occurred in institutions operated by both government and private instrumentalities. The CJC will also pursue these changes with the Attorney-General and Minister for Justice.

Although the *Criminal Law (Rehabilitation of Offenders Act) 1986* remains unamended, the main thrust of recommendation 9 was achieved by the *Family Services Amendment Act 1999* (Act No. 52 of 1999), which amended the *Family Services Act 1987*. It provides for extensive criminal-history checking of employees, applicants for positions, honorary officers, volunteers, agents of the Department and students on work experience in both the DFYCC and DSQ. The provisions of the Amending Act are designed to operate despite the provisions of the *Criminal Law (Rehabilitation of Offenders) Act 1986*.

Recommendation 20 proposed an ongoing liaison between the Department and the CJC to allow for periodic reviews of the Centre's operations and of the report's recommendations. The following review has been undertaken as a consequence of, and in conformity with, this recommendation.

The remaining 14 recommendations covered a variety of topics, which are dealt with in this review under these headings:

- **the closure of the Centre (recommendation 1)**
- **the investigation of misconduct (recommendations 15, 16 and 17)**
- **staffing issues (recommendations 8, 10 and 12)**
- **staff training (recommendations 5, 11 and 14)**
- **medical matters (recommendations 4 and 13)**
- **advocacy for clients (recommendations 18 and 19).**

Review methodology

Unlike the Stewart Inquiry of 1994, this review was conducted primarily with a research and prevention focus. It was proposed at the outset that if during the course of the review any complaint of misconduct was alleged, or misconduct observed, that it would be referred to the CJC and dealt with in the usual way. The need for such a referral did not arise.

Methods used to gather data

- **Numerous interviews with relevant staff at the BSC**, including current and former centre managers, area and unit managers, relocation and training managers and the work environment officer.
- **Documents requested from the DFYCC and subjected to critical review.**
- **Site visits to the BSC complex, a BSC community house, and the Department's community-based facility at Loganlea (Loganlea Accommodation Support Service)**, which enabled us to better understand the physical environment within which people with intellectual disability are housed and cared for.
- **Discussions with the relevant unions**: the Australian Workers Union (AWU) and the Queensland Public Sector Union (QPSU).
- **Three surveys**:
  - **(i) Relatives and friends of the current 69 BSC clients** were surveyed to assess their levels of involvement in a variety of initiatives that have been introduced by the Centre since the Stewart Report. The survey also sought data on respondents' levels of satisfaction with the treatment of their relatives and friends, positive and negative reactions to the Centre, concerns about possible abuse and how these concerns have been dealt with to date.
  - **(ii) Relatives and friends of each of the 42 clients who have been relocated from BSC since the Stewart Report** were surveyed in an attempt to document where those clients have gone and levels of satisfaction with those arrangements. The survey replicated the questions asked of current clients' relatives and friends and also sought comparative data on the standard of care provided in their new environment.
  - **(iii) All current staff of the BSC** were asked to give information about their current role, training and qualifications, staff consultation and supervision experience, organisational climate and any personal positive or negative views of the Centre. Each question related to the implementation of the Stewart recommendations.

Response to surveys

Forty of the 69 forms sent to friends and relatives of current BSC clients were returned, representing a response rate of 58 per cent. This was a fairly good response, indicating significant levels of involvement by many relatives and friends of current clients in the Centre. Responses indicated that relatives and friends appear to be reasonably satisfied with the current standard of treatment offered at the Centre.

Unfortunately, only 33 per cent of the surveys posted to relatives and friends of former BSC clients were returned. However, while the findings could not be considered representative of all former clients, they provided valuable qualitative data. Overwhelmingly, respondents reported that the quality of life of their relative/friend was now much better than it had been at the BSC (including their diet, hygiene precautions, medical treatment, behavioural management, supervision and discipline, facilities and activities); although, according to some respondents, abuse and financial mismanagement still occur.

Despite keen and written support from the AWU and the QPSU, and guarantees of confidentiality by the CJC, DFYCC and DSQ, only 74 of approximately 200 current staff members at the Centre returned the survey, making a response rate of only 37 per cent. The majority of respondents were employed at the BSC in a professional or managerial position and most had begun their employment since the Stewart Inquiry. The majority of direct-care staff at the Centre, and those who had been employed before or during the Stewart Inquiry, failed to respond, indicating an unwillingness by these groups to participate in yet another review of the Centre. This was a serious loss for our review and possibly indicative of some critical staffing issues, which are raised in the body of this report.

Despite some inadequacies in the response rates overall, the three surveys considered together provided some explicit findings. These results, along with the evidence provided by the interviews and documents, are referred to throughout this review.

Review findings

Impact of the Stewart Report

The Inquiry and subsequent report were attended by considerable media publicity which was essentially adverse and negative. This had both short- and long-term effects on the Centre.

Impact on staff

In the short term, staff (as well as relatives and friends of clients) were damaged by the publicity. Morale suffered. The public image of the BSC was poor and those who worked there felt hurt and concerned that, in spite of their own personal commitment to their clients, they were made to suffer for the sins of others. In the longer term, staff tended to become more inward looking and intent upon self-preservation. Accordingly, groups of employees have become isolated and concerned that matters do not arise to provide any basis for complaint, criticism or disciplinary action. In short, service delivery has been said to be more staff-based than client-based. The consequence of this has been a lessening of cohesion and cooperation among staff.

There has also been a serious lack of stability in the line-management structures of the BSC, which has been plagued by a series of acting appointments over a long period, even at Centre Manager level. Some reasons for this include:

- an uncertainty about the future of the BSC
- the ongoing process of relocation to the community
- an unclear idea of the final form which the Centre may assume.

The practice of making acting appointments at Unit and Area Manager level over a considerable period has adversely affected the line-management relationship of Unit Managers and RCOs. The latter were faced with an ever-changing supervisory regime that was unstable and unpredictable. At the same time, the Unit Manager's role became more difficult because RCOs were understandably reluctant to embrace suggested changes within the workplace in the certain knowledge that the acting Unit Manager would inevitably depart and be replaced by another. The same kind of instability was also apparent at Area Manager level and similarly affected the relationship between Unit and Area Managers.

