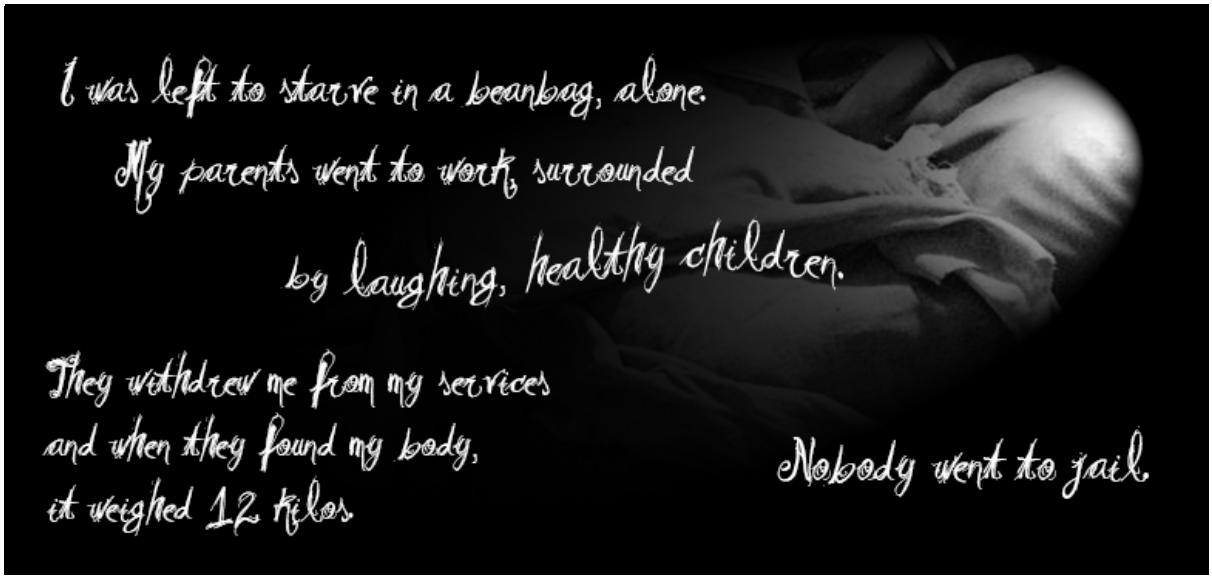

Image description: A shadowy image of a starved woman's protruding ribcage. Image text: My parents went to work, surrounded by laughing, healthy children. They withdrew me from my services, and when they found my body, it weighed 12 kilos.

Name	Kyla Puhle
Location	South Brighton, South Australia
Date	2011
Type of abuse	Domestic/family/interpersonal violence
Disability type	Spastic quadriplegic cerebral palsy, scoliosis
Outcome	Suspended sentence, no fine

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1. No Marches for Kyla

You will find it hard to find a photograph of Kyla Puhle on the internet, and most do not know her name. Unlike other murdered women, the death of Kyla Puhle invoked no marches, inspired no vigils. Seventeen months after Kyla's death, a woman named Jill Meagher went missing, and a Facebook page called "Help us Find Jill Meagher" received a hundred thousand 'likes'. When Jill's body was found, thirty thousand strong marched in the streets to protest her murder. In June 2013, Jill's murderer, Adrian Bayley, was sentenced to life imprisonment, with a non-parole period of 35 years.

Two months later, Kyla Puhle's mother was sentenced. She'd been found guilty of manslaughter, on the basis that her life had been marked by 'enormous suffering' – including the fact that she had lost her job as a high school principal when she was charged with Kyla's death. Her lawyer successfully argued that her husband, who had shot himself upon being charged, was an obsessive-compulsive perfectionist who subjected her to domestic violence. Puhle and her husband were originally charged with Kyla's murder because they had allegedly made a conscious decision to deny her basic care – withdrawing her from her day program and leaving her alone in a beanbag during the day in front of the television, refusing her medical attention. The prosecutor said that it wasn't a momentary lapse, but neglect that continued over an extended period of time…that Kyla was literally starved to death.

When she died, 27 year old Kyla weighed just 12 kilos.

The judge said that temporary respite accommodation was available to them for 52 nights a year, which they sometimes used, but said it was sad that the family did not take up other forms of care they were entitled to. He said that she was regarded by her colleagues as an excellent educator and a devoted mother. He said that it was rare for people convicted of manslaughter to get suspended sentences, but the circumstances were 'tragic' and that 'for all but a few months of Kyla's 27 years, she had devoted her love, time and energy to her welfare. "Even at the time when you objectively did not do so you believed you were acting in her best interests," he said.

In South Australia, where Kyla was starved to death, the offence of ill treatment of an animal - whether or not that ill treatment results in death - carries a maximum penalty of $50,000 or four years in prison.

There are no marches for Kyla, who died as the ultimate consequence of domestic violence. There are no vigils. And nowhere did anyone say the word 'mercy killing'.

Not out loud.

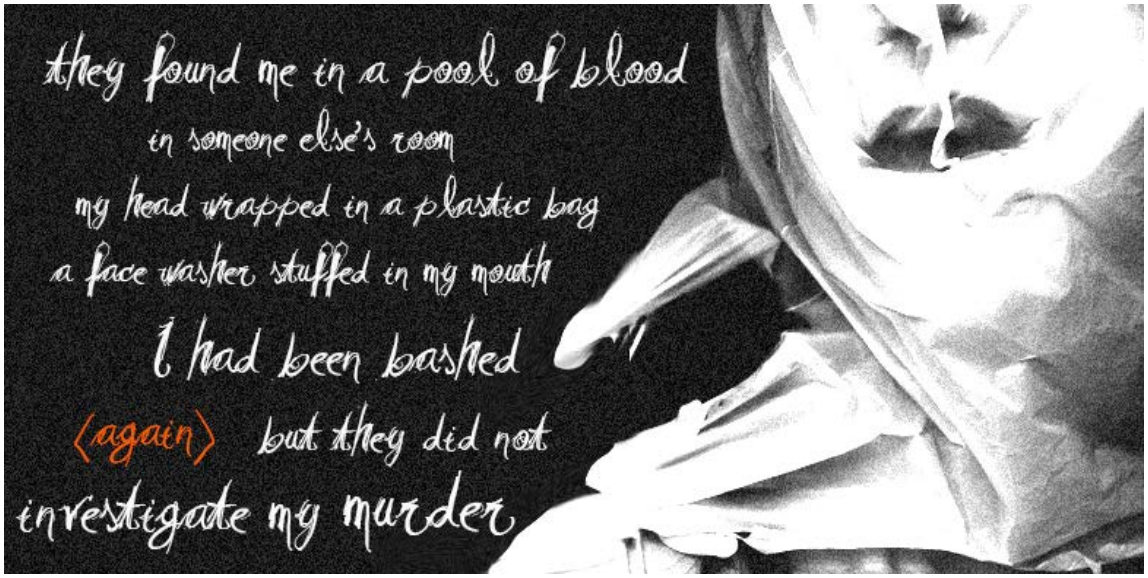

Image description: An image a man with a plastic bag tied over his face, and the words 'They found me in a pool of blood, in someone else's room, my head wrapped in a plastic bag, a face washer stuffed in my mouth – I had been bashed (again) but they did not investigate my murder'

Name	Fred Williamson
Location	Austin Hospital psychiatric unit, Vic
Date	2008
Type of abuse	Murder, co-resident
Disability type	Schizophrenia
Outcome	Failed police investigation

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2. Justice for Freddy

They found Freddy inside the locked room of another patient. He was found with a plastic bag covering his head – he was lying in a pool of blood. There was a face clothe stuffed in his mouth.

But despite his injuries and the bizarre nature of his death, investigating officers attending the scene at the Austin Hospital's psychiatric unit in Heidelberg determined that Freddy's death was suicide. Or perhaps an accident.

Freddy had severe schizophrenia, and spent a lifetime in institutional care settings. He entered into the care of the public psychiatric system in 1976, when he was 21 years old. Thirty one years later, he exited it in a body bag.

His family arrived to take Freddy out at about 2pm on March 30, 2008. Staff said that they hadn't seen him for ninety minutes, since lunch. Fifteen minutes later, nursing staff made a shocking discovery. And shortly thereafter, it became apparent to the family that police and hospital believed that Freddy had either committed suicide or died by his own hand in a case of death by misadventure, despite Freddy's gentle nature.

Things didn't add up. That included an assessment from Freddy's treating psychiatrists that his risk of self-harm was extremely low, extensive blood spatter patterns at the scene, the fact that Freddy had been recently assaulted twice by other patients – including being stabbed with a shard of glass - and an autopsy report that showed injuries indicating possible assault.

The room was cleaned, destroying forensic evidence. Important evidence, such as the plastic bag found over Mr Williamson's head, had not been collected or examined by forensic experts and had since been lost. A cloth towel reportedly found near or inside the plastic bag was also not examined and its whereabouts were unknown.

The homicide squad weren't called to attend, nor forensic crime scene investigators. Witnesses, staff and patients weren't interviewed. And it was only in 2014 that a Coroner came to the conclusion that Freddy was murdered in institutional care.

The account of Freddy's death and investigation is attached, chronicled by the Victorian Coroner.

Image description: Photocopies of newspaper clippings read 'Patients nails pulled out, shock report' 'on hospital sex abuse claims' and 'fingernails ripped out in hospital – inquiry'. The text reads, '100 patients, 300 nearby graves and 100 untold stories of violence and abuse.'

Name	Residents of Peat Island
Location	Qld
Date	2011 - 2010
Type of abuse	Violence, neglect and abuse
Disability type	Varied
Outcome	Institution closed and residents devolved

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3. The Hidden

There is no argument about whether people with disability living at Peat Island were abused. For years, a culture of violence, abuse and neglect meant that rape was normalised, abuse was part of daily life. People on the mainland didn't ever see or understand what the lives of people living at Peat Island comprised – they saw boys and men in Scout uniform on ANZAC Day, or people visiting the local shop or the fair. Until a bridge was built from the mainland, access to the island was only available by ferry – people living at Peat Island were segregated and isolated in the literal sense of the word.

For 99 years, people with mental health conditions and disabilities were raped, bashed and neglected at Peat. Children with developmental and physical disabilities were housed there from 1911. The island had more than 100 patients at its height and in 1978, women patients were introduced.

There is no argument about the history of abuse at Peat Island. What is of concern is the way that we have hidden that history, relying on journalists, families and whistleblowers to reveal the truth.

The public accounts are comparatively few. Harold Besley's murder by another inmate in 1924. Harold was repeatedly hit with a stick and his head wrapped in a bag before he was dropped in the water. The eight year old boy found floating in the Hawkesbury River in 1940, the 11 year old boy asphyxiated in a linen bin made of iron. Dozens of other unexplained deaths and uncounted reports of sexual and physical abuse, including the widely publicised case of a 17 year old boy whose ten fingernails were removed.

The last patient left in 2010.

There were many reports, including the 1983 Richmond Report[1] and the Peat Island report by the Community Services Commission, commissioned by the Minister of the day. Like most government reviews, the details are secret. The reports are generally only released once the institution has been closed.

The report by the Community Services Commission is of interest because the themes are present in accounts of violence, abuse and neglect in many current institutional settings. It found that at Peat Island, there was widespread;

[1] http://nswmentalhealthcommission.com.au/node/1521

- Mistreatment of clients including verbal abuse, neglect and failure to protect clients from predictable and often dangerous assaults
- Staff victimisation, harassment and conflict
- Staff demoralisation/ignorance, incompetence and/or disinterest
- Lack of effective systems to deal with resident to resident assaults, staff grievances, client health needs, finances
- An absence of leadership at senior levels in the Centre at the time of incidents investigated

And so they closed Peat Island, quietly, with not much fanfare.

It was helpful that the island, with its magnificent natural environment, was prime real estate.

Many of the people institutionalised at Peat and Milson Islands still live in smaller institutions today. In 1973, Milson Island was closed because it was considered to be 'highly unsatisfactory'.[2] Residents were relocated to Callan Park, Stockton, Parramatta, Rydalmere, and Marsden Hospitals, and Marsden Rehabilitation Centre. In 2009, most residents of Peat Island were relocated to an aged care village providing accommodation for up to 100 people with an intellectual disability at Wyong. Younger residents went to group homes at Wadalba. By 2009, 77 men and women with an intellectual disability aged 40-85 were living at Peat, and over the years moved into the Hamlyn Terrace village (Casuarina Grove). Bernard's story, in his own words (and in the words of his brother) are included below to help readers understand the environment in which people were institutionalised at Peat Island.

A report in 2014 from the Social Policy Research Centre at the University of NSW[3] examined four new facilities built to replace the old large scale institutions – including Casuarina Grove – were 'worse off'.

