

The Ormond Centre

– a complaint
investigation into
institutional care
of children



Community Services (Complaints, Appeals and Monitoring) Act 1999

Community Services Commission

CONTENTS

1. Introduction.....	1
2. What the complaint was about.....	2
3. Background.....	4
a) Intensive Support Services: History of Ormond:.....	4
b) Ormond: Status at the time of the complaint.....	5
4. The commission’s powers and procedures.....	6
5. The assessment of the complaint.....	7
6. How the investigation was carried out.....	8
6.1 The department’s response to the Preliminary Report	10
7. Previous Departmental Reviews and Action Taken	11
8. General Findings.....	13
9. Conclusions	15
10. Recommendations	17
11. Specific Findings	19
Part A: Findings in relation to allegations concerning individual residents and/or specific incidents.....	19
Part B: Findings in relation to general allegations concerning residents	33
Part C: Findings relating to general allegations concerning staff.....	42
Part D: Findings in relation to specific complaints concerning management.....	46

In accordance with Community Services Commission practice and the requirements of the *Community Services (Complaints, Appeals and Monitoring) Act 1993*, a preliminary version of this report was sent to the Department of Community Services for comment on the accuracy of the facts and findings prior to the release of this final report. The comments received have been considered in developing this report and our recommendations

A copy of this report has been forwarded to the department. Confidential information,

underpinning this report, has also been provided to the department. This latter information will not be released publicly.

1. Introduction

On 20 October 1997 the commission received by facsimile a complaint addressed 'To Whom it May Concern'. The complaint was unsigned with the author indicating that he/she wished to remain anonymous for fear of retribution.

The letter was headed 'Ormond Complaint' and listed 38 allegations. The allegations related to a range of staff and management issues and the impact of these on the quality of care being offered to residents at Ormond. At the time of the complaint Ormond was one of two NSW Department of Community Services facilities providing intensive support services for state wards and children, in the care of the Director General, aged between 12 and 16 years.

Numerous allegations were made about specific residents and incidents while others focussed on the failure of systems at Ormond. The letter of complaint claimed that the issues had been raised with WorkCover and the area manager.

The complainant also forwarded copies of the complaint to the then Minister for Community Services, the Hon. Ron Dyer MLC; the police; the Independent Commission Against Corruption; and Opposition community services spokeswoman, Mrs Patricia Forsythe.

On 22 October 1997 Mrs Forsythe tabled the 'Ormond Complaint' in Parliament. On 24 October 1997 Minister Dyer announced Ormond was to close. In February 1998 the commission was advised that children were no longer being cared for on the Ormond campus.

Most children placed at Ormond had in common a history of multiple placements and exhibited very difficult and challenging behaviour.

2. What The Complaint Was About

The complaint listed 38 allegations. In the letter of complaint the allegations are not presented in any obvious sequence, neither in terms of seriousness, subject matter nor chronology of events. In these circumstances we have taken the liberty of re-arranging the allegations in the following categories:

- allegations relating to individual, though unidentified, residents and specific incidents;
- general allegations about resident care;
- general and specific allegations about staff conditions of employment;
- general and specific allegations about Ormond management.

Specific allegations relating to individual residents and specific incidents

The complainant alleged (in paraphrase):

- certain residents are not receiving necessary therapeutic care to deal with their substance abuse;
- sex on the premises amongst children is condoned by management;
- residents are being made available to paedophiles with the knowledge of management;
- female residents are being sexually exploited by members of the community, with the knowledge of management;
- residents are being assaulted by other residents;
- certain residents have been placed in motels and caravan parks resulting in significant costs and damage to property.

General allegations about resident care

The complainant alleged that systems are not in place at Ormond to ensure basic quality care (in paraphrase):

- children do not have to get up, go to school, eat meals; they can do as they please;
- there are no programs in place to deal with their challenging behaviours;
- residents destroy property and cars without consequences;
- residents are not adequately clothed on arrival at Ormond and, once at Ormond, are abused 'by the system';
- counselling is not available.

General and specific complaints about staff conditions of employment

The complainant alleged (in paraphrase):

- staff have to barricade themselves to avoid assaults by residents;
- staff are not supported by management;
- staff have to complain to WorkCover and the OH & S committee to get Ormond in a livable condition;
- direct care staff receive no training;
- direct care staff are not assessed and have no career path;
- direct care staff have excessive stress and sick leave due to the poor conditions.

General and specific complaints about Ormond management

The complainant alleged (in paraphrase):

- Ormond is overstaffed for the number of residents;
- management work limited hours; never respond in person to crises; arrive late to work and take long lunch breaks;
- the current manager has no residential care experience;
- the current manager places inexperienced staff in positions of responsibility and then doesn't support them.

3. Background

a) Intensive Support Services : History of Ormond

Ormond was one of two Intensive Support Services, for young people in care, operated by the Department of Community Services ('the department').¹ Ormond was situated on 26 acres at Thornleigh, a northern suburb of Sydney. The service was established to provide short-term residential care and support for older children and young people who were state wards or placed in the care of the Director-General of the department. The children and young people who were placed at Ormond were considered to have high support needs and were commonly described by those within the department as the most difficult children to care for.

The maximum length of stay at Ormond was to be for three months.²

Until 1976 Ormond operated as a training school for girls. From 1976 until 1982 Ormond was a co-educational school for truants. In 1985 it became a secure unit for young offenders and remained as such until, in 1989, it became an intensive support unit for wards and young people in care.

Throughout the 1990s the department attempted to transform Ormond from a 'secure care' unit to a therapeutic environment.³ In 1995 dormitories were converted to individual rooms and in 1996 an 'open door' policy was adopted which saw the banning of locked doors.

By 1996 some residents were housed in three cottages (Bluegum, Bluegum Annexe and Eora) on the edge of the property. Until August 1997 some residents were also housed in a unit called Banksia. Banksia was a correctional institution style unit with cell like bedrooms and doors which dated from the time the centre operated as a young offender unit.

In 1996-97 Ormond established several 'satellite' or 'outreach' housing options, including townhouses and caravans. These options were not intended to be long term placements, but were developed as short term strategies for young people who had been at Ormond for lengthy periods of time and who presented with significant behaviour problems, and/or were difficult to place.

¹ The other service was Minali.

² Intensive Support Services. Intensive Support Project; Management Committee Briefing Papers; October 1996.

³ Secure care means that the environment was physically secure. Doors were locked and residents were not free to leave.

b) Ormond: Status at the time of the complaint

On 24 October 1997 the then Minister for Community Services, the Right Hon. Ron Dyer, MLC announced Ormond would close. In February 1998 the last of the Ormond residents were moved from the Ormond campus, which has since been sold.

In response to the commission's preliminary report the department stated:

The department acknowledges that there were problems at Ormond which meant we have not provided children in care with the level of service they require. This is the reason why the Department has proceeded to close Ormond, although not until appropriate alternative arrangements could be made for those children placed at the facility.'