The review involved lengthy and detailed discussions with Unit and Area Managers. The professionalism and commitment of these officers in their present roles, plus the fact that theirs are now permanent appointments, will enhance the effectiveness of the line-management structure. While there will be further changes in both structure and personnel, given that further downsizing is to occur, one can confidently predict that any concerns for clients based on the fact of instability in management will not adversely affect the operation of the Centre in the foreseeable future.

Impact on relatives and friends

Since the Stewart Report, a much closer and more wholesome relationship has been developed with relatives and friends of clients at the BSC. In his report, Mr Stewart noted that approximately 70 per cent of clients had little or no parental or like support. It was said during the review that the publicity associated with the Inquiry had had the effect of raising the awareness of relatives and friends to the need to support BSC residents more actively.

There is now an active Parents and Friends Association (PFA) and regular meetings are held between Centre management and relatives/friends in the Family Management Advisory Group. A meeting with this group, and the results of the survey, revealed considerable mutual respect between management and relatives/friends. This healthy and regular dialogue is a very worthwhile initiative — there is now a substantial measure of support among relatives and friends generally for the BSC (there was also general agreement that since the Inquiry the centre has improved remarkably) and the survey indicated that about 78 per cent of relatives/friends have regular contact with the Centre at least once a month (40% reported weekly contact).

This reflects a more collaborative and consultative approach in the course of which relatives/friends and clients are given the choice of residing in the community or remaining at the BSC. It is probable that the ultimate client population at the Centre will be made up of those whose relative or friend prefer that they remain at the BSC. This issue is considered again later in the review from a different perspective when considering the matters raised by QAI (see page 20).

As most people with intellectual disability in Queensland now reside in the Alternative Living Service (ALS), it would be a serious omission to fail to emphasise the importance of the ALS and the role which DSQ plays in that regard. Frequent reference is made to the implications of the Stewart Report recommendations for that environment throughout this review.

The Alternative Living Service

The ALS offers the means for people with intellectual disability to be housed in the community (in either privately or government-owned facilities) and cared for by RCOs who are managed within a regional Area Office structure.

The Loganlea Accommodation Support Service (LASS) is the most recent government initiative in this regard. It houses many of those who formerly lived at the, now defunct, Challinor Centre. LASS is impressive upon inspection, offering a high standard of accommodation for clients, who are cared for by well-motivated RCOs and managed by two Unit Managers of considerable professional skill and expertise within a very desirable and well-structured, cohesive and cooperative managerial environment. The current development of a similar style facility at Bracken Ridge will, hopefully, replicate the establishment of the Loganlea facility.

On the other hand, the ‘playing field’ appears to be quite uneven — not only in terms of the built environment for people with intellectual disability but also in relation to domestic

management. The ALS has a much broader base than the facilities offered at Loganlea and Bracken Ridge.

One does not solve the problems identified by the Stewart Report merely by downsizing or by substituting community-based care for institutional care. By 2001, the BSC will occupy a much smaller niche in the government-controlled scheme for community-based facilities for people with intellectual disability. Most clients now live and will continue to live in the community. It needs to be said that any mistreatment of clients is much less likely to occur at the BSC than within the ALS, if only because of the reduction at the BSC in clients (i.e. fewer people to complain) and staff (i.e. fewer people to complain about).

Implementation of the Stewart Recommendations

Closure of the Basil Stafford Centre (Recommendation 1)

Recommendation 1 of the Stewart Report refers to the closure of the BSC as the 'primary' recommendation. While the report envisaged the Centre closing 'at the earliest possible opportunity', a number of reforms and safeguards were to be implemented 'to secure the rights of the clients housed at the Centre'.

The BSC has not closed, nor is it presently proposed that it should. In the light of the primary recommendation in the report, the fact that the Centre has not closed and the recognition of its current status within DSQ as a viable ongoing residential care facility for persons with intellectual disability requires close scrutiny.

The decision to close or not to close became the subject of competing political decisions by governments of different political persuasions in the period 1994–1997. In 1994, some months prior to the publication of the Stewart Report, the Director-General of the Department advised the Chairperson of the CJC that the Government had announced its intention to close the Centre 'within the next three to four years'. It can be readily inferred that that decision was made against the background of disturbing public disclosures in the course of the Inquiry relating to the quality of care offered to BSC residents.

In 1996, following a change of Government, it was announced that the Centre would not close. It seems clear that this decision, at least in part, was a political response to the robust and vigorous support for the Centre by a group of people whose relatives and friends were cared for at the BSC and who preferred that this situation continue rather than that the residents be transferred to a community-based facility.

In 1997, the then Shadow Minister (now the Minister responsible for DSQ) initiated a Parliamentary Debate on issues relating to the closure of the BSC as recommended by the Stewart Report.

Current departmental initiatives are directed towards reducing the level of institutional residential care for people with intellectual disability and enhancing the prospect for such clients to be housed and cared for in a more mainstream or community-based setting. At the same time, there appears to be considerable respect for the views of some parents who prefer their relatives to remain at the Centre.

While this review identified current opposing models of supervision and care for people with intellectual disability — one institution-based and one community-based — it was not considered appropriate for the CJC to adjudicate the merits of these competing arguments. The fact is that the number of clients and staff housed at the Centre is reducing in an orderly relocation of clients to the community-based ALS while the views of those who prefer their relatives to live at the BSC are being supported and respected.

In 1994–95, at the time of the Inquiry, 122 clients lived at the BSC. At the date of this review, that number had reduced to 69. Planning for further relocation is well advanced under the BSC Relocation Project, although relocation is necessarily dependant upon the availability of suitable housing (some concerns about delays in finding suitable accommodation were raised by 16% of staff in their survey responses). Of the 69 clients now residing at the Centre, relocation planning is proceeding with 38 clients and their families. It is expected that:

- 18 residents will move by 31 December 2000
- a further 19 will move by 30 June 2001
- a further 7 will move by 31 December 2001.

