

AUSTRALIAN CROSS DISABILITY ALLIANCE



Personal Stories and Testimonies

Accompanying document to submission

Senate Community Affairs References Committee

Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings

August 2015

INTRODUCTION

This document, *Personal stories and testimonies* is a supplement to the submission 'Australian Cross Disability Alliance (ACDA) Submission to the Senate Inquiry into Violence, abuse and neglect against people with disability in institutional and residential settings'.

The supplement contains 70 personal stories and testimonies of violence, abuse and neglect experienced by people with disability. All names have been changed and identifying features removed. Many of these stories and testimonies have been provided by Disabled Peoples Organisations (DPOs) and independent disability advocacy organisations, and some have been sourced from public reports and media stories, many of which have been cited within the ACDA submission.

These are only some of the many stories and testimonies that could be told. They represent the epidemic of violence, abuse and neglect that children and adults with disability experience in institutional and residential settings, including in group homes, boarding houses, day programs, mental health facilities, prisons, schools, hospitals, out of home care, immigration detention centres, aged care facilities, workplaces and private homes.

These personal stories and testimonies categorically refute any perception that violence, abuse and neglect against people with disability is limited to a few rogue individuals, confined only to disability support settings, or confined to one State or Territory in Australia. This is a national epidemic that requires national action.

The personal stories and testimonies provide the human reality to the information provided in the body of the ACDA Submission. Whilst the ACDA welcomes this Senate Inquiry, we also recognise the inherent barriers for people with disability in being able to provide direct evidence to the Senate Committee conducting this Inquiry. Many people with disability in institutional and residential settings do not have the necessary supports, the relevant information or the extensive process that is required to facilitate and support them in coming forward to provide evidence directly to the Senate Committee.

It must also be acknowledged that in many cases, institutions will not view it as in their best interest to actively encourage and support people with disability to share their experiences of violations of their human rights in the institutions and settings in which they reside, are incarcerated or in which they receive services.

In order to show that those who have been failed by the system deserve justice, we call for urgent national leadership to establish a Royal Commission into violence, abuse and neglect against people with disability.

ACKNOWLEDGMENT

The Australian Cross Disability Alliance (ACDA) thank the people with disability whose stories and testimonies make up this accompanying document, and acknowledge the many more whose stories remain untold, hidden or forgotten.

Personal Stories and Testimonies

1. **Christine**, a 39 year-old woman with intellectual disability, was repeatedly raped and bashed in one week by several different men. She lives in a 'semi-supported residential facility', and although she is classified as having "high support needs", she receives only 2 hours of support each day. For the other 22 hours, she is left unsupervised and unsupported. In one of the attacks (in the local park in broad daylight), she was repeatedly anally and vaginally raped and beaten. When she made it back to the residential facility, a staff member made her hand-wash her bloody underwear and garments. The worker wrongly "assumed" that the woman was menstruating (despite her being on an injectable contraceptive) and she was reprimanded for getting blood on her clothes. Christine was too scared to tell the worker what had happened to her because she thought she would "get into trouble". Two days later, the woman disclosed the rapes to her friend who helped her report the rapes to the police. Three of the five police initially involved in interviewing her and taking her statement, asked her friend if the woman might be "making it up". The detectives investigating the case admitted that, although there was now clear evidence that the rapes occurred, there was "little likelihood" of a conviction due to the fact that the woman "has an intellectual disability".
2. **Tom** has intellectual disability and resides in a State Government-run group home. He was found in an appalling state of neglect. Unable to feed himself and reliant on staff to provide him food and fluids 4 to 5 times per day via a feeding tube into his stomach, Tom's feeding tube was found to be infested with maggots at the wound where it entered his stomach. It took more than a year for the 'incident' to be formally investigated. The investigation also discovered that his rehabilitation program was not being followed; he was being left unattended by staff; personal items, items of his clothing and linen were being used on other residents of the group home; a hoist provided for assisting with his transfers was not being used; and he wasn't ever taken on any outings.
3. **Suzie** was sterilised at 6 years of age. A doctor performed a full hysterectomy on Suzie at the request of her parents because she was "almost blind". In later years, Suzie and her husband – both with full time professional careers – sought to adopt a child. Their applications were denied on the grounds of Suzie's vision impairment. They fought the decision which took them several years, but by the time they had the decision over-turned, they no longer met the age requirements for adoption. Their only remaining option was to seek a surrogacy arrangement, but they were advised that this would cost them upwards of \$300,000.
4. **Hugo** died in a mental health facility. He was killed by a combination of powerful anti-psychotic medications given to him by staff, according to a Government pathologist. Staff and patients aware of the circumstances of his death say Hugo was pleading not to be given more drugs on the night he died. Staff and patients also allege there was an attempt to conceal information about the circumstances of his death from his family.

5. **Vincent** is a man with psychosocial disability and he has lived in a boarding house for approximately 15 years. During this time, Vincent experienced and witnessed countless cases of assault and abuse. These offences were predominantly committed by the boarding house proprietor and by other residents under the proprietor's instructions. Vincent said that proprietor was a 'dominating bully' who everyone obeyed.

When Vincent first arrived at the boarding house, the proprietor beat him every day for two weeks, punching him in the face and body, causing bleeding and significant bruising. Vincent described this process as taking place for all new arrivals to the boarding house to let them know who was 'in charge'. After two weeks he considered them 'broken in', and most subsequent beatings would be carried out by other residents, on the proprietor's orders. These beatings were so severe that on one occasion, a resident broke his knuckles punching another resident in the face.

During the time in which Vincent lived at the boarding house, many people died. He had witnessed people trying to kill themselves. Vincent believes that this was because of the awful things happening in the boarding house. Additionally, Vincent watched a co-resident choke on his dinner and die right in front of him. The staff did nothing to help him.

Vincent did not receive any money during the time he lived in the boarding house. His Disability Support Pension was paid directly to the proprietor. The proprietor would also write to Vincent's parents, telling them that they needed to send more money for their son's care. They always complied, as they were afraid that Vincent would be evicted from the boarding house if they didn't.

Vincent slept in a small room with two other men and conditions were very crowded. Vincent and other residents were heavily medicated with the proprietor giving the residents injections every two weeks to keep them calm and placated.

On one occasion, Vincent attempted to escape the boarding house. He hitchhiked and walked to a neighbouring town, before waiting for a train to take him to a major city. However, while waiting for this train, he was spotted by a boarding house staff member, who proceeded to take him straight back to the boarding house.

Vincent's sister eventually helped him leave the boarding house, but this took five years to achieve.