The reviews and reports are secret, the stories of many people living at Peat and Milsen Islands lost forever. Their accounts are as hidden as the people who suffered abuse at the hands of residents and abuse and neglect at the hands of staff. But sometimes the unspeakable can be conveyed through facts, like the fact that over 300 residents are buried in unmarked graves in a nearby cemetery.

Only two have headstones.

[2] http://search.records.nsw.gov.au/agencies/6426
[3] http://www.smh.com.au/nsw/report-says-institution-residents-worse-off-after-moves-20140401-35w96.html

DAILY TELEGRAPH, TUESDAY, April 26, 1983

PATIENT'S NAILS PULLED OUT

Peat Island Hospital

SHOCK REPORT

Youth's parents complain

A RETARDED youth's 10 fingernails were torn out while under temporary care in a psychiatric institution.

In a 39-page report the NSW Deputy Omsbudsman, Mr Darryl Gunter, criticises the Health Department for not investigating the matter adequately.

Mr Gunter's report stems from complaints by the youth's parents.

They left their 17-year-old son at the Peat Island Hospital on the Hawkesbury River on January 10, 1981.

By DENNIS RINGROSE and GRANTLEE KIEZA

When they collected him on January 28 he was without his fingernails.

"It's taken over two years for the report to be finalised and still the person responsible for the incident has not been identified," the father said last night. "That is of concern to me."

He said they reported the incident to Hornsby police who conducted "very brief inquiries at the hospital" and were satisfied with reports from doctors that a 12-year-old patient was responsible.

In his report, Mr Gunter says he was unable to pinpoint the person responsible.

But he rejects claims that:

- A 12-year-old retarded boy may have been responsible;
- The victim suffered a condition which made his nails "fragile;"
- The supposed disorder meant his nails could be "removed without distress;"
- The matter was properly investigated.

Continued Page 2

Fingernails ripped out in hospital — inquiry

Investigate

"Unfortunately, I cannot rule out the possibility that such action was done by an adult and such adult may have been a member of the medical or surgical staff.

"I am not in a position to find there has been wrong conduct by any public authority in terms of actually having removed the 10 nails.

"I also take the view that proper steps were not taken to investigate this matter."

The youth's father said he believed his son had been alone and unsupervised between 10am and 1pm on January 17.

"Obviously I was very concerned at the situation," he said last night.

"I would not have pursued the matter for over two years and taken it as far as I could if I had not been extremely concerned."

He blamed "inadequate staffing" for the incident.

"There is a definite need for high staffing ratios in hospitals for the retarded," he said.

"My son has been under temporary care at the hospital about eight times before and since the incident and has received excellent treatment at all times except for this incident.

"Obviously additional staffing is needed.

Supervision

He said checks on activities in the ward on that day showed the level of supervision was totally inadequate.

Between 12.10pm and 1pm the youth and one other girl patient had been alone inside the ward without any staff to supervise them.

The missing fingernails had been found scattered across three locations — the female dormitory, the female toilet and the television room.

Mr Gunter said he believed there were only three possible explanations for what had happened — that the youth had injured himself, his nails had been removed by another patient, or they had been surgically removed by an adult.

"I do not accept the view the nails were removed by a retarded adolescent or by the youth himself," he said.

"Members of the medical and nursing staff had access to the youth and the instruments necessary to effect the removal of the nails.

"I take the view that no satisfactory explanation of the removal has been put forward and I am not in a position as a result of my inquiries to sheet home responsibility to any member of staff or any combination of staff.

From Page 1

Mr Gunter expressly rejected advice given to the former Health Minister, Mr Stewart, that the victim possibly suffered from a condition — Albright's Osteodystrophy — which made fingernails particularly "fragile".

Health Department officials had claimed this condition meant nails could be removed "without distress."

Mr Gunter's report quotes two senior doctors who had examined the youth and found he was definitely not suffering from the disorder.

Both experts said his nails were normal. One of them specified that their removal "without anaesthetic would prove extremely painful."

Expert medical advice also led Mr Gunter to reject the theory that a 12-year-old patient may have removed the nails.

The Deputy Ombudsman said that patient lacked the necessary dexterity and the ability to concentrate for sufficient time.

Mr Gunter said the father had called for a police investigation but this had not proceeded, following assurances from health officials to police that they were thoroughly investigating the case themselves.

Mr Gunter said a member of the nursing staff had reported noticing the youth's injuries shortly after 1pm on January 17.

83

Collins to act on hospital sex abuse claims

PSYCHIATRIC patients were sexually and physically abused in mental hospitals branded as fire traps, it was revealed in State Parliament yesterday.

By BRONWEN GORA

Health Minister Peter Collins said the former government had suppressed a seven-volume report recommending the closure of NSW psychiatric hospitals because of neglect.

A review ordered by former health minister Peter Anderson in 1987 had found less than half the recommendations made in a 1978 report had been implemented, Mr Collins said.

As a result, the Greiner Government will launch a review into care of the mentally ill and disabled alongside a public inquiry into the state of psychiatric hospitals.

Mr Collins said the former government had never issued the Ministerial Advisory Committee report, launched after complaints into patient care at Cumberland Hospital.

The MAC report said many mental hospitals were serious fire hazards and in 87 per cent of the wards no regular fire drills were held.

Proper patient records were not available in some places and of those reviewed, 27 per cent had no record of a physical examination.

Bedrooms

There was evidence of physical and sexual abuse of patients and staff and dangerous patients were not controlled properly.

The report also revealed:

- Facilities were outdated, stark and neglected and staff morale was low due to a lack of resources.
- Patients spent most of their days watching TV, or lying, pacing or sitting.
- There was no privacy in bedrooms in 78 per cent of wards.
- The last main meal of the day was at or before 5.30pm in 87 per cent of wards.
- No record of physical examination was found in 27 per cent of patient files.
- Locked seclusion rooms were still in use 11 years after a recommendation to discontinue their use.
- Proper patient records were rarely kept.

At Peat Island Hospital, the MAC report found toilets had no doors, no seats and no toilet paper and conditions in one ward were "deplorable".

Opposition health spokesman Andrew Refshauge last night rejected allegations of a cover-up.

He said the former government had been in the process of implementing most of the MAC report's recommendations.

Welfare delays to continue

PEOPLE receiving welfare benefits in NSW face continued delays despite the return to work of nearly 2000 Social Security Department clerical officers.

The Administrative and Clerical Officers Association voted to end its six day strike yesterday but bans on public contact and payment assessment will continue to create problems.

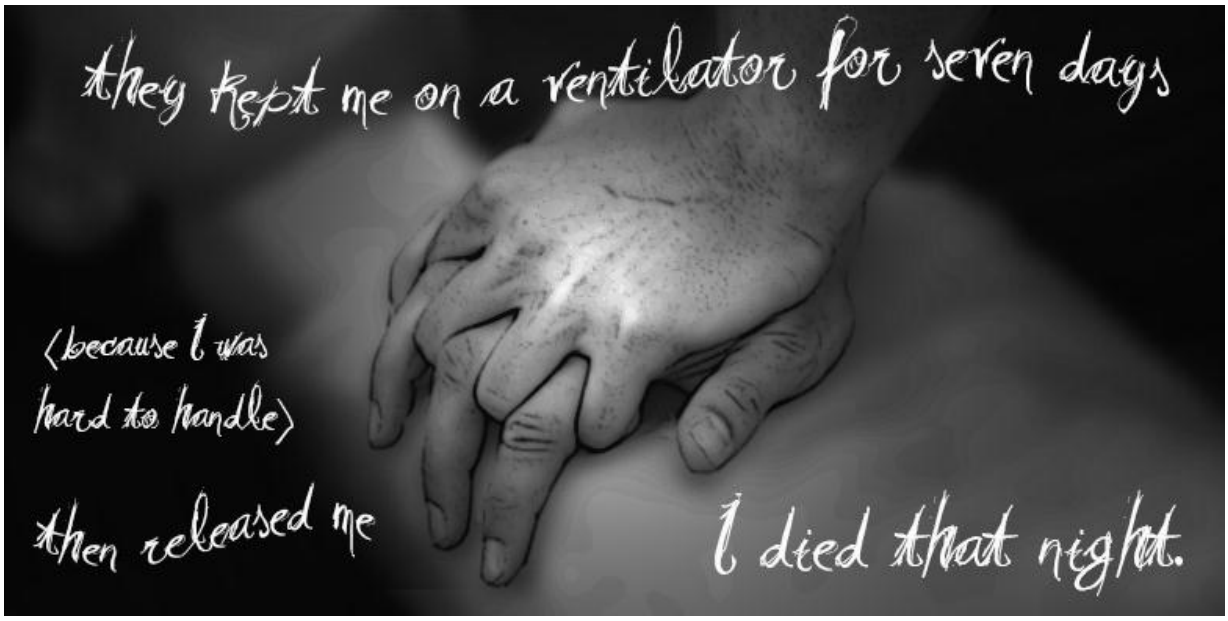

Image description: An image of two hands performing CPR. The words say, 'They kept me on a ventilator for seven days, because I was hard to handle, then released me. I died that night.'

Name	Stephen Moon
Location	ACT
Date	2003
Type of abuse	Systemic failure
Disability type	Autism and intellectual disability
Outcome	Death, Coroners Recommendations

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4. No one to Blame

Nobody was to blame for Stephen's death.

That was what the ACT Coroner found, despite the fact that Stephen died as a consequence of a 'risky' medical plan for a routine operation, to remove his wisdom teeth. Stephen was put into an induced coma, with ventilation for seven days, and released into the care of non-medical disability care workers. He was released from ICU that day, soiled himself in the ambulance bay and died that night, despite the desperate attempts from his support workers to revive him.

Stephen had autism and an intellectual disability, and he was regarded as 'difficult'. He didn't use spoken language and used Australian Key Sign English to communicate with his support staff. His behaviour was deteriorating due to pain in his wisdom teeth, and he was having episodes of severe self-injury and aggression. Everyone knew that there was now a problem, because 'staff within ACT had inadequate training to deal with Stephen's post-operative care and Stephen would be required to stay within the hospital environment until such time that he no longer needed care'. And the hospital knew they couldn't take care of a distressed, awake, Stephen – so an 'ambitious' plan was launched, to intubate Stephen on a ventilator for seven days.

Nobody was to blame for Stephen's death, despite the fact that Stephen died from ventilator acquired pneumonia, despite the fact that not receiving post recovery care was 'highly irregular', as was being transferred into the care of two non-medical staff in an ambulance bay. He was kept there for five hours until he could walk to his van – he soiled himself in the bay and at six pm was taken home. Two hours later, Stephen was dead. There is no doubt that his support staff were enormously distressed by Stephen's death – one support worker described the difficulty he had as he tried to blow air into Stephen's lungs, 'like blowing into a milkshake I was blowing in and it was just bubbling up coming out of his mouth and nose, and it was getting darker'. The ambulance arrived and commenced CPR, but Stephen was dead.

Stephen Moon was 21 years old.

Seven recommendations were placed on record by the Coroner as a result of Stephen's death, but nobody was ever held to account. Nobody was to blame for Stephen's death, except the systems that failed him.

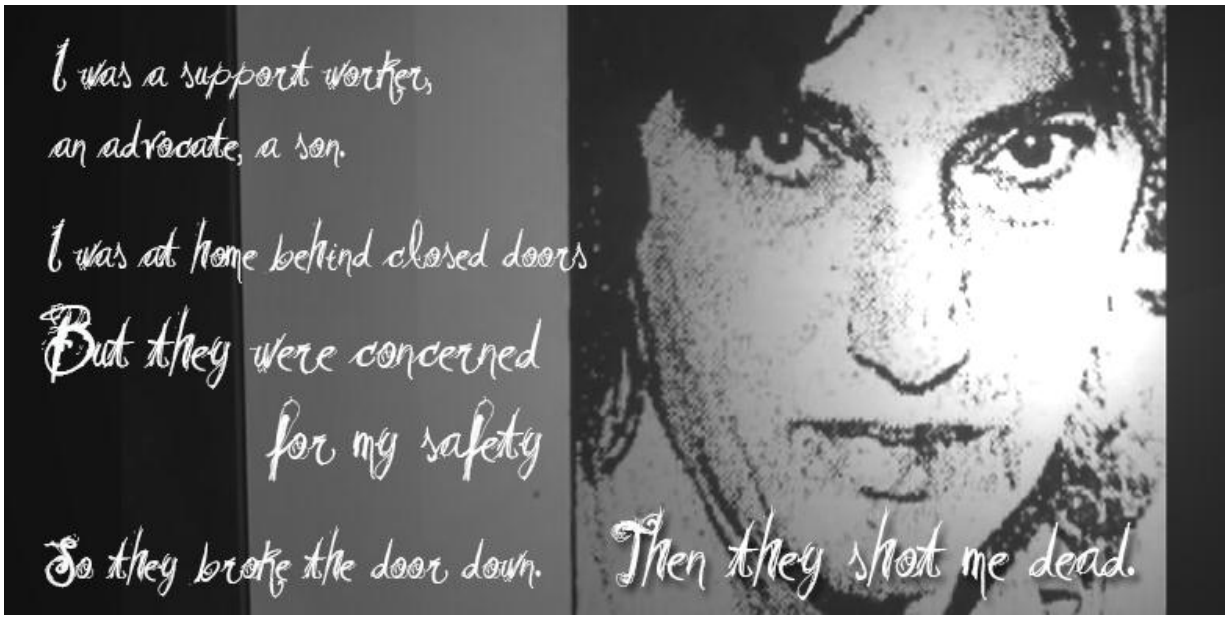

Image description: An image of Warren L'Anson. The text reads, 'I was a support worker, an advocate, a son. I was at home behind closed doors. But they were concerned for my safety. So they broke the door down. Then they shot me dead.