Financial resources have been transferred from Ormond and Minali to the 16 DOCS Area Offices to fund at least 52 and up to 66 placements. Areas have negotiated arrangements to provide up to three months' crisis accommodation and intensive support placements, either through contracts with non-government organisations or directly by DOCS. The placement options use either foster carers or beds in existing residential services. These placement options will also provide follow-up services, as required, to support the child or young person when they move to long term accommodation.⁴

In these circumstances it is reasonable for the commission to be asked why it proceeded with the investigation of the complaint. In summary, some of the allegations were serious and warranted investigation even though the closure of the service had been announced after the complaint was received but prior to the commencement of the investigation. The evidence in this report is important to understanding the systemic weaknesses in the large, institutional congregate care models and the reasons for their closure. The report is released so that its findings and conclusions will be carefully considered in the evaluation of congregate care models of intensive support services in the future.

⁴ *Just Solutions - wards and juvenile justice* The Community Services Commission 1999 p 46

4. The Commission's Powers and Procedures

Complaints to the commission are made under s.12 of the *Community Services (Complaints, Appeals and Monitoring) Act 1993* ('The Act'). There must be an allegation that a service provider has acted unreasonably in some way in the provision of (or failure to provide) a community service to a particular person.

The commission must then assess the complaint to determine whether and how it should be dealt with. [s.17]

Following assessment, the complaint may be referred for investigation if it appears to the commission that:

- the complaint raises a significant issue of public safety or public interest; or
- the complaint raises a significant question as to the appropriate care or treatment of a client by a service provider; or
- the complaint raises a question as to whether a service provider has acted unreasonably as referred to in Section 12. [s.23]

The purpose of investigating a complaint is to obtain '*information concerning the matter complained of and to determine what action should be taken in respect of the complaint*'. [s.36]

On completion of an investigation, if the commission considers there are grounds for adverse comment in respect of the service provider, it must inform the service provider and allow at least 28 days for the provider to make submissions. [s.37] This obligation does not apply where public interest reasons require immediate action. [s.37(3)] In practice, unless the public interest requires otherwise, the commission provides a full preliminary report of its investigation and findings to the service provider and the complainant at this stage.

The commission's final report, including any recommended action must be given to the complainant and the service provider. A copy may also be given to the Minister for Community Services. [s.38]

5. The Assessment Of The Complaint

The complaint raised serious concerns about the day to day care and treatment of the residents at Ormond.

Given the vulnerability of this group of young residents and the nature of the allegations, the complaint met the commission's priorities for investigation.

The commission gives priority to complaints about those people who are most vulnerable and least able to protect their own interests, particularly those in care.

The commission gave written notice of the complaint to the department on 24 October 1997 and, at the same time, advised of the commission's assessment decision to investigate the complaint.

6. How The Investigation Was Carried Out

This investigation was carried out by Michele Powell, Assistant Manager Complaints, and Gaye Josephine, Senior Complaints Officer.

In the letter of complaint the complainant noted his/her preparedness, and the willingness of other staff to 'stand up and be counted provided they would be protected by The Whistle Blowers Act'.

In response to this advice, Commissioner West wrote to all Ormond staff on 31 October 1997. Mr West urged the author of the complaint to come forward, guaranteeing that any contact with the commission would be treated in the strictest confidence.

While a number of staff responded to this letter advising that they wished to speak to the commission, no staff member identified himself/herself as the complainant.

The investigation of the complaint was constrained by the allegations not specifying: the names of subject individuals (either residents, staff or management), the dates of alleged incidents, and the commission's inability to talk to the complainant despite efforts to persuade him/her to come forward.

For purposes of confidentiality, departmental staff and Ormond resident's names have been ID protected throughout the report.

The investigation was conducted by -

Interviewing the following staff:

- Ormond manager W, substantive manager Ormond 3 February 1997- September 1997, interviewed on 28/10/1997
- Ormond manager Y, manager Ormond January 1995 - October 1996, interviewed on 4/11/1997
- Assistant manager A (on leave), acting manager Ormond 19 December 1996 - 6 January 1997, interviewed on 17/11/1997
- Deputy manager V, acting manager Ormond 7 January 1997 - 2 February 1997, interviewed on 30/10/1997
- Staff member L, Senior Youth Worker , interviewed on 5/11/1997
- Assistant manager K (on leave), interviewed on 10/11/1997
- Staff member J, Senior Youth Worker, interviewed on 11/11/1997
- Staff member I, Chief Youth Worker, interviewed on 11/11/1997
- Staff member H, Senior Youth Worker, interviewed on 11/11/1997

- Staff member G, Senior Youth Worker, interviewed on 11/11/1997

- Staff member F, program implementor, interviewed on 11/11/1997
- Acting assistant manager E, interviewed on 12/11/1997
- Staff member D, Chief Youth Worker, interviewed on 12/11/1997
- Staff member C, Senior Youth Worker, interviewed on 12/11/1997
- Staff member B, former Senior Youth Worker, interviewed on 13/11/1997
- Acting area manager Z, Hornsby/Ryde, interviewed on 21/11/1997

Reviewing the following documentation:

- 34 current and past resident files; we reviewed the files of children named by Ormond managers and front-line staff as possibly being the subject of the allegations as per the 'Ormond Complaint';
- files held by Ryde Community Services Centre in relation to Ormond;
- Ormond Operation Files, Hornsby/Ryde Area Office (now part of the Northern Sydney Area), 1995 until present;
- various communication and log books;
- Ormond Occupational Health and Safety file.

We also wrote to, and received advice from:

- The Police Royal Commission Wind Up Team;
- The New Children's Hospital;
- WorkCover NSW;
- Chatswood Major Crime Squad.

We requested that the Minister's community visitors, Dr Dianne Johnson and Mr Trevor Purkis, consider the complaint. They provided the commission with written reports in relation to the complaint on 29 October 1997 and 31 October 1997 respectively.

We visited the Ormond premises on 11 and 12 November 1997. From time to time we sought additional advice, by phone, from acting manager V and acting deputy manager R.

On 12 May 1998 the commission provided for comment a preliminary report about the investigation to the department and to the two community visitors. The department provided comment about the preliminary report on 27 July 1998.

The commission also received individual responses from three departmental officers.⁵ In addition, the Director-General of the department met with the former Commissioner, Roger West, to discuss the preliminary report. The Community Visitors provided comment on 15 May 1998 (Johnson) and 23 July 1998 (Purkis).

6.1 The Department's Response to the Preliminary Investigation Report

In our preliminary report we advised of our assessment that allegations 33, 34 and 35 did not fall within the commission's jurisdiction as they did not sufficiently relate to service provision to residents. Under the *Community Services (Complaints, Appeals and Monitoring) Act 1993* the commission has power to deal with complaints that allege a service provider has acted unreasonably in terms of service provision to a particular person or persons.

In its response to the preliminary report the department argued strongly that certain allegations made about management and staff do not fall within the commission's complaint jurisdiction.

Broadly we acknowledge the department's position and for this reason have determined not to report on those allegations that go only to staffing and management issues. The exception to this position is our decision to report on allegations 27 and 29 (in part) as these allegations, though relating to staff and management issues, also raised issues which we believed had a direct impact on the quality of services being provided to residents.