6. **Frances** was physically beaten by a group of young girls at a regional TAFE institute. The violent attack was captured on CCTV footage. The local police advised Frances not to pursue charges because she was "mentally retarded" and there would be "no chance of any conviction" against the perpetrators.
7. **Josie** is 41. She has an intellectual disability and she lives in a group home 'village' style complex. There are a number of other residents with intellectual disability living in other units on the site – some live in units on their own, whilst others share. Josie was raped by a male co-resident within the grounds of the complex. She immediately disclosed the rape to an on-site support worker who advised her to "*just keep out of his way*". The rape was not reported to the police and Josie was not offered any support or counseling.

8. **Dave** is a young Aboriginal man with intellectual disability. He was found 'unfit to plead' in a criminal matter. He was indefinitely detained in a maximum security prison. Dave does not have access to the intensive rehabilitation programs he needs to address the causes of his offending behavior.

He is often isolated in his cell for approximately 16 hours a day, and frequently shackled during periods he is outside his cell. In response to repeated banging of his head causing bleeding, prison officers strap him to a chair and inject him with tranquilizers until he is unconscious. This has happened on numerous occasions.

The government corrections department responded to complaints by stating that it has a 'duty of care' to prevent the man from hurting himself, and that the prison is not equipped to manage people with cognitive impairment.

9. **Julie**, a staff member in an aged care facility reported to management that a co-worker had taken sexually explicit photos of a number of aged care residents. These photos were of the genital region of residents, and they were being shown to students who were on placement at the aged care facility. Management of the aged care facility did not view the matter as serious, and responded by moving the co-worker to another aged care facility. A number of the students took the matter to the relevant complaints body, and Julie reported the matter to the police, who are investigating the matter within their criminal investigation branch.

10. **Kayla**, 14, has an intellectual disability and does not use spoken language. She wears a continence aid during the day and night. During the school holidays, she attended a day program for teenagers with disability. She was sent to the day program in the early morning and was wearing a continence aid. When her parent picked her up to take her home, she was soiled and her mother changed her. When she changed her, she found a very deep cut or tear to her vaginal area, between her anus and vagina. Significantly, there was no blood in the soiled continence aid. The parent took her daughter to the hospital, where she underwent surgery and had stitches to repair the injury. The hospital staff were steadfast in their opinion that this was an 'inflicted injury'. They said that the injury would have bled profusely. Kayla is 'well padded' and the only possible time and place that she could have been injured was during being changed by a staff member. She was interviewed by police but there was no outcome as she could not tell them what had happened. Staff and management at the day program said that they did not know what had happened.

11. **Leila** is a three year old asylum seeker with epilepsy. When she arrived on Christmas Island she was taking two medications which her parents had brought with her. These were destroyed on arrival, her records removed and not made available to doctors. Doctors only had one replacement form of medication and Leila started to have seizures. Doctors were in contact with the mainland to try and procure the correct medication but when it eventually arrived she had only been given a month's supply. That ran out and the entire time Leila was having seizures. After trying a third medication Leila was eventually transferred off the island after repeated requests from medical officers and a long wait. The Medical officer involved said that children with complex medical problems are unable to be supported in the immigration detention facilities without appropriate paediatric support and specialist care.

12. **Paige** is a 23 year old woman with multiple impairments, including a neurological impairment and vision impairment. She had been residing in a for-profit supported accommodation facility for approximately six years. She lived with other women, and got on well with her co-residents.

Problems arose when a new male co-resident was transitioned into the facility. This man was known for his aggression, and the parents of the other women living in the group home also objected to him being there. One day, there was only one staff member on duty in the group home. This female staff member had previously been physically assaulted by the male resident, and was scared to be left alone with him. When he started to display aggressive behaviours, the staff member locked herself in the office, leaving him alone with the other two female residents.

At this point, he raped Paige. The staff member proceeded to call the police and ambulance from the safety of the office. After the police and ambulance arrived, Paige was moved out onto the balcony, away from the male resident. She was left out there for quite a while, before being taken to the hospital by herself. While at the hospital, Paige was asked questions and treated without the support or assistance of her mother or support staff. Indeed, no contact was initially made with her mother to inform her of what had happened. When Paige's mother finally arrived at the hospital, she registered her concern at how Paige had been treated. It was clear to her that Paige was severely distressed and traumatised from her assault and consequent treatment.

Paige's mother then took out an apprehended violence order against the male resident on behalf of her daughter. As a result of this, he left the supported accommodation facility. However, when Paige's mother spoke to the police about prosecuting the man, the police tried to dissuade her from this course of action. The police asked her what the point of prosecution was, as he and Paige both had disability.

13. A 41 year old man, **Herve** has quadriplegia and no verbal communication. He lived in a State government funded group home, and spent days with an undiagnosed broken leg. His injury went 'un-noticed' by the group home staff for more than 4 days, despite the fact that the broken bone was 'poking out' through his skin. It was discovered by one of the staff on a Sunday, but rather than seek immediate treatment, staff waited until the following day to contact a doctor. The man was totally reliant on staff for all aspects of his care, yet the staff maintained they did not know how the injury occurred.
14. A woman with disability in her 50s, **Lorraine** was "digitally raped" by a staff member while showering in a government-owned group home. An incident report was made after the woman told another worker what happened, but that report was later re-written by a supervisor. The worker who allegedly raped the woman was then transferred to another home and the matter was not referred to police.

15. **Andrea** lived in a violent relationship with her husband. Police had been called to Andrea's home on a number of occasions as a result of the violence, but advised Andrea there was little they could do for her. Andrea became pregnant. She delivered her baby in the local hospital. A week later police arrived at her house with child welfare officials. The police physically restrained Andrea whilst the child welfare officials took the baby. Andrea was told at the time that her baby was being taken because Andrea had an intellectual disability and because there was a history of domestic violence. Andrea was never offered counseling or any form of support for either the removal of her baby or the domestic violence. Andrea's baby was never returned to her.
16. **Millie**, a 12 year old girl with intellectual disability experiences violence, including sexual violence, from boys in her class at school. The parents are provided with a certain number of counselling sessions for their daughter, but she needs on-going counselling and other interventions, which the parents have to pay for.
17. **Linda** is a 24 year old woman with a psychosocial and intellectual disability. She resides in a government funded group home with five other women with disability. Most of the other women are older – ranging in age between 40-60 years. The organisation managing the group home also operates several other group homes in the area. Linda is told by staff that she is being taken to visit Jack – a young man with intellectual disability who resides in one of the other group homes run by the organisation. Jack is considered to have significant 'behavioural issues' and is 'difficult for staff to manage'. Jack is considered easier to 'manage' if he is not 'sexually frustrated'. Linda is told by the staff that Jack is her "boyfriend". Linda is taken to the group home where Jack resides and sent into his bedroom. Linda is raped by Jack but Linda thinks that she has to let Jack have sex with her (even though she doesn't want to) because she has been told that Jack is her "boyfriend". This 'arrangement' continues for many months until Linda eventually discloses to a family friend that Jack "hurts her" when he makes her have sex. Linda shows her family friend the cuts and bruises on her genitalia and inner thighs. Linda is eventually taken to a sexual assault support service, accompanied by an independent advocate. After one session, the sexual assault support service says they can no longer assist, because Linda won't "open up" to them, and they don't have the resources or the capacity to work with her.
18. **James** is 24 and has acquired brain injury. He has been ordered to live in a 'community forensic facility' after being found unfit to plead to a charge of assault. The 'duplex' where he lives is on the same grounds as the prison and he lives there alone, his only regular contact being with the staff who monitor the 24 hour surveillance from the observation window.