Name	Warren L'Anson
Location	ACT
Date	1995
Type of abuse	Systemic failure – police and mental health intersect
Disability type	Schizophrenia
Outcome	Shot dead by police

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5. Shot Dead by Police

Unfortunately, there wasn't a bed in the psych ward for Warren.

That was a shame. His wife and best friend had just died – he had learned two days ago that he may have contracted a terminal illness. He'd expressed concerns about conflicts between Mental Health Foundation and the ACT Mental Health Services, and his role as a client and a support worker. And Warren was a person with schizophrenia, whose behaviour started to spiral downward.

Warren locked himself in his unit and wouldn't come out. His family and neighbours were worried – and the Mental Health Crisis Service decided that they needed to act. They called the police, and the police 'effected forcible entry'.

In the intersect between police and mental health, somebody had forgotten to mention two pertinent facts – firstly, that Warren had said that as he did not want police blazing their guns through the door, he would put a mattress against the door, and secondly, Warren had said that he would be shot. He called it 'suicide by proxy'. That's why the police couldn't open the door with the first kick.

It took a long time for Warren to die. There were phone calls and pleading by his father to seek help, to come out and be hospitalised. There were angry interchanges through the wall and lunging at a glass door with a large knife. There was Warren, dressed in scuba gear and a necklace, telling people to go away, to leave him alone. And in the end, they kicked the door down and shot him in the back when he lunged at them with the knife.

The number of people with psychosocial disability shot by police is startling, but is only ever investigated on a state by state basis. In 2014, a NSW man, 36 year old Adam Salter died from a police gunshot wound following an attempt to stab himself in the neck. The Police Integrity Commission handed down scathing findings about how police handled the case and recommended that four police officers face charges for allegedly lying to the police watchdog.

In 2013, the Australian Institute of Criminology released a report detailing fatal police shootings between 1989 and 2011. In that period, police fatally shot 105 people. The victims were almost entirely male. Of those persons shot by police, 42% were experiencing a mental health condition at the time of the shooting. Most of the victims had schizophrenia. Some had learning disabilities. Almost all of the victims were male.

Notes on police shootings across Australia

- Police shootings of people with mental health conditions - published research - at least half of all police shootings in Australia involve a person with a disability or mental health condition (psychosocial disability) - - http://www.aic.gov.au/media_library/publications/rip/rip34.pdf

- 2014 - Queensland police shot at least six civilians. Four men died. There is a current investigation underway - http://www.theguardian.com/australia-news/2014/nov/25/queensland-police-shootings-to-be-reviewed-after-four-deaths-in-two-months

- Victoria, NSW and Western Australia have also had police shootings in 2014, two of them fatal.

- 'Trigger Point' is a doco about a violent time in Australia's social history where more than 30 people were shot in a year. http://www.lemac.com.au/GeneralNews/TriggerPoint-PoliceDocumentary.aspx

- Carlisle - Brendan Lindsay, shot by police, WA. - drug addiction, mental illness, system fail, paranoia, delusional behaviours, involuntary orders. 2014. Inquest – no. Four officers arrested, threat of strike action. - http://www.perthnow.com.au/news/western-australia/man-shot-dead-by-police-after-carlisle-hostage-drama/story-fnhocxo3-1227116731660?nk=71d78aaec2bfbf930bb47ce2d8a65912 Cited lack of mental health services - http://www.abc.net.au/news/2014-11-12/5885826

  http://www.watoday.com.au/wa-news/police-union-disgusted-by-arrest-of-officers-over-carlisle-shooting-20141114-11mmvg.html

  http://www.dailymail.co.uk/news/article-2826279/Man-shot-six-eight-times-police-taking-woman-hostage-stabbing-her.html

- Sunshine Coast, Qld - 51 year old interstate man, shot by Qld police. 2014 Inquest - no. - ethical standards committee, refered to coroner, reportedly unarmed, call for damaging property with pole. Police - general duties, multiple shots fired, three shots to chest.

- Brisbane, Inala - man shot dead after negotiations failed, held heavily armed police at bay for hours, emerged holding what appeared to be a handgun. Shot by Special Emergency Response Team. http://www.abc.net.au/news/2014-09-30/police-acted-in-self-defence-in-fatal-shooting-of-man/5777992

- Brisbane, Rochedale - Man shot in the head by police, in coma, allegedly 'drove at police' with a trailer and four wheel drive, was shot in head once and arms several times. Police ethical command investigating. http://www.abc.net.au/news/2014-11-04/man-out-of-coma-after-police-shooting-on-brisbanes-south/5864392

- Brisbane, Kippa-ring - man shot twice and killed by police after tracing hoax 000 calls. 33 year old 'lunged at them with a knife' and was shot twice. Body cameras on police - Police Ethical Standards and Crime and Corruption investigating. Alleged mental health issues. Police - general duties http://www.abc.net.au/news/2014-11-18/police-shoot-and-kill-man-north-of-brisbane/5898404

- Qld, 2014, Sunshine Coast - Troy Foster, 32, shot in driveway, mentally unwell and had a learning disability, http://www.abc.net.au/7.30/content/2014/s4145574.htm

- Victoria, 2008, 15 year old with mental illness shot within 73 seconds of police coming into contact with him (Tyler Cassidy), was carrying two knives

- Perth, WA, 2015, 44 year old man shot dead by police after being called to domestic incident - http://www.abc.net.au/news/2015-03-21/man-shot-by-police-called-to-domestic-incident/6337674

- 24 year old mentally ill man shot dead by police - http://www.abc.net.au/news/2013-03-25/elijah-holcombe-inquest-resumes/4593078

- http://www.aic.gov.au/publications/current%20series/mr/1-20/20/11_pursuit.html

- In 2013, the Australian Institute of Criminology released a report detailing fatal police shootings between 1989 and 2011. In that period, police fatally shot 105 people. The victims were almost entirely male and 60% were between 20 and 39 years of age.

- Of those persons shot by police, 42% were suffering a mental illness at the time of the shooting. Schizophrenia was the most common illness (59% of those with a mental illness) suffered. In at least one of the recent Queensland shootings, the person shot was allegedly a sufferer of mental illness.

- Over the last 22 years, a total of 199 shooting deaths have been recorded in police custody-related operations (see Table 85). The vast majority of all shooting deaths (94%; n=186) have involved non-Indigenous persons, with just over half (52%; n=97) of these being persons being shot by police.

- More than two in five shooting deaths (46%; n=92) were persons shooting themselves in the presence of police. The relatively large proportion of self-inflicted shooting deaths in police custody-related operations suggests that mental health issues are playing a greater role in the prevalence of these deaths. Analysis of the data on persons shooting themselves showed that 44 percent (n=40) were persons suffering from some form of mental illness at the time of death. Mental health data for persons shot by police is presented below.

- Indigenous persons represent only a very small proportion of persons involved in shootings (7%; n=13; see Table 85). Of all persons shot by police since 1989–90 (n=105), Indigenous persons represent just one in 13 such deaths (8%; n=8; see Figure 31).

- Long-term trends show that the number of persons shot by police peaked twice, once in 1993–94 (9 deaths) and again in 1999–2000 (11 deaths). In all other years, the number of persons shot by police has fluctuated between two and seven deaths each year. It can also be seen in Figure 31 that the number of police shootings of Indigenous persons are low and occur infrequently.

- Study into police deaths in Australia - http://www98.griffith.edu.au/dspace/handle/10072/27745

- Victorian independent inquiry into police shootings - http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=15&cad=rja&uact=8&ved=0CDMQFjAEOAo&url=http%3A%2F%2Fwww.ibac.vic.gov.au%2Fdocs%2Fdefault-source%2Fopi-parliamentary-reports%2Freview-of-fatal-shootings-by-victoria-police---nov-2005.pdf%3Fsfvrsn%3D4&ei=9pNuVf2-Icn88QXO6oLwCA&usg=AFQjCNEOyKib5uFWWM6NWu3COQ2m3tMg2g&bvm=bv.94911696,d.dGY

- http://theconversation.com/shoot-to-kill-the-use-of-lethal-force-by-police-in-australia-34578

- Police shootings, by state (Coroner's Findings only) Qld

- Irwin, Perry James; Coates, Damien Lawrence (PDF, 108.2 KB) Shooting of police officer, suicide of his assailant. Recommendations concerning QPS critical incident management, adequacy of communication devices for police, access and sale of ammunition, protective apparel. http://www.courts.qld.gov.au/__data/assets/pdf_file/0007/86596/cif-irwin-pj-coates-dl-20051010.pdf

- Hatch, Clay (PDF, 141.9 KB) Police shooting, mental health issues. http://www.courts.qld.gov.au/__data/assets/pdf_file/0005/86828/cif-hatch-c-20090619.pdf

- Irwin, Brett Andrew and Semyraha, Craig Anthony (PDF, 199.2 KB) Shooting of a police officer, suicide of offender, threat assessment, coordination of special emergency services http://www.courts.qld.gov.au/__data/assets/pdf_file/0008/86822/cif-irwin-ba-semyraha-ca-20091006.pdf

- Bell, Malcolm Robert (PDF, 80.4 KB) Police shooting, self-defence. http://www.courts.qld.gov.au/__data/assets/pdf_file/0005/86657/cif-bell-mr-20060526.pdf

- Hewson, Jamie (PDF, 96.7 KB) Death in custody, police shooting. http://www.courts.qld.gov.au/__data/assets/pdf_file/0003/86637/cif-hewson-j-20060608.pdf

- Rhodes, Daniel Cory (PDF, 144.2 KB) Police shooting, self defence. http://www.courts.qld.gov.au/__data/assets/pdf_file/0006/86622/cif-rhodes-dc-20060324.pdf

- Protheroe, Jason Paul (PDF, 428.5 KB) Death in custody, shooting. http://www.courts.qld.gov.au/__data/assets/pdf_file/0012/198849/cif-protheroe-jp-20130614.pdf

- Atfield, Kelvyn John (PDF, 82.4 KB) Weapon/Firearm related. http://www.courts.qld.gov.au/__data/assets/pdf_file/0009/161829/cif-atfield-kj-20120904.pdf

- Waite, Thomas Dion; Huynh, Mieng; Jacobs, James Henry; Gear, James Michael (PDF, 811.3 KB) Inquest, police shooting, mental health assessments, involuntary treatment criteria, post prison release mental health, prescription drug screening, dissemination of information to mental health information to police officers, critical incident command training. http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/86728/cif-waite-td-huynh-m-jacobs-jh-gear-jm-20080317.pdf

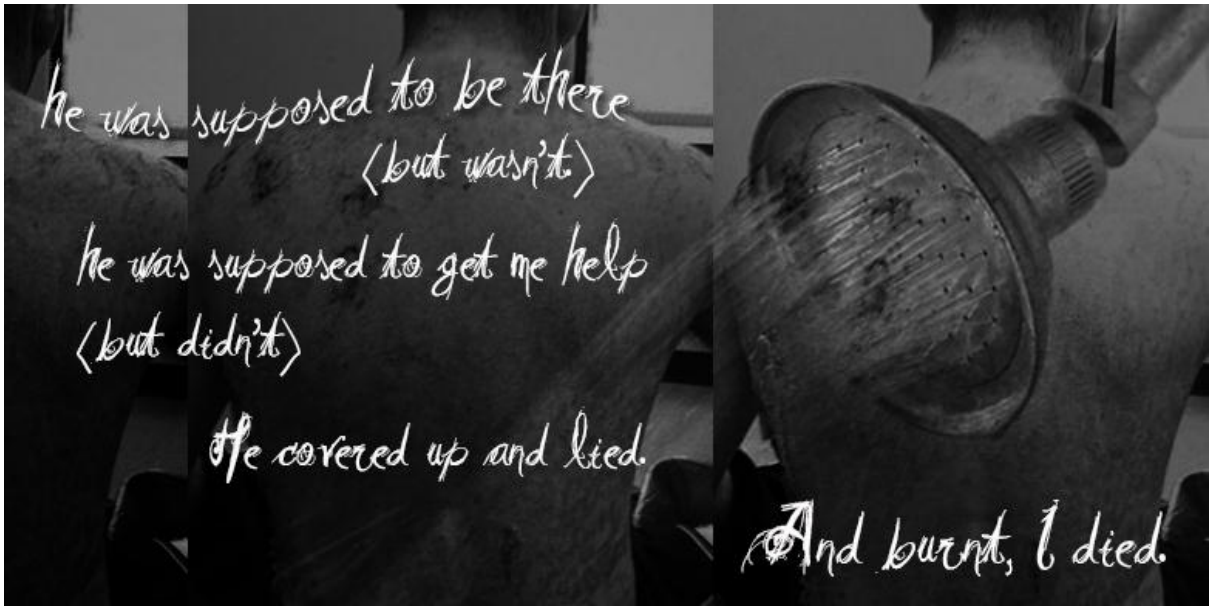

Image description: An image of a man's burnt back and a superimposed shower head with water streaming out. The text reads – 'He was supposed to be there (but wasn't) he was supposed to get me help (but didn't) he covered up and lied. And burnt, I died.