In its response to the preliminary report the department brought to the commission's attention errors of fact and questions about the adequacy of preliminary findings and conclusions. The commission has corrected errors of fact in the final report, as appropriate, in response to the department's advice. We have also given consideration to the adequacy and validity of our findings and conclusions, based on the department's comments.

⁵ These were Ormond manager W, deputy manager V, former area manager (U) Hornsby/Ryde.

7. Previous Departmental Reviews and Action Taken

In 1994 the department initiated an internal review of Ormond.⁶ This review found:

- there were no overarching departmental policies and procedures in the intensive support substitute care area;
- because of the failure of the department to clarify the role of Ormond (custodial or therapeutic) there was an entrenched ambiguity, splitting staff and drastically affecting consistency in the development and application of policies and procedures;
- those staff trained to be custodial carers (when Ormond was a juvenile detention centre) had received inadequate training to work with disturbed state wards;
- both management and direct care workers were ill-prepared and ill-trained to work with behaviourally and emotionally disturbed young people;
- casual staff received no training or induction;
- behaviour management strategies were inconsistent in both quality and implementation, leaving staff uncertain as to where they stood;
- direct care staff worked without pertinent casework information about residents;
- permanent direct care staff and professional staff had not read what departmental policies and procedures existed and were unsure how to access them, while casual staff did not even know of the existence of such policies and procedures;
- many staff could not make the adjustment required of them to care and support emotionally damaged children and resorted to what they knew best, namely adopting a custodial model of care;
- few staff evidenced insight into the needs of the children;
- daily log books were not always used appropriately with much of the information documented being of little value. Relevant information was not transferred to the residents' files.

In summary the review found that, '... in the absence of programming for residents and training for staff, the department has failed to provide a safe, stress free work environment of staff and emotional security and safety for disturbed adolescents.'⁷

⁶ Ormond Management Review: Internal departmental report by Frank Maguire, 30/8/94.

⁷ as above p25

Partially in response to these findings and partially in response to ongoing issues around the functioning of Ormond, the department, at a local management level, and centrally, initiated a number of initiatives. Some of these initiatives included:

- the dissemination of practice guidelines (policies and procedures) to the department's intensive support services in 1996
- the dissemination of *the 'Info for You'* booklet to residents and staff from 1996 onwards
- the involvement of agencies such as the State Network for Young People in Care (SNYPIC) and the Community Services Commission, in 1997, in commenting on a draft Policy and Procedure Manual for DOCS Intensive Support Services
- the development of 'house rules' for Ormond premises in 1996 and 1997
- the approval of a 'Brief for (staff) Training' in 1996 with commencement of the training in February 1997
- the introduction of induction training for new and casual staff in 1997
- the development and implementation of a Staff Appraisal and Review System for youth workers commencing in 1997
- the development and implementation of Individual Management Planning for residents in 1996, ongoing in 1997
- the implementation of procedures, in 1997, to minimise the use of police in the event of residents' challenging behaviours which involved either assault or property damage.

8. General Findings

Notwithstanding these initiatives we have found that in the 1994-1997 period:

- departmental policies and procedures in the intensive services substitute care area were still being drafted and were poorly understood by direct care workers
- lack of clarity around Ormond's role (custodial or therapeutic) was still an issue for direct care workers and this impacted on service provision
- staff remained inadequately trained to work with disturbed state wards
- while management were partially appointed for their skills in working with behaviourally and emotionally disturbed young people, a number of direct care staff remained ill-prepared and ill-trained to work with such young people
- while management believed that casual staff received a basic induction, the induction program was not consistently available to all new casual staff
- while management believed strategies were in place to ensure direct care workers received appropriate briefing about the residents they were caring for, such briefings, if they occurred, were often undertaken as a belated response to critical incidents
- behaviour management strategies remained inconsistent in both quality and implementation
- permanent and direct care staff and professional staff had limited understanding of departmental policies and procedures
- staff continued to evidence uncertainty about their role (custodial or therapeutic) and this impacted on the quality of service they provided to the residents
- a number of staff continued to evidence limited insight into the needs of the children and young people in care at Ormond
- files continued to be maintained in a less than satisfactory condition with critical information often not documented.

More specifically we found in the 1994-1997 period:

- children being adversely affected by the behaviour of other young people
- instances where the needs of staff were given priority over the needs of residents
- instances where critical incidents were not properly documented and therefore probably not adequately responded to

- examples of management having to clarify policies which should have been clearly understood by staff in an intensive support service
- instances where children were left at Ormond for excessive periods resulting in these residents' behaviour deteriorating and adversely impacting on the wellbeing of other residents

- Ormond staff not having the training or skills to deal with residents' often highly complex behaviours
- the size of the Ormond complex adversely impacting on the adequacy of supervision provided by direct care staff
- instances where residents' behaviour put other residents' at risk of physical and/or sexual abuse
- instances where appropriate steps were taken by management and staff to address a child or young person's presenting behaviours and yet the challenging behaviours continued unabated or in some circumstances escalated
- young people being placed off site to minimise the impact of an individual's behaviour on other residents
- incidents where staff could not provide the necessary intervention to prevent situations escalating to crisis levels
- incidents where behaviour was inappropriately managed by staff
- examples of staff attitudes, unacceptable in such an environment.

We have found that on many occasions staff acted or attempted to act in accordance with approved procedures and practices, but the outcomes were often unsatisfactory.

9. Conclusions

Taking these matters into account we are led to the following general findings:

1. Some children's individual needs were not met while in care at Ormond.
2. Some children's circumstances and wellbeing diminished as a consequence of their being placed in care at Ormond.
3. The model of care (institutional/congregate) was a major contributor to the poor outcomes some children experienced while resident at Ormond.
4. The strategies developed by departmental management, locally and centrally, to address the systemic problems associated with the large congregate care model of intensive support service provision, were often inadequate to prevent and/or overcome the identified problems.

In coming to these findings the commission must consider a number of issues relevant to the adequacy of the department's response to the Ormond crisis and to the future direction for the care of the young people requiring intensive support because of their serious behavioural and emotional problems. These are

- that Ormond is now closed and the department acknowledges that there were problems at Ormond which meant that it did not provide the children in care at Ormond with the level of service they required
- that the department's management structure has changed significantly since the complaint was made
- that the department has developed and is implementing a new system for of crisis intensive support services for young people who would formerly have been accommodated and supported at Ormond

- that a major review of substitute care in 1997/98 has seen the development of substitute care standards and an accreditation scheme for government and non-government services providing substitute care for children and young people. The department is presently overseeing the establishment of the substitute care accreditation and monitoring system.

In light of the significant changes to the intensive support substitute care system since the complaint was lodged, the commission has determined not to reach conclusions that go to the question of whether the department's actions, historically, were reasonable or unreasonable pursuant to s12 of the Act.

