



# Behind Closed Doors

Preventing Violence, Neglect and Abuse  
against West Australians with Disability

Samantha Connor and Ben Keely

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People With disabilities WA and  
Developmental Disability WA



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The analysis presented in this report reflects the submissions received by the researchers in response to the WA Disability Abuse Inquiry consultation process.

All direct quotes in this report are excerpts from submissions and material obtained during the consultation process. It is, however, important to note that the authors were not able to verify the accuracy of the submissions or consultation comments. Nor should the analysis be read as representative of all Western Australians with disabilities, as participants and respondents were self-selected during a time limited project.

The authors are particularly aware that there are many individuals with disability and families who have had experiences which remain untold, and we encourage the sector to continue the dialogue that has commenced with the publishing of this report.

It is also important to note that the

emphasis on disability service settings is perhaps attributable to the fact that PWdWA and DDWA are disability advocacy organisations, and that their membership has directly informed the material published in this report. A focus on disability service settings does not equate to an imbalance in violence, neglect and abuse in those settings when compared to non-disability settings – rather, it demonstrates the number of people who came forward to tell their experiences about disability service settings. This may be partially due to the way the project was framed and who it was developed by.

This report should not be read in isolation and should be regarded as a useful source of information about the experiences of people with disability and their families who have experienced violence, neglect and abuse in institutionalised settings. We believe that this report will generate much-needed discussion about safeguarding, processes and person centred practices which come from the perspective of the person with the disability, rather than the system or institution in which they reside. We hope that this report will help inform development of future systems and practices which ensure people with disability are kept safe from harm without having their rights, choices and freedoms impinged upon.

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# Preface

**“If history was taught in the form of stories, it would never be forgotten.”  
- Rudyard Kipling**

The lives of people with disability are often secret lives. We are routinely segregated and isolated from our non-disabled peers – we live, work and play in places which are not often frequented by those without disability. Often, we are lonely. If we do not have families, paid staff are sometimes the only people in our lives. We are shut out by barriers to participation in Australian life, and shut in when we are hidden in institutional settings.

It is when we are shut out, and shut in, that violence, abuse and neglect often occurs. The term ‘institutional setting’ does not exclusively define disability service settings.

Under the terms of reference for both this project and the Senate Inquiry into Violence, Neglect and Abuse in Institutional Settings, institutional settings include schools, prisons, group homes, hospitals, detention centres and even family homes. Violence, neglect and abuse was defined equally broadly – it included breaches of privacy, passive neglect and restrictive practices.

It was within that context that we heard accounts of rape on school buses and in sheltered workshops, emotional abuse and passive neglect in group homes, restrictive practices in schools and disability service

settings. Many stories were graphic in nature and intensely shocking. Many depicted smaller, daily breaches of human rights that, in isolation, were not alarming, but which painted a damning picture of institutional living. Often, the two were linked – in places where it was okay to remove people’s choices and deny them their rights were also often breeding grounds for abuse, target rich environments created by institutional culture.

For some people with disability who have been shut in for a lifetime, the stories were told by parents and siblings and in some cases, by the WA Coroner. Their voices are represented only by those who worked to support them or those family members who never lost contact. Many of the stories of those people who grew up in Graylands and Claremont, Bennett Brook, Pyrton and other institutional settings will never be told. Their stories exist only in some public records and the memories of staff.

One unusual aspect to this work is that it has been carried out for, and by, people with disability. The three researchers and authors of this report are people with disability. Two have lived experience of not just disability, but violence, neglect or abuse in institutional settings.

Over the course of this twenty week project, fifty one organisations, individuals and families contributed their shared histories. We are indebted to them, especially to those people with disability and family members who had the courage to relive their experiences through the retelling of their stories.

To those people, the change makers in our community, we thank you.



**Samantha Connor (People With disabilities WA)  
and Ben Keely (Developmental Disability WA)**

## People With disabilities WA

People With disabilities WA (PWdWA) is Western Australia’s peak body for people with disability. It is governed by a board comprised of people with a disability and almost half the staff employed by the organisation are people with disability. PWdWA’s aim is to empower the voices of people with disability in WA and provide individualised advocacy to a broad range of stakeholders in the WA community. The organisation also carries out systemic advocacy, with a general focus on those issues that impact upon the day to day lives of people with disability such as health, education, community housing, access, transport, attendant care and service provision.

## Developmental Disability WA

Developmental Disability WA (DDWA) is the peak advocacy organisation in WA for people with intellectual and other developmental disability and their families. DDWA aims to advance advocacy, policy and community for and with people with intellectual and other developmental disability and their families as well as the people who support them. The organisation supports people with developmental disability and their families to have a strong voice, partners with others to develop more connected and inclusive communities and influences government and other decision makers.

PWdWA and DDWA believe that we are the most effective and influential when we combine our voices, stories and knowledge – and that is what this project aims to do.



# Executive Summary

**“The ultimate tragedy is not the oppression and cruelty by the bad people but the silence over that by the good people.”**

**- Martin Luther King**

Violence, neglect and abuse against people with disability happens behind closed doors. It happens in institutional settings, both mainstream and disability – it happens in the family home. It happens often, more frequently than people realise. It is dismissed, reduced to administrative error, disregarded or not addressed. Our stories remain untold in our police stations and in our courtrooms. Often, the Coroner is our only biographer.

This report endeavours to provide a snapshot of what is happening for Western Australians with disability in institutional settings who experience violence, abuse and neglect.

In early 2014, People With disabilities WA and Developmental Disability WA commenced the WA Disability Abuse Inquiry, a state wide consultation designed to inform their response to the Senate Inquiry into Violence, Neglect and Abuse in Institutional Settings.

Over the next five months, fifty one people with disability, family members and organisations gave testimony about widespread abuse and neglect in institutional settings. This report, compiled at a

time when safeguards, national disability reform and other Inquiries are being undertaken, is an important step towards galvanising action between government agencies, disabled person's organisations and service providers to ensure that people with disability are safe from violence, exploitation, abuse and neglect.

The interviews held with people with disability and their families were often gruelling for both researcher and interviewee. Over the course of the Inquiry, the researchers heard stories of rapes and deaths in care; financial exploitation and physical abuse. The spectrum of violence, neglect and abuse was represented in almost every story, with some experiences stretching back over a lifetime, to Pyrron or Bennett Brook or Claremont. For some people with disability, a lifetime in care had meant a lifetime of neglect and abuse.

A clear picture emerged around the systems that people with disability lived, worked and participated in. Despite the difference in settings, the issues were often the same. People reported a lack of awareness of existing statutory authorities and difficulty engaging with complaints systems. Service providers and public authorities expressed

confusion and a lack of understanding around external processes and described existing systems as unwieldy and ineffectual. Police were rarely contacted, and of the accounts that were collected during the course of the Inquiry, not one perpetrator went to court.

Significant gaps occurred between systems – health, disability, mental health, child protection and education all presented unique challenges in addressing jurisdictional issues and clarity around responsibilities. Police processes, too, were often inaccessible to people with disability, especially for those without spoken language. Issues were raised around complaints management systems and a lack of transparency, and a key theme of the Inquiry was accountability – in almost any setting, there was rarely anybody who took the blame. This was a recurring theme which held across almost every story.

Abuse and neglect was more likely to have occurred to those who were segregated, isolated and deprived of natural supports. For those who had nobody but paid staff in their lives, there was rarely anyone to notice if they were missing or injured. Some people, forgotten, exist in institutional settings in the midst of our cities and suburbs. Some have lived in those places for fifty or sixty years.

Many people held deep seated anger against systems that had repeatedly failed them. They told us stories of incredible suffering and heart-ache and expressed their frustration about many common issues. Over and over people told us that they had been met with blockades at every turn, that there was no information or help given to them, that they were kept in the dark, that nobody was ever held accountable.

But there were some moments which revealed insight and hopefulness. The courageous young

woman who told the story of her rape was accompanied by the Complaints Officer of the agency where the rape had occurred. They supported her to tell her story, sought counselling for her and actively sought advice on how to prevent abuse ever happening again. A woman whose son was restrained in a disability service setting is now working for the provider in their quality area.

There is evidence that there is willingness to make change and to make violence, rape and abuse a thing of the past.

## **Main findings -**

### **Institutional Settings**

The Inquiry found that people with disability were more likely to be abused when they were segregated and isolated in institutional settings. People who were isolated – whether it was in a hospital, supported employment agency, aged care facility, prison, residential care facility, day centre or school – were less likely to be able to access complaints mechanisms and more likely to experience violence, abuse and neglect. Complaints systems were widely underutilised and not considered to be effective. The fear of retribution was a common factor, especially in schools and disability accommodation. Staff culture was also regarded as an important factor in both contributing towards abuse and the failure of other staff to speak up.

There was a great deal of evidence that was put forward by the Council of Official Visitors (CoOV) and other 'visiting bodies' who routinely inspect places where people with disability are segregated from the rest of society. It is one of the recommendations of the Inquiry that a Community Visitors' program be implemented in Western Australia to facilitate routine inspections of institutional settings where people with disability live.



## The experience of people with disability

People with disability reported difficulty in communicating and difficulty identifying and reporting abusive practices. Many people were isolated from both information and advocacy. A fear of not being believed was repeatedly expressed. Knowledge of existing statutory and complaints systems was underdeveloped, and many people had experienced a lifetime of living in institutional settings in a culture of compliance. For some people who had experienced institutional abuse, there was a difficulty in recognising risky or abusive questions.

People were not able to easily access police or justice systems and were not supported to do so. Most people with disability, after being abused or neglected, were not given access to counselling or support mechanisms. People were forced to return to the environment where they were abused, sometimes with the perpetrator in the same environment. In one instance, a young woman who was raped was removed from her classmates for talking about her rape, whilst the young man who had raped her remained on her school bus and experienced no apparent consequences.

## Staff

Some staff members reported issues around culture in organisations that reinforced a low expectation around the abilities of people with disability. Some staff who disagreed with entrenched poor practice felt unable to report concerns or influence change for fear or reprisal. Resourcing was a constantly cited issue as was staff competence and behaviour. The culture of the management also impacted upon staff at the organisation, especially in absence of strong leadership and communication around expectations.

## Failings in the Health Care System

Health and mental health was widely reported as being an area where jurisdictional issues and lack of clarity around responsibilities caused serious issues. Disability care and support needs are often not addressed in a health environment and issues arose when people were not provided with support in hospital. A lack of understanding of disabilities and comorbidities also presented issues, especially for people who do not use spoken language. In some public hospitals and nursing homes, oppressive regimes led to abusive and neglectful practices – for example, at one C class hospital, patients were told that they could only press the buzzer in an emergency, despite being mostly people with quadriplegia who were dependent on others for their daily care needs. There were also significant issues around health, rehabilitation and disability - some people had lived in hospital for decades because of a lack of funding, and had then never applied for funding again.

There were serious issues around resourcing and transport in country hospitals, especially for patients with psychosocial disability who required transportation to metro services. Some patients were sedated for too long and needed ventilating or required aspirating. The Health Consumers' Council presented a number of important representative case studies, including issues with access to records, financial abuse, physical abuse and a case where a man was pushed out of his wheelchair by a mental health nurse who refused to believe that he could not walk.

Another key theme resulted from an agreement between government services that was designed to prevent duplication of service.





## Disability Service Settings

Many of the people with disability or families interviewed during the course of the Inquiry told stories about lifetime neglect and abuse. Times have changed and so have practices, but the stories that were told about disability service settings in the fifties, sixties and seventies presented a picture of Bedlam-style institutions, horrific conditions and 'therapy' devices that were designed to cure but instead caused harm. Stories from Graylands and Claremont Hospitals were amongst the worst, with the WA Coroner detailing the case of one woman, Peta Doig, who died only two years ago after experiencing a lifetime of violence, abuse and passive and systemic neglect.

There were interesting parallels drawn between what happened then and what happens now. Cultures of compliance were mentioned, where people have no control over their bodies and are told what to do. The lack of dignity and privacy that occurred in many institutional settings contributed to a lack of valuing of people and seeing people as 'less than'. A failure to provide meaningful employment or activities was reflected in stories and accounts about 'community tourism' and a lack of person centred practice. Although the surroundings for some people have changed, some things seem not to have changed at all. Restrictive practices was raised as a topical issue, along with chemical restraints and restraint procedures. In one case, a restraint procedure resulted in death, but nobody was held accountable. Passive neglect, too, was raised as a widespread issue, especially in the context of being in the care of the state. For many young people who are inappropriately placed in nursing homes, there are few options to be supported well in an aged care environment.

Financial abuse is widespread, according to

advocates and providers, especially in the family home and by 'mates', and the issue of financial abuse in institutional care settings – including nursing homes – was raised by several participants.

The lack of data collected around violence, abuse and neglect – and the lack of transparency around complaints and reported incidents, as well as issues around barriers to justice – mean that it is very difficult to ascertain the prevalence of violence, abuse and neglect in institutional settings. The Health and Disability Services Complaints Office (HADSCO) report that less than two percent of their complaints (about fifty people) come from the disability sector, and people widely reported that they would not make a complaint due to fear of retribution. From the number of contacts made in a relatively limited time and accounts provided by participants, we drew the conclusion that violence, abuse and neglect (as defined in the terms of reference) is widespread in the disability sector. There was also significant evidence about the lasting impact of violence and abuse on families and the person with a disability. Some people have experienced post-traumatic stress disorder and the impact of the abuse includes a reluctance to trust strangers with family members or ever admit them to respite care again.

### Violence, Neglect and Abuse in Mainstream Settings

By far the highest proportion of complaints came about schools, with special schools disproportionately represented in the accounts. Fear of retribution was cited as an issue, and issues ranged from physical abuse to sexual abuse, including an account about a student who was raped on a school bus by another student. Taxi transport, too, was raised as an issue. Many students with disability are unable to access mainstream transport by school bus and taxi is

the only means of transport for students with high support needs or students who travel with oxygen bottles. The recent rape of five women with disability in a multipurpose van in Western Australia impacted upon the general community and raised issues around how to recognise the signs of abuse when the person does not use spoken language.

Prison environments were explored, as was the Mentally Impaired Accused Act and barriers to justice for people who have been jailed indefinitely without ever being charged of a crime. Aboriginal people are disproportionately represented in this group. Some prisons were inaccessible and others were overcrowded – Bandyup prison, which has an 'operational capacity' of 259 prisoners, is consistently overcrowded with more than 300 women. Women who do not have a bed must sleep on the floor on mattresses. Complaints systems were not routinely accessed – HADSCO received only three complaints from detainees at one prison between 2008 and 2014. The primary reason for not reporting violence and abuse was fear of retribution, followed by fear of not being believed.

### Violence, Abuse and Neglect in the Family Home

Domestic violence was explored, along with other forms of domestic abuse, including murder and manslaughter. Victims of incest and childhood sexual abuse drew clear connections between their disability and the reasons that they were abused, pointing to a devaluing due to their disability status. Providers were unsure what to do when family violence was observed in family homes.

Family and interpersonal violence was often regarded as 'taboo' with financial abuse in family homes being cited by providers and advocates as a 'huge, unspoken problem'.



**Research and Awareness**

Data on the incidence and prevalence of assaults against people with disability in institutional settings is limited. The researchers contacted Government departments, interviewed independent authorities and advocacy agencies and reviewed relevant documents and annual reports. The reporting bodies were listed by service, scope, investigation process and referral, governing laws and standards and governing body, and included federal agencies and state based organisations.

During the course of the research, it became apparent that even the statutory bodies themselves did not understand the system. Providers were generally not aware of reporting mechanisms – for example, that the whistle-blowers’ legislation for public servants also applied to funded organisations – or how to access them. The Health and Disability Services Complaints Office reported that disability sector complaints are very poorly represented (2%) and statutory powers that were invested in some statutory bodies were rarely used. There were also issues when a person was abused in a setting that had a number of jurisdictions. Disability complaints mechanisms are often attached to service sector or policy area rather than to disability status itself.

Breaches of the disability services standards were common and are no longer published in a transparent manner (since 2013). In 2013 (April to June) 25 services participated in an independent quality evaluation. 56% did not meet the service standards. Some data was obtained from Hansard (Estimates and Financial Operations Committee) about transparency, meeting the standards and complaints in the disability service sector.

A number of current projects that have been developed to address inconsistencies in complaints reporting mechanisms and promote appropriate safeguards were listed, including the Zero Tolerance Framework by National Disability Services (NDS), HaDSCO’s Disability Complaints Data Collection Project, HaDSCO’s Advocate and Community Leaders Collaboration Project and the NDS Safer Services Project.

A desktop audit of current international literature was undertaken as part of the project and national and international responsibilities were detailed, including compliance with the National Disability Strategy’s outcomes.

**Safeguarding**

There was some tension around the proposals in the NDIS Safeguarding Paper and the research conducted throughout this Inquiry, especially in terms of suggestions made by the authors of the paper, who proposed increased regulatory systems as a discussion point. The Paper framed safeguarding via a theoretical model, classifying safeguards into developmental, preventative and corrective safeguarding.

The researchers had a strong focus on the autonomy of people with disability and maximising choice and control in their daily lives – it was not clear that many of the regulatory systems (like Clear/Vulnerable Persons Cards or workers blacklists) would be effective preventers of violence, abuse and neglect. Further, it was apparent that the implementation of some of these systems would negatively impact upon choice, control and autonomy and further segregate and isolate people with disability. An emphasis on developmental safeguards, including intentional developmental safeguards, was therefore a strong focus for the report.

Preventative safeguards, too, received much attention. Access to advocacy and information was identified as a key preventative measure.

At a forum held on the 6th of July, 2015, service providers at the Safer Services (NDS) forum discussed how to best support people with disability to ensure that they had access to advocacy and information. A variety of useful suggestions were made, including a ‘story based’ tool which outlined the types of violence, neglect and abuse that people may encounter. Another discussion centred on how, by whom, where and when information about safeguarding should be received. The forum engaged a number of providers from large and small organisations who shared their experiences around safeguarding. Some providers have sophisticated training systems and in-house systems which would be well utilised by others who may need support in this area.

The implementation of a Community Visitors’ program in WA would provide a valuable preventative mechanism for those who are exceptionally vulnerable because of the absence of anyone but paid staff in their life. A local peer support and self-advocacy group expressed interest in becoming ‘community visitors’, offering peer support to people living in institutional settings, and it was considered that the combination of effective peer support (especially from those people who have effectively devolved out of those institutional settings) and a watchful eye with informal support would be an extremely beneficial combination for many people with disability.

Other issues such as staff training, the appropriateness of the Child Assessment and Investigative Team in taking disability complaints (by police) and issues around barriers to justice

and making complaints were explored. People with disability reported that they experienced distress when not being involved in the resolution of a complaint, especially when a staff member had been ‘moved sideways’ and when they were not privy to information about the outcome of a complaint. Conversely, providers reported great tension around dealing with complaints effectively and simultaneously discharging their responsibilities as an employer. IR issues were cited as being significant in posing barriers to addressing violence, neglect and abuse complaints, especially if the victim was not able to speak and if there was no possibility of a charge or conviction.

**Recommendations**

Concluding recommendations addressed the need for an independent, statutory, national protection mechanism, but recognised the possibility for State Ombudsmen to be granted equivalent powers to protect, enforce and investigate findings related to violence, abuse and neglect. Consideration was also given to the development of a uniform, national legislation to impose clear sanctions, expectations and obligations against persons or organisations responsible for the care of people with disability. Education and training and access to advocacy were also key recommendations in the report, and all sixteen recommendations are listed at the conclusion of this report.

We identified many issues in this report, but are keenly aware of what is missing. Issues for women with disability, for example, including breaches of reproductive rights and forced sterilisation - issues for people in regional and remote areas, detainees and people from CALD backgrounds, Aboriginal Australians with disability. However, we hope that this work will start an important whole of sector conversation in



# 1. The WA Disability Abuse Inquiry

At the end of 2014, and in the wake of escalating public awareness about violence, abuse and neglect against people with disability, advocates across Australia lobbied for a Senate Inquiry into abuse and neglect in institutional settings.

Previously untold accounts of violence, neglect and abuse came to light, including stories from Western Australia. As a direct response, People With disabilities WA, WA's peak disability consumer organisation, partnered with Developmental Disability WA to investigate the experiences of people with disability who had experienced violence, abuse and neglect.

In Western Australia, the prevalence of violence, abuse and neglect against people with disability living in institutional settings has long since been recognised by individualised advocacy as a major systemic issue, but issues such as lack of robust data collection systems and barriers to justice for people with disability have prevented this issue from being addressed.

In February, 2015, the inquiry was launched. PWdWA and DDWA worked in cooperation with United Voice, the disability support workers' union, to ensure that the stories of support workers were represented. A public forum was held with a panel of disability advocates and stakeholders, including

former Disability Discrimination Commissioner Graeme Innes and Senator Rachel Siewert. Over the course of the next twenty weeks, 51 face to face and phone interviews were carried out. Issues were catalogued by type and referrals were made to individualised advocacy services and in some cases to police. A website was developed and a 'Disability Safe Week' implemented, with posters and resources about abuse and neglect awareness mailed out to 145 stakeholders and disability organisations. Stakeholder consultations were held with the Disability Services Commission (DSC) and National Disability Services, and a survey was carried out for people with disability, family members and support workers. A 1800 number was deployed for a one day 'Confidential Reporting Hotline' which attracted twelve calls and call backs.