Name	Neil Summerell
Location	ACT
Date	1999
Type of abuse	Neglect, medical neglect
Disability type	Intellectual disability, epilepsy, vision impairment, hearing impairment
Outcome	Death, Coroners Recommendations

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For the Senate inquiry, we have chosen a representative number of accounts which demonstrate violence, abuse and neglect against persons with disability in institutional settings.

6. Neil Had a Shower

Neil was thirty four years old.

He worked at Pack ‘n Post half days and other half days in a day program. He had a mild to moderate intellectual disability, was able to mostly look after himself, could communicate after a fashion, was vision and hearing impaired and experienced frequent seizures.

Neil was a man of routine with a very high pain tolerance.

His family maintained close contact with him, even though he lived in an institutional setting. Sixteen years later, Neil experienced some psychiatric problems and the organisation said that they could no longer manage his behaviour. So Neil went to stay with his family, and then became homeless.

There were a lot of people who tried to get Neil some help, but there was nowhere for him to go, despite the fact that he was no longer experiencing ‘challenging behaviours’. Neil was ultimately given a permanent home with the ‘provider of last resort’, the Disability Program, in January 1999.

The provider of last resort is usually a government organisation, and it never looks like a resort. But it wasn’t the only place that Neil experienced abuse or neglect – a series of incidents led to Neil’s death.

In 1999, staff at the day program noticed an injury on his thigh and thought it was a blistering burn. They rang the group home and called the doctor. People assumed that it was a burn that was acquired in the shower.

And in October, Neil was burned again, apparently whilst making himself a cup of coffee from a wall heater. Someone noticed that he was burned on his chest and stomach when he flinched in pain after a worker tucked in his shirt. This time, Neil’s burns were acquired at work. And throughout, Neil’s seizures continued to be well recorded, frequent and unstable.

In November, something happened. Nobody knows what happened, but at 7.12am a casual staff member phoned the house manager to ask for advice. Neil was screaming in pain. The staff member had tried to call a few times earlier, but it was clear that his level of concern wasn’t high – he made other non-urgent personal phone calls in the interim. He didn’t know who to call or the procedure to follow, and eventually left a phone message with the accommodation support manager.

Some hours later, he contacted the on call manager, contacted the parents of another resident and attempted to contact the doctor, and CALMS. It wasn't until the house manager arrived at 9am that the decision was made to take Neil to the hospital.

The casual staff member denied that he did the washing, but Neil's pajamas and bed sheets were washed and were hanging on the line by nine am. He denied that Neil had a shower, although Neil told hospital staff he showered in the morning. He denied that Neil might have been burnt or scalded, and tried to cover up his neglect.

There was no temperature regulator on the hot water system. ACT Housing had given the maintenance contract to a company to carry out that work, but it had not yet been carried out. The casual staff member lied on his resume, saying that he was a nurse – in fact, he did not even have first aid qualifications. He hadn't been given any induction. He didn't have any experience. He did not take any action for three hours.

When Neil got to the hospital, he was fully dressed. The triage nurse asked why an ambulance hadn't been called – why he wasn't dressed. When she looked at Neil's burns, 'it was all of his back, behind his shoulder, on the back of his neck, down the left side of his trunk, the left buttock, the upper arm' and that there were sheets of loose skin. The staff member said that he thought the burns had happened last night, and denied that there were sheets of dead skin on his pillow or pajamas.

Neil said he'd had a shower. He called out and called out and no one came, he said. So I showered myself, Neil said.

Neil died in hospital of complications that arose from his burns and dehydration four days later.

Neil died a long time ago, in 1999. But like other disability inquests, the unacceptable delay into investigating his death meant that critical issues remain unaddressed. The Coroner noting Neil's death said that there was a lack of properly trained police officers investigating 'certain classes of inquests'.

Neil died a long time ago. But it was not until 2003 that the Coroner reported on his death. His injury was covered up by staff, as was the neglect that led to his death. Like the circumstances of most other deaths of people with disability in institutional settings, nobody was held accountable.

The Coroner's findings about Neil's death are attached.

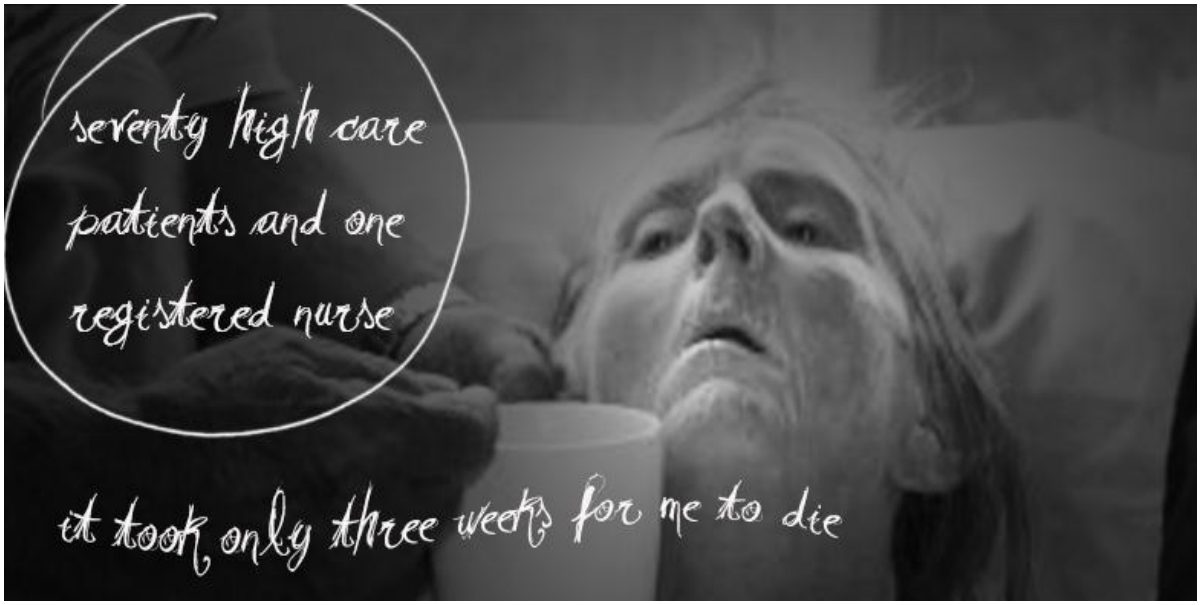

Image description: An image of Beryl Watson, with the words 'seventy high care patients and one registered nurse – it took only three weeks for me to die'.

Name	Beryl Watson
Location	Macksville, NSW
Date	2011
Type of abuse	Medical neglect
Disability type	Huntington's Disease
Outcome	Coroners Recommendations

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7. Three Weeks to Die

Beryl Watson was severely disabled and required full time care. Her husband, Clive, provided that care. Beryl had Huntington's disease and used a wheelchair.

But then Clive needed to go away for a medical procedure. He was to be away for three weeks, so he arranged for his wife to stay at the BUPA Aged Care Facility in Kempsey.

Clive printed a list of Beryl's prescribed medication. He gave them a care plan, a power of attorney and Beryl's ACAT assessment. He provided a medication summary signed off by Beryl's GP and detailed instructions about what to do should she contract a UTI. He took her to her room and unpacked incontinence pads for day care and overnight, fluid thickener, a stick blender to process her food, a spoon for feeding her, a sleeping bag and a tube of ointment. He went through the care plan with the RN, and ensured that she had enough drugs for her stay.

Five days after he collected his wife from the aged care facility, she was admitted to the Macksville General Hospital. She had weeping, open sores and skin peeling off, as well as severe dehydration and weight loss. Clive said that when he walked in, he was expecting to see the Beryl he put in there. Instead, she was 'gaunt, thin and they were sucking stuff out of her throat with a pump'.

Ten days later, she died in hospital from aspiration pneumonia.

The Coroner found that her death had been contributed to by understaffing, medical error and suboptimal nursing care, with inadequate admission procedures, a failure to assess Beryl's need for specialist allied health service and medical review, and a failure to give Beryl her prescribed medication for 13 days, which caused her to suffer from severe withdrawal symptoms. She was not given sufficient fluids or food, and medical records show that she was agitated, writhing in bed and biting at her draw sheet, making loud noises and scratching at herself.

There were 71 patients at BUPA, and 70 were high care, with one registered nurse. At the time the coroner found that nursing care was suboptimal, the home had passed an accreditation audit.

Clive went away, and Beryl died. The story of inadequate short term respite care is one echoed by many families who will no longer admit their family member into care because of the lack of reliable short term respite care.

Image description: An image of Fremantle Hospital, with the words 'I did not die because I could not speak, I died because you did not listen'

Name	Vaughn Rasmussen
Location	Western Australia
Date	2009
Type of abuse	Medical negligence
Disability type	Hydrocephalus
Outcome	Coroners Recommendations

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8. Misadventure

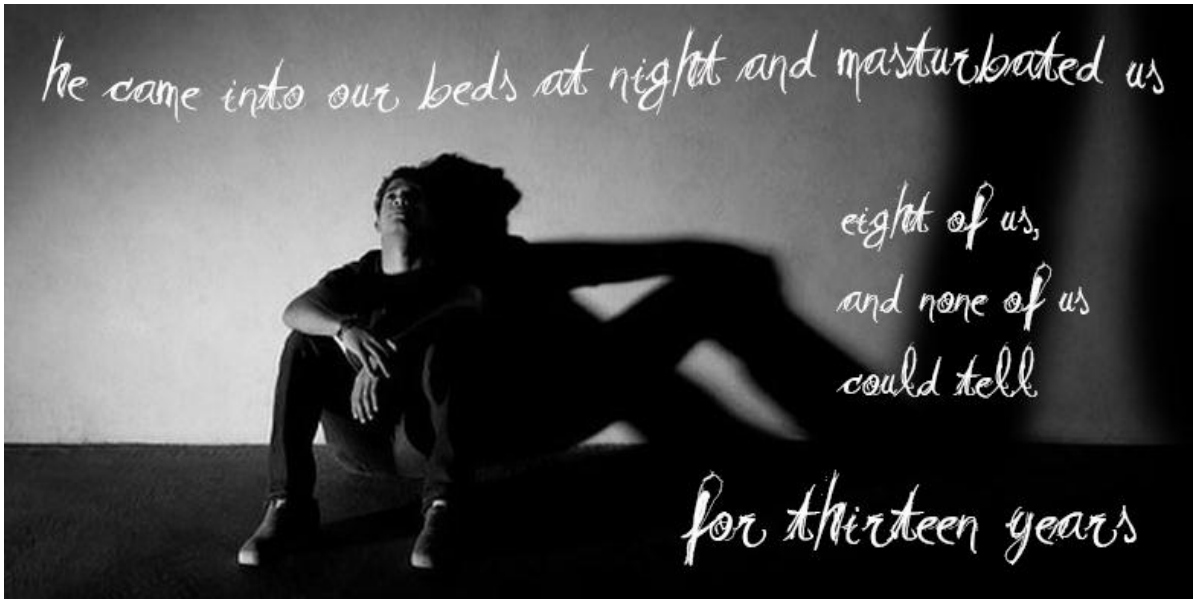
Vaughn Rasmussen died in his family's arms, in a WA hospital. He died not because he had hydrocephalus, nor because he could not communicate his agony. Vaughn died because of a series of mistakes made in a hospital system that was not well equipped to deal with the routine issues that can happen to people with hydrocephalus. More specifically, Vaughn died because nobody listened to his family.

