"Long Term Disability Care and Support Scheme"

Submission to the Australian Federal Government Productivity Commission Inquiry into Disability Care and Support by Tony & Heather Tregale, parents of a young man with autism and intellectual disability.

"How a scheme should be designed and funded to better meet the long-term needs of people with a disability, their families and carers"

- All care services must be an entitlement, rights-based, for the life of the person with the disability.
- People with a disability must have an entitlement to services deemed necessary by their, for-life, "disability support assessment"
- Their disability "support assessment" must include the views of themselves (where they are able), parents, family, carers, friends and/or an independent third person/s.
- Support assessments must be regularly reviewed, and reviewable on request.
- There must be a truly independent and accessible "complaints process" for "support assessments", "support assessment reviews" and "support services".
- Members of the "complaints process" must be from industry not directly associated with government, local government, disability or social services.
- Members of a "complaints process" must not be from government or pseudo government departments. They must be from industries such as, BHP, Telstra, Motorola, Myer, David Jones, Coles, etc, etc. Companies such as these are generally happy to provide an executive or manager, pro bono, as part of their service to the community
- Residents of supported accommodation group homes must have sufficient residential rights and individualised funding to allow them reasonable rights in their home, to approve or disapprove of direct care staff, to allow them to choose their service provider and to define, through a contract, the level and quality of service they require and expect. And, that they can be supported by parents, family, guardians or friends to achieve this

"Some of the concerns of caring parents and families"

- That there is no effective complaints system.
- Most services are "hand-out".
- Most service are little better than "Minder Care".
- There is a wide gap between Service "Intention" and Service "Provision".
- Those adult clients/residents who have no meaningful communications, and who are unable by reason of their disability to make reasonable judgements in respect of all or any matters concerning their personal circumstances and/or estate, have little

meaningful protection and/or representation within the service system, yet their parents/families/friend are restricted from assisting by privacy and similar laws

- Questionable actions by, and rights of Community Visitors
- How can captive market public servants ever accept the need for them to do other than "appearance employment - take the pay and look the other way", and accept customers, and the need for customer service? Telecom had to have competition before they would accept the need for customers and customer service

“The needs of families with a member with a disability”

- Parents/families need pro active advice and support as soon as they feel their child is not developing normally.
- Parents/families need a pro active, whole of life, rights-based service evaluation as early in the life of their member with a disability, and then regular assessments throughout their member’s life.
- Parents/families need access to good, meaningful and consistent facility based respite whilst their family member is living with them.

Tony & Heather Tregale
Parents, Plenary Guardians & Administrators

EXTRACTS FROM “BOUND TO CARE”
AN ANTHOLOGY OF FAMILY EXPERIENCES
BY RESCARE UK

“It is a great shame when so much valuable time is spent on paperwork instead of where it really matters, providing a nurturing environment for our loved ones. Our family members are human beings, but because they serve no obvious useful purpose to the community, they are generally treated as second-class citizens!”

“There was a garden and play area, but it required staff to take the residents and stay with them. As the garden was out of sight of the house, this activity was never given high priority. Staff preferred to stay in the house and watch the television!”

“It has alway been understood that caring for people involved encouraging social interaction, for example, through staff playing with residents. Shortage of staff resulting from lack of resources was always blamed. No one ever made it compulsory for staff to involve residents in activities!”

“A social worker from a child assessment unit said, You’ll have to get on our backs, it you want anything. I know it shouldn’t be like that, but we only take notice of those who really shout for what they want!”

Notes for a meeting with Janice Kronberg, MLC, Member for Eastern Metropolitan, at 3pm on 28 April 2008, at Ringwood.

Introduction: The actions of the DHS are very similar to those of the Victoria Police Department (Services Division). Public Service radio technicians did not do a days work in a week! When we were short of serviceable equipment to keep police cars on the road, the manager would outsource the work, rather than get the staff to do some. So the government paid twice! **If staff do little work in group homes, where there is no outsourcing, the residents just get less care!**

Quality of Life Care: Providing real quality of life, family involved and family friendly care is not rocket science! The "A Team" at Peugeot Pursuit proved this over a two year period, but the department/region refused to see their work as a bench mark, as this would be seen as setting a precedent which everyone would want.