Given the extent of the changes both made and currently in train, the commission has determined to focus on the future of substitute care and the care of the former residents. By this we mean that efforts should be made to ensure that intensive support substitute care services in the future do not see a repeat of the major problems experienced in the past by residents at Ormond.

At the request of the Minister for Community Services, the Hon Faye Lo Po, the commission is actively monitoring those young people affected by the closures of Ormond and Minali. Separately we are reviewing the circumstances and progress of 17 young people who were at one time long term residents of Ormond and Minali. The commission is also a member of the Evaluation Steering Committee established by the Department of Community Services to evaluate the new community based crisis adolescent services.

10. Recommendations

Recommendation 1

The Department of Community Services should carefully consider the findings and conclusions of this report in the evaluation of congregate care models of intensive support services in the future.

Recommendation 2

The Department of Community Services should develop an overarching policy regarding supporting children and young people with challenging behaviour, that takes into account the NSW Standards for Substitute Care and the SAAP Standards. This policy should stipulate the obligation of service providers to ensure that an assessment and behaviour intervention plan is developed for all children and young people with challenging behaviour.

Recommendation 3

The Department of Community Services should urgently develop procedures for its staff that reflect its policies for the care, supervision and support of children with challenging behaviour.

Recommendation 4

The Department of Community Services should undertake an audit of existing training packages or programs, in both government and non-government agencies, and of the training needs of departmental residential care staff and foster carers regarding behaviour management. Findings of the audit should be used to inform training priorities and budget allocations, so that all residential care staff and foster carers undergo behaviour management training, commencing as soon as possible.

Recommendation 5

The Department of Community Services should use its evaluation of the crisis adolescent services, other research and evaluations, and feedback from clients and staff to ensure continuous improvement and the development of best practice models for the provision of sub care to children and adolescents with high support needs.

Recommendation 6

In keeping with the approach outlined in recommendation 5, the Department of Community Services should take a lead role in establishing a multi-disciplinary pilot program aimed at better meeting the emotional, health and educational needs of wards and other young people with high support needs who are in care.

The Departments of Health, Housing and Education should actively participate and share costs, with the pilot program overseen and evaluated by an inter-departmental steering committee.

11. Specific Findings

PART A: Findings In Relation To Allegations Concerning Individual Residents And/Or Specific Incidents

Allegation 1

“Staff powerless to stop a child of 13 years sniffing aerosol spray on a daily basis, to the point where he could not speak or stand straight. Management informed. Nothing done.”

Findings

- 1.1 Without further identifying information it is not possible to establish with certainty the identity of the resident the subject of this allegation, partly because there was more than one incident of this kind that occurred at Ormond.
- 1.2 However, one resident’s circumstances closely match those of the resident the subject of the allegation. This child, 13 years of age at the time, resided in Ormond between late January 1997 and July 1997. The child left Ormond following an incident on 19/6/97 where she had been sniffing aerosols, was on the roof of the Ormond premises and jumped, breaking her leg. In the period the child resided at Ormond there are ten separate incident reports and file notes about the child sniffing aerosol spray.
- 1.3 Ormond management was aware of the circumstances of this child and took appropriate steps to deal with the child’s behaviour, including issuing clear instructions to direct care staff to remove aerosols from the child and to restrain her for her own safety. These instructions were in accordance with the relevant policies and procedures.
- 1.4 Despite the actions of management, there were continued incidents of the resident sniffing aerosols up until the time she left Ormond.

- 1.5 Of the 46 children named in the 34 children's files reviewed by the commission, thirteen were identified as being involved in aerosol sniffing.
- 1.6 Two of these children were taken from Ormond, by ambulance, to hospital because of their aerosol sniffing.
- 1.7 Two of these children, who had no reported history of aerosol sniffing, started to sniff aerosols after they entered Ormond.
- 1.8 Residents' aerosol abuse, on occasion, led to police charges.

Allegation 2

- a) **“Children ranging in ages between 12 years and 16 years having sex on the premises with the knowledge of management.**
- b) **No strategies offered to staff to deal with this. staff told by Deputy Manager to observe children and ask children if they were comfortable. A child disclosed the next day that she had not been comfortable but had been pressured into it. Management informed but no further action taken”**

Findings

- 2.1 This allegation most likely relates to a specific incident on the night of 6 June 1997. During this incident departmental records report that:
 - all residents of one Ormond unit were wandering the Ormond grounds at 11.35pm
 - they proceeded to climb onto the roof of one of the Ormond building
 - they then left the Ormond premises
 - they were returned to Ormond by Ormond staff
 - they proceeded to verbally abuse another resident and smash a window
 - they climbed back onto the roof
 - they then barricaded themselves into a room
 - where they were witnessed by staff to engage in sexual activity.
- 2.2 The 'on-call manager' was informed of this situation. Faced with the 'chief on duty' not willing to allow her staff to take action to break up the group for fear of assault, the on call manager directed the staff to supervise and ascertain each young person's well being. In this context the on call manager

- directed that supervising staff should ensure the children were consenting to being involved in any sexual activity.
- 2.3 Immediately following this incident the Ormond manager issued a written memorandum to all Ormond staff clarifying Ormond's policy that there was to be no sex between young people.
- 2.4 14 children whose files we examined, plus 5 other children whose files we did not examine but who were named in documented incidents, were identified as engaging in sex while on the Ormond premises.
- 2.5 We found the children's Ormond files that we examined to be of such poor quality that we could not tell from them whether, in relation to each *reported* incident of sex between residents we examined, departmental procedures for responding to allegations of abuse of children in residential care, were adhered to.
- 2.6 We were told by some staff that there were other staff who turned a 'blind eye' to sex between residents. This is particularly alarming given the age of the children resident at Ormond and that sexual abuse is often a reason for such children coming into care in the first instance.
- 2.7 We found some staff lacked appreciation of the fact that sex involving minors is a child protection issue. The investigation found that amongst those staff interviewed, there were widely differing understandings and significant confusions about the department's role and responsibility in dealing with residents who are minors engaging in sex whilst in care.
- 2.8 As a consequence of some staff's confusion about the service's policy in relation to children engaging in sex on the premises, the Ormond manager clarified departmental procedures.

Allegation 3

“A 15 year old boy, known to have Clamydia was having sex with the female residents, some as young as 12 and leaving the premises daily and returning drunk.”