It is recognised that the experience of people with disability who have been subjected to violence, neglect and abuse will be underrepresented in this report due to the time and resource limitations of this project. However, we believe the experiences captured within this report will provide valuable guidance to inform oversight systems and capacity and capability of organisations and individuals to respond to neglect and abuse, including capacity building for people with disability themselves.

## 1.2 Terms of Reference

### Background

1.1 The WA Disability Abuse Inquiry was established by People With disabilities WA, in conjunction with Developmental Disability WA and United Voice in February, 2015. In Western Australia, the prevalence of violence, abuse and neglect against people with disability living in institutional settings has long since been recognised by individualised advocacy as a major systemic issue, but issues such as lack of robust data collection systems and barriers to justice for people with disability have prevented this issue from being addressed in WA.

1.2 A number of external and environmental factors have prompted this inquiry. They include;

- Current and proposed national inquiries, such as the Royal Commission into Sexual Abuse of Children in Institutionalised Settings, the Senate inquiry into Young People in Nursing Homes, and the upcoming Senate Inquiry into Violence, Abuse and Neglect against People with Disability in Institutionalised and Residential Settings;
  - A public recognition that violence, abuse and neglect against people with disability occurs
  - The commencement of consultations for the development of national safeguards through the NDIS.
- 1.3 The fundamental principles and values of the Inquiry are as follows
- All people with disability deserve to be safe, happy and be able to participate freely in everyday life as Australian citizens

- Australia is a co-signatory to the United Nations Convention on the Rights of Persons with Disability, which states in Article 16 that people with disability have the right to be free from exploitation, violence and abuse;
- All forms of violence, abuse and neglect are a gross violation of the rights of a person with a disability;
- Violence, abuse and neglect against people in institutional settings may have a long term cost to individuals, the economy, and society;
- People with disability living in institutional settings, and especially people with disability who do not have natural safeguards (a good network of community and family support, an understanding of rights and equitable access to advocacy, rights protection and justice systems) are often at greater risk of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation;
- It is important that people with disability living in institutional settings can share their experiences to assist with healing and to be able to inform the development of strategies and reforms (which may include State or national reforms).

### 2. Scope of the Inquiry

The Inquiry will;

- Engage with people with disability who have been victims of abuse and neglect in Western Australia to hear their stories and experiences and to collect information
- Work with individuals and families who have experienced abuse and neglect to identify what safeguarding strategies and

identification for data collection they see as important

- Engage with police, victim support organisations, hospitals and other institutions (prisons, boarding houses), HaDSCO, service providers and DSC to determine what data collection occurs and raise awareness of abuse and neglect of people with disability
- Develop further actions which can be taken to police, victim support organisations, hospitals, HaDSCO, service providers, DSC and government.

### 3. Process

The Inquiry will be approached in three ways.

1. By conducting private sessions which are designed to enable survivors of sexual abuse and/or their families to tell their stories in a private and supportive session.
2. By conducting a public forum, in which key stakeholders are invited to inform the project managers about systemic issues in a variety of settings
3. By conducting a number of surveys and phone interviews with mainstream and disability organisations and disability support workers; and
4. By conducting a research and policy audit focused on prevention, identification, response and justice for victims.

It is recognised that this is a time and resource limited project, with only twenty weeks to undertake a broadly scoped issue which affects many thousands of Western Australians every day.

### 4. Outcomes

- Increased awareness of abuse and neglect of people with disability in institutional settings
- Increased data collection and reporting procedures
- A series of recommended actions that stakeholders can take

### 5. Definitions

For this inquiry;

- a) Institutional and residential settings is broadly defined to include the types of institutions that people with disability often experience, including, but not restricted to: residential institutions, boarding houses, group homes, workplaces, respite care services, day centres, recreation programs, mental health facilities, hostels, supported accommodation, prisons, schools, out of home care, special schools, boarding schools, school buses, hospitals, juvenile justice facilities, disability services and aged care facilities. It means any public or private body, agency, association, club, institution, organisation or other entity or group of entities of any kind (whether incorporated or unincorporated), and however described, and includes, for example, an entity or group of entities (including an entity or group of entities that no longer exists) that provides, or has at any time provided, activities, facilities, programs or services of any kind that provide the means through which people with disability receive support or services, including through their families; and does not include the family
- b) institutional context: Violence, neglect and abuse happens in an institutional context if, for example:
  - it happens on premises of an institution, where activities of an institution take place, or in connection with the activities of an institution; or
  - it is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where you consider that the institution has, or its activities have, created, facilitated, increased, or in any way contributed to, (whether by act

or omission) the risk of violence and abuse against people with disability or the circumstances or conditions giving rise to that risk; or

- it happens in any other circumstances where you consider that an institution is, or should be treated as being, responsible for adults having contact with people with disability.
- c) official, of an institution, includes:
  - any representative (however described) of the institution or a related entity;
  - any member, officer, employee, associate, contractor or volunteer (however described) of the institution or a related entity;
  - any person, or any member, officer, employee, associate, contractor or volunteer (however described) of a body or other entity, who provides services to, or for, the institution or a related entity; and
  - any other person who you consider is, or should be treated as if the person were, an official of the institution.
- Violence, abuse and neglect is broadly understood to include, but is not limited to; domestic, family and interpersonal violence, physical and sexual violence and abuse, psychological or emotional harm and abuse, constraints and restrictive practices, forced treatments and interventions, humiliation and harassment, financial abuse, violations of privacy, systemic abuse, physical and emotional neglect, passive neglect and wilful deprivation.
- People with disability is broadly understood to be a term referring to an individual of any age who fits the World Health Classification of Disability.





## 1.3 Who is this Inquiry For?

For too long, people with disability who experience violence, neglect and abuse have been unable to tell their stories.

They are prevented from doing so by systems or barriers to justice, by confidentiality settlements and by the nature of bureaucracy. Sometimes, they are prevented from doing so by disability and language barriers, and it is only physical evidence like pregnancy or marks of physical or sexual assault that enable abuse to be discovered. Perpetrators of violence, abuse and neglect against people with disability are rarely prosecuted, especially if that person cannot legally testify in a court of law.

The accounts from which this report is derived came from a variety of settings, and

we hope that the results of the Inquiry will be of benefit to disability service providers, schools and education settings, schools, government organisations and those who provide services in institutionalised settings.

But primarily, this report is for people with disability and their families living in Western Australia. Those people understand that violence, neglect and abuse happens often and that this is unacceptable. By telling our stories and demanding access to the same rights and freedoms as non-disabled people, we have the ability to make lasting change that extends not only to our people but also future generations of Western Australians with disability.

## 1.4 Structure of the Report

The report is divided into five sections.

- Section 1 provides an introduction to the report, its scope, terminology and structure;
- Section 2 seeks to define what is meant by violence, abuse and neglect;
- Section 3 provides an evaluation of existing research, including the incidence and prevalence of violence, abuse and neglect. It notes difficulties in the collection of data and seeks to identify some of the structural and individual causes of abuse.,

explores the role of law, the legal framework and its contribution to protection and upholding the rights of people with disability;

- Section 4 outlines a range of safeguarding mechanisms and cites examples of Australian and international best practice;

- Section 5 sets out PWdWA and DDWA's recommendations for action, including developmental, preventative and corrective safeguarding



## 2. Violence, Abuse and Neglect

### 2.1 Definitions

The scope of the WA Disability Abuse Inquiry was clearly defined and directed by the terms of reference for the Senate Inquiry into Violence, Neglect and Abuse of People with Disability in Institutional Settings. Within those terms of reference, the following types of abuse are defined –

‘Violence, abuse and neglect is broadly understood to include, but is not limited to; domestic, family and interpersonal violence, physical and sexual violence and abuse, psychological or emotional harm and abuse, constraints and restrictive practices, forced treatments and interventions, humiliation and harassment, financial abuse, violations of privacy, systemic abuse, physical and emotional neglect, passive neglect and wilful deprivation.’

It is helpful to think of these definitions within the context of institutional abuse, given that it focuses explicitly on the experience of people with disability in formal environments of care. Institutional abuse is explored in more detail below.

In a legislative context, definitions of what violence, neglect and abuse comprises differs greatly from state to state. For example, there are currently nine different definitions of what comprises domestic violence, and people living in institutional settings face peculiar challenges in relation to crimes against them being defined within a legislative context and also having equitable access to the law.

A useful definition is as follows –

Abuse occurs when the integrity of any person is violated by another person who inflicts physical or psychological pain on them, or in situations where an individual's civil rights are breached, negated or ignored. The unequal power that accrues to adults in our society and particularly to adults in care-giving positions is an important factor in conceptualising abuse of children and of vulnerable adults (Brown & Turk 1992).

## 2.2 Who Are the Perpetrators?

Violence, abuse and neglect against people with disability occurs within a range of settings and situations. Perpetrators may be family members or staff, their friends or peers. Co-resident and co-student abuse was strongly highlighted within the submissions received. People with disability may also be targeted by strangers and those carrying out hate crimes.

For women with intellectual disabilities living in residential settings, male residents are identified as being the most common perpetrators of sexual abuse. Secondly, family members – who may also be carers – are commonly identified as a key perpetrator group and can include the intimate partner or ex-partner of a woman with a disability. A third population group are staff in residential care facilities or disability support services, including direct care staff and staff who do not work directly with clients – for example, Peter Kasatchkow, a Perth multi-purpose taxi driver, was jailed for ten years in 2014 for sexually assaulting five women.

One young woman who gave evidence to the Inquiry described ‘grooming behaviour’ in an employee who sexually abused her at her supported workplace over a period of four and a half years.

The management at the young woman’s workplace had noticed that the employee was paying a lot of attention to Bella, but he explained that he had promised her father that he would look out for her. The complaints officer at the supported workplace says that the provider offers training

to their supported employees about identifying abuse and also how to make a complaint, but are now investigating whether they need to train staff in understanding what grooming behaviour looks like.

*“He was sneaky and such a good liar...I call him the mutt. He told my dad and my workplace that he would look out for me when my mother was sick and my father had to take time off to look after me. He didn’t just groom me. He groomed everyone.”*  
- Bella, a supported employee

## 2.3 Where Does Abuse Happen?

Abuse and neglect takes place in a range of settings, including people’s homes, family homes, places of employment, institutions and day centres, supported employment, schools, hospitals, nursing homes, prisons, detention centres and other institutional settings. In some settings, people may be less likely to be able to access disability complaints systems – for example, people with disability who are incarcerated within the prison system have reportedly limited access to or awareness of statutory complaints systems.

Although some institutional settings are regularly inspected by independent bodies – the Council of Official Visitors, for example, visits mental health facilities and Disability Justice Centres in WA, and the Independent Visitors visit prison settings – there is no formal community visitor program within Western Australia for disability settings, outside the Disability Services Commissions’ quality evaluation process, which is conducted every three years for funded organisations.

Most institutional settings have policies and procedures which directly relates to the industry or group that uses the service. Child care is regarded as a system in which there are robust mechanisms, as is aged care. However, a number of accounts of abusive practices in aged care settings were reported to the Inquiry.

*“There was one patient – about 45 years old, maybe, who actually wasn’t an elderly patient, I think he just had a brain injury and used a wheelchair, he was a paraplegic. He couldn’t move his legs. He was in his room and he had been pressing the call bell for about ten minutes and the nurse who was in charge of him kept going in and turning off his bell and saying ‘I will be back in a minute, I have other patients to care for’ and then he kept ringing the buzzer.*

*Twenty minutes later they finally went into the room and he had tried to transfer himself from his wheelchair to his lounging chair because he wanted to sit in the chair, and then became wedged in between the wheelchair and the chair and was stuck. Who knows how long he was stuck there?*

*When they went into the room, the nurse pulled him back into the wheelchair despite the fact that he wanted to get into the other chair. She shouted at him and said you can stay there now for not listening. She told me ‘you have to be stern with them because they do not learn’.*

*She was one of the nursing manager people. I was shocked. I think my face said it all. In aged care, I found there was the least amount of respect for people. There is no one to tell anyone what is going on.’*  
- Louisa, a nursing student



## 2.4 Institutional Abuse

Sobsey (1994, pp.91.93) understands institutional abuse to be made up of four contributing factors – extreme power inequities between residents and staff, the collective nature of the abuse, clearly defined patterns of environmental influence and the fact that the knowledge of the abuse may be either covered up or not shared outside the institutional setting. Brown (2007) notes that institutional abuse is not a 'type' of abuse, but contains a range of factors which combine together to promote poor or abusive practice. Those factors may include –

- Poor quality environments
- Rigid and oppressive routines
- Neglecting the needs and wishes of people with disability
- Practice which does not reflect accepted professional behaviours (for example inappropriate responses to challenging behaviours)
- Acts of cruelty from individuals and staff groups
- Negligent practices and exposing residents to risks

The types of practices that happen within this concept of institutional abuse include practices which are not considered to be abusive in themselves. For example, oppressive regimes may be considered to be 'efficient' or may arise as a result of rationing of services.

*I had to wait twelve years for someone to die so that I could get up before six am. There are only three staff on at that time, they are night shift staff. And everyone else*

*is in bed all morning, most people aren't gotten up until after 12. I like to wake up early. We're not up for long, most people are put back to bed by six or seven.'*

- Resident, Quadriplegic Centre

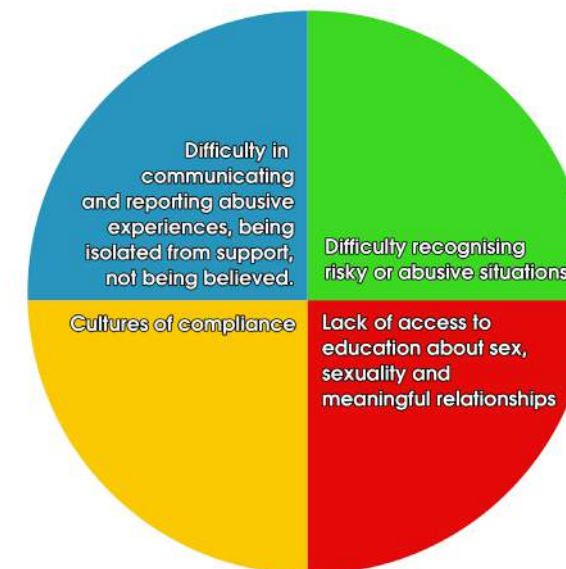
*They put him to bed at five thirty because other residents in the group home had conflicting needs, so by the time I am rolled around, he was ready to party. And he pulled his CPAP mask off, so they tied him to the bed with wrist restraints. I didn't give permission for them to do that, but they said I'd agreed to another form of restraint...so they tied him to the bed.'*

- Parent of a man living in a group home

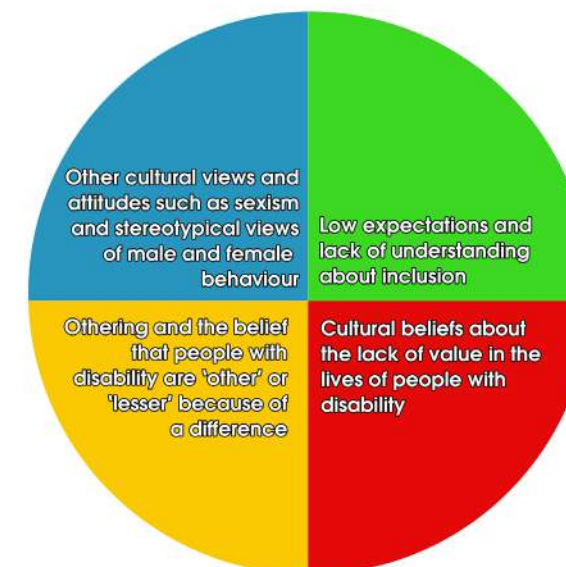
A number of international studies focus on the factors that place people with disability at risk, proposing 'ecological models' of abuse. (Joyce, 2003, Wishart, 2003, Sobsey, 1994 and Hollomotz, 2009) These risk factors are grouped within three systems – the microsystem (people who are abused, those who carry out abuse and the relationships between them), the exosystem (the environments in which people with disability live) and the macrosystem (wider cultural and social factors).

Those systems are explored in detail at right.

### Microsystems



### Macrosystems



### Exosystems



Text description -

Microsystems

- Difficulty in communicating and reporting abusive practices, being isolated from support, not being believed
- Culture of compliance
- Difficulty recognising risky or abusive situations
- Lack of access to education about sex, sexuality and meaningful relationships

Macrosystems

- Other cultural views and attitudes such as sexism and stereotypical views of male and female behaviour
- Low expectations and lack of understanding about inclusion
- Cultural beliefs about the lack of value in the lives of people with disability
- Othering and the belief that people with disability are 'other' or 'lesser' because of a difference

Exosystems

- Staff culture and the ability of staff who disagree with entrenched poor practices to influence change or report concerns
- Segregation and isolation = lack of external people to observe/report
- Staff skills, competence, attitudes and behaviour
- Culture of management including staff supervision and quality of leadership, setting positive standards

Some of the accounts received by the Inquiry were all the more disquieting because of the additional evidence received about othering or lack of interest in the person's care and welfare.

*'I followed them in my car. She wheeled Grace in...she bought herself a coffee. Grace was looking at her, but there was no interaction. She wheeled Grace down the beach path and parked her. She did point Grace towards the ocean, so that was nice – but then she just sat there and smoked until another carer came and sat with her. Grace kept looking for some kind of engagement, but there wasn't any...then she trundled Grace into the back of a car.'*

- Sister of a person living in a group home

## 2.5 Types of Violence, Neglect and Abuse

### 2.5.1 Failings in the Health Care System and Medical Neglect

Perhaps one of the most poignant stories which was collected by the Inquiry was the story of Peta Doig, whose story is told elsewhere in this report. Peta was refused hospital attention at Sir Charles Gairdner Hospital as a result of her reaction to being physically examined, which the State Coroner cited as being the result of repeated abuse. Consequently, she died at Graylands Hospital, where she had been institutionalised since about eleven years of age.

This is an oft repeated theme within the accounts that have been gathered through the Inquiry. The health care system is designed around the needs of the sick, not the disabled. There are limited resources for patients, and disability care and support needs often go unaddressed.

Parents report having to become 'experts' in their child's care, and many report significant stress associated with hospital settings. This applies especially to adults with intellectual disability and autism, and those who require routine surgeries or who are admitted through the emergency department.

There was a strong sense of frustration expressed by both parents and people with disability. It was widely reported that people with disability were not often able to access preventative dental care for a variety of reasons – lack of care and support, inability

to access inclusive or accessible dentistry services. One strongly expressed sentiment was that of 'not being believed' – this was highlighted by the death of fifteen year old Vaughn Rasmussen, who died in 2009 after two Perth hospitals turned him away on four occasions. Vaughn had an intellectual disability and was acting irregularly and having seizures, which his parents recognised as being the sign of a blocked shut. The Coroner said that doctors had missed opportunities to diagnose the problem and by the time surgery was approved to correct the blocked shunt, Vaughn had died. Vaughn's disability was cited as a reason that one doctor did not undertake a neurological examination. Vaughn's mother said that she and her husband were treated 'as though they did not know a thing'.

*“ He was in hospital for ten days and we knew something was going on, his shoulder was bruised and swollen.*

*The registrar said, 'Look, it would be really helpful if he could talk to us. Because he is non verbal, we can't tell where he is in pain. And people at the (disability service) say that nothing happened. If he could talk, he could tell us what had happened.'*

*I said, 'What do you do when people are in a coma? Wait for them to wake up?' So they x-rayed him, and sure enough, his shoulder was broken.*  
- Mary, a parent of a child with CP

Significant issues arise when people with disability are trapped between the health care system and disability system, or between mental health and disability.

In rural areas, people are often inappropriately hospitalised for extensive periods of time due to lack of alternatives in accommodation. There is clear evidence that their disability care and support needs are not met when in hospital environments.

In Fiona Stanley Hospital, people who spend extensive periods of time in bed in the spinal care unit are unable to access sunlight or fresh air, even when hospitalised for many months. At the former Ward 11 Rehabilitation Ward which was previously located at Shenton Park Rehabilitation Centre, patients were able to go outdoors for periods of time on prone trolleys or in hospital beds. A 'policy' that patients are not allowed to remove beds from the room - even though a second floor accessible courtyard has been provided for social and recreational purposes - means that patients may be shut into hospital rooms for months on end, especially when recovering from pressure sores. In addition, they are often not able to access disability care and support during their stay.

The Shenton Park Quadriplegic Centre is currently the subject of much discussion and a review by the Health Department. In 2008, a report was commissioned which recommended that the facility be made safe and refurbished. In 2011, a board of management report was tabled to government that stated that the Quadriplegic Centre had 'passed its economic life and in some cases, safe use'. 57 patients live at the institution, and 37 have been there for many years.

They are regarded as 'permanent residents'. The facility is unsafe, dilapidated and unsuitable for habitation.

Patients report institutional practices and culture which are not aligned with upholding human rights. They include;

- Being told that they could 'only press the buzzer in an emergency'
- Being roughly handled and treated, causing bruising
- Being offered a choice of two meals which must be ordered via a dietitian a week in advance, and two weeks in advance over the Christmas break
- Being told that they were not allowed to 'fraternise' with staff members
- Having restrictions on 'visiting hours'
- A couch being removed from a room due to 'infection control' concerns
- Being intimidated by management
- 'Informal' curfews imposed upon visitors

In 2015, a patient received first, second and third degree burns after he was showered and when a water heater failed. He is now acutely unwell due to his burns and associated illnesses.