In general, government departments have a aversion to precedents, as they see their role as keeping consumer demands to a minimum. Their focus is, therefore, on issue avoidance, not issue address and continuos quality improvement. Therefore, individual and systemic service level and quality problems are massive, complex, compounding and revolving door, for which we have extensive documented evidence.

1. Having been Community Visitors for may years, seeing the shocking conditions in the Institutions first hand, we agonised over seeking a place for our youngest son, Paul. But considered we needed to make provisions for him, should anything happen to us. And, that we were still able enough to monitor his care, and raise concerns.

2. Paul's first group home was certainly shocking! We had meeting after meeting after meeting with the DAS management at Preston, But little changed! Finally, a good house supervisor helped us get Paul relocated to a group home which became absolutely first class between 2004 and 2006. But has subsequently become very ordinary and questionable.

3. Families raising concerns are seen by DHS/ DAS as undesirables! Those who are really effective at challenging them, by quoting from what they should be doing, are seen as needing to be silenced - not as resources and tools to service improvement.

4. The department finally "silenced" us with the restrictive practice of blocking/redirecting our Email at their firewall, and placing bans on DHS managers, statewide, from directly responding to us….. All in total contrast with other citizens of Victoria!

   This process is sending a clear message to anyone who effectively questions the DHS, that they will be persecuted and intimidated, and will certainly not get a fair hearing. And no one will help, as the department is too big and too powerful to be held accountable by anyone!

5. There are many other caring parents who are not at all happy about a whole range of service aspects. Here are just a few examples:
   Parent "A" is a widow, is totally unhappy, but is too scared to say anything.
   Parent "B" is a very elderly a widow. She is complaining, but getting nowhere!
   Parent "C" is also a widow. She is complaining, but getting nowhere!

Parent “D” is also a widow. When she raised simple concerns, the house staff sent her to Coventry for over a year. So she is very reluctant to say anything now!
Parent “E”, has no support from her husband, and is very timid. She raises concerns very gently because she is extremely concerned about the potential intimidation of her son. But she get’s little!
Parent “F” has the full support of her husband, is very forthright because her son was abused in a house which had a bad staff reputation. With the aid of the OPA, she finally got a reasonable relocation for her son.
Parent “G” has no support from her husband. She had to fight the DAS extremely hard to get her son relocated from a house where he was being badly abused.
Parent “H” had little support from her husband, as he was running their business. She fought for her son’s quality of life for many years, but finally gave up through suffering distress.
Parents “I” have taken-on the department for many years, with little success.
Sister “J”, her parents are dead. She has fought for her sister’s quality of life for many years. Both sisters have been intimidated by DAS managers and staff. And she has had major problems with the OPA over her sister’s finances.

6. After Paul left Mornane, the department introduced a totally incompatible client who wrecked the house raped a resident, and attacked other residents. Yet the department categorically refused to accept this client was incompatible, and should be moved out. It was not until a resident sustained serious neck injuries, from an attack by this client, and extensive lobbying by united parents with two lawyers, that the department reluctantly relocated this resident to Heidelberg Road, where again he was considered unsuitable, and finally to Plenty Residential Services.

7. All parents and families we know, consider there is no truly independent complains process! Everyone we know agrees, the OPA, the Ombudsman, the HSC, the DHS and VCAT are all in bed together.

8. Almost all advocacy groups receive funding from the DHS, and/or are concerned in supporting, against the DHS, parents with major concerns. They fear, for doing so, they may be seen as undesirable in the eyes of the DHS when representing clients in the future.

9. Our experience with the new, so called, complaints process, is that the ODSC has no teeth to take on the DHS and its DAS Regions for failing to implement the direction, intent and spirit of the department’s extensive care policies, standards and values.
10. Almost everyone we know considers the Ombudsman totally useless in questioning either the DHS or the OPA.
11. It is not mandatory for Community Visitors to contact parents/families, following their visit to a group home, of those residents who have no “intentional communications”. <u>So the concerns of these residents are not raised!</u>
12. DHS responses to correspondence are almost always regulating, restrictive. in-denial, issue-avoidance and total avoidance. This forces repeated correspondence, for which they then claim is the reason for item #4 (above). The message they are therefore sending is, “Accept what we say without question, and “Anyone who assertively questions us will be punished without a fair hearing”!