> The current expectation is that about 25 residents will prefer to remain at the BSC rather than relocate to a community-based facility. Therefore, by 2001 the BSC will have changed markedly from the institution investigated by the Stewart Inquiry. It will not have closed, as the primary recommendation of the Inquiry anticipated, nor is it presently expected to be closed. It will care for a reduced client population with significantly less staff and the Centre will be conducted on a much smaller scale.

It would present a false picture to say that the primary recommendation of the Stewart Inquiry has been ignored. Clearly, it has not. Rather, the current status of the Centre and the reasonable predictions that can be made about it are consistent with the terms of the recommendation.

The culture

The Stewart Report strongly recommended closure because of the fear that the institutional facility would perpetuate its ‘insidious institutional culture’ with all of its manifestations. It was thought that the only way to destroy the culture was to terminate the facility — there was no evidence that traditional management skills would effectively counter the strongly entrenched attitudes and practices that perpetuated the culture and had become an essential feature of working life within the Centre.

This review sought to examine the evolution of the so-called culture during the five-year period since the Stewart Report. Clearly, some important initiatives have been set in place to counteract it. However, it should not be thought that these initiatives have provided a final and an entirely effective response to the problems identified — only in recent times can one see emerging a more positive and aggressive proactive approach towards ensuring an appropriate cultural environment (see the table on page 9).

In each of the three surveys, respondents were asked to make any comments (positive or negative) concerning the BSC. Many staff spoke in glowing terms of the current Centre —

Features of the culture:

- recruitment of poor-quality staff at RCO level, some of whose values were far from acceptable
- low turnover of such staff, some of whom had retained their dominant and influential status among RCOs for many years
- recruitment of persons who were related by blood, marriage or personal relationship
- the development of a significant integrated core group of influence which protected certain entrenched attitudes and work practices
- a lack of respect for clients: a mind-set on the part of some who saw vulnerable human beings as a burden and a chore, who were devalued and seen to have few, if any, civil rights and who were often discussed in perjorative or derisive terms
- an attitude which sought to justify 'thump therapy', a euphemism for assault, as acceptable at the discretion of an RCO
- the development of workplace practices designed to support the self-interest of those engaged in them
- a lack of respect by some RCOs for authority and Centre management and the development of an 'us and them' syndrome
- a reluctance to report relevant accidents or other injuries to clients
- inadequate investigation of reported incidents by line managers
- failure of management to deal adequately and efficiently with the problem
- the capacity to generate a militant response to any challenge to the culture, including the belief that to 'dob in' or 'blow the whistle' would bring an immediate response of harassment and intimidation — evidence at the Inquiry identified a variety of sanctions such as ostracism, threats of harm to one's property, life or limb, personal abuse, the spreading of unsavoury sexual rumours, the placement of dead animals and even of human excreta and soiled underwear in locations likely to be seen by the particular individual.

Initiatives implemented to counteract the culture:

- new recruitment procedures
- an enhanced training regime for RCOs
- a revised staff:client ratio
- more stringent requirements for the reporting of incidents
- more aggressive attempts to terminate the employment of those whose conduct is considered to be unacceptable
- establishment, in 1996, of the Local Consultative Committee (LCC), made up of three main groups — four management representatives including the Centre Manager, four staff representatives including RCOs and four RCO/Union representatives (two each from the AWU and QPSU), the purpose of which is to provide a forum to discuss 'a wide range of issues affecting the operation of the Centre and to facilitate regular dialogue between staff and management'
- establishment, in 1996, of the Continuous Improvement Committee (CIC), which focuses on the introduction of high-quality management practices such as the retention of staff and the improvement of communication within different segments and disciplines at the BSC
- development, in 1999, of a broad strategic direction around the Centre's five major stakeholders — clients, family, staff, the community and the organisational stakeholders.

that it had changed for the better, that staff were client-oriented, hardworking, trustworthy and committed, that quality of care for clients had improved, that management had become more stable and lines of communication had improved.

On the other hand, some of the negative responses were substantial. Poor management was identified as a major problem (by 44.6% of staff respondents). Concerns were expressed that management had failed to communicate with other staff, that there was lack of direction, that there existed a 'gulf' and a significant level of mistrust between management and 'others' and that there was a lack of inclusiveness in decision making. Other matters noted included the negative attitudes of staff, poor work practices, inadequate training and monitoring of staff, low morale and high levels of stress, the potential for continued client abuse and (for 9.5% of respondents) the view that the 'negative culture' still existed and retained a powerful presence.[1] With the implementation of the initiatives documented on page 9, one can look at the future BSC with some confidence, but the negative aspects raised by respondents need to be monitored.

It is an integral thrust of this review that the kinds of concerns that were exposed by the Inquiry have the potential to emerge in the ALS. The real challenge will ultimately be with those whose responsibility it is to oversee the management of the ALS — the ancillary recommendations of the Stewart Report may be even more relevant in the operation of the community-based model than in the institutional model. Relocation involves not only clients but also staff, often the same staff who worked in the institutional BSC, operating within more or less the same management structure. It is inevitable that there will be some transfer of the institutional culture. The closure of the BSC might have meant the end of the existing culture. The consequential need to relocate clients, however, might equally mean that the culture becomes decentralised with the inherent capacity to re-create itself in a new form, within a new management structure, in a different location and on a smaller scale.

The investigation of misconduct (Recommendations 15, 16 and 17)

The very nature of the work required in the course of providing residential care to people with intellectual disability is not risk free and has the potential to give rise to complaints of misbehaviour — complaints of criminal and official misconduct continue to be made to the QPS and to the CJC. A significant proportion of current BSC relatives and friends reported experiences of verbal abuse (12.5%), physical abuse (12.5%) and neglect (12.5%) of their relative/friend within the last 12 months. However, because of the large proportion of clients who reside in the community, these complaints are now more likely to come from within the ALS than the BSC.[2]

1 Furthermore, 8% of respondents who had lodged a formal complaint in recent years to either the QPS, the CJC or the MPU reported encountering some form of opposition from their colleagues. Incidents of harassment, sexual discrimination, rejection of requests for permanent appointment, physical and verbal abuse and lack of managerial support were described.