Findings

- 3.1 One resident’s circumstances closely match those of the resident the subject of the allegation. This resident was admitted to Ormond in August 1996. It is not clear from his file when he was discharged but it is apparent that he was still resident at Ormond in February 1997.
- 3.2 This boy was medically screened when he was admitted to Ormond and this identified that he had Chlamydia.
- 3.3 There is nothing on his Ormond file to show that this boy was having sex with female Ormond residents. However a number of Ormond staff told the commission this was the case. Because nothing is recorded on his file about these alleged incidents we do not know if the incidents were dealt with in accordance with departmental procedures on dealing with allegations of abuse in residential care.
- 3.4 Incident reports on the boy’s Ormond file record that he frequently ran away from Ormond.
- 3.5 On 30/11/96 he was found at Ormond, with a cask of wine, drunk and asleep in his own vomit. On another occasion he was found in the Ormond carpark, drunk and physically ill. A memo issued by Ormond to the child’s district officer records that the child was consuming alcohol on ‘an almost nightly basis.’ It is not possible to ascertain if this was happening on or off the Ormond premises.
- 3.6 Ormond staff implemented a number of strategies to deal with the boy’s behaviour, and the problem generally, of residents’ access to alcohol. These steps included:
 - Ormond staff writing letters to local liquor outlets and relevant police advising that underaged youth were being served alcohol
 - reinforcing that staff could confiscate alcohol
 - facilitating the boy’s access to culturally appropriate services including mental and physical health and sexual counselling.
- 3.7 Despite these steps the boy continued to abscond from Ormond and continued to abuse alcohol.

- 3.8 One Ormond manager believed the boy's behaviour was adversely affected by the length of time he was resident at Ormond.

Allegation 4

“Older men permitted to arrive at the premises to pick the girls up. Police helpless to intervene.”

Findings

- 4.1 There are two time periods when older men visited the Ormond premises or frequented the vicinity of Ormond to associate with female residents:
- a) Time period one: in the first half of 1996 when a 15 year old female resident's 21 year old boyfriend and his friends visited the girl at Ormond.
 - b) Time period two: In December 1996 and January 1997, a group of men, known as the 'tow truck' drivers, encouraged female residents to leave the Ormond premises and get into their vehicles.
- 4.2 There is no evidence to support the allegation that “older men were permitted to arrive at the premises”.
- 4.3 Rather, the evidence is that Ormond management were aware of what was happening and took appropriate steps to address the incidents. These steps included liaison with the police, the department's own legal branch, and the relevant Community Service Centres; providing staff with strategies to deal with incidents involving the 'tow truck' drivers; actively working to remove female residents from situations where they were at risk; and appropriately counselling the female residents.
- 4.4 Regardless of the steps taken by Ormond management, and the, at times, extraordinary efforts of direct care staff to protect the female residents, there is evidence that a small number of female residents continued to abscond from Ormond at a high rate and that the incidents with the 'tow truck' drivers, although diminished, continued as late as October 1997.
- 4.5 The ability of the Ormond staff, and the police, to prevent the continuation of the incidents with the 'tow truck' drivers was limited by the inability of police to charge the 'tow truck' drivers unless they were caught committing a criminal offence.

Allegation 5

“A girl brought an older man home with her and slept on the premises. Nothing was done about this.”

Findings

- 5.1 The commission was unable to establish to whom this allegation refers. Therefore we could find no evidence to substantiate the allegation.

Allegation 6

“A boy was permitted to come on to the premises and take younger boys to a paedophile for an \$80.00 fee. This resulted in a boy being raped. Staff complained long and hard about this. Management said they could not do anything. The boy was continually brought back on the premises until staff went to the union and went on a 24hr strike. The boy was placed in a caravan.”

Findings

- 6.1 One resident’s circumstances closely match those of the resident the subject of the allegation. This young person was admitted to Ormond in July 1995 and officially discharged in April 1997 although his whereabouts were unknown from November 1996.
- 6.2 This resident was one of two older Ormond residents who, in the period from September 1995 until January 1996, were absconding from Ormond and taking younger residents with them to Kings Cross.

- 6.3 There is no evidence to support the allegation that the older boys were being paid by paedophiles for access to younger residents. However there is evidence that children absconded with the older boys to Kings Cross. It cannot be discounted that these children were engaging in sexual activity while at Kings Cross.
- 6.4 On 31/12/1995 one younger child, aged 13 at the time, ran away from Ormond with the two older boys. The younger child was absent from Ormond until 2/1/1996. This child told Ormond staff that he stayed with an adult male at Kings Cross during the time he was absent from Ormond. On his return to Ormond he complained of anal bleeding. Ormond staff organised for him to be seen at the New Children's Hospital on 3/1/1996. He denied to medical staff that he had been involved in sex with the man.
- 6.5 Ormond staff referred this, and all incidents where staff suspected paedophile activity, to the police. The police were unable to substantiate allegations that the boys were engaging in sexual activities with paedophiles.
- 6.6 Ormond management initiated a number of strategies to address the subject boy's behaviour and his impact on other residents. Some of these strategies were in response to a staff complaint about the resident mix at Ormond. This complaint was made in October 1995.
- 6.7 Strategies implemented, while minimising incidents of children absconding from Ormond to Kings Cross, did not significantly impact on the boy's behaviour. He continued to abscond from Ormond and continued to attempt to encourage younger residents to do the same.
- 6.8 On 20/3/1996 direct care staff planned a stop work meeting to consider action in relation to the boy's behaviour and the impact of the boy on younger residents.
- 6.9 On 21/3/1996 the boy, supported by Ormond staff, was placed in a caravan park. It is probable that this action averted the potential industrial action.
- 6.10 Once placed off the Ormond premises the boy was not permitted by Ormond management to return to Ormond and this was clearly documented. However, he would arrange to meet Ormond residents, off the Ormond premises.

Allegation 7

“One 15 year old girl becoming pregnant to one of the boys at Ormond and taken for an abortion. Her parents were not informed.”

Findings

- 7.1 In early 1997 a young Ormond resident (aged 15) fell pregnant to, most likely, another Ormond resident, while living at Ormond.
- 7.2 Ormond staff, in accordance with departmental procedures, facilitated the girl’s access to appropriate counselling. The young person decided to have the pregnancy terminated.
- 7.3 Departmental procedure around consent in such circumstances was not clear and the then current departmental procedures gave conflicting direction. However, once the manager at the time clarified these procedures, events occurred in accordance with what she believed the procedures to be.
- 7.4 While the young person’s mother was not informed of the girl’s decision to terminate the pregnancy, the evidence is that, despite significant efforts by departmental staff, this was because the mother could not be located.

Allegation 8

“A boy placed in a caravan at Parklea which, according to our Child Protection Specialist, is the most notified caravan park in New South Wales for cases of abuse. Boy sold all the items out of the caravan including fridge and television, to buy alcohol. Staff complained they could not stay in the caravan park as it was in such a mess.”

Findings

- 8.1 On 24/4/97 an Ormond resident, who was 15 at the time, was placed in a caravan park. The placement was organised by the Ormond child protection specialist in conjunction with the child’s district officer.
- 8.2 He was moved to the caravan park as he was assaulting other residents and staff at Ormond.
- 8.3 The Ormond manager at the time did not consider the placement to be an appropriate placement, however there were no other placement options at the time. In the

circumstances, and in the absence of an alternative placement for him, his placement at the caravan park with staff support, was reasonable.

- 8.4 Items from the caravan the boy was living in at the caravan park went missing, including the fridge. This resulted in the owners of the caravan making complaints to the police.
- 8.5 There is no evidence that the boy used money from the sale of the caravan items to buy alcohol. However one Ormond manager believed this may have been possible as the boy was not supervised all the time.
- 8.6 Ormond staff complained about having to work with the boy due to the mess the boy was living in.