13. The message in the letter from Mr Joyce to the ODSC is, "We will destroy anyone who questions what we do!" And we will NOT give them a fair hearing, or provide support for the allegations we claim!
14. Yet we have proven, over the period 2004 to 2006, that the service point service level can be excellent, and well within the department's care policies, standards and values. But this was as a result of staff integrity, not management's ability. This is the main reason services are inconsistent. A factor for which the ODSC agrees.
15. DAS managers are reluctant to set, monitor and maintain staff work value expectations, for fear of staff lodging incident reports claiming "bullying"!

Heather's experience when working for the DHS

Brief Comments

- I have an ACRACS (Certificate 4) qualification.
- At no time whilst I worked (2 years) for the DHS, did any care venue ever set work value expectations on me! Whereas, they always did in the not for profit sector!
- When working as a casual, it was necessary for me to spend the first 20 mins at each house checking to see if the person I was working with wanted to work or not. To avoid problems, it was necessary for me to emulate that person.
- Many CRU staff play the power game over residents and their families. This gives the CRU, the residents' home, a "boot camp" image.
- Night staff frequently sleep when on an Active Night. Rarely are they give specific tasks to do during the night, and rarely does anyone check on what they were doing
- Few people ever questioned instructions or the actions of others. There was a culture of, "Don't make waves" and, "Take the pay and look the other way".
- Leaving early is frequently justified by staff claiming to take their meal breaks at the end of the shift.
- Leaving early is also justified by claiming TIL (Time in Lieu).
- Staff reckoned it was easier and quicker to do household duties themselves, than to supervise residents. Residents therefore lost skills!
- Many permanent staff consider it is not their duty, nor are they getting paid to direct inexperienced, casual or agency staff. So these staff frequently wander around, not sure what to do. Or just sit and watch TV, etc, etc.
- I have witnessed staff sending residents to their rooms if they were disturbing staff watching TV, talking to each other or on private phone calls.
- Was on duty with a House Supervisor until 8pm. She gave me almost no information. She was very matter-of-fact with the residents - not treating them with dignity and respect, and giving them no affection!
- Instructed by a permanent staff member to give a resident medication without a drink. When I questioned this I was told, quite abruptly, "she'll crunch 'em (the tablets) up!".
- Components of a residents Hi Fi system went missing. The staff person found to be responsible had gone to a lot of trouble to cover their tracks, police said.
- Staff had to be told to record the meals they cooked for the residents, so that they were not repeated by the other staff team.
- I was frequently asked to be a lookout for male staff playing Pool on the residents' pool table, in case the Unit Manager or Supervisor came around.
- I frequently witnessed residents being verbally abused.

- I witnessed staff tip a resident out of his wheel chair, because he was getting near to staff having a BBQ lunch.
- I witnessed a resident repeatedly forced to stand in the corner, as punishment.
- Toilet rolls only available to residents on request.
- No plates for supper sandwiches. Sandwiches placed directly on the table.
- Witnessed client being slapped across the head for soiling pants
- Witnessed client being tantalised by permanent staff, by having his slippers taken off and constantly thrown across the room.
- Clothes are not dried on the line, even in good weather. They always used the drier.
- Staff say to female clients, things like, "Get out you bitch"!
- A staff member killed flies with "Mortein", swept them into a corner, and Billy ate them. When challenged, she said, "Oh, Billy will eat anything!"
- I was frequently asked by residents when I would be working again, as they said they like me talking to them, and playing games with them. This illustrated just how little the staff interacted with the residents!
- When I asked residents if they like other staff, their main complaint was that staff either ignored them, or shout at them!

RESPONSE TO QUESTIONS PUT TO AN EX JANEFIELD RESIDENT BY TONY

The lady interviewed is neuro typical. She was placed in the Janefield Institution many years ago, when it was a place for wayward girls. She only got out because of the policy to close institutions. The now elderly lady, has been independently running her own home in the community for years.

Bath at 3:30pm; In PJs by 7pm; Film show once per week in the Hall; Long drives, rarely stopping, just there and back; Many times held in a darkened room; Food was always poor; Not much to do all day; Work money taken off us; Domestic staff made us clean-up, whilst they did nothing; Rarely used the swimming pool, even on hot days; BBQ rarely used.
Not allowed out on my own to go to local shops and cafe by bus; Like a prison!