There is no publicly available data on the number of suicides which occur yearly, but many patients note that they have an 'exit plan'. Patient movements report that 7-10 people per year die at the Quadriplegic Centre - of a population of under sixty.

*“ Am I institutionalised? Of course I'm institutionalised. I've been here for 27 years. I pay \$2000 a week for the privilege of staying here and I don't know what I will do when the money runs out.*  
- Resident, Quadriplegic Centre



There is evidence that the issue of adequate resourcing in health systems or systems that intersect with health and mental health impacts upon people with disability and psychosocial disability negatively. Significant issues were raised around transport from regional areas and the efficacy of support structures to access specialist care.

In 2005, an involuntary patient had a cardiac arrest 'possibly secondary to antipsychotics and sedatives (due to) delay in transportation', with the reason cited that the Royal Flying Doctor's Service (RFDS) was unable to get a police escort. The man waited in hospital for three days. Another two men, in 2004, had profound apnoea and suffered obstruction of an airway when being transported and treated at Karratha and Nichol Bay Hospitals – another patient, unable to be transported from Geraldton Hospital ED, was sedated and 'was obtunded and has aspirated'. Another country patient was over-sedated in 2008 and was unable to be moved for two days 'due to RFDS being overwhelmed'. The patient required ventilating and was diverted to Sir Charles Gairdner Hospital with aspiration pneumonia.

Another key issue is the failure of the health care system to address the care and support needs of people with disability. There are many people who have worked through long, painful recovery and rehabilitation processes only to become stuck inappropriately and unnecessarily in an expensive medical or rehabilitation facility due to the inability of other people, assessed as ready to leave a rehabilitation facility, being unable to achieve funding through the CAP process. These people often describe their situations as hopeless and say that they have resigned themselves

to permanently residing with groups of other similarly affected people in health-funded institutionalised care. Some people with disability have lived in hospital environments for many years – for example, one patient at the Quadriplegic Centre in Shenton Park, a C class public hospital, has lived at the facility for over fifty years. Patients are subjected to oppressive regimes with limited choice and control and often become increasingly institutionalised and distanced from their previous informal supports.

When abuse or sexual assault occurs in health settings, prosecution rarely occurs if the person has a cognitive disability or mental health condition. In March, 2015, psychiatric nurse Timothy Buckby had his registration cancelled for seven years and was found unfit to practice after he was found to have had sexual intercourse with a patient with a mental health condition. At the time of her assault, the patient was heavily medicated, had suffered anxiety, suicidal thoughts and depression. Buckby was also reported for kissing and hugging another psychiatric patient. The patient was asked why she had not reported the incidents. She said that she was concerned that no one would believe her and that she was told by Buckby, 'I know you've got a son....if you say anything, your son could be taken away.'



*One night following her 2012 admission to the Unit, Patient A was awoken by the practitioner who placed his left hand on the top of her right shoulder and then stroked her shoulder and neck. Patient A was 'groggy' when she woke up as a result*

*of taking her evening medication. Amongst other things, the practitioner said to Patient A, 'Ssh, be quiet or you'll get into trouble'.*

*Subsequently, at about 7.30 pm one evening, Patient A was alone in her room when the practitioner entered the room holding towels and stood very close to her. The practitioner then grabbed the back of Patient A's head and pulled it towards his face. He kissed Patient A and then moved towards her pushing his crotch into her. As he was doing so he made comments such as 'you like it, don't you? Feel this, God you are nice', and 'you want me, don't you'*

*Although Patient A said 'no', the practitioner continued to push himself towards her. Again, the practitioner stated 'Sssh, it's okay. It's all right. Be quiet or you'll get into trouble. You don't want to go into the locked side, do you?' The practitioner then said 'feel this', and pulled her hand towards his erect penis. He then used one hand to grab her breasts, squeezing and pulling them, which was painful. The whole time he was pressing himself against Patient A, he was saying, 'Ssh, ssh, be quiet, you can get into trouble'. He then left the room."*

*State Administrative Tribunal of Western Australia, Nursing and Midwifery Board of Australia and Buckby (2015)*

Despite the findings in the State Administrative Tribunal, Buckby is not reported to have faced a court or any criminal sanctions.



The Health Consumer Council provided a number of case studies for this Inquiry.

The Health Consumers' Council of WA (HCC) is an independent voice, advocating for patients in Western Australia. It offers a unique perspective on health policy and service delivery matters.

HCC receives funding from State and Commonwealth agencies and comments publicly on all issues affecting health consumers.

The case studies are as follows;

#### **Case One**

A woman rang the Health Consumers' Council (HCC) with a complaint about the nursing home her mother had resided in. She questioned the medication administered to her mother, and as her mother's legal guardian she requested her mother's medical records from the nursing home initially while her mother was still alive. She had some concerns about her mother becoming abnormally drowsy, to the degree that she was not able to eat, drink and communicate on her own. The daughter and others observed this sudden marked deterioration in her mother, which appeared to coincide with when she was placed on the drug Risperidone. Staff at the nursing home advised there were no records kept for the previous two weeks due to staff shortages.

After her mother's death, she applied for her mother's records again but staff told her they were not kept at the facility but in the main office in the eastern states. The head office in the eastern states advised they were not kept there but back in the aged

care facility. Upon written application to the aged care hostel, she was advised that they were unable to provide the records requested due to Privacy legislation (as per Section 86-2 of the Aged Care Act of 199).

We then contacted the Secretary of Social Services and requested that they they exercise their discretion to permit access of these records to the complainant under section 86-3(b) of the Aged Care Act of 1997. This has been an ongoing issue in a number of complaints.

#### **Case Two**

The HCC was contacted by Consumer Protection's Department of Commerce to advise that assistance was required for a vulnerable elderly consumer. Commerce noted that there were anomalies with his bank accounts that had been ongoing for four years. The consumer had tried to contact the relevant pharmacy many times without any success. He then gave instructions to the staff at the residential aged care home he was living in not to give him anything that had not been prescribed by his Doctor that was on the pharmaceuticals benefit scheme list. The pharmacy had not provided an account since September 2014 but were still providing the consumer medication daily.

The consumer claimed that residents faced the same issue of with the pharmacy supplying medication that was not required but not crediting their account when the medication was returned. He noted that other residents are too sick, too frail or too scared to raise the matter. After HCC contacted the pharmacy, the money was credited to his account.

#### **Case Three**

The younger brother of a vulnerable older sibling rang HCC with concerns about how his affairs were being managed by another sibling. His vulnerable brother had been deemed incompetent due to dementia and was being forced to sell his home and live in a nursing home. The advocate met with the older sibling and confirmed that he was vulnerable and needed care. It does not seem to be the best fit for the consumer, but there was nothing much that could be done to support him.

#### **Case Four**

A woman rang the HCC about her mother who was in residential care, aged 90, living with her 94 year old husband. She and her husband often had lunch together, they attended church together and enjoyed spending time together. She was attended by family for any needs she had and was comfortable living there. The centre was concerned about her behaviour and felt the family were not managing it. At a family meeting with the centre, the family were told they wanted the mother to be trialled on drugs and had a new guardian appointed by the SAT.

The family were told that the residential centre was sending their mother to Hospital to be placed on the Psychiatric Ward, for a short-term two week stay. They rang HCC when she had been in the Psychiatric Ward for three weeks. Their mother mentioned that other patients screamed and yelled, and the family felt that this probably made her behaviour more agitated and as a consequence was kept in a sedated state and was not given any exercise. The family were eventually advised they could pick up their mother and they organised for

her to be placed in a private dementia specific facility. When they arrived at the Hospital to pick her up, they were informed that she could not leave. After further advocacy assistance, she was able to re-locate to the care facility with much improvement.

#### **Case Five**

A forensic mental health patient was referred to HCC by the Council of Official Visitors (CoOV) as he was attending a tertiary hospital for orthopaedic assessment for two reasons. He had an old shoulder injury from a motorbike accident, and more recently he reported having been tipped out of his wheelchair by a mental health nurse. HCC tried to assist with obtaining medical care however the patient was moving between voluntary and involuntary status and was also working with CoOV.

#### **Case Six**

A daughter in law rang HCC appalled at the treatment of her mother in law at a residential facility. She reported that her mother in law had been abused and had suffered bruises. HCC ensured the family was connected to the hospital Social Worker who facilitated her removal to a closer and better aged care home.

#### **Case Seven**

A woman rang HCC advising that her pharmacist had expressed concern about the medications prescribed to her husband. The pharmacist expressed the view that the complainant's husband was being overmedicated. An advocate attended a follow up meeting with the complainant and GP, and the GP agreed to remove the "dispense as needed" instruction for Risperidone and halve the dose for the first



week with a view to removing it all together by two weeks. After the meeting the advocate and complainant discussed the possibility of removing the use of antidepressants gradually as well. Further meetings included discussion of the importance of person centred approach to care. For example the facility agreed that if the husband became agitated they would call the complainant any time of day or night

Another episode unfolded where her husband was agitated and the nurse on duty called the complainant and noted that he was going to be sent to hospital. The complainant went immediately to the centre, calmed her husband down and no further drugs or interventions were required. She expressed a concern that the suggestion to take him to hospital was due to the interference over the Risperidone. There was another incident, where the aged care facility rang her to tell her that her husband had a fall and bumped his head. The complainant asked staff what medications he had been given, and he had been administered a sedative about 2 hours before his walk, and then he was given permission to have an unaccompanied walk, which resulted in the fall. Another nurse commented to the complainant in relation to her concerns about the chain of events – medication then unaccompanied walk - "This is what they do. This is what they do." The complainant noted a correlation between her husband reacting badly, and the presence of a particular nurse.

The complainant was concerned over the use of medications to sedate patients for ease of management rather than for their welfare.



**“...tipped out of his wheelchair by a mental health nurse.”**



## 2.5.2 Intersectionality Between Systems

Overwhelmingly, one of the strongest themes expressed via this inquiry is that overlapping responsibilities between agencies and the lack of clarity about responsibilities often contribute to the incidence of violence, neglect and abuse. Those intersectional failures and jurisdictional gaps occur within a number of systems – health and mental health, disability and health, disability and mental health, disability and education, disability and child protection. The problems are regularly cited but rarely remedied.

In some cases, the jurisdictional issues appear to be attributable to existing agreements which have been developed to avoid duplication of services. For example, if you are a person with disability living in a government care setting, your disability support is not provided in hospital – it is provided by hospital staff, who may not know the person well and may not understand their disability care and support needs.

This was well demonstrated by one account, of a woman whose neck was broken at home in an institutional setting. The family suspected and still suspect abuse, but the incident report cited an unobserved fall from a bed after a suspected epileptic seizure. The woman was admitted to hospital and the family was called some eight hours after the incident. Her sister reports;

*“So I go in the next afternoon and I am shocked initially that there is no one with her. She’s the type of person who will get up and walk out and perhaps be on the road. She needed constant supervision. Hence the lockdown that she lived in. Highly at risk, I couldn’t believe that she was here on a bed alone. So I said to the staff, is there a carer here? She looked at me and the nurse said, no? And I said how can she be here alone? And she looked at me oddly...*

*I go over to Grace. I look at the swelling of her neck. It’s like nothing I’ve ever seen before. And the fact that she’s lying prostate in the bed which she’d never do. Her hands and wrists are incredibly swollen and puffed, I realise that she’s in extreme pain, she’s twisting her head to the point where it’s knotting her hair. She’s got dirty hair, there’s dirt in it and dried blood. Like dirt from outside, like you’d been out on the ground. And when I look, when I part her hair there’s a deep gash in her head. I can’t tell you if it had been stitched or not, I don’t know. She had a crushed right thumb, grazing to one cheek and bruising to another. I was shocked because this is not what I was expecting, she looked like she’d been beaten. And I’m no doctor, but I’m looking at this person who would never lie still, in agony, and I’m thinking from what I’m seeing of her neck and her inability to move, that she has a back or neck injury.*

*So trying to get a straight answer from the nurses was very difficult. Finally one tells me that she is just there for observation, they’ve done an x-ray or one type of test and she’s fine, this is her normal condition, she’s been going downhill rapidly, and she will be going back to (redacted) House.*

*...The hospital did not know that she could not speak. For a week I am begging them...the nurses kept coming in offering coffee, the nurses are talking to them, and I put a sign up in the end. Saying yes, I cannot speak, I would like a cup of tea...’*  
- Sister of a woman seriously injured in disability residential accommodation

Grace eventually was given an MRI, which diagnosed a broken neck. She required surgery and extensive rehabilitation. Grace’s sister reported a number of other issues which highlight jurisdictional gaps. For example, when Grace was taken home from hospital after neck surgery, she was given a medical model wheelchair which was not suitable for her needs as a patient with a spinal cord injury. Consequently, her sister says, she was refused transport by the disability system (because of the safety issues around the wheelchair) and was unable to access rehabilitation until an appropriate wheelchair was provided.

Former quality evaluators for the Disability Services Commission report that intersectional issues made up a number of the issues that they regularly reported against, and that an existing agreement between health and disability (to avoid duplication of services) was often cited as

an issue. One former evaluator gave evidence to the inquiry about intersectional issues –

*“If the issue was about something that had gone wrong when the person was in hospital, we were told to take it out. Because, you know, it was Health’s responsibility, not Disability’s. But the real issue was that the person wasn’t having their needs met. It wasn’t anyone’s fault, if you look at it that way – it was just that the type of support that Health would provide would not actually be disability care and support, which is what the person needed as well as nursing care and medical attention. It was the fault of the system... and there is not really any clarity about who is responsible for what.’*

- Former evaluator

Ownership arrangements are complicated even for those who work in the field and varying practices in different policy settings mean that the human rights of people with disability are often breached in a variety of settings. For example, there are increasingly stringent rules around restrictive practices in disability service settings. The Voluntary Code of Practice for the Elimination of Restrictive Practices (2012, reviewed in 2014) was adopted some years ago after an amnesty period where providers were able to freely work together with the Commission on solutions around challenging behaviours and restrictive practices. However, the interviews that were undertaken during the course of the inquiry revealed that there were widely differing



views about restrictive practices in non-disability service settings.

A large service provider told the Inquiry that their clients, who are not restrained in disability settings, are often 'restrained for weeks on four point restraints' in health and mental health settings, or chemically restrained. This differs significantly from the way a person with disability would be supported in a disability service setting or at home and the perception is that the person is being restrained as a consequence of their disability, not their mental health needs, due to a failure of the system or process to cater for their disability support requirements.

People with disability who fall 'between the gaps' are often described as 'tricky', but in many cases, their disability type directly informs their comorbidities and should inform our intersecting care systems. Although the life expectancy of people with Down syndrome has increased dramatically in recent years, they are more likely to develop Alzheimer's disease and are consequently more likely to access nursing home care. 50 – 70% of people with autism experience a lifetime mental illness such as depression or anxiety disorders. Many people with acquired injuries, especially those with acquired brain injury, have issues with drugs and alcohol – 60 – 80% of people in alcohol treatment will show some form of cognitive impairment, and 14% of people develop a drug and alcohol problem after a head injury. People with quadriplegia often need to access mainstream hospital treatment for issues related to their disability, including management of pressure sores, blood clots and urinary tract infections.

Mental health is another area in which ownership and intersectionality is a major issue, especially for those with comorbidities. The Council of Official Visitors cites the case of a consumer with a physical disability which had worsened since they moved into the NGO managed hostel was told they would be evicted because they could no longer carry out activities like clean their unit. The hostel licensee said they were not sufficiently funded to provide the level of care required.

"It was argued that the resident was being discriminated against and being evicted because of their physical disability. With a looming deadline for the eviction there was no other suitable accommodation for the resident. All that was suggested was an older style hostel, which would have been a significant downgrade for this young person in terms of both the physical amenities and because it offered no recovery or psychosocial programs, nor was it properly equipped or staffed to deal with physical disabilities.'

It was also noted that, despite having such a serious physical disability, the resident was falling between the gap of the Mental Health Commission (MHC) and the DSC. The resident also fell between the gap of State and Commonwealth funded services as they were rejected for Health and Community Care (HACC) services which would have assisted the resident with daily activities so they could continue living at the hostel." - Council of Official Visitors Annual Report, 2013 - 2014

Systems should intersect seamlessly and ensure that people with disability are able to equitably move between systems without being subjected to violence, neglect and abuse.



### 2.5.3 Violence, Neglect and Abuse in Disability Service Settings

#### History

It is important to recognise that current violence, neglect and abuse against entire populations of people with disability is sometimes directly informed by the history of the institutionalised setting in which they have grown up.

A number of the people who told their stories to the Inquiry had experienced lifetime institutionalisation and for those who have had repeated unconscionable breaches of their human rights committed against them – including abuse and neglect – experiences of abuse may be normalised or difficult to recognise.

The vast majority of people who reported abuse in disability service settings to the Inquiry were people with cognitive disabilities (intellectual disability, acquired brain injury and autism). For many of those people, they had been sent to Claremont, Heathcote or Graylands Hospitals as very young children where they mixed with those with mental health conditions. Some families cited little support, or had been told by their doctor to 'give him/her up'...the medical profession routinely advised parents to send their children away and forget them.

*“That’s what they told Mum and Dad, the medical people, ‘Just forget you ever had a son or daughter’...in those days you were just told to put them away, forget that you ever had a son or daughter. He stayed at home til he was six.*

*When DSC and DADAA did the Lost Generation, which he was in, they found that there were so many people who did not have family connections who were living in DSC accommodation... and somewhere along the line the records got lost. During the Lost Generation project, they tried to connect people with their families...they connected some, but not all.’*

*- Sibling of a man who lived at Claremont Hospital*

In the 1950s, a parent who visited Claremont's infamous J ward for children wrote a letter to the Perth Daily News. In it, she said:

**“** ‘The ward is a large barn in which 70 or more mentally deficient children are housed. Most times there are only five or six paid personnel on duty to look after this large number. The bulk of the work is done by poor souls who are themselves inmates and are probably just as much in need of attention ... it was hard to believe that it exists in the 20th century but rather looks more like the 18th century bedlam.’

Not much had changed by the sixties and seventies, according to interviewees who told of conditions in the institution;

**“** There were these beautiful grounds and beautiful lawns and then you got to the actual building – it had a ten foot cyclone fence and barbed wire. Locked gates, locked like a prison, with the kids all standing around, bored, or hanging off the fences looking out like caged animals.

- Sibling of a man who lived at Claremont Hospital

**“** There was a big room where people sat on benches around the walls, doing nothing, smoking like mad. The benches were fixed to the walls, and a lot of people sat around on them all day, doing nothing. And the bathroom, I remember waking in one morning and seeing a massive room, tiled cold place,

and people queuing up to get processed through the baths and showers. My first through as I walked in was that it looked like people queuing for the gas chambers. We were shown the padded cells, too, they were sort of attached to the walls with a canvas type of fabric.

There were male and female sections, not in the day time but at night. In 1974, there was no gender separation and there were a lot more men in psych nursing than females.

You can count on the fact that there were terrible things going on. In the news there were cases of sexual abuse by male nurses.

You have got no bodily integrity and you just do as you are told. That complete compliance... you are fair game for anyone to do anything to you. Day after day relentlessly the same thing, over and over.

Nothing has changed. If you think that is okay, if you think it is okay for people to line up naked waiting for their shower, if you see people less than, if people are allowed to do nothing all day...that's when abuse happens. When people see you as less than. The conditions are better, but abuse happens because people are seen as less than human.

It's awful things to recall, because forty years later it is still as upsetting and it feels the same, nothing much has changed. For a long time I felt guilty that I hadn't spoken up more, but I realised that I wasn't in a position to, it was so huge. I was so totally shocked. I didn't expect it to be so bad for the people with intellectual disability.'

- Former student nurse, Swanbourne Hospital

After many years, parents began to lobby for change. The change they wanted to see was largely change around a better life, but because of community attitudes at the time, a separate life was still desirable – special schools, training centres, farm colonies and sheltered workshops. Places where their children could be safe from abuse and harm.

In the 1950s, the Government set up a home for 50 children. The Nathaniel Harper Homes were the first of disability institutions for children, and the creation of other hostels, like Pyrton Training Centre in Guildford (set up in 1967) followed.

The stories from Pyrton are as harrowing as the stories from Claremont.

**“** I started working for the Authority at Pyrton Training Centre in the late 60's. Children aged four and under had been moved from Graylands in a move from the locked away wards to another institution under a different model of care. At the start of this process most of the care workers were caring mature woman and the children who has been kept in cots all their short life were provide many opportunities that children at home were given. They learnt to walk, talk, play and laugh. It was for a while a fun place to work.

Within a few years the children under 16 were moved to Pyrton and then adults. The management of the older children changed into more institutional care with psych involvement. Some of the things

I was required to do in my position distressed me. The children had all in one clothing that were fastened at the back put on them to stop them masturbating. Children were restrained on toilets for long periods. We would have to sit and spoon feed them condensed milk to keep them there.

One child with autism was targeted by an abusive worker who to my knowledge was never identified. The child was so very distressed in this institutional setting that he spent many hours hidden under sheets often standing on any high area he could find. For the gentler staff it was acknowledged he was most comfortable when he could be quiet and hide. The dorms were locked and staff carried keys on chains. The abuser would whip this child with chains. He would be found with bruises over his back and legs. Although frequently reported I never knew who was doing it and I so wanted to take this child away from that place.

One of the psychologists introduced a mushroom shape object that was required to be inserted into a child's anus. When faeces start to move toward the object and touch the cap a sound would ring to prompt child and staff to get the child to the toilet. I recall it wasn't done for long in the dorm I worked in because it caused infections.