2 One relative/friend of a former BSC client reported verbal and physical abuse to their relative/friend and two respondents reported neglect of their relative/friend since moving into the community.

Shortcomings in reporting and investigating complaints

Shortcomings in the reporting and investigation of complaints were highlighted by the Stewart Report. Since the Inquiry the following actions have been taken:

- Management now insists on compliance with departmental standards and has responded to complaints by terminating the employment of staff identified as perpetrating either abuse or financial fraud against clients.[3]
- Deliberate measures are being taken to ensure reporting of suspicious occurrences and all client injuries, even those occurring accidentally or without fault.
- RCO training now emphasises reporting requirements.
- Unit Managers take a more proactive role in encouraging and monitoring reporting behaviour.
- A more permanent and effective process of line management is now in place.
- The Misconduct Prevention Unit (MPU) was established in October 1994 (see page 12).
- Managers have ready access to the MPU, both in the reactive implementation of policies and procedures to a formal complaint and in a proactive supportive role by the provision of workshops. The MPU also offers considerable support on a consultative basis to various agencies within the Department, in particular to personnel within DSQ, not only at the BSC but within the ALS.
- The MPU enjoys a close and cooperative working relationship with the Complaints Section of the CJC. Complaints are monitored and discussed in detail.
- The staff:client ratio and other staff issues are seen as integral factors in minimising the risk of client abuse and/or of misconduct and criminal conduct. This ratio has reduced since the Stewart Report (see page 14).

However, the following factors may reduce the effectiveness of these initiatives:

- *A heavy workload:* Unit Managers have an onerously heavy workload at the BSC. An effective, constant and predictable supervisory regime between Unit Managers and RCOs is of fundamental importance to the prevention of misconduct. If the Unit Managers' capacity to effectively supervise the RCOs under their control is being adversely compromised by the workload, problems are inevitable.
- *A relatively high staff:client ratio:* Similar concerns apply at RCO level. If allegations of misconduct are more likely to emerge in houses where the staff:client ratio is high (as it was at the time of the Inquiry — 1:6) then the case for lowering the ratio remains valid. At the BSC, the overall ratio has been estimated to be 1:4.1, but it is clear that a ratio of 1:5 applies in many sections of the BSC facility. More details follow.

3 Since 1995, 33 complaints about BSC staff have been received by the CJC. Eleven of these complaints were either substantiated or resulted in the resignation or termination of the staff member involved. A further four complaints were placed in the hands of the QPS for investigation and several are ongoing.

- *An inadequate response to lodged complaints*: Many current and former relatives and friends commented in their survey responses that they had lodged complaints with the DFYCC, DSQ or Centre management within the last few years about the treatment of their relative or friend, both at the BSC and in the ALS. Many, however, were dissatisfied with the response they received, the most common reason being that, despite the complaint, 'nothing has ever been done to rectify the situation'.

It will remain an ongoing challenge for management, both within the BSC and the ALS, to remain vigilant for the proper identification and investigation of cases of misconduct. It needs to be repeated that the proactive misconduct prevention strategies referred to will need to be monitored strenuously.

The Misconduct Prevention Unit

On 17 October 1994, the then Government approved the establishment of the MPU within the Department. This decision was taken at about the same time as the Government announced the closure of the BSC. It was initially intended that the MPU be established on a 'trial basis for at least one year but not more than two years'. However, the MPU remains operative and is a valuable initiative. In the course of this review, several of the management staff at the BSC and the CJC spoke well of the Unit.

The Unit's original purpose was to strengthen the capacity of managers to deal effectively with suspected misconduct and to more effectively support and increase the competence of managers in responding to reported or suspected misconduct. Managers now frequently consult the MPU for assistance and advice. Perhaps more importantly, the MPU has initiated workshops for Centre staff such as *Managing the Investigation Process*, and has established Self-Paced Learning Programs on subjects such as *Ethics and Fraud Awareness*. Other prevention initiatives include publication of the *Fraud Prevention Guidelines Manual*. The MPU also has an effective working relationship with the CJC, the CJC's Chief Complaints Officer meeting monthly with representatives of the MPU.

In short, the MPU is a very positive initiative and, while its establishment was not a recommendation of the report (the report at recommendation 17 noted that no further investigative body was required), it has assisted the Department to respond effectively to the kinds of concerns contained in the report and to render more efficient the investigations that have been undertaken by the QPS and the CJC.

MPU statistics. Since the publication of the Stewart Report, there have been 24 referrals by the MPU to the CJC. In the majority of these there was insufficient evidence to support charges. However, charges were laid in two cases, and in a third the officer resigned. In eight cases the CJC did not commence action and referred the matter back to the Department. There were 14 cases where assault was alleged — while in four of these cases there was insufficient evidence to commence criminal or disciplinary proceedings, the officers concerned were either dismissed or they resigned. In one case charges were laid but later withdrawn. There have also been isolated cases of verbal abuse, fraud and misappropriation. In 1999–2000 there have been six occasions when staff or management have referred concerns to the MPU and advice has been given by MPU personnel to the inquirer.

The MPU now has an expanded role in criminal-history screening of employees, other agents of the Department and job applicants. This came as a result of recent amendments to the *Family Services Act 1987*. The need for criminal-history screening consumes a considerable portion of the resources of the Unit. Staff at the BSC commented that in more recent times the involvement of the MPU in conducting workshops for staff, either at the BSC or within the ALS, has reduced.[4] It is likely that this is a direct result of the additional workload the MPU has attracted.