His parents, Donna and Richard, made four trips with Vaughn to two Western Australian hospitals before he was correctly diagnosed. And by then, it was too late. The technician – who didn't work on Mondays – didn't know that Vaughn had died seven hours before when he looked at the CT scan that Vaughn's mother had been pleading for and was refused. Both parents made repeated requests for a CT scan and were refused over and over again, 'because of Vaughn's disability and his inability to speak.'

Vaughn was a happy and healthy teenager, but the last days of his life were spent in agonising pain. When a CT scan was eventually performed, they found a large amount of fluid on his brain. A further test confirmed the Rasmussen's suspicions – there was a blocked valve in his shunt.

His parents turned off the life support machine after being told that Vaughn was not expected to survive. Vaughn was fifteen years old.

The Coroner found that Vaughn's death was by 'misadventure'. His story, as chronicled by the WA Coroner, is below.



Text description: A man sits against a wall, looking up. His shadow is looking up at a pair of towering legs. The text reads, 'he came into our beds at night and masturbated us – eight of us, and none could tell – for thirteen years'

Name	Multiple (eight) unnamed men
Location	Victoria
Date	1998 – 2011 – charged in 2014
Type of abuse	Sexual abuse
Disability type	Multiple including deaf, blind, intellectual disability
Outcome	Pending court case

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9. Thirteen Years

[redacted] was a model disability support worker. No complaints had been made against him and there were no investigations into any misconduct. He self describes as 'a devout Christian'.

[redacted] handed himself into police last year, telling them that it was important for his faith to do so. And he confessed to thirteen years of sexual abuse against eight male victims, including one person who was deaf, blind and cognitively impaired.

The men, aged between 25 and 50, were abused between 1998 and 2011 whilst living in DHS disability supported accommodation in [redacted], [redacted] and [redacted] was employed by DHS as a disability development services officer to care for the men.

Instead, he walked around their homes naked, climbed into bed with them at night and masturbated some of them. Eventually he resigned in 2013.

After he confessed, police charged him with 19 counts of indecent acts by a carer. His lawyer argued that his matter should be dealt with by a magistrate rather than a judge, but the Melbourne Magistrates Court said that his offending was too serious. Despite the fact that it was 'unlikely [redacted] sentence would exceed the five years prison term a magistrate could [redacted]

[redacted] is now listed with the Disability Worker Exclusion Scheme [redacted]

* http://www.heraldsun.com.au/news/law-order/human-services-worker-craig-gilbert-handasyde-targeted-severely-disabled-in-13-year-sex-abuse-spree/story-fni0fee2-1227319320988

Text description: A wall has been spraypainted with the word 'neglected'. Text across the image reads 'Sometimes the people who are supposed to protect us…don't.'

Name	AA – 'Stephen'
Location	NSW
Date	2010
Type of abuse	Medical, family and systemic neglect
Disability type	Obesity and sleep apnoea
Outcome	Death

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10. Stephen's Story

Not all children are born disabled. Some are made disabled. And some are made disabled by abuse.

Stephen* ('AA') was killed by medical neglect. His parents, drug addicts, neglected their children for decades. The other children survived, but Stephen, who had sleep apnoea as well as being morbidly obese, did not.

They fed him and fed him, and eventually he became so ill that he required surgery. His parents did not take him to medical appointments and refused him treatment, and the child protection system did not understand the issues.

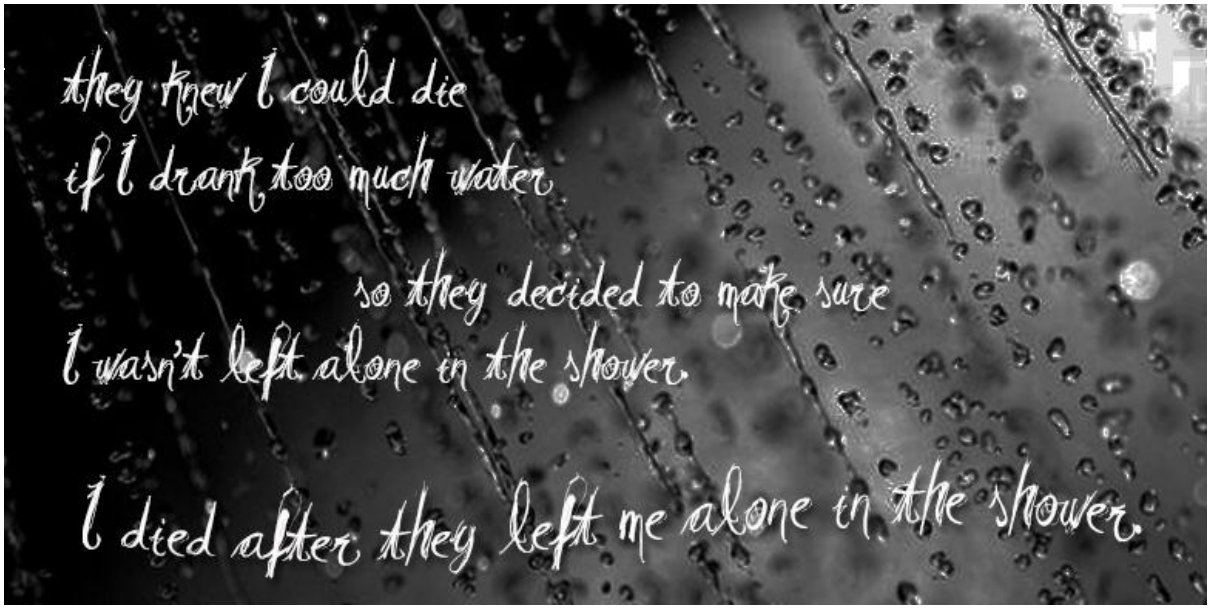
There's no intersect between a number of systems. People with disability live in silos, and there is nobody bashing holes into the side of the silos so that agencies can shout between them. Health and disability is one such silo – child protection and health is another. The intersection of Stephen's medical needs with neglect were not understood and there was no joint child protection and health service intervention.

A recipe for disaster for twelve year old Stephen, who died in the family car after going into cardiac arrest. Add two parents with serious addiction problems, entrenched disadvantage, a child protection system with high workloads, competing priorities and inexperienced staff in key roles and poor interagency collaboration, and the result is a dead twelve year old child in a car outside a hospital.

Who killed Stephen? Was it reasonable to expect that a child born to parents who were clearly unable to care for his medical needs would be seriously at risk? Who bears the responsibility for his demise?

Stephen's story – and the reasons for his death - are chronicled below, by the NSW Coroner.

*Stephen's name has been changed to protect his privacy



Text description: Beads of water on a dark background. The text says 'they knew I could die if I drank too much water, so they decided to make sure I wasn't left alone in the shower. I died after they left me alone in the shower.

Name	Jamie Johnson (and Brett Ponting)
Location	ACT
Date	2000
Type of abuse	Neglect
Disability type	Intellectual disability (ABI)
Outcome	Death

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11. Unacceptable Risk

Jamie was regarded as a difficult customer. He had spent time in the Quamby Juvenile Detention Centre before becoming a resident of Bruce Hostel. Prior to that, he'd moved from the Melba Flats to a group home in Conder, a group home at Kambah and the John Knight Hostel. And in 1993, he moved to Campbell Street, a small government institution for the disabled.

As well as an intellectual disability and obsessive compulsive behaviour, Jamie had very low serum sodium. This meant that he was also prone to psychogenic polydipsia, a compulsion to drink seven to ten litres of water a day.

In 2000, Jamie was admitted to hospital following a collapse. His carer had been employed casually for about three and a half years and had been given a two to three week induction training course. He'd never been taught to use an individual plan, but knew they existed. He knew that Jamie tended to drink water to excess and in the past, this had been 'solved' by removing the tap handles in the residence. And he knew that he had to 'monitor' Jamie with his water consumption, especially in the shower – he had a written instruction in the IP. His manager had explicitly written the instruction into the IP as a risk management measure.

He knew what he had to do, but he said he had difficulty supervising Jamie in the shower – another resident had behavioural problems and required supervision. He said that he chose not to obey the instruction, because there was a clear occupational health and safety risk to himself. On the day Jamie suffered a seizure, he had soiled himself 13 times between 7am and 12.40pm. He showered himself and was not supervised in the shower. That was when Jamie drank unknown, large quantities of water – that failure of supervision, the Coroner said, 'clearly contributed to the death of Jamie Johnson'.

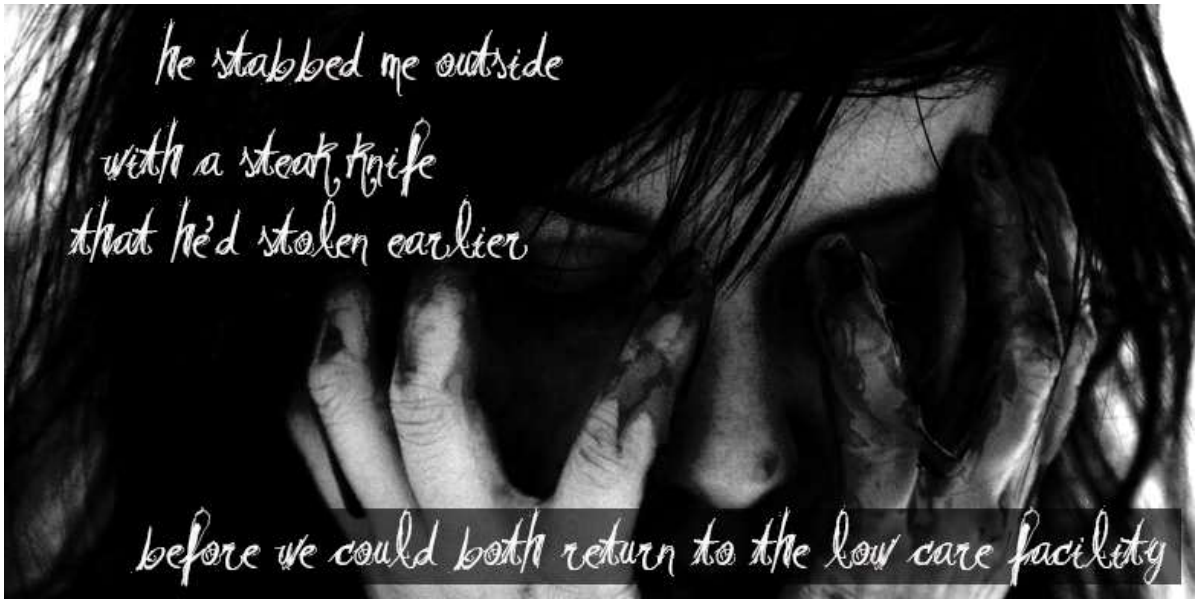
Workers were off on leave, and there was no continuity of care or management. The hospital refused to provide accurate and detailed information about Jamie's condition. There were issues relating to privacy – the Coroner notes that the preparation of an incident report seems only to trigger a 'statistic keeping exercise'. For example, one worker observed Jamie inserting a toilet brush into his body. Instead of creating an incident report, she passed on that information to her line manager and regional director. This information was not passed on to other people responsible for his care, and Jamie's privacy was cited as a reason. The same reason was cited for neglecting to supervise Jamie in the shower.

Documentation was not completed, and Jamie was not supervised. But the Coroner declined to make an adverse finding against the worker. He saved his wrath for two staff members who deliberately covered up the incident. One, a disability services manager for the house, told the court that she did not know Jamie had an ongoing problem with water, but it was later revealed that she had written a risk report on the issue. She was handed a 12 month suspended jail term and a $2,000, three year good behaviour bond for giving false evidence. Another staff member, the regional manager, was prosecuted in relation to evidence given at the inquest and then acquitted.

The Coroner faithfully chronicles the failings of another government run institution – an old building, a passing parade of casual staff, poor management practices. A risk management report that was not implemented. Later, in the Gallop Report – an ACT disability report in the wake of three deaths in disability group homes - more recommendations are made.

Jamie died from “diffuse cerebral oedema caused by hyponatremia caused by excessive self-induced water drinking”. His age and further details were not recorded by the Coroner.

Jamie’s story is attached and the story of Brett Ponting, a young man who drowned in an ACT group home in very similar circumstances in the same year, is also attached.



Text description: A girl with bloodied hands over her face. Text: he stabbed me outside, with a steak knife that he'd stolen earlier, before we could both return to the low risk facility.

Name	Rebecca Lazarus
Location	Victoria
Date	2007
Type of abuse	Murder (domestic/interpersonal)
Disability type	Intellectual disability
Outcome	Death

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12. The Killing of Lazarus

Rebecca had lived in institutional settings for a long time, despite being only 25 years old. She had a mild intellectual disability and was born to a mother who had cerebral palsy – after her father's death when Rebecca was aged five, she lived in a series of foster care placements.