A cage covers the small outside yard and windows and doors are locked, including the bathroom so he must request permission to use the toilet, shower or to get water. The duplex contains one table and bench bolted to the floor and a bed. James has no visitors as his parents live hours away, he has little opportunity to exercise and there are no recreational opportunities - he has no books, TV, radio or computer to maintain contact with the outside world. He told his independent advocate, "I don't understand why I'm here, I'd rather be in prison".

19. **Joan** has Autism and was restrained by staff at her school at one stage for up to 45 minutes every morning. Her parents withdrew her, and the next school also restrained her. She is now so traumatised she cannot attend any school. She is only nine years old and the State Government Education Department has made little effort to assist her with the psychological treatment she needs to recover from the abuse.
20. Between 2000 and 2011 allegations were made regarding rape, sexual assault, theft, poisoning and physical assault involving over 40 residents of a boarding house. A committee of seven residents at the boarding house exercised control over the others, meting out physical punishment, rape, solitary confinement, and massive prescribed doses of psychotropic medications to sedate residents deemed 'out of control'. One man said he had been grounded in his room for a month, and another said he had been "hit everywhere, kicked and punched everywhere" over the course of 10 years. Despite repeated requests for action from disability advocates the police, guardianship authorities, ombudsman and state government failed to intervene. Residents were not removed from the house until 2011 and are now seeking compensation for false imprisonment, physical injury and financial loss against the boarding house owner and the state government.
21. **Angela** is a woman with intellectual disability who was raped by multiple perpetrators. On reporting this to Police, a rape kit was proposed to be done and she was transferred to the forensic section at the emergency department of the hospital. However, on arrival the medical team refused to perform the kit, on the grounds that Angela had an intellectual disability and couldn't consent. She was not under guardianship, but the medical team assumed that she was unable to consent to this procedure. As a result, vital time was lost seeking someone else to consent. By the time it was clarified that no one else was required for consent, it was too late to capture the physical evidence.
22. **Peta** has intellectual disability and lives in supported accommodation. She was raped by a support worker. The police were notified, and although believing Peta's evidence, they felt that they wouldn't be able to obtain a conviction against the support worker because Peta's testimony would be deemed unreliable by the court. Consequently, the police didn't pursue the investigation. The support worker is still working for the same organisation, but at a different facility.
23. Deaf parents of an 18 month old toddler, who is hard of hearing, were detained in an offshore immigration detention facility. The parents had never had access to an appropriate sign language interpreter and had been unable to communicate with health and support staff or government officials. Their hearing aids had been damaged on the boat journey to Australia, and the child had outgrown her hearing aids. Neither the parents nor the child had access to hearing services, audiology assessments or replacement hearing aids. The family was not linked with any Deaf community information or supports. After intensive advocacy from health practitioners, the family was eventually transferred to another detention placement where they could receive some specialist hearing supports. However, the delay in assessment and specialist intervention occurred at a critical time in the child's development and may lead to long term communication and developmental delays.

24. **Shelley**, is a young Aboriginal woman with intellectual disability who works at an Australian Disability Enterprise (ADE). Shelley has been subject to ongoing and intense workplace bullying and sexual harassment from 3 or 4 other workers.

One day, one of the male employees who bullies Shelley, took her by the hand, saying, 'Come on, come with me,' and then grabbed her on her bottom. Shelley reacted, saying, 'Don't do that, don't touch me like that, I don't like it.'

She complained to her supervisor, who told the male employee that his behaviour was inappropriate. He is known to have sexually assaulted several other female employees. Although, this behaviour is ingrained in the workplace culture, there has been limited intervention by ADE management, in breach of all the usual protections afforded employees by industrial law. The ADE management claim that sexual harassment and sexual assault is the responsibility of the police to investigate, but the police did not respond or investigate these reports.

Shelley began to respond violently to the bullying and sexual harassment, and so ADE management suspended her from her job.

25. **Carlos** lived at a boarding house for 22 years. He assisted with the maintenance and upkeep of the private supported accommodation facility. For his labour, he would receive a cold drink.

Carlos received no payments for his work or from his disability pension during the time he lived at the boarding house. He had not even seen his pension details for over 20 years, and had no idea how much his pension was.

Carlos had no money saved at all. On occasion, his mother would send him pocket money. However, the boarding house proprietor would always take this away from him. He told Carlos that he would get this money upon leaving the boarding house, but this has not yet happened. Additionally, upon leaving, a number of Carlos' belongings have not been sent to him.

26. A family complained about the failure of a government run respite care centre to protect and care for their daughter. The family says they found their young daughter, who has cerebral palsy, aphasia and quadriplegia, left alone outside at night and covered in ants at the respite care centre.

27. **Gary**, a man with intellectual disability, was subject to ongoing physical and emotional abuse in a non-government group home. The abuse was being perpetrated by a female co-resident. Support workers who witnessed the abuse reported these incidents to the service coordinator of the group home. However, despite these reports being made, the service did not take appropriate action to ensure Gary's safety.

28. **Adam's** death at a hospital's psychiatric ward during a struggle with security guards was the subject of a recent inquest. Evidence to the inquest suggests he was asphyxiated while being held face down by security staff. A witness told the inquest that the victim apparently yelled "I give up", but security did not ease off. He died soon after.

29. **Natalie** is 50 years old and is a resident at a psychiatric hospital. She is Deaf, and has intellectual disability, schizophrenia and epilepsy. She lived with her family until her parents were unable to care for her personal needs, and then moved into a residential care facility. During the first three years, Natalie complained that a night worker was hurting her. She also began to experience delusions during this time. Her complaints were not taken seriously and Natalie eventually stopped talking about the violence. However, she began to have violent outbursts and staff reports reveal that she was restrained, sometimes for several hours, due to these outbursts. When the violence escalated to endanger other residents, Natalie was moved to the psychiatric hospital where she was placed under stricter medical supervision. At the hospital Natalie began to wet her bed at night and to pull out large sections of her hair. She was also heavily medicated. A new case manager experienced in working with survivors of sexual assault began to suspect that Natalie had been sexually assaulted. With the help of an interpreter, Natalie disclosed that for over three years, a night worker at the residential care facility had regularly come into her room and sexually assaulted her. The case manager scheduled a medical exam where it was discovered that Natalie had a sexually transmitted disease.