Heathers Brief Notes on Paul's Care

1. In all the years Paul has been in a DHS group home, rarely have we had any communications from his Key Worker, except between 2004-2006. And even more rare is a key worker report!
2. We never hear from Paul's present Case Manager!
3. The totally incompatible client which DAS introduced with no consultation, totally destroys the quality of life for other residents, as staff are constantly stressed by the continuos and excessive noise and rage-about which limits their motivation in doing many quality of life activities with the others. The level of incompatibility is reinforced by the need to maintain a "Client Special" after almost 2 years. Whereas, the normal length of time for a "Client Special" is 6 to 8 weeks
4. Brian Joyce's letter rubbishing us, provides no evidence of the allegations.
5. Staff names removed from progress notes - no accountability or service transparency.

6. The lack of feedback from staff on Paul's activities illustrates little motivation. It is human nature that people doing things, like to tell others what they are doing!`
7. No sleep charts provided to us pro actively, yet they have been repeatedly told that we need feedback on Paul to track his mood-swing frequency and amplitude for potential medication fine tuning.
8. Staff Roster no longer provided with, at least, first names, in accordance with Regional Director's agreement Ref: EXC/03/12077. This is yet another reduction in service transparency!
9. We see little evidence of departmental policy of staff working with families being implemented at Peugeot Pursuit. The atmosphere is generally that of, "matter of fact, clinical – them and us".
10. Active Support Handbook. We do not see evidence of Active Support according to the Handbook!
11. Dietician recommendations, staff never sent a copy to us, and we are Paul's Plenary Guardians. And we finally discovered, they had sent a copy to the wrong G.P.
12. Clothes going missing, when all Paul's clothes are clearly marked with sew on name labels.
13. Activities not being recorded in Paul's communications diary!
14. Revolving door staff, programs not being implemented consistently!
15. Staff are told of Paul's medical and dental appointments, but no one bothers to turn up except us! Parents have to live for ever!
16. Behaviour Management Plan review, outstanding for three months.
17. Would not implement the behaviour management plan as it has not been reviewed
18. Cannot give Paul a food supplement as it is not on the treatment sheet, yet he has been having this on and off for a number of years.
19. Paul taken to hospital and kept waiting for three hours, <u>not good for Paul</u>.
20. 6/2/08. six staff on duty, 1-1 ratio. Wow!!
21. Casuals not being directed what to do, so consequently they stand around, or sit down and watch T.V, etc, etc.
22. Some residents put in pyjamas before their evening meal. Evening meal is usually around 5:30pm.
23. Since the introduction of the incompatible client, residents at Peugeot never go out for a meal together, as a group. There are now no picnics or barbecues out, or indeed a barbecue at home.
24. There have been no Christmas Parties with residents, families and staff since 2005, ever since the incompatible client came there. Prior to this, the Christmas and Birthday parties <u>were wonderful</u>. <u>A real party atmosphere with families and friends!</u>
25. The department is paranoid with "Privacy", to the extent of placing residents in silos, rather than a bunch of friends living together. People with a limited lifestyle need it expanded through people knowing about them. An example of the privacy taken to extremes, is when we were told, "Paul enjoyed a birthday party with <u>a co-resident</u>!"

In Summary: The Department's Disability Services, the N&W Metro Region DS/DAS especially, has provided inconsistent, in-denial and in-crises services for as long as they have been the government's service contractor. Yet, the Department's Head Office produces an extensive range of excellent care policies, standards and values. And these are promoted through a range of excellent workshops, seminars and conferences.

Tony & Heather Tregale

Parents, Plenary Guardians and Administrators
27 April 2008.

NOTES FOR THE PARLIAMENTRY INQUIRY HEARING ON 28 NOVEMBER 2008.

1. DHS supported accommodation group homes are “Hostels not Homes”, as residents and their families are frequently not consulted over changes, and as the direct care staff consider the group home is their workplace and they cannot be moved if they do not wish to be.

   Most of us here today have control of who comes into our home. When we become elderly and need the support of HACC services, if we do not like a particular HACC (Home & Community Care) worker from the local authority, we can call the HACC office and request that particular person not be sent to our home again. This is NOT so for the residents of DHS Group Homes! They do not, therefore, have reasonable rights in their long term home!
2. The public service culture of job security through captive market government funded services having no reason for, and no reliance on customer service and satisfaction, is not conducive to the provision of consistent quality of life care for the very vulnerable residents of its supported accommodation group homes. The department should not, therefore be providing direct care services.

   It appears the main reason the department’s direct care services have not been handed over to the “Non Government - Not For Profit” sector is the pay differential. Department staff get paid more than NGO staff!