There was institutional abuse with no facilities to clean children that had soiled themselves. The children had to be sluiced down in a bath. There was only two baths for 22 children, many of whom were not toilet trained. These baths were used to wash all the children as well as being used as a sluice. After much lobbying I resigned and informed the agency I would report the situation to the health department. Shortly after this sluices were installed.'

- Former nurse, Pyrton



Siblings and parents reported widespread use of 'treatments' and restrictive practices.

*I can tell you that at Pyrton, there were things they did to her such as Tabasco treatment, I know there are lots of families who told me about sensory deprivation, I don't know whether she had that. Again, in her files there are doctors - up to twenty drops of Tabasco on her tongue...and then eventually someone said you have to stop.*

*They also used to use restrictions, they used to tie her. That's in her files too.'*

*- Sibling of a woman with disability*

Pyrton remained open until the mid-1990s.

Historically, Australia has had a cultural and social response to segregate and isolate people with disability because of perceptions about our need for 'protection' and views about people with disability being 'other'. Many accounts provided to the inquiry reveal that the act of segregating and isolating people with disability, in itself, can be contributory to violence, neglect and abuse.

An article in the Australian summarised the issues around the death of Peta Doig, an Autistic woman who died in Graylands after being abused for many years and repeatedly harmed;

“

*'Peta Susan Doig was nobody and everybody all at once.*

*Institutionalised at the age of eight with severe psychological, intellectual and, later, physical disabilities, she lived for decades locked away from society before her death at 12.21pm on January 4, 2013.*

*Her life was not chronicled through the usual keepsakes, milestones and photo albums of family or community. For the last six years of her life she had no contact with family whatsoever and was "so severely institutionalised she had no meaningful relationships with anyone outside the hospital".*

*She lived desperately afraid of the people around her, perhaps because she was "vulnerable to sexual exploitation by other patients". She spent her last days in agony, banging her head repeatedly. And then her heart stopped.*

*Peta's life story was eventually told not by anyone who knew or loved her, but in the dispassionate, clinical prose of a coroner's report.'*

*- Rick Morton, The Australian, May 4, 2015*

There are reports of Peta Doig's injuries – her arm was broken, she became paralysed – but little detail about the abuse she suffered. There are no police reports. Although she was a ward of the State, her medical records are sealed. Peta's one brother could not be found by the Coroner.



### Current issues

Living in institutional settings can expose people with disability to significant risk. When people are forced to live together in congregate care settings, especially in residential services and larger congregate settings, cultures of abuse and exploitation can become entrenched in the culture of the service setting. There is also a greatly increased risk of co-resident abuse. This has been observed in institutional settings around Australia and documented in a number of interstate reports as well as reports by watchdogs in WA who report against mental health settings.

### Constraints and Restrictive Practices

In Western Australia, there has been significant progress in some areas, such as restrictive practices. The Voluntary Code of Practice for the Elimination of Restrictive Practices saw widespread cultural change

in disability services in WA where providers agreed to work to implement the Code in their services. The purpose of the Code is to raise awareness of the human rights of people with disability, contribute to the elimination of the use of restrictive practices for people who 'experience challenging behaviours', ensure safeguards in place when restrictive practices are used and to assist disability sector organisations to demonstrate compliance with the National Standards for Disability Services, Quality Management Framework and Serious Incident Reporting Requirements.

The implementation of the Code followed an amnesty period, where providers were encouraged to disclose the use of restrictive practices in order to work together with the Disability Services Commission and other stakeholders in developing solutions.

The Code is very clear about the use of

restrictive practices. It says that they cannot be for organisational or staff convenience or to overcome a lack of staff, inadequate training, a lack of staff support and/or supervision. However, some of the accounts given to the Inquiry indicate that despite this clear framework, support, and guidelines, people with disability continue in some cases to experience restrictive practices, in and out of disability service settings.

The issue of chemical restraint was the issue that was most often raised, along with the issue of 'sleep versus passive shifts'. The issue of adequate communication and permission from the family was also raised - in the case of one man who was tied to a bed with wrist restraints, the family cite a letter which said 'use arm splints or other means'. The family had discussed and approved the use of arm splints as a last resort to prevent their son removing his CPAP machine mask at night, but when the cost of the arm splints proved prohibitive and when no ready-made solution could be adopted, the man was tied to the bed by the wrists. The man's family observed that he was being put to bed in the late afternoon to accommodate the needs of the other residents in the group home.

It is of note that the Voluntary Code applies to disability, not health. In 2007, the arm of a patient was broken at Graylands Hospital during a 'restraint procedure'. There are no other details available, other than the observation that the patient was a paraplegic. In 2006, the arm of another Graylands patient was broken during 'a struggle with staff'. The woman's arm was broken so severely that she was taken to Sir Charles Gairdner Hospital for surgery. In the same

year, a patient at Fremantle Health Service suffered a fracture of his right humerus during restraint. Another Graylands patient in 2006 allegedly had a pillow held over his face during restraint, and yet another (at Bentley Health Service) sustained injury to his nose and carpet burn to the side of his face during a restraint procedure.

In 2011, the WA Coroner handed down his findings around a 27 year old man with schizophrenia who died during a restraint procedure in 2007. Warwick Ashdown was pinned to the ground for 'three to five minutes' by four nurses and a security guard before he vomited and started to lose his vital signs. The post mortem examination found 'significant bruising' on Warwick Ashdown's neck and said that his death was due to cardiac arrhythmia during restraint. It found the pressure on his neck likely cut his oxygen supply and increased his heart rhythm, killing him.

The Coroner found that the staff were undertrained and that WA Health should review its restraints procedures. There were no criminal or civil sanctions in place, so nobody was held accountable. Warwick was legally strangled, under the law. In July 2012, Professor Bryant Stokes concluded (in a report about mental health facilities in WA) that "... the governance of public mental health in WA is fragmented, variable in type and method of service delivery, and that there is no robust uniform clinical accountability across the system."

There was no available data on the number of 'approved' restraint procedures carried out in or out of mental health or disability settings.

Disability advocates and families are forthright about the treatment of people with disability and psychosocial disability.



*They can do what they want, as long as it is written in a plan. And the plan doesn't say how often it will be done or how it will be done...they can do what they want and they do...it made me terrified because I am not there to see what happens. And what will happen after I am dead and gone?*

*They keep saying restrictive practices are going to be gotten rid of but in a lot of cases it comes down to money. It is cheaper to give someone a pill or lock them in a room than it is to pay someone to do an active shift at night time or supervise and support someone properly. It comes down to money and resources.'*

*- Parent of a child with autism and high support needs*

A rural provider candidly admitted that in regional areas and in smaller organisations, there was 'not as much understanding about the human rights aspects' and that 'things were still done the old way by a lot of workers'.

Peter, who gave a comprehensive account about severe neglect carried out by a large metropolitan provider, also reported an incident when his wheelchair was switched off or switched to the rear controller so that he had no mobility.

### **Passive neglect**

One of the most difficult areas to address within the terms of reference in this report was the issue of 'passive neglect'. Passive neglect is unintentional neglect, withholding or failure to provide the necessities of life, and is often characterised by a situation where the person with a disability is left alone, isolated or forgotten.

The difficulty in defining passive neglect arises when the person suffers passive neglect as a result of systemic failure or lack of resourcing. When a person does not have family or a caregiver and is in the hands of the State, does a failure to provide support comprise passive neglect? What about a failure to provide funding by the State or Commonwealth?

A 2014 report by the Community Development and Justice Standing Committee about WA's Accommodation and Intensive Family Support funding described the issues faced by people with disability and their families who have been unable to secure funding to provide the basic necessities around accommodation, health, rehabilitation and disability care and support.

The report describes unmet need in WA and the impact that it has on the lives of people with disability. For those without funding, life looks very different from the lives of those who are well supported.

In their submission, the Multiple Sclerosis Society outlined the issues for people with disability who are not in receipt of funding and who are forced to live in hospital or nursing home environments.



“

Bob was diagnosed with MS in 1998 at the age of 36. His disease was progressive and by 2008, he had lost his relationship, his job and his mobility. In a wheelchair and experiencing the embarrassment of double incontinence, fatigue and difficulties with his activities of daily living, we lodged a CAP application for a care package, requesting \$37 000. HACC and the MS Society services were in place but becoming increasingly inadequate. Bob continued to deteriorate and develop the trigeminal neuralgia, an extremely painful condition of the face, triggered by eating and drinking. He also experienced significant side effects from the medications he used to treat that condition.

From 2009 to 2012, he had numerous hospital admissions and we were able to place him in and out of our residential respite home because his poor nutritional status and immobility were leading to diminishing health.

In late 2012, the CAP was updated, seeking funding for a high support accommodation option as he clearly needed access to 24- hour care and support. If support failed to turn up, he was found sleeping in his wheelchair and often sitting

in faeces. Bob was admitted to hospital for surgical cleaning of a pressure sore and with no funding through CAP, had an ACAT assessment and was transferred to a nursing home in July 2013. He became increasingly depressed and teary, wanting to go home. Sharing a four-bed room with elderly men was distressing for him. Sadly, Bob died in October 2013, aged 50.

We withdrew his CAP application.

- (Ms Susan Shapland, General Manager, Member Services, Multiple Sclerosis Society of WA, Transcript of Evidence, 12 March 2014, p9.)

“

An 18-year-old that an aide used to support had a very sad accident on holidays and went straight from hospital into nursing care. He was 21 when he moved into a nursing home. He could not do anything for himself. To say “yes”, he was able to open his mouth slightly to indicate a “yes”, and to say “no”, he would cry, and that was the only control he had over his body.

Sadly, in the nursing home there are a number of other people very different to young Kell who needed support. A number of those people, sadly, had a degree of dementia. One of the ladies with dementia developed a soft spot for this young man and felt that she could ... care for him.

With her condition, she did not understand that the young man could only swallow food that has been pureed to almost a thick liquid. He could not chew; he had no chewing muscles. So he existed on a diet of slop, basically. But, like all young men, the lady thought that young Kell would love chips from the canteen, so she would go and buy potato crisps and give them to him, and he cannot chew. So he was often getting pneumonia because the pieces of chip that she crushed up and put in his mouth will go straight to his lungs.

The only way to keep him safe from a very well-meaning co resident was to lock him in his bedroom. This guy, he cannot call out, he cannot unlock his bedroom, he cannot say, “Hey, I need the bathroom now” or “Hey, I’d like to watch telly” or “Can you change a channel” or “I have an itchy head.” So he would stay locked in his bedroom between meals where someone will go in and give him his slops for his meal, and he really existed in his bedroom with the door locked. Sometimes someone would remember to put the telly on. I do not know whether he wanted to watch The Morning Show or not but that is what he would get. And that was his existence, because he did not have any alternatives for funding. There is many a sad story like that of

younger people with disabilities living in aged care facilities.

- Ms Frances Buchanan, Operations Manager, National Disability Services WA, Transcript of Evidence, 12 March 2014, pp9-10.

## Financial Abuse

In Western Australia, there are few studies around financial abuse in disability service settings. The Inquiry heard that financial abuse was most commonly perpetrated by family members and by ‘mates’, but the issue of financial abuse in institutional care settings was raised by several participants.

A sibling of a woman living in government residential accommodation maintains that her sister experienced financial abuse in the small institutional setting she lived in. When her sister moved, she packed for her and discovered that the clothing that her sister was wearing was ‘old and ratty’ and ‘really inappropriate clothing’.

“

‘Old maternity pants, see through tops...there were receipts for new things from Suzannes, from Katies...but I went through her clothes, there was nothing from Suzannes or Katies. I went to (the head of the organisation) and asked where her watch was, why was a watch bought, she can’t tell the time? Oh, it was probably a gift. Where are the clothes? There are many questions about her finances.

Who would she have bought a gift

*for? And how would she have communicated that she wanted to buy someone a gift?*

*Things went missing, too. I always made a big thing of buying her a Jag or Cherry Lane tee-shirt at Christmas or birthday, and they were never there the next time I would go to see her."*

*- Sister of a woman living in residential accommodation*

A disability advocate reported that staff financial abuse was common in the regional area where she lived.

*"She was a really well-meaning support worker. One of those people who you could tell really cared about her clients. But then she told me that (her client) would spend her money on magazines or takeaway, and so the support worker hid her money around the house. (Her client) would go to the bank every day, she had her own card, but we'd gotten the money out beforehand and she would always forget...she would get really upset. But she told me that there was no way her client could manage her own money. She was overweight, she said, so she shouldn't be buying takeaway, she should be making healthy eating choices.*

*The funny thing was, I knew her client, and she was two dress sizes smaller than the support worker. I wondered if she (the*

*support worker) had ever skipped lunch so she could buy a women's magazine, or bought takeaway because she really wanted Subway. And why it wasn't okay for her client to do the same.'*

Other regional areas reported similar stories.

*"We have a Nursing Home in our region that is controlling a client's access to her bank card when she goes on outings. Sometimes they refuse to give it to her, or to give her advocate access to private documents when requested. They will not provide her with lockable storage for her valuables. Also, she was provided with an unsuitable electric wheelchair and this was never addressed, so she has been dependent on others for basic mobility every day.'*

*- Regional Advocacy organisation*

A man with quadriplegia stated that he had been financially abused by a government nursing employee who 'preys on disabled men' despite living in a defacto relationship. He claimed that she had been forced to resign from the organisation for 'living a double life with a client' and that it 'took him a year to catch her out'. The employee had now allegedly moved to work in a disability institution in the metropolitan area.

### **Neglect**

There were many cited incidents of neglect, including emotional and physical neglect, amongst the accounts given to the Inquiry.

Neglect is generally typified by an ongoing pattern of inadequate care that inhibits the development of a person's physical, intellectual and/or emotional capacities, and is readily observable to those in regular contact with the neglected person.

Generally, there are considered to be four types of neglect, all of which are acts of omission that may impair an individual's chances to develop normally and reach their full potential. They are:

#### **Physical Neglect**

This includes abandonment, inadequate supervision, failure to provide adequate food, shelter, clothing and failure to maintain basic levels of hygiene.

#### **Emotional Neglect**

This includes the failure to provide nurture or the stimulation needed for the social, intellectual and emotional growth and well being of an adult or child. It includes withholding affection, ignoring, and rejecting.

#### **Medical Neglect**

Failure to provide access to appropriate medical care, medications, necessary therapy needs.

#### **Educational Neglect**

Involves non-enrolment, denial of needed special education support, the permission of chronic truancy.

(Secca, Abuse and Neglect, 2006)

In the context of institutional neglect in disability service systems, concerns were raised primarily around physical, emotional and medical neglect by several providers of residential services, primarily large

residential services.

Educational neglect was restricted to accounts which focused on family abuse, and medical neglect was not examined in the context of psychosocial disability. However, the literature review identified major systemic failures in the mental health system which have been widely documented in Western Australia and which are under current scrutiny by the WA Coroner after a spate of suicides at the Alma Street clinic.

In the disability service system, accounts were provided which revealed serious inadequacies in disability care and support in institutional settings.

One account was given by Peter, who said that he experienced 'grossly inadequate care and neglect, which eventually resulted in severe depression, weight loss, dehydration and hospitalisation'. Peter, who lived in an institutional setting, said that he was often left wet or soiled, or left in his room without support. Other clients and staff alerted support workers that his 'chair was dripping with urine' that had pooled under his chair in his room, his personal care was not attended to, and failure to have hydration and toileting requirements correctly addressed. As a consequence, Peter was hospitalised for dehydration and severe constipation. Peter reported many instances of inadequate personal care, damage to personal property, lack of attention to hygiene, emotional abuse and a lack of care routines being attended to properly.

Peter said that the neglect had a profound impact upon him.



“

*...my isolation and on-going neglect resulted in me requiring psychiatric intervention and additional medication to manage my deepening depression. It left me anxious and insecure; afraid of what would happen if future support workers took advantage of my vulnerability, so dependent am I on others for all my daily care needs. My experience (moving out of home for the first time), which should have made me feel valued and supported, left me for many years feeling apprehensive and fearful of the future.'*

Neglect around medical needs was also highlighted by many family members of people in institutional care as a comprehensive issue, especially when incidents had occurred. One child was left for six hours before being sent to hospital and treated for a fracture. He was put outside in a play area, screaming, for many hours – the incident which led to the fracture occurring was never explained, and his pain response was written off as a 'behaviour'.

Many parents expressed their concern about emotional neglect and the failure to understand their children and address their disability support and care needs.

One parent of a child with an intellectual and physical disability said:

“

*People are so often dismissed, schools, medical, agencies, community agencies, agencies that support, all of them – they don't listen to families. They (the family) know the child better than anybody. That has got to be a factor. That's where a lot of this abuse and neglect comes into play because these professionals think they know better. Don't take her to the movies, if she doesn't like it. If she screams every time she goes to the movies, she probably doesn't like it. She does the same activity week in and week out. Would you do the same activity week in or week out?*

*Why do they have to do the same thing day in or day out? That to me is a form of abuse...they talk about people being included. I am constantly saying change it up, change it around, but no, it is too bloody hard. It is not convenient. It is going to cost them something in travelling. It is just bloody pathetic*

*She might not be able to make a decision, but if she is screaming every time she goes swimming, she is telling you that she doesn't want to go swimming. There's a real lack of being included in decision making...why take her if there's evidence that she hates it, just because someone wants to fill in a few hours to tick a funding box?"*

### **Physical and sexual violence and abuse**

Perhaps the area which provided the most cause for concern in the Inquiry was that of physical and sexual abuse in disability service settings. Those settings included day programs, sheltered workshops, group homes and disability residential accommodation.

Responses to abuse consistently came too little, too late, or not at all. Bella is a young woman who reports being sexually harassed and assaulted by two staff members in a sheltered workshop, despite the provider providing training in how to recognise abuse and how to make complaints. The complaints officer (from the sheltered workshop) has been supporting Bella throughout the process and assisted her to tell her story to the Inquiry. The provider has also paid for Bella's counselling in the wake of the abuse.

Bella did not feel able to disclose the abuse, and 'blurted it out' to her mother four and a half years after it commenced. After one employee was dismissed, she felt safe enough to disclose further abuse. Both employees had federal police clearances and WA based working with children's cards, but came from interstate.

Bella reports that a number of incidents happened in the back seat of the car, where she was sitting with another employee and whilst her father drove the car. It was an informal arrangement between employees, and the second abuser also used the car pooling arrangement. Bella says that the abuse continued in other forms when she got to work.

“

*One time it was behind the welding bay and it also happened behind the packs of wood, beds, boxes and pallets – it happened in lots of places where people were in line of sight.'*

Bella's police complaint was not upheld in the absence of forensic or 'other evidence'. It was felt that police 'did not try very hard' and that some staff did not really understand intellectual disability, nor how to effectively work with a victim with an intellectual disability.

Another case of sexual abuse was reported against the same agency, in a different location. The abuser was jailed.

There were a number of physical injuries reported as being acquired in disability service settings reported, which were not attributable to any known cause.

One twelve year old child returned home from her day program with a cut to her vagina that was so severe that it remained unhealed for over a year. The cut required eight stitches.

The child, who used continence aids and was described as 'well padded' went to a disability provider day program in the early morning and returned home in the late afternoon. She was soiled, and her mother changed her continence aid, then discovered blood on the wipe and a large gash under her labia. A friend advised that she take the child to the hospital, and she was admitted for some days and stitched under a general anaesthetic.

Her mother reported what happened.

“

*'I was shocked. I've never had to deal with anything like that. I didn't know what to do. I took her into emergency, and I had to whisper to tell the lady at the desk. She told me to speak up louder and I said, I can't! And then they took us into the side room.*

*The doctor came, they rang PMH child protection unit, notified the police. Princess Margaret wanted her old nappy and clothing. The nappy stunk like shit. They wanted the clothing that she was wearing and then they took me away and gave me information about what would happen if she had been interfered with...I hadn't thought about that. I lost it, I hit a wall. They said they would sew her up and check her uterus and make sure she hasn't been interfered with.*

*It was awful. She was really, really clingy, really emotional. We had to go to the child's area, not a general ward, and the nurse threatened to call security on her because she wouldn't calm down. She was fed up and scared...she is still sensitive down there a year later because of the position it is in, after six months it was still not healed.'*

The doctor said that there was no way she could have caused it by falling. The child had clearly been changed since the injury occurred, as the medical evidence was that the wound would have bled profusely. The family provided three continence aids every day and two were left at the end of the day. However, the provider denied any knowledge of the injury occurring and as the child does not use spoken language, there is no way of accounting for the injury.

The mother says that it has had a profound effect on her.

“

*I have lost myself, I have lost my faith in anyone looking after her, I couldn't put myself...I don't trust anyone to look after her. She was there for two and a half years and when that happened, I just cut it off straight away...if she was verbal or could say what happened, or if someone owned up to what happened, that might be different. I am never taking her back there, no, I am not taking her back there, no way in hell.'*

Another case of suspected sexual abuse has been recently before WA police. The child, who was then aged 12, was removed from her family, who were having great difficulty in dealing with her behaviour. The child has autism and an intellectual disability.

After being removed from her family, 'Abby' was placed in government emergency accommodation. She spent eighteen months in emergency accommodation, before being moved back home, then to a non registered respite service for eight months, and back to government emergency accommodation for a year.