30. In 2014, **Jane** found out through a Freedom of Information request that her 8 year old son, who has Autism had been locked in a room smaller than an accessible toilet, two out of every three days, 2-3 times per day while attending his school. He had also been subjected to physical restraint. The documents setting this out had been kept from her. Numerous parents at the same school who had seen similar abuses over a number of years formally complained to the State Government Education Department. They refused to investigate, and the same Principal still leads the school. The School Diary sets out restraint as a consequence for inappropriate behaviour.

31. **Eddie** is a 35 year old with intellectual disability. A disability advocate visited his home on a tip off from a service provider that he needed support. On entering the home the advocate found that Eddie was being kept captive in a cage with three solid walls and bars on the fourth. His carers only allowed him to wear adult nappies and his diet consisted solely of mashed banana, milk and cereal. Family members used a plastic pipe to prod him through the bars. It's not known how long he has lived like this. When the advocate made further inquiries he discovered that police had visited Eddie and found nothing wrong.

32. **Nelson** lived in a boarding house for 22 years. Nelson was a victim of multiple assaults and all kinds of abuse. He was kept hidden from visitors so that he could not speak out and tell them about the violence and abuse occurring in the house. Nelson jumped from the upstairs balcony at the boarding house in a suicide attempt. This resulted in him smashing his ankle and sustaining serious injuries. He had one operation on his ankle, but needs further corrective surgery. Nelson has never received this additional surgery, despite a number of doctors recommending it.

33. **John**, an Aboriginal man in his mid-20s living in a rural area was participating in community access and day programs through a disability service provider. He uses a wheelchair. On one occasion, a staff member took control over his wheelchair, and ran him into furniture repeatedly. He experienced significant swelling and bruising, which left him in pain for weeks.

When he reported this to the service, they suspended all of the services he was receiving while they investigated. They advised that accessing another service provider would involve extra costs because that service was 13km further away, and that John would have to pay these extra costs. As he required a maxi taxi or community bus, these were withdrawn, so John sat at home for 6 weeks before contacting a disability advocacy organisation for assistance.

34. A 16 year old girl with disability, who lives in a State Government run group home, was found to have a broken femur. The young girl has cerebral palsy, severe spastic quadriplegia, cannot mobilise herself or bear her own weight and uses a wheelchair. At some time over a period of two days she sustained a fracture of her right femur. Her mother was the first person to notice the injury. Despite a medical specialist determining the injury most likely resulted from abuse, a subsequent investigation was unable to provide an explanation as to how the injury was sustained. The investigation did, however, determine that the group home's processes relating to reporting and management of injuries, and/or possible abuse of clients, were inadequate.

35. **Toni** is 44 years old. She has an intellectual disability. She lives in a supported accommodation facility with approximately 20 other residents. Toni is unhappy in the facility. She wants to make her own decisions. She is not allowed to manage her own finances. Toni sometimes packs her bags and "runs away" from the facility and because she has no money, she hitchhikes. On four separate occasions within the space of a year, Toni has been raped by men who have 'offered her a lift'.

36. **Frank** has multiple impairments including Autism Spectrum Disorder. Frank told his mother he was taped to a chair while at school, and this was confirmed by the tape marks on his wrists. He was locked in rooms and subjected to restraint on numerous occasions, at least once witnessed by his mother. When attempting to make a complaint some years later, the school refused to admit the abuse occurred, and said they had no documentation so could not investigate the complaint. Frank was a young primary school child, and still suffers the trauma of those years. No assistance has ever been offered by the State Government Education Department at any time and Frank ended up being hospitalised halfway through his primary school years due to psychological damage.

37. Several women with intellectual disability living in a group home were brutally assaulted and raped after being left alone with a male employee. For one of the women, it was the second savage attack she had endured, having previously been bashed by a violent male co-resident in another group home. The severely traumatised women were provided with a single session of counselling two weeks later.

38. **Luka** is 30 years old and has Down Syndrome. He was attending a day program run by a non-government organisation. Luka had been scratched across the face by a fellow day program attendee. This occurred on the bus to the day program, and was witnessed by the bus driver. Luka felt very threatened by his attacker, and expressed reluctance to attend his day program as a result of this incident. In addition, Luka was assaulted by a staff member. Luka returned home from his day program with very red marks on his wrists. He then enacted a scene of having his wrists twisted, and named the perpetrator of this attack.

Luka's sister, Ivana raised these issues with the day program. However, the day program manager claimed that contact with the staff member would continue until an investigation had been finalised, and continued to place them together.

In other incidents, Luka suffered dehydration from gardening in the sun without being given water to drink, or supported to apply sunscreen. This was despite the fact that his family had provided sunscreen for him to use. Ivana lodged a complaint against the day program on Luka's behalf. However, the government disability services agency that investigated the day program and the complaint found that the day program was following its policies and procedures appropriately. They recommended that the day program manager attend mediation with Ivana to address the concerns she had raised. Ivana refused this option as she felt it was a waste of time, and did not deal with the assault and neglect that Luka had experienced.

39. Two members of the public independently contact an advocacy organisation to ask for assistance in reporting and getting support for, a 60 year old "severely disabled" woman who is being repeatedly abused by her de-facto male partner who is also her carer. The allegations of severe violence and abuse are very disturbing. The callers reporting the violence both claim that they have reported the violence to the police in the past, but the police are "not interested" in intervening. The advocacy organisation contacts a range of services, including police and crisis services to seek urgent intervention and support for the disabled woman experiencing the violence. The advocacy organisation contacts more than 10 separate services/agencies (including the National Disability Abuse & Neglect Hotline) but each agency advises it cannot assist in any way.

40. **Carol**, a group home resident, was reported missing. A couple of hours later, she was brought back to the group home by a taxi driver. Blood was found on her underwear and she was taken to the doctor. Carol disclosed to her doctor that she had been sexually assaulted twice by two different people in the time that she was missing. She also said that the group home manager had previously sexually assaulted her. Carol had disclosed the sexual assaults to group home staff a number of months earlier but nothing was done about it. Police advised charges would be laid against the manager, however, proceedings ceased when he died.

41. A "severely disabled" teenage girl had her nose almost bitten off in an attack at a government funded group home. The young girl was unable to fend off her older male attacker who was a co-resident. The man climbed into her bed during the night and tore into her face and chest with his teeth, leaving her with severe bites, black eyes, bruises and scratches all over her body. No charges were laid.