Her brother, Andrew, says that she had a very happy personality and was able to function normally – she was 'very independent, and to look at her, you wouldn't know she had a disability'. And when she was twenty years old, she moved into Hazelwood Supported Residential Services.

That's how she met her boyfriend, a man named Travis Cooke. Travis was 31 years old and had a lengthy history of paranoid schizophrenia. His physicians described his condition as 'chronic and treatment resistant'.

Travis was described as having a long history of verbal and physical aggression. He had threatened to kill his parents and threatened a co resident at a hospital with a knife. He was described as being a 'longstanding risk of harm to both himself and others in view of his chronic treatment resistant illness'.

Rebecca told others that Travis once punched her in the nose. A close friend of Rebecca's said that '"Over the year and a half that I have known them both they were always arguing. He would go to punch her in the face but would stop before actually hitting her."

Others noticed that Rebecca was exposed to ongoing threats and harassment, but people working in close proximity to her did not.

That was a shame, because Rebecca's life ended some months later, outside a weatherboard house in Victoria.

Travis stabbed Rebecca in the chest, stomach and left hand at 3.40pm on 4 July, 2007. He'd stolen a steak knife from K-mart to do it. Travis stood above her for a few seconds, pressing his hands against her chest, then walked away, leaving her to die.[1]

Rebecca was able to say the name of her murderer before dying in hospital.

[1] https://newmatilda.com/2013/07/11/why-did-rebecca-lazarus-die

The Coroner raised questions about the appropriateness of Travis's placement in a mixed gender and low care facility, given his complex presentation and the documented risks that arose from this. But there was only one recommendation made – that the Department of Health should produce a training model about family violence.

A New Matilda report documented the outcome of the training model, which at the time of the article being written had still not been produced.

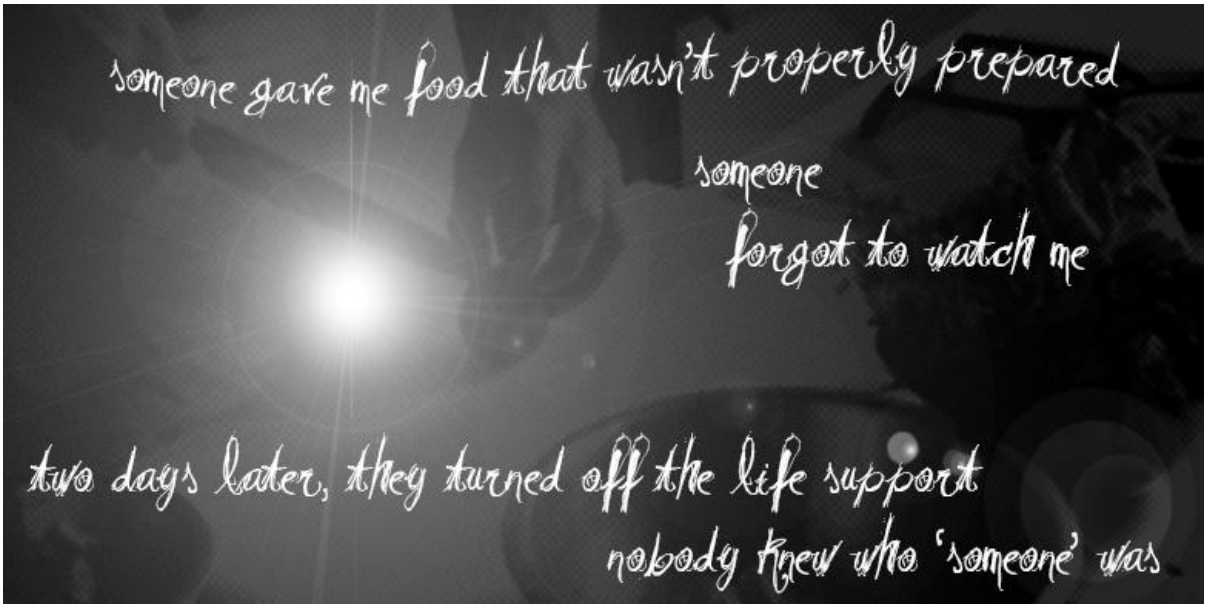
Although tougher legislation was introduced in 2012 for SRS, it made no reference to the placement of high-risk individuals in low-care facilities. There is also currently no independent reviewer for SRS. [2]

It took five and a half years for the findings from Rebecca's inquest to be published. On 14 November, 2012, 1960 days after Rebecca's brutal murder, the Coroner's Court of Victoria released its report.

It stopped short of making a recommendation about the placement of high risk individuals in low risk facilities.

The Coroner's finding about Rebecca's murder is attached.

[2] https://newmatilda.com/2013/07/12/no-place-vulnerable



Text description: A person cutting up a meal. Text reads – someone gave me food that wasn't properly prepared. Someone forgot to watch me. Two days later, they turned off the life support. Nobody knew who 'someone' was.

Name	[redacted]
Location	Victoria
Date	2009
Type of abuse	Neglect
Disability type	Amputee, stroke victim, used wheelchair
Outcome	Death

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13. They Turned Off the Machine

There was always a risk that [redacted] would choke. His speech therapist completed a dietary alteration form, which said that [redacted] should commence a soft, cut up diet and increased gravies and sauces. And that dry and crumbly goods, such as pastries and biscuits, should be off the menu.

There's no way anyone should have given [redacted] a sausage roll. And [redacted] was to be supervised when he ate – so there was no way he could get into trouble whilst eating.

His brother in law said that a female delivered [redacted] evening meal and left. The contents were covered and he left before seeing [redacted] eat. Which he clearly did – because it was what caused him to choke. A nurse found [redacted] in his wheelchair, cyanotic and dyspnoeic. He took two breaths on his own, but then his heart rate and respirations ceased. They started CPR, but [redacted] had suffered a severe brain injury. They turned off the machine two days later.

Emergency crews pulled what looked like a sausage roll from [redacted] throat at the scene. The paramedics said that 'someone at the scene stated that someone had brought them in as a treat'. But afterwards, nobody seemed to remember giving [redacted] his meal that night. After three days of inquest, there was no evidence about whether his meal was finely chopped or not on 23 June, 2009 – especially not by the time the inquest rolled round, three years later.

Again, nobody was to blame.

Many years later, the inquest notes that things have now changed as a result of [redacted] death. But there were policies and procedures in place back then that were not followed – and again, nobody was held accountable.

[redacted] death is chronicled by the Victorian Coroner and is attached.

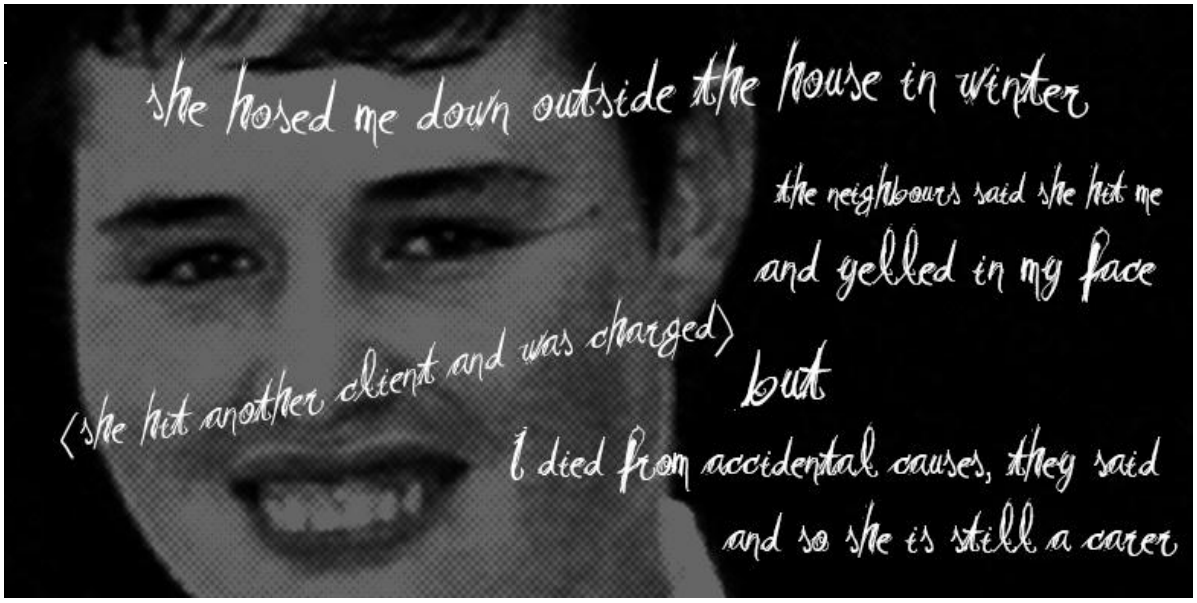

Image description: The image of a young man (Stuart Lambert). Text: She hosed me down outside the house in winter, the neighbours said she hit me, and yelled in my face (she hit another client and was charged) but I died from accidental causes, they said, and so she is still a carer.

Name	Stuart Lambert
Location	Queensland
Date	2009
Type of abuse	Abuse, neglect, various
Disability type	Cerebral palsy, autism and epilepsy
Outcome	Death

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14. An Unforeseen Effect

It looked suspicious. Stuart Lambert was only 31 years old and he had died at her home with 23 fractured ribs.

She told police he'd had a seizure. A plausible explanation, but when the autopsy results were returned six months later, the cause of death was revealed as 'flail chest'. He had extensive rib fractures.

She was asked in the Coroner's Court how an hour 'disappeared' between her client falling over and her triple 0 call. She was asked to explain why her neighbours said that they'd seen her verbally abusing Stuart, slapping him and washing him with a hose in the backyard in winter. She was asked if her husband had thrown a bucket at Stuart, and she was asked about her conviction for assaulting a different client in 2007.

When they did the autopsy, they noticed that Stuart had a lot of scars.

Stuart was in residential accommodation, but Stuart's mother preferred that he stayed overnight with her. It became harder to get him back from a day visit because of the upgrade to a motorway. The family made a private arrangement and didn't tell the department that they were continuing Stuart's overnight stays.

Stuart started sustaining injuries, including two serious ear injuries. However, his parents did not raise their concerns with the Department. About the time she was to be charged with assault, her employment was suspended, and the Department informed them. Stuart's mother requested that she continued as carer for Stuart, and this was agreed to. The terms of agreement were that she was not permitted to be alone with Stuart and had to be supervised at all times. Bizarrely, because Stuart's funding was for respite, the supervision was to have been provided by his parents.

A number of complaints, by then, had been made about non specific injuries and more serious injuries which resulted in medical treatment and/or hospitalisation. The Coroner said that 'it seems no detailed inquiry was made about some of the causes'.

The neighbour had a lot to say. Stuart was being slapped, pushed, hosed down, yelled and sworn at. He was being hosed down outside during winter time. On other occasions he observed Stuart outside at night in winter with only his underwear on. He thought the hosing down was perhaps Stuart's bath arrangement. He said that

on the occasions that he observed the swearing, slapping and pushing, that Stuart sounded upset by this.

After the assault, for slapping a male client, she kept her 'positive notice' card. She was sentenced to a $500 12-month good behaviour bond on November 29, 2007, with no conviction recorded.

When the Department of Communities asked her to explain why she should keep her positive notice card, similar to a Blue Card, she cited references from other clients' families and a psychologist's report. As a result, she was able to continue working with disabled clients and remained employed by Individualised Community Access Services (ICAS).

The Coroner's findings contains some useful lessons about the vagaries of regulatory systems, including positive notices and blue and yellow cards. Not useful to Stuart, though – he was failed by the Department, the agency, his 'caregiver' and others. The Coroner declined to make formal recommendations, noting that it was 'difficult with limited resources for additional oversight to be put in place, and in some cases such oversight can have other unforseen effects which might reduce the quality of life of disabled persons.'

Death is probably one such unforseen effect.

Stuart's story is attached.