Abby's parents had asked for help before in parenting their child and the Positive Behaviour Team had offered assistance. However, Abby's behaviour had spiralled out of control, and going into residential accommodation made it worse. Agencies refused her, saying she was too hard.

Abby's mother provided images of the emergency accommodation facility. It is a large, newer, sparsely furnished institutional setting. There were no items of personal adornment. The bedroom contains a metal locked filing cabinet, some pastel curtains on a small window and a metal framed tube bed. The front doors are made partially of glass and in one of the images there are coverings on the glass 'to stop people from seeing Abby when she undressed, but open just at the top so she could still see out, we had to ask them to do it'. There is a high fence in the courtyard like a pool fence. The grassed area is inaccessible and the only outdoor area that is accessible is the courtyard. The kitchen, toilet and other facilities have locks on the doors.

In the first eighteen months, Abby's mother saw marks on her head, scratches on her face, chipped teeth and grazing. When she asked how it had happened, the workers said that it must have happened at school. When she asked at school, they said that it must have happened at the care facility.

Abby returned home for a few months, but her behaviour again escalated. She went into care at the respite facility, which she loved. Due to the non accredited status of the respite facility, the facility was more expensive and the funding ran out. She returned to emergency accommodation with a very large funding package, over \$200,000.

There were significant issues at the emergency accommodation unit. The guidelines say that residents may only stay for three months, but this child stayed alone in the unit for well over two and a half years. She was showered by male support workers, who were often alone with the child, despite the protests of family. She was used to a place where she could run around, but there was nothing to do other than watch television...there was no grass, only a six foot high fence. Her parents visited for a while, but she became too distressed, so they stopped visiting to prevent distress.

An alleged sexual assault is before WA police currently, so no details of the allegations are provided in this account. However, there were significant other issues, including police reports about a number of incidents.

One incident involved Abby being dragged out of the car as the support worker drove away. He did not stop to check on her safety.



2.5.4 Violence, Neglect and Abuse in Mainstream Settings

There is no comparative data around violence, abuse and neglect in mainstream settings versus disability settings, and systems are so fragmented it is impossible to even quantify the issue. In addition, there was a reluctance to release data around neglect and abuse by many government departments.

The highest proportion of complaints came about schools and disability service settings, with special schools disproportionately represented amongst the accounts. Limitations imposed by time and funding constraints to the Inquiry, as well as the lack of available disaggregated data around disability and abuse, contributed to difficulties in ascertaining the extent of the issue.

**Schools and school environments**  
Complaints were made about physical and sexual assaults by both students and staff, as well as cases involving segregation, isolation and neglect. There were a number of complaints involving school buses and school accommodation.

One significant theme was that of failure of the education system to support or enable parents to interact with ‘external’ investigation mechanisms, like police or public sector authorities. Parents were encouraged to report only to Standards and Integrity, the Education Department’s in house investigation unit. The Standards and Integrity Directorate deal with the administration of complaints regarding alleged misconduct by staff, investigate complaints,

coordinate disciplinary process, carry out screening and internal risk assessments, deal with misconduct and develop policy, standards and legislation.

A number of accounts cited unhappiness with the Standards and Integrity process. One parent said that she received a letter from the department to say that a staff member had been stood down for an alleged incident involving her son, but she had not received any notification from the school. The letter was received on a Friday afternoon, and she spent a tense two days waiting for Monday so that she could ring and find out how her son had been abused. Another parent said that after the complaint was made (after her son was physically assaulted by a school teacher) her son was returned to the classroom with the teacher who had assaulted him, ‘pending investigation’. When she objected, she was told that the child would be removed to the library until the investigation was concluded. She told the school that this was unacceptable, and his aide was deployed from another classroom to ‘supervise’ the teacher until the investigation was concluded. When the investigation was concluded, the teacher made an apology and ‘received counselling’ – no further action was taken.

The Standards and Integrity Directorate collect information about complaints in special schools, but did not provide data to the Inquiry by the time of publishing about the number and type of complaints.

A very high number of accounts received by

the Inquiry referred to students with autism and students with intellectual disability. A smaller number were made around students with other types of disability, including physical disability.

- The types of incidents that were reported included:
- An hour long rape by a 16 year old student against a 13 year old student on a special school bus
  - A child who was pinned down and restrained by a member of administrative staff
  - A child who fractured a bone during a school activity and who was returned to the school, school bus and then home. The school did not provide information about the incident where the child had fallen until the hospital threatened the parents with a criminal investigation
  - An incident where a child’s ponytail was fastened to the back of her wheelchair to stop her head falling forward
  - Widespread use of ‘time out’ rooms to segregate and isolate students, including reports of a pink padded cell and a white padded cell in two metropolitan special schools
  - A student who was tied to a chair by a member of staff
  - A student who was physically assaulted by a member of teaching staff
  - A student who was regularly hit by a school bus driver who kept a rolled up paper under his seat for the purpose of doing so
  - A student who was locked in a cupboard
  - A purpose built outdoor, uncovered

- cage (which no longer exists) which was used to segregate students outside in a school yard
- Assaults by students against other students

There has reportedly been some engagement between the Disability Services Commission and the Department of Education about the elimination of restrictive practices in education settings.

There were significant issues raised around intersecting systems, reporting processes and access to information for parents. One young woman with Prader-Willi syndrome, who was digitally raped on a bus by another student in an incident that lasted over an hour, was segregated from the rest of her classmates for the rest of the term after reporting her rape to the school principal. Her account is below:

13 year old Taylah was raped by a 16 year old student, who also has an intellectual disability, on a special school bus. Although there was an aide on the bus, the aide said that she did not observe the rape. Taylah went home and did not tell anyone about the rape until the following day, when she disclosed to an Education Assistant, who took her to the Principal.

Taylah was told by the Principal that she had not been raped, and she was spoken to about the seriousness of making accusations. She was told that she should not tell anyone that she was raped, and told not to use that word.

The school said that they attempted to call Taylah’s mother, but could not get in touch with her. When Taylah’s mother came home,

her older daughter said that she needed to speak to Taylah urgently. Taylah was visibly distressed. In her school bag was a letter saying that the school would like to speak to the parent about suspension.

Taylah's mother asked her to write down the account of the rape. Taylah wrote a two page account which is quite explicit. It was later given to the Department of Child Protection (DCP).

Taylah's family contacted a psychologist at their therapy provider and a meeting was arranged between the Principal, Taylah's mother, the psychologist and the school social worker. On the advice of the psychologist, Taylah's mother contacted the Department of Child Protection and also the LAC.

When Taylah's mother arrived for the meeting, the boy who had raped Taylah was sitting in the foyer with his father. Taylah's mother flatly refused to meet with the boy and his family.

The mood of the meeting was hostile and the school had concerns that Taylah continued to use the word 'rape' to refer to the rape that was carried out against her on the bus. They told Taylah's mother that a 'containment policy' would be implemented to minimise exposure of other children in the learning support unit to the word 'rape'. She would be sent to detention in the office every day until the end of term. Taylah would have been kept under constant supervision. No specialist counselling was offered or discussed. From the time that Taylah's complaint was made, the young man was not removed from his usual school setting, nor the bus.

Taylah's family was not at any time given any access to advocacy or information about procedures relating to sexual assault. The Department of Child Protection, after initially saying that they would investigate, said that it was outside of their mandate because it had 'occurred in a community setting'. DCP further communicated with Taylah's mother some time later and said the police had refused to investigate as the perpetrator has an intellectual disability. No contact was made between Taylah and her family and the police.

The school did not contact the Department of Child Protection as required in line with mandatory reporting policies. Two years later, Taylah has changed schools, which has impacted upon the family in negative ways. Taylah now has psychological issues, including a diagnosis of anxiety. She is seeing a psychologist to whom she has expressed a desire to complete suicide. She hates to be alone.

Her mother says that she lives 'day to day'.

The Inquiry did not investigate or receive complaints about historic cases of violence, neglect and abuse in school systems, but the Royal Commission is currently investigating cases of abuse at Castledare Junior Orphanage in Wilson, St Vincent's Orphanage in Clontarf, St Mary's Agricultural School in Tardun and Bindoon Farm School.

A recent WA inquiry examined historical abuse at St Andrew's Hostel in Katanning, St Christopher's Hostel in Northam, Hardie House in South Hedland and St Michael's House in Merredin from 1960-2006. It found a number of authority figures failed to act on sex abuse claims after they were told

about them. There is further evidence about the abuse of children with disability at St Andrew's Hostel, but like most reports about historical abuse, the incidence of disability is mentioned only in passing.



*'It is Mr Parks' evidence that late one night at about 11 pm he was roused from his sleep by a telephone call from Wayne McKenna:*

*"...he didn't go into details, but he told me that Dennis, from what I can remember told me that Dennis was picking on a student. This student had come in, I don't know whether, what the story was fully, but apparently he'd been elsewhere and had a disability of some kind, I don't know whether it was a learning disability or what, and Dennis wasn't treating him as well as he should have been."*

*The subject of that call was "S" who, according to Wayne McKenna, was "a lonely boy" who didn't have many friends. Also his "hygiene was no good" because he wasn't taking any showers.'*

*'S', who was a ward of the state, gave evidence to the hearing about being masturbated and sexually abused by Dennis McKenna. 'S' was regarded as a vulnerable child, being 'relatively small and underdeveloped' for his age, and his foster parents had moved overseas. 'S' became a boarder at St Andrew's Hostel and*

*was sexually abused when he was between 13 and 15 years old, in the 1980s. He reported that he did not know what sexual abuse was, as it was not something his foster parents had discussed with him. "S" made a complaint but was never advised of the outcome.*

*- St Andrew's Hostel Katanning: - How the system and society failed our children, Hon Peter Blaxell, Government of Western Australia*

McKenna is serving 22 years in jail for 63 offenses against 28 victims and his brother, Neil, is serving six years for raping a 15 year old girl at the same hostel.

#### **Taxis**

In early August, 2014, Perth taxi driver Peter Kasatchkow was jailed for ten years after pleading guilty to indecently assaulting five women with disability.

It was only after his fifth victim, aged 29, was raped in a Belmont car park that the alarm was raised. Four other victims, who were unable to report their experience, were identified on the taxi's video surveillance system.

There appears to be a widespread lack of acknowledgement of the problem of taxi related crime in relation to vulnerable passengers in both WA and across Australia. Nationally, the statistics are alarming. Recent revelations that more than 1300 Victorian taxi drivers have been charged with serious crimes, including murder and rape, come to no surprise to the disability community.



In February of 2014, a South Australian taxi driver was found guilty of indecently assaulting a disabled passenger by placing his hand down her top. A taxi driver from Sydney's southwest has recently been charged with the rape of a ten year old girl with profound hearing difficulties. And there have been a multitude of reports of sex crimes against other vulnerable passengers, specifically young women who are intoxicated, with or without a disability.

There are other issues around sexual assault against people with a disability, especially for those who are regarded as exceptionally vulnerable. It is unclear how Western Australian taxi companies and the Department of Transport collect and address complaints, but the issues around establishing that an offence has occurred against a person with a disability is a nationwide issue.

Even when a person is charged with sexual assault, laws that deem some disabled people 'unfit to plead' effectively mean that offenders are able to repeatedly abuse their victims and walk away without charge. There is no doubt that if the last victim of Peter Edward Kasatchkow had not been able to report her abuse, the offender would have continued to rape and indecently assault women, unchecked.

The effect on the disability community, and especially amongst parents and women with disability, has been widespread. Taxi users report a heightened feeling of anxiety and vulnerability and many individuals refuse to catch taxis. For parents whose children cannot use school bus or private transport, the Kasatchkow case has had a devastating effect - many parents

refuse to entrust their children to taxi drivers, impacting on the participation in everyday life for a number of individuals with disability. The impact upon the Western Australian disability community has been immeasurable.

Concerns have also been raised about the possibility of unreported rapes or sexual assaults of other vulnerable individuals by Kasatchkow. Police say that they think it is 'unlikely' that this man started committing offences when the taxi camera started rolling - thirty three offences in thirty four days. Kasatchkow was reportedly a taxi driver for four years, driving individuals with disability to and from their day programs, workplaces, homes, schools and social activities. Wheelchair users report that he was regarded as a 'favourite', and routinely gave out his card to potential clients. It is difficult to believe that he began a career as a sexual predator in early January, when the tape began rolling.

There are a number of systemic issues which were identified during discussions with the taxi industry council and the Department of Transport (DoT). They include the following:

- a lack of disability confidence training (the national accreditation and training for taxi drivers is currently under review)
- difficulties with the capabilities of the taxi surveillance hardware. The introduction of the Taxi Camera Surveillance Unit (TCSU) Standard, 2011 meant that improved TCSUs were installed in every metropolitan taxi, but images are only retained for 288 hours (before being recorded over) and are only able to be accessed by police
- Lack of TCSUs in country taxis (non metropolitan services), although plans are being

undertaken to install them

- Operational difficulties when accessing data - retrospective and reactive system where an offence must be reported in order to access footage, and the taxi must be taken to DoT and effectively 'confiscated' (in the words of a taxi driver) in order to download footage
- Issues with despatch and capacity which may impact on the safety of passengers. For example, there are currently only 99 MPTs (Maxi Taxis) operating across WA, and many taxi users and drivers choose to circumvent the despatch system by making private bookings.
- A lack of female drivers in the industry due to a heavily male-dominated culture which is reportedly not always 'female-friendly'
- An identified culture of 'rotting' around the Taxi Users Subsidy Scheme (TUSS) system (which is currently being changed)
- A system which does not have a business model which encourages best practice - taxi drivers are not direct employees of the taxi plate holders and there is no impetus to improve passenger safety
- A market which is dominated by one taxi company (which holds 94.6% of the market share)
- Potential upcoming issues with 'Uber', a new app based passenger charter service which does not require drivers to undergo any training or regulatory activities other than the standard 'F-extension' for criminal background checks to their drivers licences.

Both the taxi and transport industries and people with disability and their families noted that there are often cultural issues around taxi drivers from culturally and linguistically diverse backgrounds which urgently needed addressing. According to the Department of Transport, substantial

number of Perth taxi drivers were born and raised overseas, including in India and the Middle East. National Ethnic Disability Alliance President Suresh Rajan has called for urgent action to educate and mentor taxi drivers from CALD backgrounds. Identified issues involving taxi drivers from migrant backgrounds include:

- language barriers between people with disability and taxi drivers
- a lack of cultural competency (as opposed to cultural awareness) amongst the driver community
- a lack of disability confidence and also a reported lack of understanding of the status of women in this country
- disproportionate representation by taxi drivers from CALD backgrounds in sexual assaults and rapes in WA
- inappropriate behaviour which is often attributed to cultural differences and perspectives towards women and people with disability
- Issues with obtaining routine background checks for recent migrants from certain countries (countries which enable drivers to transfer an overseas license and also have a reciprocal agreement for criminal checks are listed here <http://www.transport.wa.gov.au/licensing/recognised-countries-table.asp>)
- Issues with policing compliance with predominantly migrant drivers, where taxi licenses are reportedly 'shared' with family members illegally sharing driving responsibilities

The over representation of taxi drivers overall in sexual assault statistics has dropped since the installation of TCSUs in metropolitan taxis. In 2011, four taxi drivers were charged with sexual assault in one week. Sex Assault Squad Detective Sergeant Craig Martin says that there have

been four or five requests for footage last year, including the Kasatchkow assaults.

The concerns for the disability community are not unlike the concerns raised by the wider community, especially by women. People in Western Australia want safe, equitable and dignified transport in mainstream settings.

## Prisons

### **Mentally Impaired Accused Act**

Given that 44% of male and 56% of female offenders have been told by a professional that they have a mental health condition (Australian Institute of Health and Welfare, 2012), it is unsurprising that there are claims that Western Australians with psychosocial disability are being routinely detained in prison environments because of a lack of available mental health beds and disability support funding. There is also a lack of appropriate accommodation, therapeutic and disability support options for those people with disability who are deemed unfit to stand trial under WA's Mentally Impaired Accused Act, which until very recently has meant that people who have never been convicted of a crime have been incarcerated without charge.

The Disability Services Commission has responded by building Disability Justice Centres in the community, where people with disability are able to be held with targeted developmental interventions. Until now, there have been no 'declared places' so the Mentally Impaired Accused Review Board has had to choose between imprisonment (often for a lengthy period, despite no conviction) or releasing the person into the community. There have

been criticisms about creating further institutional places of detention, with features such as long term solitary living arrangements, CCTV and locked windows and doors, especially in the context of creating stigma. However, Western Australian advocacy organisations have welcomed the move as a better option for Western Australians with disability than prison settings.

During the period 1 July 2013 to 30 June 2014, the Mentally Impaired Accused Review Board had under its statutory authority 27 accused with a diagnosed mental illness (69%), seven accused with a diagnosed intellectual impairment (18%) and five accused with a dual diagnosis of a combined intellectual impairment and mental illness (13%). In their last Annual Report, the Board Chairman, His Honour Judge Robert Cock, QC, reported:



*'The location of mentally impaired accused people in a prison environment is often harsh for them, they often find their imprisonment difficult to understand and even more difficult to manage. The mainstream prison environment is rarely an appropriate location in which to place a person with a significant intellectual disability. The Board has this year heard a number of distressing reports regarding this very vulnerable cohort, and endeavours to facilitate the release of mentally impaired accused under its authority as soon as they can*

*safely be permitted back into the community. Regrettably that is often a slow process, as the supports for them which are often necessary to satisfy us that they can be safely released are frequently inadequate and services not readily available.'*

*– Mentally Impaired Accused Review Board Annual Report, 2013-2014*

About thirty percent of people held under the Mentally Impaired Accused Act are Aboriginal people. Despite the limited places, over half the people ever held under the Act have been held in hospital, and generally those people are held for more serious offences than those placed in prisons. Those people tended to progress faster than those placed in prisons. All of those people who have a cognitive impairment are placed in prison.

The Office of the Inspector of Custodial Services states that prisoners with a cognitive impairment are more likely to be exploited by other prisoners and demonstrate deterioration in their mental health and adaptive skills due to the demands of prison life. They also learn a variety of negative institutionalised behaviours through the modelling of peer group behaviour.

Former prisoner-without-charge Marlon Noble is perhaps the West Australian who has attracted the most media attention of this cohort. When Marlon was 19, he was charged (in 2001) with sexually assaulting two children. In March 2003, he was declared 'unfit to stand trial'. The court had the choice of releasing him or making

a custody order. It decided to hold him in custody and his case was transferred to the Mentally Impaired Accused Board. In 2010, nine years later, a forensic psychologist found that he was now able to plead. His lawyer said that he would like to plead to the charges. However, the charges were withdrawn, with the Director of Public Prosecutions explaining that he would not seek to continue with those charges because Marlon had been imprisoned for so long. That meant that he was unable to plead not guilty.

In addition, the alleged victims and their mother denied that Marlon ever harmed them. There was no evidence to support or disprove the allegation made by the child that he had sexually assaulted her and the second child did not remember a sexual assault either. The mother believed that Marlon did not rape her daughter.

Marlon had spent ten years in prison without charge. In 2010, he was given day release for two consecutive days a week. He carried out some gardening for his support worker and told her that he 'had the flu bad', so she gave him a Sudafed tablet.

That was when Marlon tested positive with a 'presumptive positive' finding for amphetamines. Robert Cock, QC, explained that "the screening test does not establish the presence of illicit drugs, it does no more than suggest the desirability of a more sophisticated analysis", but Marlon was charged by a prison prosecutor with an aggravated prison offense. His day release was withdrawn. Nine years after being convicted for a crime for which there was no evidence, he was convicted of another crime for which there was no evidence.



Marlon was finally released ten years after being incarcerated but under stringent conditions that remain in place to this day. Marlon must never be out of line of sight of a support worker – he is not allowed to drink alcohol. He is not allowed to spend a night away from his home in Geraldton without permission. If he wants to leave Geraldton, he must apply to the Board for permission.

Many of the people who are currently incarcerated under the MIA Act are Aboriginal people. 23 year old Rosie Anne Fulton spent 18 months in a Kalgoorlie jail without charge or conviction after she was convicted with driving offences. Rosie Anne has foetal alcohol syndrome.

The Office of Custodial Inspections regularly inspects prisons, but does not collect discrete disability information. However, it has noted issues around access and inclusion in a number of its reports. For example, although the Department has a Disability Access and Inclusion Plan, in 2014 Casuarina did not have a strategic plan for the management of disabled prisoners. A report detailing the inspection said that ‘the prison was engaging with issues relevant for disabled prisoners in a reactive manner.’

Casuarina’s older units were designed with stairs leading to the wings, which meant that most of the older units were not suited to prisoners who had mobility impairments. Although two units have ramp access, the prison is not regarded as wheelchair accessible. The prison sought to place prisoners with physical disabilities in the newer units, but reactively built ramps to provide wheelchair access via prison industries if they were not available.

There were reports that some prisoners experienced untreated hearing impairments and could not access adequate health services, which in turn affected access to and participation in education, employment and social life. Prison staff were not trained in disability awareness and the report notes that ‘some seemingly non-compliant behaviour may have been caused by hearing impaired prisoners not understanding oral directions.’ Representatives from the Disability Services Commission reported there were a lack of sufficient interpreting services at Casuarina and that they had encountered resistance from officers to obtaining a professional interpreter when required. There was also a need for Auslan and Relay interpreters, for hearing impaired prisoners. (Report of an announced inspection of Casuarina Prison, OIC, 2014)

Other inspection reports detail conditions which are not suitable for general prisoners, let alone prisoners with disability. Bandyup prison, which has an ‘operational capacity’ of 259 – a term which includes bunk beds in single person cells – is now consistently overcrowded with more than 300 women. Women who do not have a bed must sleep on mattresses on the floor, often with their head adjacent to the toilet. The situation is unhygienic and lacking in privacy. In December 2014, at least 30 women were sleeping on mattresses on the floor. Accessibility is limited and the centre is overcrowded.