42. **Sarah** employed her own support worker to assist her with personal care. Sarah had managed pretty well but now at 45, and with a degenerative disability, it was becoming more difficult for her to manage her personal care. Sarah lived alone. The new female support worker started off well and Sarah felt relieved that she was finally getting assistance. But two weeks later, Sarah was sexually assaulted by the support worker whilst in the shower. Sarah was trapped and unable to fend off the attack. Later she reported the attack to the police, and although it transpired that the support worker had a past history of a similar incident, the police advised Sarah that it would be “pointless” to pursue charges, as it would be impossible to “substantiate” the complaint. Sarah’s “support worker” had passed all reference checks and police checks prior to Sarah employing her.

43. **Rose** is eight, has limited mobility and limited verbal communication. She suffered a broken hip at an after school hours care program. When her mother collected her from the centre, the staff didn’t acknowledge that Rose had suffered an injury, claimed that Rose had been throwing a tantrum. Staff stated that Rose refused to walk, so they left her on the floor in the hallway to think about her behaviour.

Upon presenting her daughter to hospital with a serious unexplained injury, Rose’s mother was promptly investigated by the state government child protection agency. The child protection agency referred the matter to the government community services agency. This agency responded by referring the case to the state government education agency that regulates after school hours programs, including the centre where Rose had been injured. However, the investigator from this agency stated that they do not investigate child protection matters, and handed the matter back to the community services agency. The agency for community services, in turn, stated that they only investigate threat of harm in the home and ‘their hands were tied’ in the matter. Nothing had been done to investigate the staff at the after school hours care program, nor to investigate the cause of the injury.

As a result, Rose’s mother lodged complaints with two government agencies and the relevant complaints body about how poorly the after school hours care program managed the incident. Rose eventually named the staff member who was responsible for her injury, and she was interviewed by the police. However, her mother was not allowed to act as her support person, as the police deemed that she would be able to interpret too much of Rose’s unspoken communication, and this would be inadmissible as evidence. Instead, an independent advocate accompanied Rose during the police interview.

The interview was a very stressful process for Rose. She spoke to the police through Assistive and Alternative Communication. Rose was unable to disclose any details about the nature or origin of her injury during the interview. The advocate suggested that a different form of questioning, such as using more contextual questions concerning Rose’s injuries, be attempted, but the police deemed that all communication strategies had been exhausted. The police stated that Rose, her communication methods and her story were not reliable enough to take the investigation further. They claimed that her interview would not be admissible in a court of law, and ceased investigating the issue.

44. **Trudy** lives with her husband in a rural area. Trudy has a degenerative disability and is reliant on her husband for assistance. Trudy has experienced repeated physical, sexual, and psychological violence from her husband for over a decade. She is socially and geographically isolated, there is no public transport and she is completely reliant on her husband for everything. She has no friends because her husband doesn't allow her to have friends. Her husband refuses any service support even though Trudy's GP suggested district nursing might remove some of the "burden" for Trudy's husband. One day when Trudy's husband goes to the regional shopping centre, Trudy decides to ring a Domestic Violence Crisis Service. Trudy is advised that the service can't assist her directly as they don't have accessible transport and Trudy lives several hundred miles away from the closest metropolitan area. The Crisis Service tells Trudy that there are no women's refuges that take "women in wheelchairs".
45. An elderly woman was neglected, physically assault, and financially exploited by her daughter. Her daughter left her on the floor after a fall, withheld medications, and failed to feed her. The elderly woman agreed she was the victim of violence but as she wanted to stay out of residential care and her daughter was the only person who could assist her to remain living in the community, she was prepared to experience the violence and abuse and risk losing all of her money.
46. **Trish** is a wheelchair user and she has an intellectual disability. She resides in supported accommodation run by a not-for-profit, religious organisation. Trish asked for assistance from a disability advocacy organisation as she felt she was not being properly cared for by support staff. This involved being put to bed at 5.30pm every night, and not being got up until 8.30am the next day. The support staff did not provide Trish with toileting assistance, and as a result she was wetting the bed.
- Trish and her parents were also concerned that staff in the supported accommodation had made no effort to report or make necessary repairs to Trish's wheelchair. The wheelchair was still under warranty and needed urgent repairs. An individual advocate provided Trish with support to ensure she was receiving the treatment and assistance she required. The advocate managed to get Trish's wheelchair fixed, and made a report to the state government disability services agency and the National Disability Abuse and Neglect Hotline about the group home.
- Despite being concerned about Trish's wellbeing, Trish's parents were also very concerned about where she would go if they 'rocked the boat' with the service provider. They entered into negotiations with management staff, and it was decided that Trish would be moved to a purpose built group home. Regardless of the fact that the service had withdrawn services to cut costs, Trish's parents were happy with what was offered, as they did not want to lose Trish's place in the home.
47. A young woman was pressured by her perpetrators to retract a police statement which outlined substantial sexual violence. The police then charged her with making a false report. One of these perpetrators had previously been imprisoned in relation to sex acts against the young woman.

48. **Nat** is an Aboriginal woman in her 40s. She has an acquired brain injury post-surgery. She is in a relationship with a non-indigenous man, who appears very caring. Nat's disability case manager has not always believed her claims about the partner being violent, and the police have also believed the partner when called to the home by Nat, and did not take action to remove him from the home (leased in Nat's name) until the guardian advocated strongly for this. The partner received a carer's benefit but did not take Nat to medical appointments. He received rental assistance but did not contribute to the rent. Nat was largely reliant on him to buy food and for personal expenses. When he did buy food for the household, it would often be in packaging that because of her impairments, Nat was unable to open.
49. **Adrien** has recently been moved to a new boarding house, but, he is unhappy there. He is away from the support network of his family and friends. Additionally, after the move his spending money reduced by half, and there was no money paid to him by his court-appointed financial manager.

When an independent advocate looked into this issue for Adrien, it was found that Adrien's money was reduced and paid directly to the boarding house proprietor. This was explained as a way to manage his alcohol consumption. When Adrien asked the boarding house to give him the money, they stated that they had provided him with cigarettes, and it was him that now owed them money for the cigarettes.

The advocate arranged for Adrien to have \$20 put into his personal bank account every week, so that he could withdraw and use the money how he liked. This was difficult to achieve, as it was the government disability service agency that had made the arrangements to pay Adrien's money directly to the proprietor of the boarding house. This was not done with the consent of the financial manager. Eventually, the financial manager began paying Adrien's weekly allowance directly into his bank account instead of to the boarding house proprietor.

50. **Sebastian** is 11 and has intellectual disability. He attended an after school care facility every day. Sebastian was sexually assaulted by a 14 year old boy who attended the after school care. His mother reported this to the police and to the after school care facility. Nothing was done by either agency to ensure Sebastian's safety. Instead, the after school care facility recommended that Sebastian attend counselling at a local sexual assault counselling service. They stated that this was to prevent Sebastian turning into a perpetrator himself.