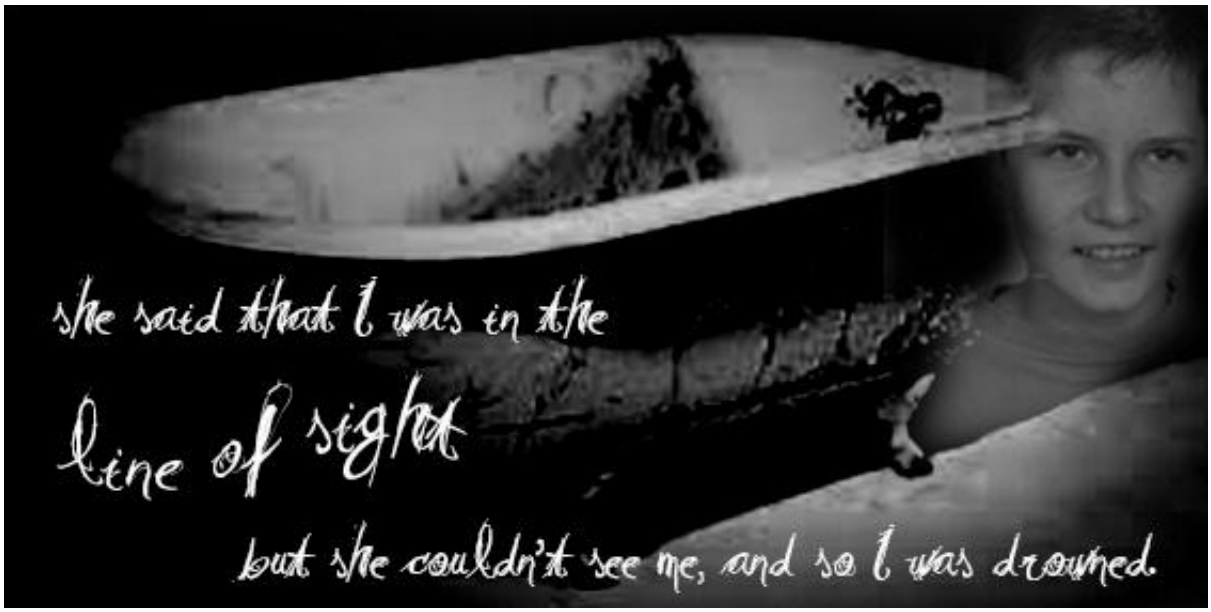

Image description: An image of a young man (Jack Sullivan) is superimposed over the image of an old bathtub. The text reads; 'She said that I was in the line of sight, but she couldn't see me, and so I was drowned'.

Name	Jack Sullivan
Location	Queanbeyan
Date	2008
Type of abuse	Neglect
Disability type	Autism, epilepsy
Outcome	Death

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For the Senate inquiry, we have chosen a representative number of accounts which demonstrate violence, abuse and neglect against persons with disability in institutional settings.

15. No Honest Answers

Jack Sullivan's mother did not know that the respite facility had many allegations of physical, sexual and emotional abuse recorded against it.

If she had known, she would have not admitted her child to respite. But she did not know, and in early 2008, in respite care funded by Disability ACT, Jack Sullivan drowned in the bath.

The eighteen year old was severely epileptic and it was standard practice that he was never left alone in a bathtub. After Jack died, the support worker told police that she had left him alone for a few minutes to go to the toilet, but he was 'always in the line of sight'. But when the NSW Coroner came to check, it was discovered that the bath was not visible from the toilet.

There have been a number of deaths of disabled people in bathtubs. Some years before, another disabled ACT resident died in a government funded respite facility. In 2000, Alice Louise McTye died at Kangaroo Villa in Adelaide in similar circumstances. She was 34.

It took Jack's mother two years to persuade the NSW Coroner's office that there was the need for an inquest. The inquest was suspended after only three days, and she was forced to wait two years more whilst the Director of Public Prosecutions decided whether to bring charges against a person whose name the Coroner had ordered to be suppressed.

There was no chance of prosecution, because the exact cause of Jack's death could not be specified. The Coroner's finding of 'partial drowning while in the bath' was the most descriptive cause of his death. And now that there was no chance of prosecution – because the exact cause of Jack's death could not be specified – nobody was ever held accountable.

Nobody was ever prosecuted. Despite the fact that an ACT government funded disability service agency warned senior officers in Disability ACT that they had serious concerns about the Queanbeyan service and that they did not want to use it – only eight months before Jack was drowned.

Despite the fact that there had been a history of failing to meet residents needs, including at least one other death.

Despite the fact that the respite worker failed repeatedly to meet the standards required by disability agencies. That the worker's licence to provide childcare services was withdrawn in 2006.

In 2007, OCHFS's Child and Protection Services branch emailed all staff with the following: "It is important we do not use [the Queanbeyan service] under any circumstances. Please do not refer or direct any member of the public to use this service. Doing so may imply an endorsement of the service they provide." Yet clients continued to be referred and directed to the service, well into 2008.

You won't hear all the stories about people with disability drowning in baths or being seriously injured in care, because settlements and confidentiality agreements abound. Last year, it was reported that a woman with autism and epilepsy was suing an Adelaide residential care facility over severe injuries she suffered from a hot bath which a nurse allegedly tried to cover up. The 35-year-old woman's parents claimed she suffered burns to 30 percent of her body in March 2011 after being left in bath water exceeding 60 degrees Celsius for fifteen minutes by a nurse who was supposed to be looking after her.

The woman was living at the Braham Lodge, operated by Disability SA and the South Australian Department of Communities and Social Inclusion, and owned by the Intellectual Disability Accommodation Association.

In 2015, a 34 year old man with quadriplegia, Gregory Evans, received first, second and third degree burns to his body after a hot water system failed at the dilapidated WA Quadriplegic Centre, an institution which warehouses almost sixty people with disability.

There are many other accounts, some of them involving the deaths of young women and men like Jack.

Jack liked to swim, roller-blade, ice skate and ride a bike. When he was thirteen, he saved his sister's life by donating bone marrow, after she had been diagnosed with a rare blood disease. He was an active young man who loved sport. But Jack Sullivan died in care from neglect, and there have never been any honest answers – or accountability – about the circumstances in which he and others died.

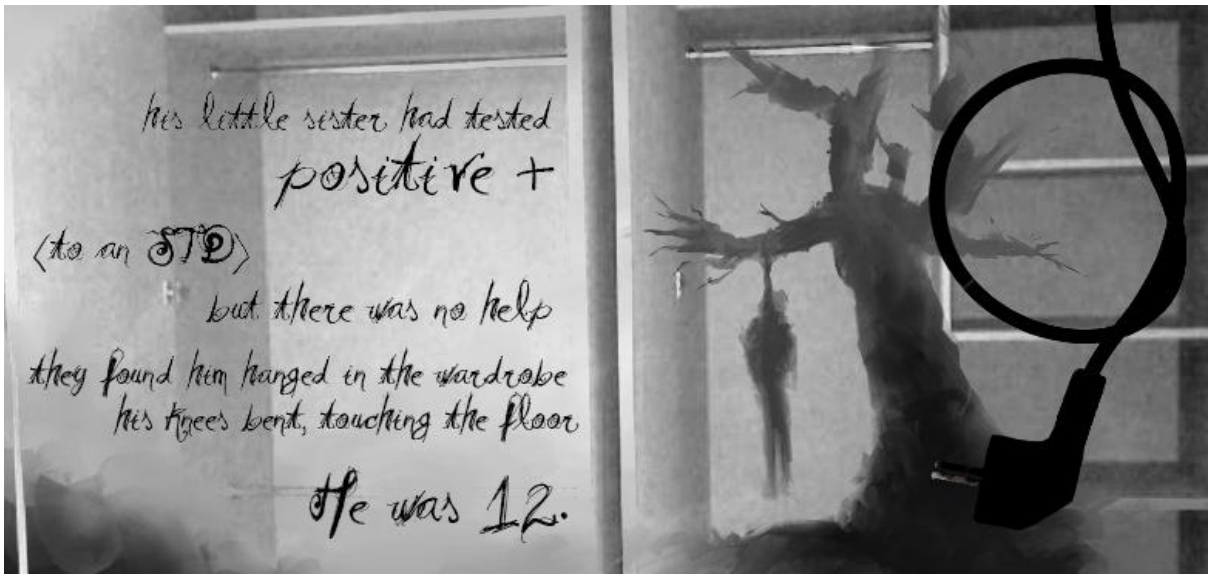

Image description: An image of a hanged person in a tree superimposed on a wardrobe. A looped cord is silhouetted in the foreground. The text reads, 'His little sister had tested positive + (to an STD) but there was no help – they found him hanged in the wardrobe, his knees bent, touching the floor. He was 12.

Name	Redacted
Location	[redacted]
Date	2004
Type of abuse	Systemic failure
Disability type	Foetal alcohol syndrome, intellectual disability
Outcome	Suicide of a 12 year old child

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16. Twelve Years

He lived all his life in [redacted] All twelve years. He was disadvantaged from the start - this child was born with foetal alcohol syndrome and a mild intellectual disability and he acquired a profound emotional disability. His mother was only seventeen when he was born and 'could not care for him', the Coroner's report says. Her congenital intellectual impairment was apparently exacerbated by alcohol and substance abuse.

And so he went to live with a relative, as did his two sisters, and then the troubles began. When he and other prepubescent boys were reported as having 'sexually inappropriate behaviour', nothing happened. He was in the state system, but nothing happened.

In June 2003, one of the 12 year old boy's sisters tested positive to chlamydia, a sexually transmitted disease. Suspicion fell on the stepfather, but nothing happened. This was an Aboriginal family - the Coroner notes with some sarcasm that 'it seems unlikely this would have been acceptable had the child been Caucasian and living in a major centre.'

This is a good Coroner. He or she is critical of the fact that the family visit took place five months later, but also of the terrible protocols in place and lack of resourcing and giant case load of the workers in the system. The workers had no training and no cultural awareness training, and walked from place to place, with no transport, no computer. They were probably aware of the enormous disadvantage this boy lived with, but it was probably one in a sea of others. In this particular family, there are reports of great family dysfunction.

The suicide of this 12 year old boy was discovered by a man who slept in the same bedroom as his adoptive mother. The man was 'mentally disabled'. He found the boy when he opened the wardrobe to look for cigarettes. The boy was hanging from the rail of the wardrobe - he had hung himself by the electric cord of some hair clippers.

In the photos, his knees are bent, touching or nearly touching the floor of the wardrobe. No impulsive act, this.

Layers and layers of cumulative disadvantage.

The Coroner’s report is attached.

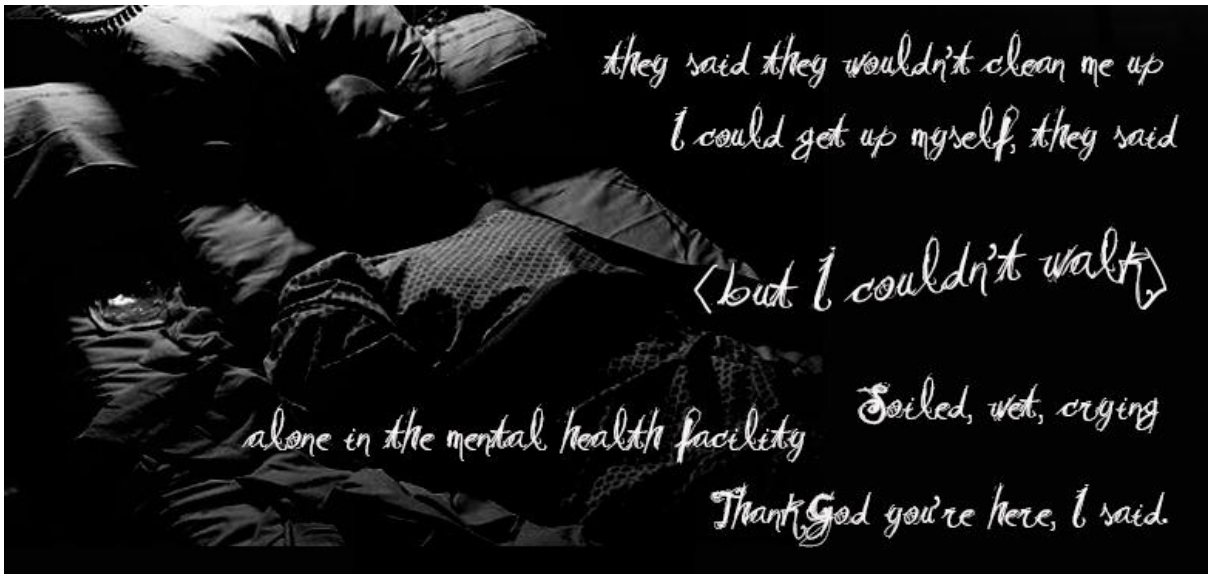

Image description: An image of a woman in a bed. The text reads 'They said they wouldn't clean me up, I could get up myself, they said (but I couldn't walk) Soiled, wet, crying, alone in the mental health facility. Thank God you're here, I said.'

Name	Various
Location	WA
Date	Current
Type of abuse	Violence, abuse, neglect
Disability type	Various
Outcome	Various

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17. The Visitors

Not every state has an Official Visitor program. In Western Australia, Official Visitors are visitors who are appointed to visit people in mental health facilities.