Allegation 9

“Children placed in motels and at caravan parks. One such boy, his mother and staff ran up a bill of \$4,000 on food and alcohol for one week-end in a motel in Kings Cross. It is amazing that these children are sent to the Cross as this is where they gravitate to and are removed from.”

Findings

- 9.1 In the 1996 October long week-end a child was placed in a city motel, by a departmental Community Services Centre.
- 9.2 The placement in the motel eventuated because Ormond was full and the relevant Community Services Centre claimed they could find no better alternative placement.
- 9.3 Ormond assisted by providing names of Senior Youth Workers who could be employed by the Community Services Centre to support this boy in the hotel.

- 9.4 During the weekend a bill of \$4,000 was accrued. This included the cost of video movies which were used the entire week-end, and items taken from the mini bar in the hotel rooms.
- 9.5 Ormond management's investigation of the incident identified:
- the overuse of videos during the week-end to be a serious issue
 - the contents of the mini bar were predominantly taken by the child's mother when she visited
 - alcohol was consumed by a particular Senior Youth Worker.
- 9.6 In response to this situation Ormond management:
- determined not to re-employ the Senior Youth Worker who had consumed the alcohol
 - developed a protocol/procedure for situations in which Ormond staff were required to support children in motels/hotels and caravan parks
 - recognised that staff in such situations were quite unsupported and unsupervised.
- 9.7 In the circumstances, the actions of both the supervising Community Services Centre and Ormond management to meet the child's immediate need for supervision and accommodation were reasonable. However, the actual situation was poorly managed.

Allegation 10

"Residents set fire to the kitchen to the tune of \$20,000."

Findings

- 10.1 On 25 May 1996 three Ormond residents were on the roof of one of the Ormond buildings.
- 10.2 Staff were attempting to talk the children down.
- 10.3 One of the children threatened to hurt herself with a sharp object during this process.
- 10.4 During these events one of the residents on the roof lit a fire in the airconditioning unit on top of the Ormond kitchen. The fire spread to the kitchen.

- 10.5 The fire brigade was called and the fire put out. No one was injured.
- 10.6 The young person who lit the fire was arrested and charged and subsequently sentenced to nine months in a juvenile detention centre.
- 10.7 This young person had, three days prior to the fire, been excluded from the Ormond internal school.
- 10.8 The cost of the fire was \$20,000.

Allegation 11

“Manager found a 'bong' in a resident's room. Nothing done. Incident passed over.”

Findings

- 11.1 One of the managers found a bong in one of the resident's rooms. This was in mid 1997.
- 11.2 The bong was confiscated by the manager and the child was reprimanded.
- 11.3 At the time of these incidents, departmental procedures in relation to drug use were not explicit. There was opportunity for confusion by staff about how substance abuse should be dealt with.

Allegation 12

“Residents are given money on a regular basis. Management refused to take a boy to the shop when he demanded \$40.00. The boy smashed the bus windows with a cricket bat. The boy was not charged but taken to the shops and given the \$40.00.”

Findings

- 12.1 In August 1997 a resident smashed a bus window. He was not charged but grounded and made to pay \$40, over a four week period, for the damage.
- 12.2 There is no evidence to support the allegation that he was positively rewarded for his behaviour.
- 12.3 There is evidence that pocket money was distributed in accordance with departmental procedures and in consultation with residents’ supervising Community Services Centre.

Allegation 13

“One full time Senior Youth Worker was placed 24 hours per day at a cottage with one girl. This girl was removed due to abuse from other children at Ormond.”

Findings

- 13.1 In June 1997 a young girl with a mild to moderate intellectual disability was placed at Ormond, after having been found by Mt Druitt CSC living in a disused warehouse.
- 13.2 While in Ormond, the young person was picked on and victimised by other Ormond residents.
- 13.3 To ensure she felt safe, the young person was placed, with full staff support, in one of the Ormond units earmarked for closure. At the time the young person lived in this unit, there were no other residents in the unit.
- 13.4 Steps taken by Ormond staff, in the circumstances, were appropriate and took into account the girl’s need to feel safe. However in meeting her need to feel safe, her other needs were negated.

Allegation 14

“When management offer consequences for actions, they go from the sublime to the ridiculous. They either get nothing or everything. One girl was taken off all phone calls, television, videos, outings, takeaways, late nights and not permitted to go past the driveway of the house for three days. All fairly pointless considering they are permitted by management to come and go as they please.”

Finding

- 14.1 The commission was unable to establish to whom this allegation refers. Therefore we could find no evidence to substantiate this allegation.

Allegation 15

“A boy of 12 years old had to be removed by staff in their own car, as he was being assaulted by the other residents. This was after staff had complained to management on several occasions with no assistance.”

Findings

- 15.1 This allegation most likely relates to an event that took place on the night of 9/10/1996.
- 15.2 The incident involved an 11 year old boy who had been placed at Ormond on 12/9/1996 following the breakdown of the boy's foster placement.
- 15.3 The boy had previously resided at Ormond. He had a history of alleged sexual assaults on other children. These included an incident in September 1995 when he allegedly coerced another Ormond resident into performing oral sex on him. His foster placement broke down when it was alleged that he had sexually assaulted the foster parent's seven year old daughter.
- 15.4 On the evening of 9/10/1996 a group of residents went bowling. During this time the boy revealed to the other residents some of his history.

- 15.5 The group returned to Ormond. The other residents became angry with the boy. To protect the boy staff barricaded him in his house on the Ormond property. Seven children tried to break into the house. These children were making threats, banging on the windows and challenging staff.
- 15.6 In these circumstances the acting manager, with the assistance of several staff, transferred the boy from the house, to a car.
- 15.7 At around midnight the acting manager placed the boy in a motel.
- 15.8 The boy did not return to Ormond.
- 15.9 Prior to these events it was obvious that the boy's placement was a troubled one. There was an incident on 19/9/1996 when some other residents were reportedly planning to push the boy from a roof at Ormond.
- 15.10 Both Ormond direct care workers and management had expressed concerns about the boy's placement at Ormond because of his age and other residents' verbal and threatened physical abuse of him. At a case conference on 1/10/1996 the Ormond manager clearly indicated the boy's placement would be terminated on 18/10/1996.

Part B: Findings In Relation To General Allegations Concerning Residents

Allegation 16

“Residents are continually put at risk when they are brought to Ormond. Many of them come into Ormond without a criminal record and in a very short time have been charged with numerous offences.”