It would be a matter of considerable concern to the CJC if the effectiveness of the MPU were to be diluted by a lack of resources. The statistics noted above, and the experience of the CJC, emphasise the need for a continuing and effective MPU to be working in close consultation with the CJC's Official Misconduct Division. Although complaints of misconduct in the care of people with intellectual disability will reduce, they will not cease with the downsizing of the BSC. Rather, the complaints will substantially relate to care provided within the ALS. Nor does the downsizing of the BSC mean that management can be less vigilant in reporting cases of inappropriate behaviour.

The workload of the MPU is currently being reviewed by an external consultant engaged by the Department to ensure that the Unit's resources are used effectively. A CJC corruption prevention officer is a member of the consultation group formed to assist that review.

Staffing issues (Recommendations 8, 10 and 12)

The Stewart Report noted that recruitment of RCOs, a comprehensive training scheme, effective risk-management strategies and the rigorous performance appraisal of staff were key issues in the provision of high-quality care and in the reduction of misconduct or criminal behaviour. It is inherent in the Stewart Report that most, if not all, of the problems exposed by the evidence emanated from the conduct in one form or another of RCOs.

One cannot overestimate the inherent difficulties involved in the working shift of an RCO. They provide around-the-clock, seven-days-a-week, care to their severely intellectually disabled clients, some of whom have only restricted mobility, many of whom are severely inarticulate or unable to communicate effectively and all of whom have enormous needs. However, there is some unevenness in the assessment of RCOs across the broad range, and the passage of time has not wholly transformed the overall RCO profile. Management at the BSC, for example, identified a core of about 10 to 15 per cent of RCOs whom they believed would be better-off working in another environment.

Statistics on RCOs. In Queensland, there are about a thousand RCOs engaged in caring for people with intellectual disability. At the BSC, there are currently 145 RCOs (including casual, temporary, full-time and part-time positions). About a half of these RCOs commenced employment at the time the Inquiry ended (1995) or since. The other half were in employment at the BSC at the time of the Inquiry and before. Thirty-four of the current establishment of RCOs (approximately a quarter) have been employed there for 10 years or more.

4 According to the staff survey, only 8% of respondents had done the *How to Run an Investigation* workshop during the last 12 months. However, 45% had participated in the *Code of Conduct* training run jointly by the MPU and the CJC during the same period.

Staff recruitment

Recommendation 8 was directed towards the recruitment of more suitable people as RCOs and the provision of better salary and working conditions.

An altered process of recruitment for RCOs was introduced into the Disability Operations Services in 1998. Details are given below.

> **Training requirements for RCOs since 1998**. Potential applicants must first complete the 'Introduction to Direct Support' course conducted at the Centre by staff-training personnel. In 1998, there were four intakes for this course (with a total of 80 attendees) and in 1999, five (with a total of 79 attendees). Those enrolled are not employees, nor are they paid — it is voluntary and completion does not guarantee employment. Trainees who complete the course are eligible to apply for employment, but a further selection process involving an interview and referee checks is undertaken.
>
> Those selected are required to undergo a further two weeks of induction (in 1998, 36 applicants proceeded to this training and in 1999, 40). By this time, intending employees will have completed the first two modules of the Certificate in Residential Care, which is accredited by the Vocational Education, Training and Employment Commission. Selection is based on merit and those selected for employment are required, in the course of the next 18 months, to undergo training. This is based on the acquisition of five modules and 39 competencies, for which each RCO is required to pass two assessments. Competency Based Performance Assessment (CBPA) at this level is largely the responsibility of the Unit Managers. During this period, the person is employed as a temporary and, after a period of working under supervision, will then be rostered as an RCO-in-training to work a shift.

While there were considerable reservations expressed by Unit and Area Managers about some parts of the Centre's operation, in particular the training program, there was general agreement that the recruitment procedures have been much improved and that the new process of recruitment has attracted some high-quality staff. Indeed, the staff survey indicated that significantly more RCOs-in-training had a degree (15.4%) than did qualified RCOs (4.3%). It would seem, therefore, that the initial 'Introduction to Direct Support' course has been an important filter in the recommendation process — it has provided the Department and management with the opportunity to induct and train the right personnel for engagement in this very challenging role.

The adoption and development of the recommendations so far is encouraging, but needs careful and regular review. The concern was expressed in the course of this review that recruitment, certainly for the BSC, targets those who are unemployed — accordingly, applicants for employment may be driven more by necessity than by a sense of commitment or vocation. Furthermore, the question of acceptable working conditions, including salary (referred to in recommendation 8), will no doubt continue to engage the attention of the Department and the relevant unions, and invariably provoke a discussion about the availability of sufficient financial resources.

Staff:client ratio and workload

Recommendation 12 was a critical recommendation. It argued for an improved staff:client ratio and the allocation of two staff to work each shift, particularly in the mornings and

afternoons. The same recommendation sought more stringent supervision by an increased number of direct-line managers.

There is no doubt that the staff:client ratio has improved. The current ratio is estimated to be 1:4.1 (at the time of the Stewart Inquiry and before, it was 1:6). However, there is some doubt that it is yet at optimal level. In most of the community houses there is a staff:client ratio of 1:3. As at July 1999, a ratio of 1:5 applied to 75 per cent of all villas at the Centre. By March 2000, however, only eight of the 17 villas (47%) had five residents. We were not provided with the latest staff:client ratio.

Of further concern is the possibility that clients with the greatest needs are among those who remain at the BSC where the staff:client ratio may be less adequate than elsewhere. Survey respondents indicated, for example, that more than half of the BSC clients (60%) have special needs over and above those of other clients at the Centre (including autism, epilepsy, behavioural problems, poor speech, vision impairment and a variety of medical conditions requiring specialist treatment), whereas less than a quarter of the former residents who now reside in the community (21.4%) have special needs such as these. Furthermore, 17 per cent of BSC respondents with relatives/friends with special needs were dissatisfied with the way those needs were being met by the Centre; this may relate to the staff:client ratio.