Statistics around disability for Bandyup were not available, with the exception of the notation that almost sixty percent were women with psychosocial disability. Additionally, more than fifteen percent of women who assaulted staff were assessed as

having an intellectual disability.

Significant concerns were raised about complaints mechanisms at most of the prisons in WA, including Banksia Hill Juvenile Detention Centre. Although prisoners are able to make complaints through ACCESS (Administration of Complaints, Compliments and Suggestions branch of DCS) or the Commissioner, or to external agencies such as Independent Visitors, the Ombudsman, Health and Disability Services Complaints Office or the Minister, there was little information available about how readily complaints systems were engaged with. The Office of the Inspector of Custodial Services says that the low number of complaints during periods of considerable disruption (a riot at Banksia), when a single Independent Visitor report typically generated as many complaints as ACCESS fielded in two years, is significantly concerning. In addition, HaDSCO received only three complaints from detainees between 1 July 2008 and 3 September 2014.

Attitudes around complaints were reflected in and out of disability service settings. The primary reason for not reporting violence and abuse was fear of retribution, followed by fear of not being believed.

HaDSCO recently conducted a public consultation and found that the number one reason people did not complain was they feared some kind of retribution from the service on which they relied.

## 2.5.5 Violence, Neglect and Abuse in the Family Home

Violence, neglect and abuse against people with disability in the family home is often regarded as a taboo subject by Australians, despite the statistical evidence that people with disability are often abused by family members or others close to them. Service providers reported widespread financial abuse, for example, and individualised advocacy statistics backed up that account. Financial abuse is generally only reported to advocacy groups by providers and local area coordinators when they notice that a person has no money to purchase their services.

Family violence for people with disability is complex. It is largely undescribed – the barriers that women escaping domestic violence face, for example, are undocumented. It is difficult to ascertain the prevalence of family violence. Police do not categorise victims by disability type. Victim support centres do not count the number of people with disability who access their services. Hospitals do not record disability status when a person is abused or assaulted. Researchers do not regard the issue as an important one. All of these factors contribute to the invisibility of people with disability who are subjected to violence, abuse and neglect.

The Australian Public Health Association defines abusive behaviour as follows:

Physical abuse, causing pain and injury; denial of sleep, warmth or nutrition; denial of needed medical care; sexual assault; violence to property or animals;

disablement; and murder.

Verbal abuse, in private or in public, designed to humiliate, degrade, demean, intimidate, subjugate, including the threat of physical violence:

Economic abuse, including deprivation of basic necessities, seizure of income or assets, unreasonable denial of the means necessary for participation in social life; and

Social abuse, through isolation, control of all social activity, deprivation of liberty, or the deliberate creation of unreasonable dependence. (Australian Public Health Association, 1990).

Other forms of domestic abuse include emotional abuse, psychological abuse, and carer abuse (threats to withdraw care).

In 1993, a joint project – ‘Silent Voices: Women with Disabilities and Family and Domestic Violence’ - was undertaken between Judith Cockram, PhD, People With Disabilities WA, the Ethnic Disability Advocacy Centre and the Centre for Social Inclusion, Edith Cowan University, to ascertain the prevalence of domestic violence carried out against women with disability in Western Australia. <http://wwda.org.au/issues/viol/viol2001/silent1/> The report, which is available at the Women with Disabilities WA website, reports widespread violence and abuse occurring against women with disability living in Western Australia.

Submissions to the Inquiry told of incest, violence and abuse by family members against people with disability, especially women with disability. Physical and sexual abuse were the most commonly reported abuses.



*‘I went screaming to my bedroom where he followed, and he whipped me with a thong, a wire coat hanger, and a belt. I’ve got scars. I switched off again went into the foetal position and was rocking and making this weird noise...both Mum and I have been diagnosed with PTSD.’*

*- a woman with a disability*

‘In some accounts, there are clearly defined connections between disability and physical abuse.



*The first time he hit me properly I remember it well. I did something. I don’t remember what, but from memory it was something like staying up after I was supposed to go to bed, or sneaking food and he got out his belt and hit me with it with the buckle end until the skin broke. I was crying and screaming and he told me to shut up or I would be given ‘something to cry for’. And then my back and legs started bleeding, there was blood on the bedspread. I was then seven years old.*

*I think that scared him because he didn’t ever break my skin again. He was careful about how he hit me. He used a braided rope from then and he used it so that it*

*would not break the skin. The belt had hard edges on it and when he hit me with that I would have to have time off school and he would tell the school that I was sunburnt, or that I was sick and had to stay home. I had a lot of time off school.*

*I didn’t ever connect that with the fact that I had a disability and could not run away or that he hated me because I had a disability. I always thought he just hated me. But then when I was older, he would make comments about my disability that showed just why he hated me. He said that the bad blood came from my mother’s side of the family, not his. Comments about how children with disability in his day would be killed so I should be grateful. And then of course there was the fact that he would never speak to or of me.’*

*- a woman with a disability*

Another common theme was that of the connection of abuse to ‘public stripping’, which is often cited as having a lasting psychological impact and is in some cases regarded as desensitising children to being touched by strangers. Doctors at hospitals and clinics which specialise in paediatric conditions such as spina bifida, cerebral palsy, muscular dystrophy and osteogenesis imperfecta traditionally displayed their patients in front of colleagues, residents, therapists and students. Many adults with disability say that the requirement for them to ‘publicly strip’



had a lasting impact upon them as an adult,



*One night the lady, his wife, went out to meet with friends and I was alone with her husband. He told me to come and sit on his lap and I did. I was very naïve and these people had been kind to me. So I sat on his knee and after a while he asked me if I was comfortable and started tickling me. I was laughing and giggling and then he put his hands between my legs and started rubbing, still pretending that he was tickling me. That was the start of sexual abuse and rape that happened over two years and which did not stop until I told my mother.*

*And this was the worst thing. I told her, and she told my father. He did not say anything to me until she left for work, he was supposed to take me to school. Then he called me a slut and a whore and he did not just hit me with his belt. He picked up a cricket stump and started to hit me with that and then started to hit me across the breasts and ask me if I still liked someone 'touching me'. And then he sexually assaulted me. I was home alone with him and I could not do anything to get away and I was trapped in the house with him all day...I sat in my room just shaking and shaking, it was so much worse than it was with the man who had sexually assaulted me.*

*During that time I had to go to the hospital to be looked at by specialists and they always made you strip to your underwear and stand there in your pants to look at your body. There were always men there who were old men and they would look at you and touch you to show other men what parts of you were different and wrong. My mother was always there. And after that last incident I went in to be looked at and I had to take my clothes off, and there were still marks. They were marks from the cricket stump and they made me take my Bonds vest off and they saw them. The doctor asked me what the marks were and my mother said quickly that they were marks from where I fell down, because I fell over a lot. I don't think they believed her. I looked at her face and saw that she was lying and that meant she knew that the marks came from my father. They kept touching my spine and my hips and legs and then they told me to get dressed and the next day, I ran away. I kept running away and one day I never came back. I went to stay with relatives in the country. I didn't come back til my parents divorced. '*

*- a woman with a disability*

Family interpersonal violence against people with disability – including murder – is traditionally downplayed in the media in Western Australia. Early last year, 60 year old Brian Honeywood allegedly murdered his paraplegic son, Tyron. A month later,

Andrew Devine pleaded guilty to killing his wife, Janene, from severe neglect – he was her sole carer and she weighed just 30 kilos when she died.

One of the accounts given to the Inquiry has been referred to police in two states of Australia, as well as other statutory authorities and advocacy agencies. It documents extreme torture, violence and many breaches of human rights in a family violence setting. Given the ongoing and sensitive nature of the account, and concerns for the victim's privacy, the account has not been documented in this report. However, there are a number of issues which have been taken into consideration around domestic violence legislation (which differs from state to state) and jurisdictional issues.



# 3. Research & Awareness

## 3.1 Data from Western Australia

In WA, data on the incidence and prevalence of assaults against people with disability in institutional and residential settings is limited. To gain some insight into data collection and reporting processes we contacted several Government departments, independent authorities and advocacy agencies, and reviewed relevant documents and annual reports. The information we collected is presented below.

3.1.1 Complaints Mechanisms  
Table 3.1 outlines the complaints, investigation and referral processes adopted by Government departments and independent authorities.

Table 3.1: Complaints, Investigation and Referral Processes

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
National Disability Abuse and Neglect Hotline (The Hotline)	Australia-wide telephone hotline for reporting abuse and neglect of people with disability. Cases of abuse and neglect can include physical, sexual, psychological, legal and civil abuse, restraint and restrictive practices or financial abuse. It can also include the withholding of care and support which exposes an individual to harm. Anyone, Australia-wide, can contact the Hotline to report abuse and neglect including people with disability, family members, friends, carers, advocates, staff at services and health professionals.	The Hotline works with callers to find appropriate ways of dealing with these reports. The Hotline provides support to callers on how a complaint about abuse and neglect might be raised and resolved at the local level. If a caller reports abuse or neglect in a government-funded service, the Hotline will refer the report to the government body that funds the service. The funding body will investigate the report. If a caller reports abuse or neglect in any other situation, the Hotline will refer the report to an agency able to investigate or otherwise address the report, such as the police, an ombudsman or complaints-handling body. The hotline also refers callers to services and organisations for advocacy, legal aid or counselling.	Disability Services Act 1986 (Cth) National Standards for Disability Services	Department of Social Services

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Complaints Resolution and Referral Service (CRRS)	An independent, fair, impartial and nationally accessible complaints resolution and referral service for people with disability who are service users of Disability Employment Services, Australian Disability Enterprises or Advocacy Services funded under the Disability Services Act 1986 (Cth).	The CRRS will investigate abuse and neglect matters referred from the Disability Abuse and Neglect Hotline about the DSS service. The complainant may also make a direct complaint to the CRRS about the DSS service provider or about other service recipients and how their behaviour impacts upon the complainant. Complainants may be assisted by their families or advocates. Complaints may be referred to relevant States and Territories.	Disability Services Act 1986 (Cth) National Standards for Disability Services	Department of Social Services

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Complaints Resolution and Referral Service (CRRS)	Complaints can be made on any aspect of a DSC service, or DSC funded service, including complaints about abuse and neglect. DSC officers can provide information about how concerns and complaints can be addressed. The DSC and organisations funded by the DSC must comply with six national standards. Standard 1 Rights - refers to the protection of human rights, freedom of expression, decision making and prevention of abuse and neglect	If a person has a concern about a DSC service, they are instructed to: • raise the issue with a coordinator or supervisor at the direct service level; • ask to speak to a manager about lodging a complaint; • lodge the complaint directly with the DSC's Consumer Liaison Officer. The Consumer Liaison Service is an impartial and confidential means of ensuring concerns and complaints about services provided by the DSC are acknowledged and addressed in a thorough and timely manner. If a person has a concern about a DSC funded service, they are instructed to: • in the first instance, raise it with the organisation. The organisation will review the complaint in accordance with its established complaints management policy. As part of their service agreements with the DSC and obligations under the National Standards	Disability Services Act 1993 (WA) National Standards for Disability Services.	Government of Western Australia



SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Disability Services Commission (DSC)	The DSC also has a quality assessment process to ensure service providers are meeting the Standards and delivering on their obligations. Service quality is assessed in two ways: 1. Self-assessment (annual requirement for all service providers). 2. Independent quality evaluation (once every three years).	for Disability Services, State-funded organisations are required to have a complaints management policy and related procedure. The Consumer Liaison Officer can advise on other ways to pursue the matter such as via the Health and Disability Services Complaints Office (HaDSCO) or the WA Ombudsman. Note that the Ombudsman Office generally deals with complaints about Government administration, rather than service-related issues. The Consumer Liaison Officer is also available to confidentially discuss ways of disclosing sensitive information about a disability service, and whether the Public Interest Disclosure Act 2003 (WA) may be applicable.	Disability Services Act 1993 (WA) National Standards for Disability Services.	Government of Western Australia

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Public Sector Commission & Public Interest Disclosure	The WA Public Interest Disclosure Act 2003 (PID Act) provides a system for matters of public interest to be investigated and for appropriate action to be taken. Any person may make a disclosure of public interest information. Public interest information must: • relate to a public authority, public officer or public sector contractor ("a public body") • relate to the performance of a public function of the public body • tend to show that the public body is,	A disclosure must be: • made by a discloser who believes on reasonable grounds that the information is or may be true; • a disclosure of public interest information; and • made to the appropriate "proper authority". The PID Act requires that each public authority has a PID Officer responsible for receiving disclosures of public interest information. When the disclosure relates to offences under State law, the "proper authority" to disclose the public information to would be a police officer or the Corruption and Crime Commission. When the disclosure relates to matters about	Public Interest Disclosure Act 2003 (WA)	Government of Western Australia

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Public Sector Commission & Public Interest Disclosure	has been, or proposes to be, involved in improper conduct. As public interest information covers public sector contractors, a person may disclose under the PID Act improper conduct involving DSC funded disability services.	the public authority or its officers, or which the public authority has the function of investigating, the "proper authority" to disclose the public information to would be the PID Officer of the public authority. The PID Act requires all proper authorities to provide to the Public Sector Commissioner information annually about the number of disclosures received, investigations conducted and actions taken. The Corruption and Crime Commission and the WA Ombudsman have functions in relation to the disclosure under their own legislation.	Public Interest Disclosure Act 2003 (WA)	Government of Western Australia

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
The Health and Disability Services Complaints Office (HaDSCO)	HaDSCO is an independent statutory authority providing an impartial resolution service for any complaints relating to WA health or disability services. Complaints can be lodged by the service user or a nominated representative (e.g., a family member, carer or guardian) against individuals or organisations that provide a health or disability service. Disability Services include: The Disability Services Commission, In-Home Support, Carer's Respite, Accommodation, Therapy Services, Day Activities, Recreation and Leisure Services and Advocacy Services.	There are two complaints resolution processes: negotiated settlement and conciliation. Negotiated settlement involves an exchange of information between parties via a case manager. The role of the negotiator is to assist in the exchange of information and promote resolution of the complaint. Conciliation generally involves all parties engaging voluntarily in a face-to-face meeting to discuss the complaint. The conciliator will meet individually with each party to discuss and clarify issues that have been raised and ensure everyone is prepared for the conciliation meeting. Investigation Processes: Individual complaints may only be investigated when HaDSCO's Director or the Minister is of the opinion an investigation is warranted.	Health and Disability Services (Complaints) Act 1995 (WA) Disability Services Act 1993 (WA)	Government of Western Australia

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
The Health and Disability Services Complaints Office (HaDSCO)	Health Services include: Ambulance Service, Chiropractors, Dentists, Hospitals, Medical Practitioners, Nurses and Midwifery, Occupational Therapists, Pharmacists, Psychologists, Screening and Immunisation Services, and Social Workers in a Health Setting.	Before agreeing to investigate a matter, an assessment is made to determine whether the matter would be better addressed by another agency (e.g., WA Ombudsman or Disability Services Commission). Investigations are undertaken via a formal process through which HaDSCO determines if any unreasonable conduct has occurred on the part of a service provider and typically looks into systematic issues. HaDSCO's Director has the power to: <ul style="list-style-type: none"> <li>• summons individuals or documents;</li> <li>• apply for a warrant to enter a premises; and</li> <li>• enter and inspect premises and take copies of any necessary documents.</li> </ul>	Health and Disability Services (Complaints) Act 1995 (WA) Disability Services Act 1993 (WA)	Government of Western Australia

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Office of the Public Advocate (Public Advocate)	<p>The Public Advocate works to promote and protect the human rights of more than 65,000 Western Australian adults with decision-making disabilities.</p> <p>The Public Advocate can, on request, examine the personal and financial welfare of people with decision-making disabilities in order to advocate on their behalf.</p>	<p>In conducting investigations the Public Advocate:</p> <ul style="list-style-type: none"> <li>• examines whether it is in the best interests of an adult with a decision-making disability to have a guardian or administrator appointed</li> <li>• advocates for the appointment of a guardian or administrator when there is no other way of meeting the person's needs</li> <li>• investigates complaints or concerns from the public that indicate a person with a decision-making disability may be at risk of neglect, exploitation or abuse and may be in need of a guardian or administrator, or may be under an inappropriate order</li> </ul>	Guardianship and Administration Act 1990 (WA) Criminal Law (Mentally Impaired Accused) Act 1996 (WA)	Department of the Attorney General

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Office of the Public Advocate (Public Advocate)		<ul style="list-style-type: none"> <li>• investigates whether a person held in custody under the Criminal Law (Mentally Impaired Accused) Act 1996 is in need of a guardian and/or administrator.</li> </ul> <p>Investigators gather as much information as possible. This usually involves interviewing friends, family and service providers and seeking the views of the person who is the subject of the application or community referral. Investigators play a key role in seeking less restrictive alternatives to the appointment of a guardian and help family members become better informed about the role of substitute decision-makers. Investigations may identify ways of resolving a problem without resorting to a guardianship or administration order.</p>	Guardianship and Administration Act 1990 (WA) Criminal Law (Mentally Impaired Accused) Act 1996 (WA)	Department of the Attorney General

SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
State Administrative Tribunal (SAT)	The State Administrative Tribunal (SAT) is an independent body that makes and reviews a range of administrative decisions, including reviews of guardianship decisions.	<p>SAT's approach is informal, flexible and transparent. SAT:</p> <ul style="list-style-type: none"> <li>• aims to make the correct or preferable decision based on the merits of each application;</li> <li>• is not a court and, therefore, strict rules of evidence do not apply;</li> <li>• encourages the resolution of disputes through mediation;</li> <li>• allows parties to be represented by a lawyer, a person with relevant experience or by themselves;</li> <li>• holds hearings in public in most cases; and</li> <li>• provides reasons for all decisions and publishes most decisions on its website.</li> </ul>	State Administrative Tribunal Act 2004 (WA) SAT receives its power to hear matters from a large number of different pieces of legislation, including the Guardianship and Administration Act 1990 (WA)	Government of Western Australia



SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Council of Official Visitors	The Council of Official Visitors is an independent agency established by the Parliament of Western Australia. The Minister for Mental Health appoints members of the Council, known as Official Visitors. Official Visitors are members of the general community who have an understanding of mental illness and the problems faced by those who are affected by it. The Council was established to assist 'affected persons' under the Mental Health Act 1996 (WA), including: • individuals receiving treatment involuntarily or mentally impaired defendants in an authorised hospital; • individuals on Community Treatment Orders; and • individuals with a psychiatric disability who live in a licensed private psychiatric hostel or group home. The Council is not able to assist voluntary patients/ consumers.	The Council is primarily there to ensure that: 1. individuals are aware of their rights; 2. these rights are being observed; and 3. to investigate and seek to resolve complaints. The Council is also responsible for inspecting authorised hospitals and licensed private psychiatric hostels to ensure that they are in a safe and suitable condition. Consumers or their concerned family members or friends may contact the Council to request assistance. If the Council is unable to assist an individual they will be referred to an agency that can. With the consent of the consumer, the Official Visitor may speak to the treating team or other staff and may access medical records. The Mental Health Review Board may also consider the case which may also be referred to the Mental Health Law Centre. An Official Visitor may inform the Chief Psychiatrist or Minister for Mental Health about an incident if there is cause for concern.	Mental Health Act 1996 (WA) Mental Health Act 2014 (WA) Note: The Mental Health Act 2014 (WA) provides for a statutory mental health advocacy service that will replace the Council of Official Visitors. It is envisaged that services will be provided by mental health advocates under the direction of a Chief Mental Health Advocate. All other jurisdictions in Australia, and New Zealand, have established bodies that offer individual and/or systemic mental health advocacy.	Government of Western Australia
SERVICE	SCOPE	INVESTIGATION PROCESS & REFERRALS	GOVERNING LAWS AND STANDARDS	GOVERNING BODY
Office of the Chief Psychiatrist	The Chief Psychiatrist of Western Australia has independent responsibilities, powers and duties prescribed by the Mental Health Act 2014 (WA). The Chief Psychiatrist is responsible for the medical care and welfare of all involuntary patients, and the monitoring of standards of psychiatric care throughout the State.	Mental Health Services, monitored by the Chief Psychiatrist, are to report to the Chief Psychiatrist: • deaths and serious clinical incidents (e.g., serious assault or aggression, sexual contact or allegations of sexual assault); • non clinical incidents (e.g., serious or significant criminal activity, allegations of staff misconduct or unreasonable use of force on the person by a staff member of the mental health service).	Mental Health Act 2014 (WA)	Department of Health

### 3.1.2 Disability Service Standards

From 1 July 2014, all disability services funded or provided by the WA Disability Services Commission have been required to comply with the revised National Standards for Disability Services (National standards). The National Standards have been endorsed by ministers across all Australian jurisdictions and replace the former WA Disability Services Standards (WA standards). Both these sets of standards are discussed below in relation to the quality assessment processes that have been implemented by the Government of Western Australia.

#### 3.1.2.1 WA Disability Services Standards

Listed below are the 9 former WA Standards, including Standard 9: Protection of Human Rights and Freedom from Abuse and Neglect.