   So whilst department staff get more pay, and department bureaucracy is extremely wasteful, there is far less accountability for the provision of quality of life care for very vulnerable and disadvantaged people – the residents of DHS group homes.

   Service inconsistency, as reported by the Auditor General, is further compounded in DHS direct care services by the department’s trend towards the reduction of central management, in favour of autonomous House Supervisors. Most DHS group homes have offices equipped to run BHP! There is now even less central supervision to ensure all houses provide consistent QOL care within the direction, intention and spirit of the department’s care policies, standards and values. Different house supervisors interpret these policies differently!
3. There is a current trend towards support packages and individualised funding for those with the ability and support to seek generic services. Yet the residents of DHS group home are denied individualized funding of their government funded support costs, and any form of residential tenancy rights. The residents’ choice of service provider is, therefore, totally restricted. Yet another restrictive factor is the department’s despotic control of the DSR (Disability Support Register). Yet another is availability of services.

   Without these restrictive practices and factors, the residents of DHS group homes could say that we don’t like the DHS service, we are going to City Mission, Nadrasca, etc, etc. They would have choice! Many times we have been told by DHS staff, “If you don’t like what we do, take your kid away!” They can say this, because they know we have no choice, and that their job is not dependent of customer service and satisfaction.

4. With the few service accountability factors available to the residents of DHS group homes, residents and caring families have to look at every available avenue available to them. Yet Community Visitors are not obligated to contact parents/families following their visit to a group home where the residents have no meaningful communications.
5. Thousands of very elderly parents, struggling to care for their disabled family member at home, are being both blocked from access to reasonable respite, are queue jumped by able bodied parents who abandon their disabled family member on respite services.

   Dumping on the few available respite services is an epidemic. Most respite houses cater for 5 or 6 residents, yet most have at least two places taken by abandonment. Some have all but one place taken by abandoned family members.

   With the Department of Human Services under extreme pressure to free respite places for their legitimate use in giving a well deserved break to families doing it tough 24/7, the department is dumping totally incompatible people on the very compatible residents of existing group homes. One incompatible person can totally destroy the quality of life of 4 or 5 others.

   The department is moving the problem around, rather than solving it. Apart from allowing respite facilities to become blocked from their legitimate use, they are effectively moving an incompatible member with whom the family cannot live, on to a compatible group of already disadvantaged people in a group home.

   The problem is compounded as respite places become depleted for those doing it tough in caring for their family member at home. Families are therefore driven to the despair of now having to consider abandoning their family member at respite because there is little hope of their family member ever getting into a permanent group home.

Department of Human Services, Disability Services, Questionable Activities in Official Denial by DAS Management, but for which they and staff are well aware.

It should be noted that the following list is not exhaustive, and is not exclusive to any one location. Many of these practices, directly or indirectly, restrict the residents' quality of life.

1. Many direct care staff rorting their rostered hours….. Arrive late, leave early!
2. Many direct care staff rorting work hours on private business (phone calls, etc), watching TV, chatting and drinking coffee with other staff for long periods, etc, etc.
3. Direct care staff rostered on a shift where there is no specific work, as a result of some questionable HACSU agreement.
4. Direct care staff lore negating management's right and role to manage service within departmental care policy, standards and values.
5. Erroneous bullying claims on House Supervisors by staff as a work avoidance tool.
6. Direct care staff "Factional Division and In-Fighting".
7. Direct care staff peer pressure to work at the lowest common denominator.
8. Direct care staff using "Client Choice" as a work avoidance tool.
9. Poor man-management of direct care staff by unsuitable managers and house supervisors.
10. Managers not adequately supporting House Supervisors.
11. Managers (above house supervisor) rarely visiting the houses.
12. Managers (above house supervisor) failing to ensure the house staff are compatible and work as a team.
13. Managers (above house supervisor) failing to ensure all staff in an "Active Support" house are fully supportive, in practice, of the defined "Active Support" principles for the residents.
14. Managers (above house supervisor) have insufficient "Industrial Training and Experience" to support the House Supervisor to fully implement departmental care policies, standards and values, in the face of HACSU supported staff lore.
15. DAS management issue avoidance and sweep-it-under-the-rug tactics when facing families questioning service level and quality.
16. Families having to continually repeat their stories on questionable service provision, in the face of revolving door DAS management (above house supervisor.
17. Direct care staff withholding from, or claiming client refused to take their (psychotic) medication, so the client's behaviour gets worse, and the staff can persuade the doctor to prescribe a higher dose.
18. Food items in house, going missing.
19. Staff having Bistro food at client expense.
20. Little accountability for pharmacy items.
21. Time sheets signed for every day, at the start of the week.
22. Residents' personal cash vulnerable to pilfering, and management not concerned as the department is responsible for its replacement.
23. Direct care staff at PRS allowed to do 12 hour shifts. They could not possibly provide QOL care after 8 hours!
24. House Supervisors say the residents are no problem, it's the staff who create most strife.
25. Staff have been known to bring their dogs to work and bath them in the resident's facilities.