Some other aspects of the surveys deserve to be mentioned:

- About one-fifth of the relatives and friends of current clients (21.7%) were dissatisfied with only one RCO being rostered during the daytime. On the other hand, all respondents were satisfied when two or more RCOs were on duty.
- The majority of staff regarded the workload as generally too high and that too much was expected of them (about 60%). Most felt that staff experienced a lot of stress (83.8%) and were frustrated with their job (70.3%). Two other sources of data support these opinions:
  - Between 1996 and 2000, 264 claims for injury and 15 claims for psychological or stress related illnesses[5] were submitted by RCOs for workers compensation.
  - A review of the communication logs kept by Residential Duty Officers (RDOs) since 1995 revealed significant on-site staff injuries (often on a weekly basis), frequently caused by aggressive clients and occasionally by environmental factors such as insufficient lighting.

For RCOs, these issues may be directly related to the staff:client ratio, along with the intensely physical nature of the work required.[6] In some houses at the BSC, the workload for RCOs must, therefore, be considered to be excessive. There is a strong belief that the load for Unit Managers is also excessive — the Unit Manager has the obligation in terms of

5 In comparison, other BSC staff have only submitted 22 physical injury claims and eight psychological or stress-related claims during the same time frame (Data source: DFYCC).

6 The staff survey revealed that RCOs need to call their supervisor for assistance with a client on a regular basis (48% reported doing so at least once a week and a further 26% reported doing so at least once a month). This illustrates how difficult direct-care work can be for individuals working on their own.

line management for approximately 20 clients (assuming s/he manages four houses; some have until recently had responsibility for five houses) and for 25–30 staff depending on the number of houses under his/her management. We therefore conclude that the workload for both Unit Managers and RCOs at the BSC should be reviewed and that the staff:client ratio should be adjusted accordingly.

A possible consequence of the low staff:client ratio and high workloads was revealed in the surveys. Just over a quarter of the staff (27%) chose to raise serious concerns about the lack of developmental work and activities provided to clients due to a lack of time and resources. Fears were held for such inactivity, with claims that it could lead to declining health and poor skill development. Likewise, the source of greatest dissatisfaction for relatives and friends (for 20% of all respondents) centred on the lack of daily activities provided to clients — a further 18 per cent raised this as an area of concern in their open-ended comments.

Staff appraisal

Recommendation 10 calls for the adoption of rigorous, fair and realistic standards of performance appraisal for all staff, particularly RCOs. Records indicate that formal performance appraisals occurred with some staff groups since the Inquiry, but not consistently and only for professional staff — there is little evidence that RCOs have undertaken any formal process of performance appraisal.[7] Of further concern was that, according to the RCOs-in-training who responded to the staff survey, almost one-quarter (23.1%) met with their immediate supervisor less than once every six months — this has serious implications for the monitoring of trainees.

Plans are now under way to commence a number of concurrent pilot activities with a 'performance development/appraisal model' designed for effectiveness and efficiency. This system requires that Unit Managers work within the framework of goals and priorities defined for the Centre, the Area Office and the particular household and that performance development plans for staff be articulated within these goals. Unit Managers will have assigned workshop days to develop these goals and RCOs will have time to work with the Unit Manager to identify (and review at later workshops) individual goals which relate to the established house priorities. It is expected that the first set of activities will occur in June 2000.

Ongoing assessment of each RCO's performance in accordance with appropriate standards would appear to be essential. The Unit Manager is probably the best-placed person to do this, but it would be unduly simplistic to regard the operation of the CBPA system (whereby Unit Managers assess RCOs on various competencies) as satisfying the requirements of this recommendation adequately. Additional and ongoing appraisal will be important — but the workload of the Unit Manager must again be brought into question.

Furthermore, our interviews suggested that not all Unit Managers are sufficiently trained

7 Respondents to the staff survey indicated that about 39% of staff had *ever* undertaken a performance appraisal (not necessarily at the BSC), but less than half of those respondents had experienced that assessment within the last two years (44%).

and properly equipped to fulfil this role to its optimal level and that this must have an adverse effect on the Unit Manager's capacity to be an effective supervisor. The Department has advised that by the end of 2000 all Unit Managers are expected to have completed Workplace Assessor Training.

On a positive note, direct-care staff reported a frequent need to call on their immediate supervisor for assistance with a client, during both day and night shifts, and many (about a half) were satisfied with the support they received.

Staff training (Recommendations 5, 11 and 14)

The emphasis in recommendation 5 of the Stewart Report was upon first aid training. The recommendation is that all officers, whether those working directly with persons with intellectual disability or not, including those in management positions, are properly instructed in the application of first aid techniques, and that all officers regularly receive first aid training.

The possession of a current first aid certificate is a prerequisite for employment as an RCO. Therefore, all new RCOs complete first aid training before being rostered to work with clients and annual refresher training is provided by the BSC for all staff. This training is coordinated by the training section of the BSC and staff are rostered to attend. Two programs, Essential First Aid and Cardio-Pulmonary Resuscitation (EFA/CPR) are completed by staff, each being provided on a biannual basis. Since 1995 and up until 31 December 1999, 1042 have participated in these courses.

While some differences in role were detected, the staff survey generally pointed to the successful implementation of this training — most respondents (87.8%) indicated that they held a current First Aid Certificate and that they had undertaken recent refresher training course.[8] In this context it should also be noted that the BSC has a nurse on site 24 hours a day, seven days a week. In addition to tending to clients, nursing staff also instruct residential care staff 'on the job' in such matters as the operation of oxygen cylinders and specific health-care management strategies for individuals.

Recommendation 14 speaks of the need for improvement in the knowledge and practices of staff concerning basic hygiene. Although respondents to the survey of relatives and friends expressed some concerns relating to hygiene,[9] there appears to be a heightened awareness within the Department of the need to implement acceptable training programs over a wide range of issues. However, it is important to recognise that the changing nature of the residential-care scheme will create new and different demands: adjustments in both practices and mind-set will need to be made. This will be effectively accomplished by a greater emphasis on the training and development of staff, not merely in basic matters such as first aid and hygiene.