Standard 1 - Service Access

Standard 2 - Individual Needs

Standard 3 - Decision Making and Choice

Standard 4 - Privacy, Dignity and Confidentiality

Standard 5 - Participation and Integration

Standard 6 - Valued Status

Standard 7 - Complaints and Disputes

Standard 8 - Service Management

Standard 9 - Protection of Human Rights and Freedom from Abuse and Neglect

In 2012-2013 the Disability Services Commission published quarterly Quality Updates on their website. These updates provided a summary of the required actions that had been identified during their Independent Quality Evaluations, that each service is required to have once every three years. Required actions resulted when a service failed to show evidence of meeting one of the nine Disability Service Standards.

Once a required action was identified, the service was then given a specified time by which they needed to address the required action.

Quality Updates are no longer published on the DSC website.

Example Quality Update - April to June 2013  
25 services participated in an Independent Quality Evaluation. 44% met the Standards and 56% did not meet the Standards.

Table 3.2: Required Actions April to June 2013:

Standard	Description	Required Actions
8	Service Management	10
9	Protection of human rights and freedom from abuse and neglect	6
4	Privacy, dignity and confidentiality	2
7	Complaints and disputes	2
2	Individual needs	1
1-9	All standards	1

In 2012 and 2013, required actions relating to Standard 9 included:

- The service provider demonstrates that their written policies and procedures are updated and implemented.
- Updating systems to monitor currency of staff training in relation to Standard 9.
- Ensuring the safety of individuals using an Alternatives to Employment service when they exhibit challenging behaviours.
- Responding within seven days to allegations of abuse and neglect of people with disability.

On 8 December 2014, at the Estimates and Financial Operations Committee Annual Report Hearing , Hon Alanna Clohesy (Member for East Metro region) asked the Disability Services Commission a number of key questions relevant to this Inquiry.

The responses to these key questions are presented below.

**1. How many service providers have published the results of their annual self-assessments?**

The Commission does not monitor publication of self-assessments. While they may choose to do so, service providers are not required to publish their annual Self-Assessment or their Quality Evaluation report.

**2. Of those self-assessments that were lodged with the Commission, how many identified that they had not met the nine disability service standards or had some other failure to meet the standards?**

The Self-Assessment reports on continuous improvement actions. It does not ask organisations to report against the Disability Service Standards.

**3. In terms of the independent evaluation process, how many of those were identified as not meeting the standards, what standards, what sub-standards and also what actions were taken?**

In 2013-14, 54 service providers were evaluated across 83 different services. The total number of Required Actions given (for not meeting a Disability Service Standard) was 63. These 63 Required Actions occurred within 28 of the service providers evaluated. Data on sub-standards is not collected.

Table 3.3: Required Actions 2013-14

Standard	Description	Required Actions
8	Service Management	38
2	Individual needs	13
9	Protection of human rights and freedom from abuse and neglect	9
3	Decision making and choice	2
7	Complaints and disputes	1

**4. What types of issues were raised as complaints and what is the breakdown of those issues?**

A total of 26 complaints were received by the Consumer Liaison Service for the year 2013-14. Of the 26 complaints, 12 related to more than one issue. In all, 41 issues were raised by individuals, families, carers and advocates.

Table 3.4: A breakdown of complaint type 2013 - 14

Complaint Type	#
Funding policy	3
Quality of service	4
Lack of resources	0
Staff conduct	8
Quality of Communication	12
Staff eligibility	0
Service Access	3
Other service user conduct	0
Carer recognition	7
Outsourcing	3
NDIS/My Way trial transition	1

**3.1.2.2 National Standards for Disability Services**

There are Six National Standards that apply to disability service providers (listed below). Each service provider is required to produce an annual report against the Standards and are to undergo an Independent Quality Evaluation once every three years.

**National Standards**

1. Rights: The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.
2. Participation and Inclusion: The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.
3. Individual Outcomes: Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.
4. Feedback and Complaints: Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.
5. Service Access: The service manages access, commencement and leaving a service in a transparent, fair, equal and responsive way.
6. Service Management: The service has effective and accountable service management and leadership to maximise outcomes for individuals.

Each standard has set of indicators of practice to assist services in the implementation of appropriate policies and safeguards. The indicators of practice for Standard 1 are presented below:

**Indicators of Practice**

- 1.1 The service, its staff and its volunteers treat individuals with dignity and respect.
  - 1.2 The service, its staff and its volunteers recognise and promote individual freedom of expression.
  - 1.3 The service supports active decision-making and individual choice including the timely provision of information in appropriate formats to support individuals, families, friends and carers to make informed decisions and understand their rights and responsibilities.
  - 1.4 The service provides support strategies that are based on the minimal restrictive options and are contemporary, evidence-based, transparent and capable of review.
  - 1.5 The service has preventative measures in place to ensure that individuals are free from discrimination, exploitation, abuse, harm, neglect and violence.
  - 1.6 The service addresses any breach of rights promptly and systemically to ensure opportunities for improvement are captured.
  - 1.7 The service supports individuals with information and, if needed, access to legal advice and/or advocacy.
  - 1.8 The service recognises the role of families, friends, carers and advocates in safeguarding and upholding the rights of people with disability.
  - 1.9 The service keeps personal information confidential and private.
- Another safeguard that has been implemented by the DSC is compulsory Serious Incident Reporting, outlined below.

**3.1.3 Serious Incident Reporting**

Under section 25(4) of the Disability Services Act 1993 (WA) it is mandatory for service providers to report the death or non-trivial injury (including physical, psychological and



sexual abuse or neglect) of a person in their care.

Under the General Provisions of Service Agreement, Clause 3.7, service providers are also required to report all serious incidents.

A ‘serious incident’ is defined by the DSC as one or more of the following:

- a) the death of a person with a disability who is a current service user
- b) serious physical injury of a person with disability who is a current service user
- c) serious avoidable illness (for example food poisoning or instances where medication has been wrongly administered) of a person with disability who is a current service user
- d) abuse or neglect of a person with disability who is a current service user
- e) the person is judged as posing a serious risk to the health, safety or welfare of themselves or others
- f) exploitation or unauthorised restrictive practices used with a person with disability who is a current service user; and
- g) an assault on staff or a visitor to the service by a person with disability who is a current service user.

The guidelines also state that:

- All serious incidents must be reported to the DSC within 7 days.
- The DSC is to report to the Minister and the DSC Board on a quarterly basis, as well as monitor and initiate any follow up action that may be required.
- Where the matter involves the potential for criminal charges, such as sexual abuse or serious physical abuse of a person with disability by a staff member or contractor of the DSC or a disability sector organisation, it is essential that the police are consulted as

part of the process of external investigation.

**3.1.4 Health and Disability Service Complaints (HaDSCO)**

In relation to complaints processes and HaDSCO’s functions, a ‘disability service’ is defined under the Disability Services Act 1993 (WA) and Health & Disability Services (Complaints) Act 1995 (WA) as:

- (a) a service provided specifically for people with disability;
- (b) a service provided specifically for carers; but does not include –
  - (a) such a service where it is provided wholly or partly from funds provided by the Health Department; or
  - (aa) such a service where it is provided wholly from funds paid to the service provider by the Commonwealth of Australia; or
  - (ab) such a service where it is provided by a carer; or
  - (b) such a service where it is prescribed by regulation.

In their Annual Report (2013-14), HaDSCO reported that they received 2,421 complaints and closed 2,485 complaints. 74% (1833 complaints closed) related to health services, 2% (44 complaints) related to disability services, and 11% (252 complaints) related to mental health services.

Table 3.5 lists the top 5 disability service issues. Relevant to the present Inquiry, are the top two issues ‘staff conduct’ and ‘complaints resolution’. HaDSCO reported that issues relating to ‘staff conduct’ included “behaviour that was inappropriate, offensive, unprofessional or discriminatory”; while issues relating to ‘complaints resolution’ included “information about complaint and dispute resolution processes not being made available” and “is-

sues that were not resolved within a reasonable timeframe”. Disability services most often identified in complaints were accommodation providers (39%), in-home support providers (23%) and day activity providers (9%).

Table 3.5: Top 5 Disability Service Issues (2013-14)

	2013-2014	Number of issues
1	Staff Conduct	9
2	Complaints Resolution	9
3	Communication	7
4	No/inadequate service	7
5	Failure to consult carer	7

Note that similar issues have also been identified in annual reports from previous years.

Table 3.6: Top 6 Disability Service Issues (2009-10)

	2009-10	Number of issues
1	Staff Conduct	7
2	Service Quality	5
3	Complaints Handling	4
4	Communication	3
5	No/inadequate service	3
6	Grants/funds refused	3

The following case study outlines a disability service complaint dealt with by HaDSCO during 2013-14.

**Disability Case Study - Maxine’s Story**

Julie’s sister, Maxine, is a person with disability and does not use spoken language. She is housed in a residential service that provides shared care 24 hours per day, seven days a week.

Upon checking Maxine one morning, a day shift staff member found Maxine crying on the floor, appearing to be injured. However, no injury had been reported when Maxine was checked the evening before, indicating there was potentially a substantial period of time between the injury occurring and it being reported. Maxine was taken to hospital and was diagnosed with a broken leg, which required surgery.

Julie raised concerns with staff about the incident. She believed that Maxine’s injury was a result of something that happened during the night shift, yet it was not reported until the following morning.

Julie alleged that Maxine has been left in considerable pain and distress and had not received the appropriate level of care, despite being accommodated in a 24 hour care unit. Julie further alleged this was because night duty staff were allowed to sleep during their shift. She added that she felt measures had also been taken to ensure that staff members’ sleep was not disturbed during this period; suggesting that Maxine was unable to get the attention of a staff member.

Julie was also concerned that no explanation could be provided about the cause of Maxine’s injuries. Julie contacted HaDSCO about her complaint.

**Julie’s objectives**

- To receive a consistent and suitable level of service, responsive to Maxine’s needs.
- To have the provider clearly define company policy for staff on night shift in regard to sleep and levels of care.
- To be provided with an explanation as to why Maxine’s injuries occurred, and why they were not acted upon sooner.
- To receive an explanation as to why Maxine was unable to contact a member of staff during the night for assistance.
- To take the steps necessary to ensure this never happens again.

**Julie and Maxine’s Story  
Outcomes from the complaint**

HaDSCO undertook an inquiry into this complaint and as a result proposed a number of recommendations to the service provider to improve service delivery and reduce areas of concern.

- The service provider complied with all the recommendations proposed and implemented a number of changes. These included:
- Working with Julie to better understand Maxine’s needs and requirements in terms of her care plan. This included looking at alternative support services where it was identified that service provision was outside of the providers’ remit.
  - Clarification of staff procedures in regard to the supervision of residents through the night. Clear and precise documentation is now available for all residents, highlighting their care needs and the type of supervision required by staff at all times.
  - Documentation and information for prospective and current clients has been

- made clearer, to ensure service users are aware of the level of service they can expect. This is especially acknowledged in the funding plan each client receives.
- An update was made to the in-house Occupational Health and Safety Policy with staff re-educated in the prevention of injuries.
  - Sleeping facilities for staff were revised to better meet the demands of service users.

**3.1.5 Current Projects**

In Western Australia, there are several initiatives that have been developed to address inconsistencies in complaints reporting mechanisms and promote appropriate safeguards. These include, 1) National Disability Services (NDS) Zero Tolerance Project, 2) HaDSCO’s Disability Complaints Data Collection Project, 3) HaDSCO’s Advocates and Community Leaders’ Collaboration Project and (4) the NDS Safer Services Project.

**3.1.5.1 Zero Tolerance Project**

Zero Tolerance is a National Disability Services (NDS) Australia wide project to prevent and better respond to abuse of people with disability in non-government services. NDS has been working with service providers, advocacy organisations, governments and universities to develop a national framework and resources to improve the sectors response to cases of abuse, neglect and violence of people with disabilities. The Zero Tolerance project aims to build the capacity of service providers so people with disability can exercise choice and control whilst remaining safe from the risk of abuse, exploitation and neglect.

The project identified that the voice of people with a disability is often missing when talking

about ways services can perform better in cases of abuse, neglect and violence. The project wanted to hear from people with disability about their views of safety and what they think services can do to help people feel safer. The aim of the project was for one focus group to be held in each state throughout Australia. In April 2014, PWdWA represented Western Australia and were responsible for facilitating and recording outcomes from the focus group for feedback to the project. The group varied in age, disability and residential status and consisted of two females and three males.

Participants identified and provided recommendations about what services could do to make people feel safer. Responses included:

- ongoing and regular staff training;
- allowing people with disabilities to be involved in the recruitment and selection process;
- undertaking regular police checks, having a regular review and performance appraisal process;
- employing staff with a mature outlook;
- allowing people with disabilities to deliver training and having staff that listen and who are honest and trustworthy.

PWdWA created a report outlining the responses of the participants and this was sent to NDS.

**3.1.5.2 Disability Complaints Data Collection Project**

Section 48A of the Disability Services Act 1993 (WA) and Section 75 of the Health and Disability Services (Complaints) Act 1995 (WA) gives the Director of HaDSCO the authority to request from ‘prescribed service

providers’ information relating to the number of complaints they have received each year, and the actions taken by service providers to resolve these complaints. In the past, prescribed service providers have only included health services, that may account for the large proportion of complaints from health services when compared with disability services.

In recognising the need to identify disability service complaints and to bring disability complaints data in line with health sector data, HaDSCO has established the Disability Complaints Data Collection Project. As part of this Project, 20 participating disability services have been working with HaDSCO to develop a new format for collecting complaints data. From 1 July 2014, participating disability services have been collecting data in accordance with the new format. The purpose of the data collection process is to identify systemic issues that may relate to all, or a percentage, of disability services.

Advocacy organisations have not been included in this data collection project, although discussions have recently been held between HaDSCO and advocacy organisations regarding complaints data collection processes, as outlined below.

**3.1.5.3 Advocates and Community Leaders’ Project**

In April 2015, HaDSCO partnered with advocates and community leaders in WA to explore how they could work together to more effectively manage complaints.

- Attendees included over 40 individuals from the following agencies:
- Advocare
  - Arafmi



- Carers WA
- Consumers of Mental Health WA (CoMHWa)
- Council of Official Visitors (CoOV)
- Disability Services Commission (DSC)
- Ethnic Disability Advocacy Council (EDAC)
- Health Consumers' Council (HCC)
- People With disabilities WA (PWdWA)

Topics raised by attendees included:

- Education/training – Effective complaints handling.
- Getting information about advocacy past gatekeepers.
- How do we make complaint processes more accessible to people with a disability with decision making?
- What constitutes a complaint?
- How do we ensure CALD communities are heard?
- Data – feedback, collection, analysis, response – local, regional, state.
- How do we better engage with Aboriginal families to provide our services especially outside of Perth?
- Relationships, partnerships, sharing and networking.
- Regarding HaDSCO's processes - Where does substantive equity fit in the paradigm of impartiality between consumers and providers?
- How can we engage Police and Justice systems better?
- Fears of retribution.
- When “complaint” becomes a “dirty word”. Managing and healing the wounds.

In discussing complaints data collection and referral processes, advocates and community leaders expressed concerns about their own capacity to collect complaints data due to inadequate IT systems and suggested that

their own systems were made more compatible with HaDSCO's complaints database. They also highlighted the need for adequate data categorisation, stressing that existing categories may be too broad to match the types of complaints received by organisations. Furthermore, there were concerns that issues were not being communicated to external agencies due to fear of retribution, and concerns over the external agencies capacity to deal with the complaint. In particular, there were concerns that police officers may not recognise complaints from people with disability and that more education was needed in this area.

To assist organisations and other interested parties in sharing information and keeping up-to-date with project developments, HaDSCO has set up an Advocates and Community Leader page on their Officer's online engagement site 'Collaborate and Learn'.

#### 3.1.5.4 NDS Safer Services Project

Lotterywest has contracted NDS to undertake research jointly with Curtin University in order to develop sector development strategies to build the capacity of disability service organisations to safeguard people with disability who are often at increased risk of abuse, neglect and harm.

This two year research project aims to -

- identify safeguarding concerns for people with disability
- investigate existing safeguarding practices amongst West Australian disability service organisations, including identifying gaps and processes or interventions that might address gaps, and
- develop, trial and evaluate strategies, processes and tools to enhance and/or build safeguarding capacity

## 3.2 National and International Data

Large scale national studies that assess the incidence and prevalence of violence, abuse and neglect against people with disability is limited. People with Disability Australia (PWDA) and Women with Disabilities Australia (WWDA), in their fact sheet on 'Violence Against People With Disabilities in Institutions and Residential Settings' reported that:

- People with disability are at a far greater risk of violence than others in the population and that this violence often goes unrecognised or addressed.
- 18% of people with disability report being victims of physical or threatened violence compared to 10% without disability
- people with intellectual disability are ten times more likely to have experienced violence than people without disability
- Violence against women with disabilities in Australia is far more extensive than violence amongst the general population.
- Violence perpetrated against women with disabilities is significantly more diverse in nature and more severe than for women in general.
- Women with disabilities in Australia continue to experience violence (particularly sexual violence) in residential and institutional settings, where they frequently experience sustained and multiple episodes.
- Compared to their peers, women with disabilities experience significantly higher levels of all forms of violence and are subjected to such violence by a greater number of perpetrators.
- Women with disabilities are 40% more likely to be the victims of domestic violence than women without disabilities, and more than

70% of women with disabilities have been victims of violent sexual encounters at some time in their lives.

- Twenty per cent of women with disabilities report a history of unwanted sex compared to 8.2% of women without disabilities.
- The rates of sexual victimisation of women with disabilities range from four to 10 times higher than for other women.
- More than a quarter of rape cases reported by females in Australia are perpetrated against women with disabilities.
- 90% of Australian women with an intellectual disability have been subjected to sexual abuse, with more than two-thirds (68%) having been sexually abused before they turn 18 years of age.
- Women and girls with disabilities have far less chance of being believed when reporting sexual assault, domestic violence, and other forms of violence, than other women and girls.
- Crimes of violence committed against women with disabilities often go unreported, and when they are, they are inadequately investigated, remain unsolved or result in minimal sentences.

There are also some large scale international studies on the incidence and prevalence of abuse against adults and children with disability. A sample of these studies, outlined below, highlights the importance for reporting mechanisms to take into account demographic information (e.g., age and gender), the person's disability status, the form and severity of abuse, the type of perpetrator and reporting outcomes.

### USA - Sullivan & Knutson (2000)

In a USA based population study involving over 50,000 children, Sullivan & Knutson (2000) found that children with disability were 3.4 times more likely to be maltreated than children without disability. Children who were maltreated tended to be subjected to multiple incidents rather than single incidents, where neglect was reported as the most prevalent form of maltreatment. The researchers found that incidents were more likely to be perpetrated by a family member; although maltreatment from outside the family was clearly evident, particularly with sexual forms of abuse. Their findings also showed the age the first incident was reported was significantly associated with the child's type of disability. Furthermore, significant gender differences were found, with boys with disability being more at risk of being maltreated than girls. In contrast, among the group with no disabilities, girls were more likely to be maltreated than boys. Sullivan & Knutson's findings were obtained by school records and reports from social services, foster care and police departments. Their study highlights the importance of early intervention and the major role schools and education support centres have in identifying, preventing and treating childhood abuse and neglect. Sullivan & Knutson's research is well cited and considered to be one of the most reliable sources of research in assessing the maltreatment of children with disability.

Israel - Hershkowitz et al (2007)

In another large scale study reviewing the prevalence of abuse against children in Israel, Hershkowitz et al (2007) assessed over 40,000 forensic reports. 1.2% of the alleged victims were categorised as children with severe disability and 11% children with minor disability. They found that children with

disability were proportionally more likely than children without disability to identify themselves as a victim of sexual rather than physical abuse, and that the severity of the disability was related to a higher risk of sexual abuse. The study also showed that children with disability were more likely to either fail to disclose incidents or delay disclosure than children without disability, with the researchers concluding that children with disability may have more difficulties in reporting violence and abuse than their peers. International - Hughes et al (2012) and Jones et al (2012)

In 2012, Hughes et al and Jones et al published findings from their systemic review and meta analysis of the prevalence and risk of violence against adults and children with disability. Their reviews involved a comprehensive search of 12 databases and over 10,000 references from 1990-2010. The results from the reviews confirmed that both children and adults with disability were more likely to be victims of violence than children and adults without a disability.

### USA - Disability and Abuse Project

In 2013, in the USA, the Disability and Abuse Project published findings of their online survey on the abuse of children and adults with disability. 7,289 people completed the survey; including people with disability, family members, service providers and advocates. The results of the survey revealed that more than 70% of people with disability who completed the survey reported that they were victims of abuse. The incidence of abuse experienced by survey respondents was associated with the type of disability (mental health 75%, speech 67%, autism 67%, developmental disability 63%, mobility 55%). Results also showed differences in the form

of abuse reported (verbal-emotional 87%, physical 51%, sexual 42%, neglect 37%, financial 32%). More than 90% of the people with disability who had experienced abuse reported that they had experience multiple incidents, with 46% reporting that the abuse was too frequent for them to count. 63% of people with disability who reported the abuse for the purpose of the survey had not reported the incident(s) to the authorities; with 40% of victims of physical abuse and 41% of victims of sexual abuse expressing that they had not contacted the authorities to report the incident(s). Reasons for not reporting included 'believing that nothing would happen', 'had been threatened or were otherwise afraid', or 'did not know how to or where to report'. In cases where the person with disability reported the abuse to the authorities, 53% reported nothing happened and 10% reported that the alleged perpetrator was arrested. When reports to the authorities by family members were also considered, 8% of alleged perpetrators were arrested, with 43% of the reports resulting in no action by the authorities.