Additionally, the police completely failed to investigate the sexual assault. This was despite Sebastian's mother finding out that the 14 year old had sexually assaulted younger boys on a number of other occasions. Apparently the other incidents had been reported and investigated. Sebastian's mother was distraught that her son's case was not being looked into by the police or the after school care facility.

51. **Hilda** had been living in a private supported accommodation facility for 3 years. She said that she experienced and witnessed extensive violence there. She stated that she felt like a prisoner, and was very happy when she finally escaped. Hilda was frequently assaulted by the proprietor. This generally happened after she had expressed her wishes to leave and live somewhere else. The proprietor would hit her on the lower back with a belt as she lay crying on her bed. The proprietor would also give her medication to calm her down, especially when she was upset and crying about wanting to leave the boarding house. This was in addition to him administering monthly injections.

Hilda was frequently vaginally and anally raped by some of her male co-residents. She needed medical attention and stitches for an anal tear caused by this frequent rape. Her roommate disclosed to Hilda that she was also being raped. She told Hilda that she was being forced to have sex with a male co-resident, and that she had caught a 'germ' from him.

After moving, Hilda felt very uncomfortable living where she was placed, because some of the people from the room house were placed there too. This brought up too many painful memories. She also experienced frequent nightmares about the proprietor and the beatings he had given her. Hilda is very afraid that the proprietor may find out where she is living. She is fearful that he will find out that she has been talking about her experiences, and that she has been to the police.

52. **Tracey** is a woman in her 70s who suffered a major stroke and now requires full assistance with her activities of daily living. At the time of the guardianship application she was being supported to live at home with services and case management through an aged care package, but the agency raised concerns about her husband's ability to care for her. Tracey's husband would leave her at home in her bed for hours, with her mobility aid out of reach. He started seeing another woman and would have sex with her while Tracey was in the house, unable to move to another room without his assistance. The husband also perpetrated physical violence against Tracey. Although Tracey acknowledged that the violence occurred, her expressed wish was to remain at home. The care agency were reluctant to provide care and thought Tracey should move to residential aged care, however, the guardian encouraged them to continue to support Tracey at home. The care agency always sent two carers to the house at once because they felt ill at ease around the husband, resulting in Tracey receiving only half as many hours of care as the funding would usually provide. This reduction in hours only made Tracey more reliant on her violent partner. The husband was claiming a carer's benefit and the guardian believes this was the major motivator for him wanting Tracey to remain at home. In addition, he believed he would no longer be eligible for public housing if his wife relocated. After some time trying to improve the home environment and support Tracey's wish to remain at home, the guardian ultimately decided that Tracey needed to move to an aged care facility.

53. **Martin** has intellectual disability and was living in a not-for-profit group home. He was assaulted by a co-resident, and taken to the doctor. The assault was also reported to the police. The matter was raised with the senior management of the group home. However, nothing was done about the situation, and after visiting his mother, Martin expressed severe reluctance to return to the group home. Two months after the assault, Martin ran away from the group home. He was missing for a total of 12 hours.

Martin's parents attended a meeting with the managers of the group home. Their concerns about the conflict in the house, and other issues relating to Martin's safety, were trivialised by the management staff. A month later, there was another incident in the group home, and Martin's parents took him home. Martin was living at home for two and a half months before a new group home was found for him. Martin was happy with the new services, and his new co-resident. At the conclusion of the ordeal, and upon Martin finding more appropriate accommodation, Martin's parents decided not to submit a formal complaint about the first service provider.

54. There were serious concerns for the welfare of **Cynthia**, a resident with disability in a group house. Cynthia could not speak and needed staff to help her with all her activities of daily living. One evening, staff noticed bruising and swelling to one of her feet. A doctor and the ambulance were called but as the nearest hospital emergency was full, it was decided Cynthia would remain at home overnight. The doctor ordered paracetamol to ease her pain. The next day, Cynthia went to the hospital and was diagnosed with a broken ankle. She was returned home. Two days later, Cynthia went back to the hospital as staff who knew her thought she was in considerable pain. The hospital further diagnosed that both legs were broken. Old fractures to both hips were also identified. She was discharged from hospital two weeks later with minimal staff training provided. Shortly after Cynthia's return from hospital Community Visitors attended the facility. They were so concerned about her wellbeing, they notified the State public advocate. They found Cynthia still did not have a mattress to relieve the pressure on her lower limbs or any other appropriate equipment. She also had head lice and diarrhoea. A forensic physician was asked to report on the unexplained injuries, but there is still no explanation of how these injuries occurred.

55. **Christian** has been living at a private supported accommodation facility for 24 years. He was one of the first residents to move into this facility. He ran away a total of 10 times, as he was very unhappy living in this environment. He disliked the fact that the proprietor had such total control over the boarding house. Christian didn't even have access to his own pension, or the extra pocket money that his mum would send him to buy lollies at the local shop. Eventually, Christian says that he resigned himself to living at the boarding house, and stopped trying to run away.

56. **Phillipa** experienced repeated physical, sexual, and psychological violence at the hands of her partner for over 8 years. Her partner was a 'well respected' member of the local community. She tried on a number of occasions to report the violence to the Police, but this was difficult as the Police told her that it was "too expensive and time consuming" for them to organise an Auslan interpreter. The police told Phillipa that she was "imagining" the violence and that she was "lucky" to have a partner who "cared" for her because she was "deaf".

57. **Chloe** is ten and lives in a small regional town. She has attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) and anxiety. Chloe was attending a mainstream primary school in her local area. This school had a room purpose built for Chloe which they would put her in when she would act out. This purpose built area was a walled off section of a room, with Perspex windows.

Chloe was made to remove her shoes before entering the room. There was no furniture in the room, nor any resources or activities to keep Chloe amused. Chloe was put in this room on a daily basis for hours on end.

Her mother was concerned by the use of the room, and contacted an independent advocate for assistance. They in turn contacted the government education agency and the agency came to the school and assessed the room. They reported that the room fit within their policies and guidelines, and the police were not contacted.

Chloe's mother pulled Chloe out of this school. She had a lot of trouble enrolling Chloe in another school, as the town was quite small, and word had got around that Chloe was a 'problem' student. After one year of advocating for Chloe's right to an education, a school finally agreed to enrol her. Nonetheless, Chloe still experiences difficulties in her education as a result of her previous experiences.

58. **Sergio** resided in a not-for-profit group home. He has intellectual disability and autism. His co-resident, Isaac, recently started displaying 'challenging behaviours' as a result of working with one particular staff member. To manage Isaac's 'challenging behaviours', management instructed the staff member to cease working with Isaac and instead, begin working with Sergio.