8 Most direct-care staff appeared to be adequately trained: 95.7% of RCOs and 100% of RCOs-in-training and RDOs held a current certificate, compared to 88.9% of managerial staff and 50% of resource officers, project and relocation officers and administrative and domestic staff.

9 Seven and a half per cent were completely dissatisfied with the hygiene treatment of their family member/friend and several raised hygiene as an issue of great concern in the open-ended section of the survey.

The Department advises that it has implemented:

- hygiene practices as one of the competencies on which RCO trainees are assessed
- regular nursing-staff visits to all houses to instruct staff on hygiene matters
- easy access to a Communicable Diseases Policy and Practice Manual in all service areas
- easy access to a Health and Well Being Practice Manual in all DSQ accommodation services
- a comprehensive health-care resource kit in all houses
- universal infection-control procedures for handling body-substance spills
- easy access to appropriate materials and equipment (such as antiseptic cleaning materials, disposable gloves, face masks and aprons).

Recommendation 11 emphasised the requirement to ensure that RCOs are better equipped to carry out their work for the benefit of clients. Our review, however, revealed some risks:

- Not all RCOs have completed formal qualifications. According to the staff survey, only 65.2 per cent had gained the Certificate in Direct Support [10] and fewer (47.8%) had completed all five modules of the course. However, some RCOs may have:
  - completed training in earlier years when the training course was called by another name
  - completed equivalent training and have worked in another organisation and were thus granted Recognition of Prior Learning status
  - completed training and all associated assessment requirements, but not yet participated in a formal graduation ceremony.
- Those RCOs who in the past have performed their duties in a way which attracted strong criticism in the Stewart Report may now advise new RCO trainees to 'ignore' the content of their formal training and to adopt the time honoured practices of those who are more 'experienced'. It is safe to assume that included among the latter will be practices that are inappropriate and borderline unlawful, if not outright unlawful.
- Significant levels of dissatisfaction with the Introductory, Induction and Certificate courses were noted by many respondents to the staff survey (between 22 and 28%). These figures give some rise to concern — wherever training is considered to be irrelevant or unsatisfactory, the ensuing standard of work may be likely to suffer.

A process of effective staff development to complement the training regime appears to be a necessary element in the development of quality RCOs. This can only be effective in an environment where the RCO carries an acceptable workload and where the Unit

10 Paradoxically, about one-quarter (23.1%) of the RCOs-in-training reported that they had completed the course. Possible explanations for this may be that some staff:
- have completed the formal classroom training for all five modules but are still completing the related assessment requirements; or
- have completed both in less than 18 months and must await the full period before converting from RCO-in-training to RCO (these people may perceive that they have completed training when this is not formally the case).

Manager's responsibilities are such as to permit time to oversee the RCO's performance and to provide effective support and efficient performance appraisal. As already discussed, it is questionable whether the workload of Unit Managers really permits a desirable level of supervision and support for RCOs.

Some RCOs appear reluctant to show initiative for fear it could lead to criticism and complaint. The paradox is that well-motivated Unit Managers seem to value those RCOs who go beyond doing 'the basics' and who show not only initiative, but preparedness to deal with a problem themselves rather than pass it to the Unit Manager or another discipline.

The Centre, Area and Unit Managers are presently intent upon developing a well-organised and coherent culture of service within which each of the relevant disciplines can make its contribution to the well-being of the client in a coordinated and coherent way. Only then will the suspicions, the uncertainties and the introspections of the past, created in no small measure by the Inquiry itself, be broken down and replaced by a new spirit. It is against this background that the effectiveness of the current training programs has to be assessed.

It is obvious that the role of the training officer and the section within which he presently operates is in need of urgent review. The area appears to be seriously under resourced. There is only one training officer — formerly there were more. The officer's main role now seems to be to focus on the basics of recruitment and training for RCOs and organising others to deliver training material as part of the program, but the quality and effectiveness of this service is questionable. It seems that administrative, nursing and maintenance staff at the BSC receive no form of induction and operate quite independently. A multidisciplinary team approach presently seems to involve little more than regular house meetings between the Unit Manager and those RCOs who are available to attend.

The Stewart Report's emphasis on the need for a comprehensive training program and for rigorous performance appraisal remains relevant. An effective management regime, the maintenance of a cohesive and cooperative multidisciplinary environment and appropriate staff training and development will greatly enhance the prospects of ensuring an effective ongoing misconduct prevention strategy. Training and staff development requirements extend well beyond RCOs and should encompass all levels. For instance, Area and Unit Managers should have greater opportunity for ongoing development by accessing appropriate programs, seminars and workshops — such opportunities at the moment appear to be largely ad hoc.

Medical matters (Recommendations 4 and 13)

There has been a definite improvement in the provision of medical services to clients since 1995. The more recent engagement of general practitioners and specialists on a consultancy basis to the Centre and an increase in the use of community practitioners and specialists have ensured access for clients to high-quality medical services. Perhaps the most valuable contribution to the provision of expert medical support for clients has been the Developmental Disability Unit (DDU). This initiative, based on access to high-quality medical practitioners at the Mater Hospital and elsewhere, focuses on the specialist medical

issues that arise in the proper medical treatment of people with intellectual disability. Dr Robyn Wallace consults with clients not only at the hospital but also at the Centre and most, if not all clients, have had the benefit of accessing her specialist medical skills.

While inadequacies in arrangements for transport and staff for clients to attend external medical appointments were identified by many respondents to the surveys and documented as regular crises in the RDO Communication logs, the major medical concerns apparent at the time of the Inquiry have generally been addressed.

Advocacy for clients (Recommendations 18 and 19)

Recommendation 18 calls on the Department to consult with concerned and reputable advocacy organisations in the field of intellectual disability, such as QAI, to ascertain how the resources and abilities of such organisations can best be deployed for the benefit of clients. Recommendation 19 calls for recognition of the benefits to be had by strong individual advocacy for each client at the Centre.