Findings

- 16.1 In February 1997 the newly appointed Ormond manager contacted the local police because of the high police arrest rate involving Ormond residents.
- 16.2 This manager held the view that referral to the police was the most highly used behaviour management strategy on the Ormond site when she arrived in February 1997.
- 16.3 For the month of January 1997 the arrest rate for Ormond residents was 42.
- 16.4 Based on studies conducted by the manager, she concluded that children would come into Ormond without a record and, within three weeks, they would have a record. The charges were usually in relation to assault of other residents and/or staff, and malicious damage.
- 16.5 In this context the manager initiated a number of strategies to reduce the incidence of referrals to the police. These strategies included:
 - establishing liaison between Ormond and Hornsby police;
 - directing staff not to contact the police in respect of certain types of property damage;
 - encouraging staff to use their judgement and physically intervene where property damage appeared to be malicious;
 - urging staff to consider the residents’ behaviour in context, and also the possible role staff may be playing in the onset of that behaviour.
- 16.6 Following the introduction of these strategies the arrest rate dramatically dropped from 42 in January 1997 to 2 in April 1997. However, during this period incidents of malicious damage, on the Ormond property, were ongoing.
- 16.7 The actions of Ormond management, as from February 1997, to address this situation, were commendable, appropriate and reasonable.

Allegation 17

“There have never been any formal programs for the children despite the fact that there is an Assistant Manager Programs and a Program Implementor. For the past four years, staff have been threatening industrial action in an effort to get some.”

Findings

- 17.1 In 1994 a departmental review of Ormond found:
- behaviour management programs, if developed at all, were developed reactively
 - such programs were not monitored for effectiveness
 - there was evidence of staff acting inappropriately in response to challenging behaviour leading to injuries for both residents and staff and a climate of things being out of control
 - where programs did exist, staff were neither briefed nor trained in the program’s implementation
 - challenging behaviour was dealt with inconsistently by staff
 - there were no clear guidelines or enforced consistency in managing challenging behaviour
 - in the absence of guidelines and training, the staff, poorly trained and untrained, either
 - a) resorted to physical restraint causing damage to the resident, staff, other residents and property damage, or
 - b) chose to do nothing
 - time out was in use and not necessarily recorded.
- 17.2 As a consequence of these findings a designated Assistant Manager/Programs was created at Ormond in 1995.
- 17.3 As of June 1996 an Individual Management Plan (IMP) system was implemented at Ormond.
- 17.4 The person appointed to the position of manager Ormond, in February 1997 found:
- programs that were in place were very controlling and inadequate
 - referral of children to the police was the most highly used behaviour management strategy at Ormond.
- 17.5 As a consequence of these findings the manager deleted the position of Assistant Manager/Programs and created the position of ‘Program Implementor’.
- 17.6 The commission examined a number of files of children resident at Ormond in 1996 and 1997. We found the files to be of poor quality. Consequently, in cases where Individual Management Plans had been included in the file information, it was difficult to establish if plans had actually been

implemented, monitored for effectiveness and modified accordingly.

- 17.7 We found no evidence of there being any system in place to ensure that if there was a program in place and if there was a new staff member on duty, this staff member would be made aware of the program and briefed in its implementation.

- 17.8 In August 1996 Ormond staff threatened to go on strike if a number of issues were not urgently addressed by management. One of these issues was resident individual management plans.
- 17.9 On 27 August 1996 the issues were addressed by a special meeting attended by Ormond staff and management, and representatives from the union and the department's Industrial Relations Branch. An Action Plan was developed and agreed to by the representatives. Strike action was averted.

Allegation 18

“Children do not have to go to bed, eat meals, shower, change clothes or do anything they do not want to.”

Findings

- 18.1 Ormond staff threatened industrial action in August 1996. Reasons for the threatened action included a staff perception that there was a lack of consequences for children's behaviour and that there were inconsistent rules between residential units.
- 18.2 The potential industrial action was averted, partially as a consequence of Ormond management agreeing that all residential units were to establish house rules.
- 18.3 In late 1996 Ormond management enlisted the assistance of the State Network for Young People in Care (SNYPIC) to assist in the development of house rules at Ormond.
- 18.4 At the time of the commission's investigation (November 1997) we found house rules were in place in each of the units. There is evidence of some staff attempting to:
- put the child's behaviour in some context and respond accordingly
 - remind children of the house rules
 - negotiate with children about their behaviour
 - counsel children about smoking
 - negotiate consequences for children returning late to Ormond, grounding residents for their previous day's behaviour, getting residents to contribute towards the cost of property damage
- 18.5 This was in contrast to events in the latter part of 1996 where incident reports recorded a very high level of children rising late, not attending school and very frequently absconding.

- 18.6 Regardless of the progress made in 1997, some of the direct care staff we interviewed in November 1997 did not particularly value the rules in place. Some direct care staff believed the residents just ignored them. Some of these staff also held the view that if they imposed consequences for breaking the rules, the consequences would not necessarily be supported by management.
- 18.7 For her part, the 1997 substantive manager believed many of the staff were not, in their day to day work with the children, evidencing the motivation needed to work with children placed at Ormond.

Allegation 19

“Residents are permitted to come and go from the premises as they please.”

Findings

- 19.1 The 1994 departmental review of Ormond resulted in a recommendation that the department clarify the role of Ormond - whether it was to be a secure care or therapeutic unit. This recommendation reflected the finding of the review that the role of Ormond was unclear.
- 19.2 Between 1995 and 1997 Ormond was reconfigured. Doors were no longer locked, dormitories were closed, and children were placed in cottages on the Ormond site.
- 19.3 At least from 1996 residents were not physically restrained from leaving the Ormond premises, unless they had an approved behaviour management plan that allowed for such physical restraint. For all residents there was an unwritten expectation that they would tell staff where they were going and when they would return. Often, however, residents absconded from Ormond without providing such information.
- 19.4 There is evidence that during this period (latter part of 1996 - 1997) some staff took active steps to stop children absconding from the premises, including counselling the children.
- 19.5 Regardless of this, there was a high rate of absconding from Ormond during the latter part of 1996 and during 1997.

Allegation 20

“Children do not have to go to school, but are permitted to stay in bed.”

Findings

- 20.1 Children who were placed at Ormond were expected to attend school. For the majority of residents, this meant attending the school on the Ormond premises.
- 20.2 In the latter part of 1996 and in 1997 there were many recorded incidents of children either absconding, staying out late at night or wandering the Ormond premises late into the night.
- 20.3 Some direct care staff believed this made it difficult for children to get up in the morning. This in turn impacted on their school attendance.

Allegation 21

“Children who are brought into Ormond for their own safety, are permitted to walk out and go back to the abusive situation, without management taking any action.”

Finding

- 21.1 The commission did not consider this allegation as aspects of it are dealt with in the consideration of allegation 19.

Allegation 22

“Many of these children have come from horrific abusive backgrounds and they are brought to Ormond where they are abused by the system. These children are not given any form of counselling.”

Findings

- 22.1 In 1996 and 1997 resident’s counselling needs were identified shortly after a child’s admission to Ormond. Ormond used internal staff and external specialist counselling services, depending on the identified needs of the child.
- 22.2 A number of factors impacted on counselling outcomes for children including:
- the nature of counselling arrangements (off campus)
 - uncertainty about a child’s length of stay at Ormond
 - the children admitted to Ormond were often in crisis and therefore not responsive to counselling
 - limited appreciation by some staff of the child’s circumstances and complex needs
- 22.3 As established elsewhere in this report counselling did not necessarily prevent some children from engaging in self harming behaviours while resident at Ormond.