### UK, BBC Victoria Derbyshire Report

On 18 May 2015, UK BBC presenter Victoria Derbyshire released a media report stating that between 2013 and 2015 there were 4,748 reports of sexual abuse against adults with disability. These findings were based on data collected from 106 local councils in England with responsibility for adult social services. The findings showed that 63% of the reported victims were people with learning difficulties, while 37% of reported victims had a physical disability. The UK's National Society for the Prevention of Cruelty to Children (NSPCC) stated that these findings may merely be the 'visible peak' of a much larger issue.

### 3.2.1 Australia's compliance with its international obligations as they apply to the rights of people with disability

"States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects."

- UN Convention on the Rights of Persons with Disabilities, Article 16

There is national recognition, through the ratification of the UNCRPD by Australia in July 2008, that all people living with disability have the right to live their life free from any form of abuse or restrictive practices. Article 163 states:

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by



independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services.

Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

### **The National Disability Strategy**

The National Disability Strategy 2010-2020 highlights issues relating to rights, protection, justice and legislation in Policy Area 2 which undertakes that “people with disability [are to] be safe from violence, exploitation and neglect.”

The Strategy provides an important framework for governments to work together with the wider community to come up with solutions. In outlining a high level strategic vision, submissions to the Shut Out report argued that the Strategy must ensure that there is coordinated and comprehensive planning across all portfolios and between all levels of government.

The six areas of the Strategy were aligned to the articles of the Convention on the Rights of

Persons with Disability.

The Strategy provided a shared agenda to help achieve the vision of an inclusive Australian society that enables people with disability to achieve their full potential as equal citizens.

Western Australia is a signatory to the National Disability Strategy and must report against each outcome, including Outcome Area 2, Rights Protection, Justice and Legislation.

The policy directions for Outcome Area 2 are as follows -

1. Increase awareness and acceptance of the rights of people with disability
2. Remove societal barriers preventing people with disability from participating as equal citizens
3. People with disability have access to justice
4. People with disability to be safe from violence, exploitation, and neglect
5. More effective responses from the criminal justice system to people with disability who have complex needs or heightened vulnerabilities

The areas for future action are as follows -

- 2.1 Promote awareness and acceptance of the rights of people with disability.
- 2.2 Monitor and ensure compliance with international human rights obligations.
- 2.3 Develop strategies to reduce violence, abuse and neglect of people with disability.
- 2.4 Review restrictive legislation and practices from a human rights perspective.
- 2.5 Examine recommendations arising from

the report of the Joint Standing Committee on Migration on migration treatment of disability, Enabling Australia.

2.6 Improve the reach and effectiveness of all complaint mechanisms.

2.7 Provide greater support for people with disability with heightened vulnerabilities to participate in legal processes on an equal basis with others.

2.8 Ensure people with disability have every opportunity to be active participants in the civic life of the community—as jurors, board members and elected representatives.

2.9 Support people with disability with heightened vulnerabilities in any contacts with the criminal justice system, with an emphasis on early identification, diversion and support.

2.10 Ensure that people with disability leaving custodial facilities have improved access to support in order to reduce recidivism. This may include income and accommodation support and education, pre-employment, training and employment services.

2.11 Support independent advocacy to protect the rights of people with disability.

2.12 Ensure supported decision-making safeguards for those people who need them are in place, including accountability of guardianship and substitute decision-makers.



# 4. Safeguarding

## 4.1 Working Together to Achieve Good Practice

'It's a very sobering feeling to be up in space and realize that one's safety factor was determined by the lowest bidder on a government contract. - Alan Shepard

It is simple to look at a series of problems and arrive at the conclusion that a regulatory system might prevent those problems from occurring. It is less simple to understand how those systems that we impose upon people with disability may be implemented in a way that does not restrict their choices or control, or prevent developmental safeguarding occurring. When people with disability live in institutionalised settings, they are arguably in a 'protected' environment. It is clear that our efforts to protect people by segregating them do not work, as institutionalised settings can become petri dishes for violence, neglect and abuse to occur.

The NDIS Safeguarding Paper framed safeguarding via a theoretical model, classifying safeguards into developmental, preventative and corrective safeguarding. In health, the model of primary, secondary and tertiary prevention classifies interventions into different stages.

When classifying prevention, it is helpful to use a four way 'prototype' that is often used in addressing violence in schools. The prototype involves thinking about different ways that prevention can be framed:

- Situational prevention, that is attending to the environments in which abuse may take place through for example the design of establishments or staff supervision;
- punitive prevention, where by attending to detection, prosecution and appropriately serious punishment sets up a sufficient deterrent;
- treatment-based prevention which conceptualises abuse as a consequence of individual or family dysfunction or prior victimisation of the perpetrator;
- social prevention, which deals with the problem in the broader social context, for example by addressing specific manifestations of abuse against a backdrop of widespread discrimination against people with disabilities. (adapted from Dubet & Vettenburg 1999)

A third dimension is also described, which explores the nature or orientation of the intervention in terms of whether it is primarily reactive or proactive.

In relation to abuse, a reactive strategy would be one that seeks to avert danger. An example of this would be a Clear Card, where unsuitable staff are screened out. A proactive strategy, on the other hand, would enhance user involvement, promote key areas of practice of implement quality assurance programmes. An overly reactive strategy may impact upon choice and control, further segregate and isolate people with disability and reduce autonomy.

The authors of this report argue strongly that action should be taken at all levels, but that abuse needs to be seen within the context of a human rights framework, that reliable information must be acquired in order to address issues and that people with disability, their families and the service sector are sufficiently resourced to work together to challenge violence, abuse and neglect.

## 4.2 Developmental Safeguards

The NDIS Safeguards Paper says:

The developmental domain is about building people's own natural safeguards. A person with sound knowledge of their rights and who understand how the system works, who has support from others in their lives, will always be better protected by these natural safeguards than they could be by a safety-net built by governments.

The NDIS aims to help participants to become active consumers with choice and control over the supports they need to live the life they want. This means participants need access to high-quality information that can give them the tools to choose the best providers of their supports." - NDIS Safeguarding Paper

It is easier to develop preventative and corrective safeguarding mechanisms than to build a framework that builds and invests in citizens' capital. In order to think about developing capital for people with disability and their families, we need to understand that each person has their own 'natural' capital in terms of capacity. Those aspects of capital include personal capital (ability to

self advocate, inner strength and resilience, self esteem) knowledge capital (skills, knowledge and the ability access high quality information and act on the information), social capital (relationships, family support, friends and community) and material capital (community, home, income).

When developing and supporting appropriate developmental safeguards in the context of institutional abuse and neglect, it is important to consider that existing capital and assess people's own capacity in order to build on existing strengths and eliminate gaps.

Kendrick (2005) describes developmental safeguards as safeguards which aim to produce socially desirable conditions for the inclusion and prevention of people with disability, supporting their valued status in community and developing supports through family and intentional relationship building.

For people who have 'low personal capital' and are therefore potentially more 'at risk', the development of and investment in intentional developmental safeguards will be far more effective than a focus on regulatory systems.

When looking at the accounts provided to the Inquiry, it is clear that there is no one 'silver bullet' that will address violence, neglect and abuse - rather, it is a combination of factors which enable people with disability to develop and build upon their natural capital, enable them to access support when they need it and reduce the factors which contribute to abuse and neglect.

Abuse being prevented by not being segregated and isolated in institutional settings is one of the clear conclusions of the Inquiry, but people with disability are



also abused in their homes and by strangers. Attitudinal change is therefore necessary to change the culture of both workers and society to ensure that we are not 'othered' or regarded as 'lesser' because of difference'.

Other important mechanisms are access to information and advocacy, ensuring that people with disability are able to recognise risky or abusive situations, making sure that people have adequate sex education and that cultures of compliance are removed.

Building of effective peer support systems and encouraging the development of People First and self advocacy organisations can assist with the development of social capital and ensuring that people with disability challenge the status quo. It is also important that people with disability are able to be included in the community and for intentional relationships to be supported in the absence of informal supports.

There are few disabled persons' organisations in Western Australia, and supporting people with disability to speak up with others is a key mechanism in supporting them to be safe from abuse and being the authors of their own lives.

### 4.2.1 Preventative Safeguards

people with disability and their families should have access to more information on identifying the effects of abuse, neglect or violence.

Another major issue raised was lack of resourcing in the disability sector. On one hand there are difficulties finding competent staff suitable for the demands of the job. On

Preventative safeguards prevent abuse from happening at all.

They can include;

- Risk management (including self identification of vulnerabilities)
- Training of staff
- Registration and worker safety systems
- Access to advocacy

Provision of information about advocacy and existing statutory complaints mechanisms was one of the key issues that arose as a result of the Inquiry. It was also felt that the other hand there are difficulties keeping competent staff due to monetary restraints or high burnout rate.

Government and service providers should work together with advocacy groups across Australia to increase awareness about the effects of abuse, neglect and violence in the wider community.

On a community level, there needs to be capacity building around disability confidence, especially in the areas of justice, law enforcement and health. Work needs to be done to ensure that staff in all settings value people with disability and do not regard them as 'other'.

Australia has varied screening process varies across states and territories. Currently all states in Australia have mandatory legislation for pre-employment screening processes for people who work or volunteer with children with disability. However, only South Australia, New South Wales, Queensland, Tasmania and the Australian Capital Territory have mandatory legislation for pre-employment screening for

people working with adults with disability. Tasmania and Australian Capital Territory have a joint working with children and vulnerable person scheme, whereas in South Australia, New South Wales and Queensland the schemes are separate. In Western Australia and the Northern Territory the pre-employment screenings include a working with children check and a national police clearance, but there are no legislative requirements for pre-employment screening of people who work with adults with disability. In Western Australia, organisations working with Disability Service Commission are contractual but not legally required, under the service providers Service Agreement to ensure workers employed possess current police clearances.

If a person has been terminated for alleged acts of abuse, neglect or violence, it should be mandatory for employers to disclose that information to ensure that person does not get another job working with people who are most at risk for abuse, neglect or violence.

#### Service Level

While it is necessary to have pre-employment checks in place to screen out people who have been convicted of criminal acts, it is not an effective approach to preventing acts of abuse, neglect or violence when taken in isolation as a safeguarding mechanism - they do not provide sufficient information of one's experience and attitudes towards people with disability. There should instead be more focus on human rights training among staff and people with disability.

Although Western Australia does not use the term 'institution' often, the culture of

systemic care and institutionalised practices has not changed much over the years. Although the concept of an institution has undergone changes, the practices and standards of care has not improved markedly. Oppressive regimes still exist in and out of institutionalised settings and staff culture urgently needs widespread reform. Staff should be trained in recognising and addressing signs of abuse and support must be given to people with disability to access support, police, advocacy and legal services. Staff must also be given clear guidelines around handling issues such as;

- sexuality;
- challenging behaviour;
- control and restraint;
- handling money;
- administering medication.

Training of staff should be carried out via human rights based organisations and disabled persons organisations.

The implementation of a Community Visitors' program in Western Australia would provide a valuable preventative mechanism for those who are exceptionally vulnerable because of the absence of anyone but paid staff in their lives. There are no recommendations about which statutory body the Program should sit under, other than to note that it would be more effective if people with disability and their families were encouraged to codesign the Program. A Community Visitors program that was disabled-persons led would also facilitate peer support, especially with the involvement of a People First self advocacy movement.

## 4.2.2 Corrective Safeguarding

Corrective safeguards involve actions that agencies and governments need to be able to take to respond to incidents after they have occurred.

- access to complaints systems
- ensuring that abuse is properly identified
- referral to appropriate agencies who will intervene to stop it recurring, including police and mainstream systems
- treating individuals who have been abused and helping them to recover without sustaining longterm problems related to trauma and distress
- access to disability advocacy
- handling of serious incidents
- effective reporting

The Inquiry revealed widespread confusion about existing complaints mechanisms, the existence of statutory bodies and reporting agencies and the powers of the relevant agencies to effect change. For example, a Commonwealth funded agency were not aware that they needed to report abuse, because it was not clearly articulated in their contract. Another issue that repeatedly arose was the absence of timelines and clear steps for staff to match response to incident - police were rarely notified as a consequence of abuse, even when mandatory reporting (for children) was in place.

Few individuals were appropriately referred to independent advocacy or provided with information about where to find help, and it was an oft-repeated complaint that families were not involved in the serious incident

notification process, especially in the outcome of the complaint. This caused significant stress for some families and people with disability who did not know if abusers had been dismissed or 'moved sideways' and if they would come into contact with those individuals again.

Complaints systems were not regularly engaged with, especially within prison systems and other mainstream systems. Disability complaints were almost non-existent when compared to health complaints received by HaDSCO. The absence of an effective independent reporting body has meant that complaints mechanisms are only perceived as part of a funding arrangement in a notification, not complaints management, system.

Whistleblower legislation exists in this state, but is underutilised and the processes to engage with it are not well understood. Service providers should ensure their staff are supported to report any acts of abuse, neglect or violence and engage with existing whistleblower legislation and public interest disclosure mechanisms. The fear of ramifications (e.g. losing one's job or being ostracised) may result in acts of abuse, neglect or violence not being reported, or when reported, clients' complaints are not taken into serious consideration or investigated.

It is debatable whether the Disability Services Commission should maintain authority for serious incidents, especially if legislation is developed which imposes clear sanctions,

expectations and obligations upon heads of organisations in the same way breaches of care for workers in the Occupational Health and Safety system imposes sanctions, expectations and obligations. Although there will always be a need for reporting to a funder as part of the funding process, the independence of an agency is critical to ensuring that responses are robust and that change occurs. In Victoria, the Disability Services Commissioner has been recently criticised for rarely referring disability abuse to police; he cited his preference for an 'education approach'. Similarly, investigations are rarely carried out against organisations in Western Australia who have breached disability service standards, although their funded status is removed with repeated breaches. There is no clear intersect or articulation pathway for reporting between police, funding organisation, person with disability and service provider.

There were many reports received in the Inquiry of difficulty with police processes and the lack of awareness and responsiveness of police to disability issues. One young woman was interviewed without support and 'didn't really know what to say'. Another young person, who was at the time a child, was interviewed without her mother being present, despite her mother not being a suspect in the case. The child understood only certain words and was not acquainted with the language the police were using. In another case (of suspected child sexual abuse), the police have asked to re-interview the child, almost a year after the incident originally occurred. In some cases police allegedly refused to even investigate the case (when the perpetrator was a person with an intellectual disability), even when there was clear evidence and when the person had

issued a confession. The inappropriately named 'CAIT' (child assessment and investigative team) is currently used to receive disability complaints, but clearly requires renaming and additional resourcing in conjunction with disabled persons' and consumer organisations.

The lack of transparency and visibility around violence, neglect and abuse, especially in disability settings, compounds the issue of a failure to understand how violence, abuse and neglect happens. When quality evaluations are conducted, it is up to the organisation to make them public. Many do not. There is no requirement for the Disability Services Commission to make visible reported cases of Serious Incidents, unlike reporting within the health system. Complaints to providers are reportedly often 'dealt with inhouse' with one large provider citing being 'conservative' with Serious Incident Reports and preferring to use their own inhouse system. There were also reports of support workers being asked to falsify reports prior to quality evaluations being conducted and providers being unsure when to complain and to whom. Some people with disability said that the Serious Incident Report that related to their abuse could be 'hung onto' - there were no clear timelines articulated to providers about when the report must be submitted.

It is noted that the Disability Services Commission has addressed this issue recently.

An urgent priority is to ensure that people with disability and their families are able to easily access complaints mechanisms and robust structures which will enable them to access justice systems equitably.



# 5. Recommendations

There is an urgent need for change in mainstream and disability services in Western Australia. The project team have developed sixteen recommendations - key recommendations are bolded.

People With disabilities WA and Developmental Disability WA recommend that:

- 1. An independent, statutory, national protection mechanism be established with broad functions and powers to protect, investigate and enforce findings related to situations of exploitation, violence and abuse. A secondary consideration, should states fail to reach agreement, may be that each State's Ombudsman be granted equivalent powers and form a cohesive national body.**
- 2. Consideration be given to the development of uniform, national legislation to impose clear sanctions, expectations and obligations against persons or organisations responsible for the care of people with disability in the same way that OHS legislation responds to breaches of duty of care against workers.**
- 3. Immediate priority be given to strengthening and renaming WA's Child Assessment and Investigation Team to assist with the elimination of barriers to justice. Police officers who are not involved in the CAIT team should also be trained in disability confidence by an accredited human rights organisation.**

- 4. The development of education and training be adequately resourced for people with disability and their families in the areas of human rights and speaking up, sex, sexuality and meaningful relationships and education for both people with disability and providers in understanding what statutory mechanisms exist and how to access them.**

- 5. A Community Visitors' program in WA be implemented which actively involves people with disability and their families as Visitors and which facilitates communication with other Visiting bodies (Official Visitors, Independent Visitors)**

6. Communication for complaint processes be improved throughout mainstream and disability service systems including clarity for providers about matching response to incident

7. The Disability Health Network work on intersectionality in systems and devise a way to identify needs that are not duplicated by existing disability/health support

8. Mainstream victim support services be provided with training and made accessible to people with disability and pathways articulated to provide clear triaging and support for people with disability

9. Improved data collection in hospitals, victim support centres, prisons, jails, schools and other mainstream settings around violence, abuse and neglect against people with disability

10. Service providers be supported to share good practice in sharing best practice responses to prevention and addressing of violence, abuse and neglect.

11. The existing powers of the Disability Services Commission be more effectively utilised to investigate complaints in disability service settings and put sanctions in place if required

12. Transparency and accountability be improved by ensuring that complaints are reported against in funded disability service providers' annual reports and that quality evaluations be made public on the Disability Services Commission's website annually

- 13. Service providers establish clear pathways to support people with disability to access information, training and independent advocacy**

14. Consideration be given to the establishment of a complaints management system be undertaken at DSC (as opposed to a notification and reporting system) where trends are made visible and monitored via an industry and human rights based working group which has the ability to influence policy and legislation

15. Capacity building for people with disability and their families to be able to be directly involved in governance and policy making at the provider and government level with an active role as changemakers

16. Promote widespread awareness raising about the prevalence of violence, neglect and abuse against people with disability and its effects and the promotion of and acceptance of the rights of people with disability in practice.

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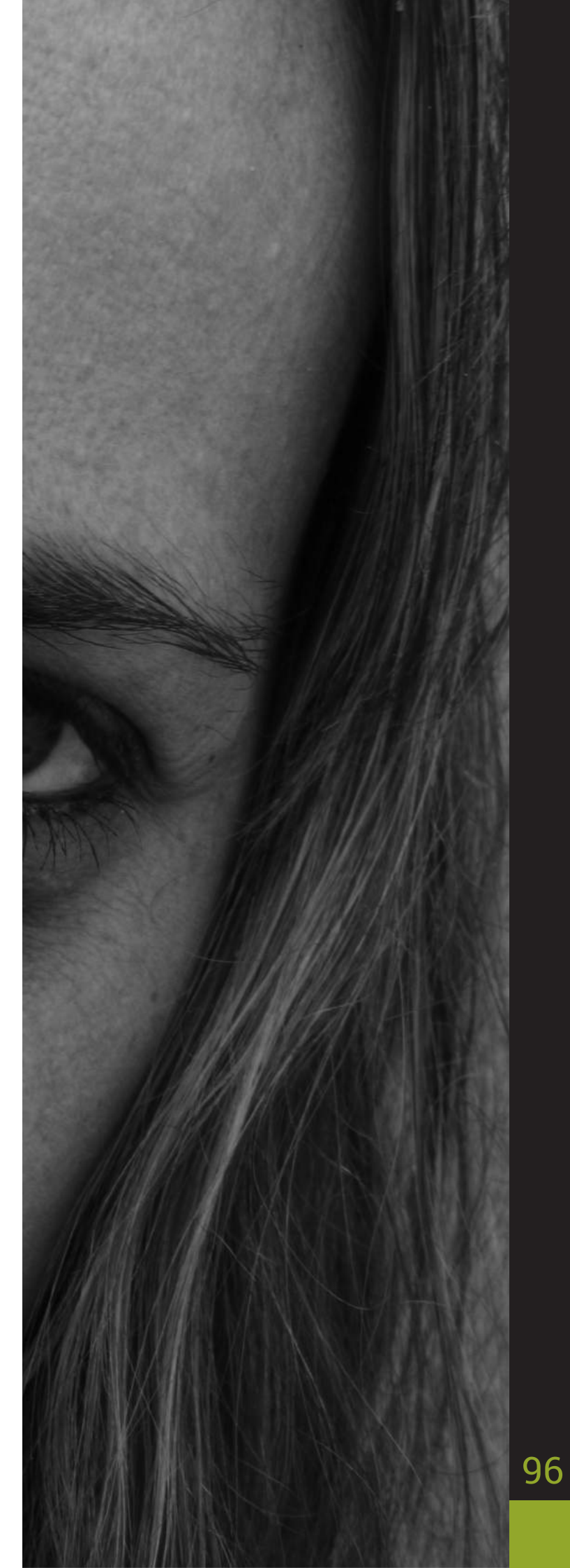
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