Isaac eventually disclosed that he had been physically assaulted by the staff member. He reported this to the police, telling them that the support worker had kicked him, and that he had also broken a camera over Sergio's head.

The police failed to investigate the assault because Sergio and Isaac both have intellectual disability. The service then stated that as the police would not investigate, they could not dismiss the staff member who was accused of assault.

Sergio's sister supported him to leave the group home, and organised counselling for him. She found a respite place until he could get more permanent accommodation in a different group home. Sergio's sister wanted to ensure the issue was investigated and responded to appropriately for the sake of the other residents who still resided in the group home and at risk of being assaulted by the staff member. Sergio's sister reported the matter to the National Disability Abuse and Neglect Hotline.

The case was not thoroughly investigated because the guardianship body said they couldn't proceed with the case as Sergio was no longer living in the house in which the assault occurred. No further complaints had been made by other residents, so no further action has been taken.

59. A distressed agency staff member called an advocacy advice line about a resident who was “in agony” as a result of what appeared to be serious injury. A Community Visitor contacted the disability department regional manager and made a notification to the Public Advocate, who contacted the department. Community Visitors visited the home that day. While an incident report had been completed when the injury was identified, there was no report of how the injury actually occurred. The injury occurred on a Friday, the service manager did not receive the incident report until the Monday and was only preparing to act on the Tuesday, when notified by the program about the injury. The department requested that a forensic medical specialist review the injury; he found that the injury was so significant and substantial that it was unlikely that it had not been witnessed. The resident had a fractured arm and extensive bruising relating to the fracture, but there was also bruising to the back of her shoulder, chest and hip.
60. Four women with disability have grown up and lived together since childhood. They are currently in their 60s and 70s. They are residing in a government run group home and all get along very well and consider themselves to be family. They have lived together peacefully and harmoniously for many years. 18 months ago a fifth female resident, Lydia was introduced to their group home. This transition changed their living environment dramatically. The new resident, Lydia, physically and emotionally abused her co-residents and staff members.

Lydia’s presence brought a great deal of stress and tension to the house, which was detrimental to the health of the other residents. For instance, one of the residents, Addison, has intellectual disability, osteoporosis, anxiety and depression. She recently also presented with dissociative personality disorder symptoms, which have previously presented at times of great stress. The group home is no longer a peaceful, safe place for her to live. Addison was incredibly fearful of Lydia. Additionally, her depression worsened, and she began spending about 90% of her day in bed in the foetal position. Other residents have been hospitalised after being assaulted by Lydia. In one instance, a resident required stitches to her head. At other times, Lydia has given her co-residents black eyes and painful bruises.

Some of the physical assaults were reported to the police. They suggested that the four women should take out apprehended violence orders against Lydia. However, the women did not understand what this process entailed, or what taking out an apprehended violence order would mean. Consequently, they did not take an apprehended violence order out against Lydia.

Staff report being very stressed, and being under a lot of pressure. They are distressed by the violence being perpetrated by Lydia and the impact it is having on the other residents. Staff have taken photos of the physical bruises and injuries that Lydia has caused, and have reported it to managers of the group home.

A representative of the official community visitor program visited the group home and reported the violent and abusive environment in which these women were now living. The representative and the regional managers of the group home have had multiple meetings with Lydia’s family, but there has been no resolution. Lydia and her family were offered the option of moving Lydia to a more suitable group home which had trained staff experienced in managing ‘challenging behaviour’. The family rejected this offer and has refused to negotiate any other changes to accommodation.

61. **Savannah** is a young woman with intellectual disability and autism. She began living in voluntary out of home care at age 14 when her mother voluntarily relinquished care, although wanting to remain involved in her life. Since this time, there have been three service providers involved in the provision of her care. Recently, Savannah's mother raised concerns about how the latest service was treating her daughter. This was prompted by changes in Savannah's behaviour, including damaging furniture, smashing windows, destroying window screens, and attacking staff. Savannah's school had also documented an increase in her 'challenging behaviours', which coincided with the change to the latest service provider.

These 'challenging behaviours' were generally triggered by interactions with inexperienced staff. Savannah was being supported by a mix of staff who hadn't received training in supporting people with disability or implementing individual plans. Furthermore, the staff members often acted unprofessionally and on more than one occasion failed to turn up for their shifts. They were not following appropriate documentation procedures; they failed to document the administration of medication, and failed to report 'incidents' when they occurred. At a fundamental level, the service provider did not have the correct communication or supervision procedures in place to support Savannah.

As the provision of support continued to deteriorate, Savannah's health and wellbeing also declined. The staff did not bother to support her to use the toilet, and would instead place her in incontinence pads all day. Savannah was unsettled and anxious. At times, Savannah became very distressed and engaged in self-harming, hitting her head with her fists until the skin on her forehead was red, swollen and broken. A particularly concerning incident involving support staff was observed by a family friend: Savannah had thrown her plate of dinner from the table and onto the floor, which she sometimes did if the food was too hot, too cold, or otherwise inappropriate; the staff member scraped the food off the floor, put it back on the plate and re-served this food to Savannah.

The service provider was using a buckle guard and protective screen in the car in order to restrain Savannah's movement in the car. An individual advocate repeatedly requested that the service provider send her documents outlining the authorisation for the use of this restrictive practice, but these requests were constantly ignored. It was eventually discovered that the service did not take the issue to the restrictive practices panel, which makes the use of the buckle guard and protective screen a criminal offence. Countless reports had been made regarding this service provider. The agency responsible for the guardianship of children had received similar complaints about the service provider and was investigating whether it was complying with voluntary out of home care standards. The state complaints body was working alongside the agency responsible for the guardianship of children on this case as well. A number of reports were also made to the National Disability Abuse and Neglect Hotline about the inadequate support provided by the service.

Savannah's mother eventually requested that the service provider no longer provide accommodation support for her daughter. Overall, Savannah was receiving accommodation support from this service provider for over a year. Once removed to another service provider, Savannah's 'challenging behaviours' gradually declined.

62. **Mia** lives in a supported accommodation unit and works for an Australian Disability Enterprise. She has multiple sclerosis. Mia receives support from staff in the mornings and in the evenings. However, there are no staff at her unit during the night. One night, a man entered Mia's unit after the staff had left. He brutally raped Mia. The police were called, but soon decided that they couldn't pursue the case. The police demonstrated no understanding of her disability, and merely passed her off as being unreliable and incapable of providing sufficient evidence. No rape kit was performed. After the rape, service staff took Mia to see a doctor. The service has not undertaken an internal investigation of the incident, as they are of the belief that if the police thought nothing could be done, they had nothing to follow up on. No changes have been made to increase Mia's safety at night time.

63. **Lincoln** has spinal muscular atrophy and mobility problems, and uses a wheelchair. He sustained injuries while being transported by a bus organised by his support workers.