Allegations 23 and 24

- **“Residents destroy cottages on a regular basis by smashing windows, kicking holes in doors. Management do nothing.”**
- **“Vehicles destroyed regularly with no consequences for actions.”**

Findings

- 23/24.1 There is evidence of serious and significant property damage having occurred at Ormond from 1995 onwards.
- 23/24.2 Prior to March 1997, incidents of property damage were automatically referred to the police and the resident/s charged with malicious damage. After this date direct care staff were strongly encouraged by Ormond management not to automatically refer property damage to police.
- 23/24.3 The investigation found some staff believed that this change in policy meant that residents were able to get away with unacceptable behaviour.

- 23/24.4 The last substantive manager of Ormond identified the following as possible reasons for property damage at Ormond:
- direct care workers not providing adequate supervision of residents
 - direct care workers not prepared to become involved with the residents
 - direct care workers not prepared to increase their skills/knowledge in working with challenging young people
 - the individual circumstances of residents when admitted to Ormond
 - environmental factors associated with living at Ormond

Allegation 25

“Children brought to Ormond on crisis admission and are not given any clothes to change into but are expected to stay in the clothes they arrived in.”

Findings

- 25.1 The allegation that children were brought to Ormond on crisis admission and expected to stay in the clothes they arrived in is not supported by the evidence.

Allegation 26

“Management supply children as young as 15 years with cigarettes or money to buy them.”

Findings

- 26.1 There is no evidence to support the allegation that management were supplying residents with cigarettes.

- 26.2 There is no evidence to support the allegation that members of the management team gave residents money with the intent of the residents then buying cigarettes.
- 26.3 It appears that a large number of direct care workers and residents smoked cigarettes. Ormond's local policies on smoking were not being adhered to in all aspects, as a number of direct care staff were smoking in front of residents.

PART C: Findings Relating To General Allegations Concerning Staff

Allegation 27

“The state of the premises is a disgrace. Staff have to call on Workcover and OH&S in an effort to get the place in a livable condition.”

Findings

- 27.1 A WorkCover inspection of the Ormond premises, carried out mid 1994, identified issues of concern at Ormond, including:
- the repair and maintenance of the facility;
 - the high incidence of assaults upon workers by residents;
 - the lack of policies and procedures.
- 27.2 WorkCover was satisfied with the outcomes from the WorkCover investigations and closed its Ormond file in late 1994. There has been no further involvement by WorkCover.
- 27.3 In November 1997 the Minister’s Community Visitor to Ormond advised the commission that, in her view, the premises seemed to be satisfactory. Previously she had complained to Ormond management about two units in particular (Cascade and Banksia):
- the presence of rats (12/5/96)
 - the state of certain bathroom and toilet areas (17/10/96)
 - the absence of doonas, blankets and cups (25/10/96)
 - the need for professional cleaners to prepare one of the units for a higher resident intake and the fact that this unit flooded at ground level whenever it rained (22/1/97).
- 27.4 In November 1997 Ormond management told the commission that whilst buildings not in use were in disrepair, those in use were maintained in a reasonable condition.
- 27.5 Direct care staff supported this observation.

- 27.6 Following the involvement of WorkCover, the OH&S committee at Ormond met monthly. At the time of the commission's investigation (November 1997) issues raised by the committee were being promptly addressed by management.

Allegation 28

“Several staff off on long term compensation with stress claims. There is excessive sick leave.”

Findings

Allegation 28 does not fall within the commission's jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 29

“No staff training for front line staff. Management are regularly on training courses.”

Findings

- 29.1 The 1994 departmental review of Ormond found that those staff trained to be custodial carers (when Ormond was a detention centre) had received inadequate training to work with disturbed state wards. It also found that both management and direct care workers were ill prepared and ill trained to work with the sort of child being placed at Ormond after 1989.
- 29.2 The view of the area manager in March 1996 was that as a consequence of the lack of development of core competencies for senior youth workers, the history of temporary employment and the absence of a long term framework for the service at Ormond, staff training at Ormond was fragmented, reactive and not developmental.
- 29.3 In early 1997 the department agreed to a training package for youth workers at Ormond and Minali and the department's Intensive Services and After Care staff. The package included 'catch up' training, orientation/skills training for new staff and core competencies.

- 29.4 The consultant contracted by the department to develop and provide the training package, wrote in his training proposal that the proposal was based on the premise that, “training provided to Ormond and Minali staff to date has been at its most basic level and has been ad hoc. It does not appear to be highly valued by staff and therefore often avoided...Neither centre has a comprehensive and structured human resource strategy.”
- 29.5 In early 1997 all staff at Ormond underwent the two day ‘catch up training’. Some direct care staff also underwent a five day training course on supervision and looking after children.
- 29.6 Prior to Ormond’s closure, direct care staff received no core competency training.
- 29.7 Many of the 1996/1997 training proposals, generated both locally and at Central Office, did not come to fruition prior to the closure of Ormond in February 1998.

Allegation 30

“No assessments done on staff and no career path.”

Finding

Allegation 30 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 31

“Staff often have to barricade themselves in the office to avoid being assaulted by residents.”

Finding

Allegation 31 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 32

“Staff are continually put in compromising positions with no support from management.”

Finding

Allegation 32 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

PART D: Findings In Relation To Specific Complaints Concerning Management

Allegation 33

“Management work 9am-5pm Monday to Friday, do not work public holidays despite the fact that they are paid an on call allowance and an incidence allowance of approximately \$9,000 a year to cover this.”

Finding

Allegation 33 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 34

“Management arrive at all hours of the day and take two and three hour lunches. There have been eight managers at Ormond in the past six years. One of the managers applied for the position on a permanent basis and was unsuccessful. However, this person was left in the position.”

Finding

Allegation 34 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 35

“There is an excess of staff on duty for approximately nine children on a daily basis. This uses an excessive amount of public money. They are as follows: Manager, Deputy Manager, Assistant Manager (there were two until one month ago), Program Implementor, Child Protection Specialist, District Officers x 2 (Part time), Full time clerk, Part time clerk Full time receptionist, Fifteen Senior Youth Workers, Six Chief Youth Workers, Full time school Principal, Full time Deputy Principal, Four full time teachers, One full time school youth worker, Two full time outdoor officers.”

Finding

Allegation 35 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 36

“The current manager has no experience in the management of a residential unit and has stated on several occasions that if there is a fire call the fire brigade, if there is an accident call the ambulance and if there is a death call her. The manager has stated she does not want to be called unless someone dies. To this end, management have put their phones on voice mail as they do not want to be disturbed.”

Finding

Allegation 36 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 37

“Management NEVER attend the premises to support staff regardless of how bad the situation gets.”

Finding

Allegation 37 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.

Allegation 38

“The current Manager continually places inexperienced staff in positions of responsibility and then denigrates them if they ring her for advice or direction.”

Finding

Allegation 38 does not fall within the commission’s jurisdiction as it does not sufficiently relate to service provision to the residents.