> The Department advises that the Disability Program has developed a Quality Framework applicable to all disability services in Queensland. The Program undertook a series of consultations statewide with families, service providers and advocacy groups to identify those factors that influence quality, the barriers to quality and mechanisms to safeguard quality services and supports. So far, the Program has completed statewide consultation in relation to abuse prevention, behaviour support and communication for people with a disability. The knowledge gained will be used to develop information packages in each of these areas for the ultimate benefit of Centre residents.

Parents of residents at the Centre regard themselves as the primary advocates for their relatives, and all but a small number of residents have contact with their families. Furthermore, the PFA is involved in advocating the needs of residents of the Centre by hosting social events and information sessions for relatives and friends. It also has regular contact with Centre management in relation to matters of interest or concern. The PFA has a strong view that it is a more appropriate organisation to advocate for the needs of Centre residents than external advocacy groups.

A Family Members Advisory Group has also been established at the Centre (membership includes 12 family members). The purpose of the Group, which meets monthly, is to provide advice on Centre policies and practices, to make recommendations to management about any issues affecting the care of residents, to raise issues of concern, and to endorse proposals for expenditure of the Centre's General Interest fund.

Not only parents and relatives but some staff, at both RCO and management level, advocate on behalf of clients — a situation that may be affected by the enactment of legislation to enhance the powers of the Office of Adult Guardian.

The emphasis has so far been to strengthen the role of families in the lives of relatives living at the Centre. It was said earlier that at the time of the Inquiry a low percentage of clients enjoyed family support. Since the Stewart Report, this position has been reversed

and there is now a much stronger and more influential role played by families and friends, which is encouraged by Centre management and staff.

The QAI would contest the extent of departmental effort and would argue that an independent advocate has the capacity to best develop the interests of clients. Their concern is that parents and relatives may lack some measure of objectivity and could be influenced by self-interest.

The Centre has sought to affirm the development of the family's role as advocate by:

- the involvement of families in developing individual plans for their relative
- the establishment of a home-visiting program
- the involvement of families in planning and decision making in relation to clients relocating from the Centre to the community
- the provision of regular information on the health and well-being of their relative
- the provision of monthly trust account statements detailing all transactions for their relative
- the hosting of activities to encourage the participation of families in their relative's life, including activities jointly hosted with the PFA
- the distribution of a monthly newsletter to all families providing information on developments and affairs at the Centre
- the involvement of families in the development of annual goals for the Centre
- participation by family representatives in assessments of household service standards
- the establishment of an independent Family Support program to assist families participate in the process of relocation of people from the Centre, and to obtain information from an independent source.

Most respondents to the relatives-and-friends survey confirmed receipt of regular information on the health and well-being of their relative/friend (85%), regular trust account statements (95%) and monthly newsletters (100%), but, while they have been offered the opportunity to participate, few reported active involvement in any of the above centre-based initiatives (generally about 35% or less). The only activity in which most respondents reported participation was in authorising specific health-care services for their relative/friend (70%). With the enactment of the Powers of Attorney legislation in 1998, families of BSC residents are now Statutory Health Attorneys for their relative, and must be informed of and authorise specific health-care services before these can be carried out.

The Office of the Adult Guardian is currently undertaking preparatory work in anticipation of the introduction of a Community Visitors Scheme for a broad range of disability services, including the BSC. Under this Scheme, it is expected that community visitors will be appointed to visit residents of the Centre regularly, and will have powers to inquire into matters of concern, question staff and obtain required documents. Reference has already been made to proposed legislation affecting the powers of the Adult Guardian. This issue may need to be reconsidered in the light of such legislation.

Conclusions

- Since the Basil Stafford Inquiry of 1994–95, considerable changes have taken place at the BSC, transforming it into a very different facility.
- Given the current quality of management and the further improvements proposed by Centre management, it is unlikely that the state of affairs that justified the Inquiry in 1994–95 will re-emerge. Problems in individual cases may recur from time to time, but one can be reasonably confident that the proper structures are now there to deal with them.
- It is imperative in terms of misconduct prevention for there to be ongoing development of the risk-management strategies referred to in the Stewart Report and dealt with here:
  - improved recruitment
  - effective staff training
  - staff development within a cohesive and collaborative multidisciplinary environment
  - continual emphasis on the importance of achieving the newly developing Centre Goals.
- In the future, the BSC will occupy a relatively small place in the wider picture of residential care for people with intellectual disability. Bearing in mind that most people with intellectual disability will be residents at government-operated facilities within the ALS, the substance of the Stewart recommendations will require implementation on a much wider basis.
- The Government's ALS facilities vary in quality. Some can be seen as centres of excellence. Others are of lesser quality, but the core issues are all as relevant, perhaps more so now, to the care of people with intellectual disability who reside in the community as they are to those whose home is and will continue to be the BSC:
  - high-quality, properly trained staff at primary care-giver level
  - efficient and effective management
  - an acceptable staff:client ratio
  - the implementation of processes for effective staff development within the achievement of identified goals.
- The ALS remains a source of complaints, attracting the intervention of both the QPS and the CJC. The Department and the CJC will be concerned to ensure that the non-government facilities to which the Department provides significant funding will not themselves be the source of complaints similar to those that gave rise to the Basil Stafford Centre Inquiry.

Appendix: The Stewart Recommendations

1. The primary recommendation of this report, foreshadowed by me during the hearings, was to be that the problem 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 CJC 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 de-institutionalising 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 de-institutionalisation 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 an RCO. [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 an RCO. [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 need 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 the 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 A J 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. Department endeavour to attract more suitable applicants for RCO positions. The selection criteria for the RCO 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 RCOs. In particular, an initial training period must be provided which, in all the circumstances, adequately prepared newly appointed RCOs 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 RCOs must be created in order to attract more suitable clients. All staff should receive continuing training, with attendance by RCOs 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 RCOs, 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 consideration 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 CJC 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]