26. Staff seeking increased medication for sitting residents, to give staff more time to cope with an incompatible client forced on them by client services.
27. Related staff working in the same house – potential conflict of interest, cronyism and nepotism.
28. Staff refusing to use CERS credit cards to get housekeeping and the resident’s expenses.
29. Staff refusing to drive department vehicles despite having a current drivers licence.
30. Staff watching “Foxtel TV” that is paid for by the residents, whilst the residents are in bed by 6:30pm.
31. Ghost Shifts. Shifts where staff sign on, usually the previous day, but don’t do the shift.
32. Staff stealing the residents’ PRN medication. Easy to do, as this is often not used often.

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WHY CARING PARENTS HAVE TO LIVE FOR EVER

Caring parents having a son or daughter with an intellectual or multiple disability need to live for ever because almost all services, **supported accommodation**, in-home support, respite day services, sheltered workshops, education, etc, etc cannot, at present, be relied upon to get it right for those with little or no ability to adequately advocate for themselves.

Just some of the reasons why (If you know more, let us know):

1. Clothes being mislaid or lost, even when clearly marked.

2. Wearing the same shoes all the time, especially runners (when has a range of shoes)
3. Washing quality poor - stains frequently not removed with Preen – woollens ruined in hot water, etc, etc.
4. Clothes not ironed, or consistently ironed.
5. Inappropriately dressed for the weather and environment.
6. Generally, poorly dressed.
7. Bed made up when wet.
8. Top sheet not consistently put on bed.
9. Manchester and towels in poor condition.
10. Meals poor – lots of takeaway
11. Cut lunches, for day activities, poor.
12. Poor grooming, including teeth cleaning and nail cutting.
13. Shoes not cleaned.
14. Reluctance to use generic services for medical, hair care, etc, etc.
15. Very little meaningful interaction, developmental and social activities – loss of skills.
16. Failure to make or attend medical and dental appointments – Not in the staff diary, no one read the diary, or no staff wanted to go.
17. Casual staff sent with resident to medical appoints, because regular staff don’t want the bother
18. Staff infrequently attending a resident admitted to hospital.
19. Injuries frequently not noticed or reported.
20. Reluctance to treat minor abrasions and rashes.
21. Residents needs have to fit in with staff needs, mood and availability.
22. Delays in taking residents to a doctor (Example: Sector manager visiting a CRU on a Friday, observed a resident with a streaming cold. On asking when the resident will be taken to a doctor, the staff said, “On Tuesday when his key worker is back!”
23. The “Key Worker” is intended to represent the resident’s interests with the service provider, especially where the resident has no family or effective family. Yet key workers frequently do little more than the average workers (staff). And the key worker’s loyalty is naturally with their employer – the service provider.
24. A “Case Manager” is also intended to represent the resident’s interests with the service provider. Again, the case manager is employed by the service provider!
25. Apart from parents, family and friends, there is no provision for purchasing or replacing items and equipment which would help to enhance the resident’s lifestyle. The resident’s finances build year after year, with the resident having few possessions. Whereas, most residents can benefit from such items as, a trampoline, an exercise bike, balls, talking toys, communication aids, TV, video recorder, drawing boards, etc, etc.

26. Staff loaned a resident’s radio to another resident for an extended period, without consulting the parent of the resident to who the radio belonged. The resident to whom the radio belonged had no meaningful communications.
27. Staff threw all washing in together, into the industrial washing machine – colours, whites and soiled clothing!
28. Staff refused to soak stained clothes in Napisan, just sent it to the mother of the resident to deal with.
29. Resident’s rooms and windows frequently dirty.