In one instance, Lincoln was sitting in the area designated for wheelchair use, and was holding on to the bus, as it didn't have an appropriate mechanism for him to secure his wheelchair. The bus took a sharp turn, and Lincoln ended up on his side in his wheelchair. The driver did not stop the bus, but instead yelled out to ask if he was ok. Lincoln could not answer the driver, as he was short of breath and in shock from the fall. After a couple of minutes of Lincoln not responding, the bus driver stopped the bus, pulled over and came to see if he was ok. The bus driver tried to sit Lincoln up to assess his injuries, but could not manage to sit him up properly. Lincoln requested that the bus driver call an ambulance to assist him. The bus driver refused, and said that he might get in trouble. Lincoln got very agitated and repeatedly asked the driver to call an ambulance. The bus driver eventually called his boss, and only after this point did he call an ambulance.

In following up with the bus company, the response was that he shouldn't have been travelling on the bus as his wheelchair was too big. They also stated that he should have been travelling with a carer. Lincoln himself is still very physically shocked by the accident, and doesn't want to use the service again. He was very shaken by the experiences, and it has impacted his physical and emotional wellbeing. It has also been a setback to his ability to live independently.

The police were notified of the incident, and legal advice was sought. A disability advocacy organisation supported Lincoln to lodge a complaint with the Australian Human Rights Commission. Lincoln wanted an apology from the bus company, mechanisms installed to increase the safety of travel for people with disability, disability awareness training for staff, and some financial compensation for his injuries.

64. **Luke** is 21 and has autistic spectrum disorder. He lives in a residential facility. Before going into care Luke was well groomed and spoke quite well. Since entering the facility Luke's condition has deteriorated to the point of self-harm, after spending hours each day locked in a room with little more than a bed and a toilet. He is severely depressed, refuses to wear clothes and often will tear them to shreds. He is completely alone, even his food is passed through a door.

65. **Martina** has an intellectual disability, and currently resides in a not-for-profit group home with four male co-residents. Martina has expressed a number of concerns with her living situation. Martina wanted support to make a complaint to management. She was unhappy with how she was being treated by the staff. She felt threatened by the staff, and was worried that if she spoke out against them, they would treat her even more poorly. Martina complained that the staff treated her like a two year old and that they wouldn't let her do things for herself. She also said that they tell her to 'piss off' to her face, and that one staff member in particular shouts at her and this makes Martina think that the staff member 'hates her guts'. Another staff member complains about Martina's diet and calls her fat.

Martina also reported that a male support worker 'pervs' on her while she's getting dressed, and walks into the bathroom while she's in there as there is no lock on the door. Martina feels like she has no privacy in the house.

Martina told an individual advocate that she had been sexually assaulted in the group home. She also told the advocate that she was explicitly told by the team leader not to tell the advocate about this incident.

66. **Max** lives at home with his parents. He is in his 50s and works at an Australian Disability Enterprise (ADE). Prior to a supported employee meeting with his advocate and ADE staff, Max disclosed to his advocate that his stepfather was sexually assaulting him. He asked her not to tell anyone, as he had never told anyone this before. Max explained that as he uses a cane to walk, he cannot get away from his stepfather when he physically or sexually assaults him. After a long chat with his advocate, decided that he wanted to feel safe, and wanted to move out of home.

Max's advocate spoke to the ADE facility. The ADE did not know what to do in this situation, so the advocate assisted by following the appropriate interagency policy guidelines, and called the police.

Max told his advocate and the ADE staff that he did not want them to contact his mother or tell her what he had disclosed. However, he agreed to speak to the police, but the police did not have an independent, support person to assist Max through the interview. After speaking with Max, the police decided that it would be best if Max stayed in respite for the night.

In the meantime, the ADE called his mother to inform her of the situation. Furthermore, the police went to Max's house to speak to his mother and stepfather. They told Max's stepfather that he was to stop the 'inappropriate behaviours' he was engaging in. The police told him that if Max contacted the police again, they would proceed further with charges. There was no further investigation.

67. A primary school implemented a 'behaviour management' practice that confined children with autism to a fenced area during lunch. The area had one tree, a bench and dirt covering. The practice was defended by the education department as a practice to support supervision of students with autism while they settle into school.

68. **Zac** voluntarily admitted himself to a hospital's psychiatric inpatient unit. At no time was he given information regarding his rights as a voluntary patient, and there was a failure to provide him with services for his pre-existing diabetes. Zac became concerned that his 'treatment' involved only medication and not a referral to a social worker, psychologist, or community counselling service, despite the psychiatrist recommending this. Although the issue was raised with hospital staff, no action was taken. He notified staff of his intention to discharge himself (which was within his rights as a voluntary patient), however he was warned his status would be changed to 'involuntary' should he attempt to discharge himself. Zac then attempted to leave the ward, and was subsequently reclassified as an involuntary patient and put into seclusion for 6½ hours, and stripped of his clothing. He was not provided with an explanation of his change of patient status to involuntary or the reason for being placed in seclusion. Due to his experience in involuntary seclusion, Zac continues to experience emotional and physical symptoms, including chronic depression.
69. **Maria**, a fifty year old woman with a spinal cord injury was living with her much younger partner who was the primary carer. The domiciliary nurse visited daily and reported being intimidated by the partner. The domiciliary nurse ultimately informed the case manager that there was neglect occurring, such as the catheter not being emptied, the woman not being showered regularly, and frequent verbal abuse from the partner to the woman. Property inspection revealed holes in the walls covered over by pictures. A financial administrator became involved due to abuse of the woman's finances by the partner. Neighbours reported disturbances which resulted in a hearing and the couple was evicted. The partner ultimately left the woman and moved away. The woman was now at risk of being put in care facility.
70. **Lesley** is young woman with a moderate intellectual disability. A family violence support worker made an application for guardianship, due to concerns about Lesley's vulnerability to exploitation and abuse by her partner. When that relationship ended, new concerns arose about sexual violence by her subsequent partner. The new partner has forced Lesley to have sex when she does not wish to and to have sex without a condom; he has photographed and filmed their intercourse without her consent; and he has made her watch him have sex with other women, which causes her great distress. These are often other women with disability that she introduces to him. In addition, Lesley is exploited financially by the partner, who controls the money she has access to, and has pushed her to seek bank loans for his use. A restraining order against the partner was taken out by the police, however, the police have not always followed up when the order has been breached. Therefore, despite numerous breaches, neither party has experienced any consequences over the order being breached. The guardian sought case management from the state disability department and this was allocated to Lesley. Initially the case manager was reluctant to accept direction from the guardian, and would seek to undertake only what was requested by Lesley, which was very little. This situation improved when a more proactive case manager was assigned to work with Lesley. The family violence support worker remains involved.