That includes people with other forms of disability than psychosocial disability. And for many people, mental health facilities are not set up to accommodate people with other forms of disability. It is common for people with autism to be restrained, physically or chemically – it is common for people with physical disabilities to be refused treatment because of inaccessible facilities.

In many states of Australia, it is considered to be 'duplication' if a person receiving state care goes into another 'system'. There are agreements between health and disability, disability and mental health, disability and justice. Disability support is different from nursing or mental health care and people are often left without support, accommodation or treatment.

There is no other 'visitors' program, including Community Visitors, appointed to do this work in the disability sector in WA.

The Council of Official Visitors is one of a number of Australian bodies which are housed under a statutory authority and who faithfully document incidents and allegations of sexual assault, abuse and neglect, including systemic neglect.

A few examples are provided below.

'An Official Visitor responding to a request for a visit, found a consumer lying on a hospital bed in a nightgown that was pushed up around her shoulders, wearing an adult incontinence "nappy" that was partially pulled down and was full of faeces. The consumer was shaking, crying and very visibly distressed. The bed linen beneath her was wet through. Her first words to the Official Visitor were:

"Thank God, you're here, please save me".

The Official Visitor quickly reassured the consumer and then went to find the senior nurse for the ward.

Together they cleaned the consumer up. The consumer said she couldn't move or walk so could not get out of bed to help herself. The consumer normally wears callipers on her legs. She also said that her nurse had been shouting at her for some

time that she had to clean herself up and that staff were not going to help her, not even help her out of bed.

When the Official Visitor had telephoned the ward earlier in the day to speak to the consumer, she was told by a nurse that the consumer wouldn't come to the phone and they refused to take the cordless phone to the consumer. When the Official Visitor turned up to visit the consumer she asked a nurse where the consumer was. The nurse replied: "She's in her room and will be going to a medical ward but she won't be going anywhere till she gets out of her bed and cleans herself up". The nurse then took the Official Visitor to the consumer's room, first checking through the peephole into the room.

The nurse opened the door and let the Official Visitor in. The Official Visitor said that the stench in the room was overwhelming immediately after the door into the room had been opened, but the nurse shut the door behind the Official Visitor and left.' (Council of Official Visitors, 2012-2013 Annual Report)

'… 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.

Apart from attending numerous meetings, Council wrote to the CEO of the NGO to complain about the eviction, and to the Mental Health Commissioner, asking him to get directly involved in the case. 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 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 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)

You can read more case studies and examples at the Council of Official Visitors' website at http://coov.org/

Image description: An image of a hall in an institution, with the gravestone of Peta Susan Doig superimposed onto the image. There is a bunch of flowers in the foreground. The inscription reads 'Died 2013, aged 59 years' The text on the image reads, 'A lifetime in institutional 'care', they wouldn't take her to the hospital any more, forgotten, she died screaming.'

Name	Peta Doig
Location	WA
Date	2013
Type of abuse	Lifetime institutional neglect and abuse
Disability type	Autism and intellectual disability
Outcome	Death

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18. The Biography of Peta Doig

'Of every great and eminent character, part breaks forth into public view, and part lies hid in domestic privacy. Those qualities which have been exerted in any known and lasting performances may, at any distance of time, be traced and estimated; but silent excellencies are soon forgotten; and those minute peculiarities which discriminate every man from all others, if the are not recorded by those whom personal knowledge enabled to observe them, are irrecoverably lost. - [Johnson, "Life of Sir Thomas Browne," 1756]'

But what if that person never, or rarely, broke forth into public view?

Peta Doig had a biographer - a rare occurrence for a person with a disability. Even rarer for a woman who was institutionalised at an early age and hidden from the world - someone who never worked, married, had children. Someone who was surrounded only by paid staff and people who tried their best to change things and make life better for her, against insurmountable obstacles.

Those obstacles are a daily reality for people with disability and people with psychiatric conditions who fall between the cracks. There are men and women all over Western Australia who are unable to access funding, unable to live in the community and who 'just don't fit' - and often, the system is the problem.

Shut in a psychiatric hospital for most of her life, Peta was not regarded as a 'great and eminent character'. Her story remained untold, hidden in hospital and public records and in the memories of staff, until now.

Peta was young, healthy and autistic. She was 'sexually exploited' over more than fifty years in institutional care – injured, paralysed. Eventually, the dwindling circle of her regard grew ever smaller – her small family on the outside died. The few attempts to get her out of the mental health facility failed, and her world grew even smaller. Eventually, she stopped taking things out of bins, or eating other people's food. She was put in a bed, in a day room. Nobody could physically examine her – after a lifetime of abuse, she screamed when people came near. Eventually, the hospital declined her admissions.

Peta Doig had a biographer. There's only one problem. Her biographer was the WA Coroner.

She started screaming on Christmas Day, and although a doctor was called and some antibiotics administered, she was not admitted to hospital or given appropriate medical care. The mental health facility nursing notes talk about Peta lying with her head cradles in her hands, record her screaming, crying, tearing the bed linen. The medication did not have any effect, and she continued to scream and they continued to watch her.

She died at Graylands Hospital on the 3rd of January, ten days after she'd started screaming.

Peta's story is attached, and you can read an article about her life and death by Rick Morton in a 2015 article (from 'the Australian' newspaper) below.

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.

“Peta Doig had a biographer. There’s only one problem. Her biographer was the WA Coroner,” disability advocate Sam Connor says.

Peta couldn’t have had any way of knowing that she was just one of many. As the federal Senate inquiry into violence, abuse and neglect of people with disabilities moves across the country, the brutal scale of a previously hidden problem is beginning to emerge.

Not that anybody in the sector is surprised by the detail; they’ve been screaming about it for decades, cries absorbed by the vacuum of a sort of national apathy. It was a struggle to even establish the inquiry and it’s a struggle, too, to get people to listen to the often horrific details.

A 13-year-old girl raped on a school bus and given detention, a man with an unexplained mutilated penis, police asking the accused abusers of their spouses to interpret for them in interviews because they are deaf, a woman carted to a court appearance in the back of a ute because her wheelchair wouldn’t fit in any of the cars available.

The institutions referred to in the miasma of evidence given so far are not just those in which people with disability are living. The term refers to the way they are helped or hindered in interacting with the justice system, the police, service providers, schools and the community at large.

At every turn there is evidence these problems emerge not from people being vulnerable in the first place but because the systems on which they rely are making them vulnerable.

They are seen as “other”. A long-running segregation over generations has forced them into this otherness and politicians, the community and the sector are having a mighty time figuring out how to unpick that damage.

“Historically, we have had a -social and cultural response to isolate people with disability,” says disability researcher Sally Robinson.

“People were told that the best way to respond to people with disability was for them to be in separate schools, separate houses, separate facilities. We have had a move to inclusion for a very long time now but it’s been a very incomplete move.

“Probably some part of their memory is that people with disability were sent away or went away. That is still very much a part of our culture, they are still elsewhere. They are other. Part of our social response is that it is someone else’s problem, that it is the sector’s problem to resolve.

“While ever it is the problem of the disability sector to resolve it will be an endemic issue because we are not in DisabilityLand anymore.”

Robinson, a research fellow at Southern Cross University’s Centre for Children and Young People, says the system, though obviously fallible, is set up to respond to critical incidents — the most violent and criminal elements of abuse.

She tells the story of her own research in which she interviewed nine people with intellectual disabilities about their care. Between them they recorded 228 separate incidents of abuse.

Just two were successful in making a complaint.

“That is very illustrative of how hard it is for people to make complaints and how marginalised and disenfranchised they are in the system,” she says.

“It is set up to respond to abuse on a critical-incident, extreme-situation basis. It’s not set up to appreciate the fact that what happens most often is this drip, drip, drip of monotonous, subtle, poor treatment.

“It happens in children’s lives where they experience often bullying and worse abuses.

“One of the things children talked about was that it was really chronic and it happened often. It ranged from cruel teasing through to physical and sexual assaults.”

These accounts, while individually harrowing, cannot and do not give weight to the national problem. That data, however, does not exist. There is no national reporting scheme, nor even one in any jurisdiction, that comes close to painting a faithful picture.

The Australian Bureau of Statistics’ Personal Safety Survey, which records incidents of sexual assault, harassment and other violence, is the nearest thing to a complete dataset in Australia. It finds no “statistically significant” difference between the rate of violence against people with disability and others in the community.

However, it specifically excludes anyone living in an institutional or residential care setting, and does not include interviews with anyone who needs a support person or an interpreter. In other words, not only are the people made vulnerable by the system most likely to be the victims of such abuse but not even the largest survey in the nation is capable of hearing their story.

There is a National Disability Abuse and Neglect Hotline but the rich data it collects is kept under lock and key. It’s too personal, the Department of Social Services says. But even if identities were stripped and only the highest level of information were released — types of abuse by location and care setting — it would still be useful, advocates say.

What the sector knows it infers only from the international evidence: children with disability are 3.4 times more likely to experience abuse and violence than their peers; women with disability experience domestic violence 37.3 per cent more often than other women; and women with intellectual disabilities are somewhere between 50 and 90 per cent more likely to be raped or otherwise sexually abused.

A theme emerges in DisabilityLand: everything is in the shadows almost all of the time. Attempts to crack the door open and let in the light are viewed as complicated, expensive and disruptive to the status quo.

Jess Cadwallader, violence prevention advocacy project manager for People with Disability Australia, says a “perfect storm” of barricades has come together in the sector. There are few places for people with severe disabilities — such as Peta Doig — to live. Their services are often provided by the same people who provide the home. There is nowhere to complain about either the home or the services — at least not without the fear of losing it all.

For those living with acute disabilities, even the poorest accommodation is considered better than the alternative: homelessness. So abuse is tolerated and, shut away from the rest of the world, it becomes almost normal.

“People kind of assume that everyone knows what community standards are, but it’s the background of the culture we live in,” Cadwallader says.

“If you are living in a setting where that line is not drawn for you and you are not exposed to those community standards, then you may not recognise when you experience violence or abuse, or you may dismiss it as not mattering.”

There is hope, and fear, in what the vaunted National Disability Insurance Scheme will bring. On the one hand, the $22 billion scheme promises the elixir of choice and, with it, the dramatic rebalancing of power in a musty old sector which for decades has jealously kept control from the people it is meant to help.

The scheme gives money to people with disabilities to buy what they need from whoever they choose, subverting the old system year by year before it comes fully on line in 2019-20.

But there are fears it won’t be enough. Or that it is seen as the only thing governments need to achieve in order to fix, once and for all, the multiple maladies in the sector.

“The NDIS is a really big, national, noble effort to (change) and there are some really great opportunities in it for those things to happen, particularly for those people with good, strong networks of people around them,” Robinson says.

“I do worry for those people who aren’t well networked or connected in how the NDIS is going to safeguard them.”

Last month the federal government wrapped up consultation on a national “quality and safeguards” standard that will, once agreed, aim to protect staff and people with disabilities, and limit the use of restrictive practices in which -clients are sedated or physically restrained for treatment.

In the intervening period people with disabilities hope the anger at a well-hidden scourge will erupt in public view, forcing larger change at the federal level.

At the earliest stages of the Senate inquiry it is clear advocates and many in the sector want a national, statutory body that can investigate and resolve complaints at arm's length from the people who have previously overseen the complaints system.

Only then, they say, can the fear of speaking up be ameliorated. If housing and a genuine, dramatic shift in the market do not keep pace, even a watchdog such as that proposed can only change so much.

For people such as Peta Doig, the anger will come too late.

Earlier this year the WA State Coroner found she died of "natural causes" and "those caring for her appear to have managed her well".

Despite this the report made numerous references to the "inappropriate" nature of the places in which she was cared for.

"But the coroner's job was to find out why she died, not why she lived such an appalling life," Connor says.

In life, Doig was all but forgotten. The momentum forming behind the Senate inquiry builds towards one outcome: that it may never happen again.

Fifield waits for inquiry to report

Assistant Social Services Minister Mitch Fifield has resisted calls for a royal commission into disability abuse, neglect and violence. He says the Senate inquiry should do its work first before he looks at the evidence it produces.

"It is always extremely concerning to hear allegations of abuse or mistreatment of people with disability by those who are in the privileged position of providing them support. There has been some deeply disturbing testimony received by the Senate committee inquiry," he says.

"Some people with disability are more vulnerable to abuse, so we need a strong system to keep them safe.

"Until the full rollout of the NDIS is complete, the states and territories retain responsibility for disability services in their jurisdictions including complaints, regulation, quality assurance and law enforcement."

The inquiry chairwoman, Greens senator Rachel Siewert, says the government was dragged into the inquiry.

“Clearly, it would have been very stupid for the government to stand in the way, they saw the writing on the wall,” she says.

“People are paying attention, people are starting to be heard; the more we can get them to be heard, the more we can expose this and the broader community will get angry about this.

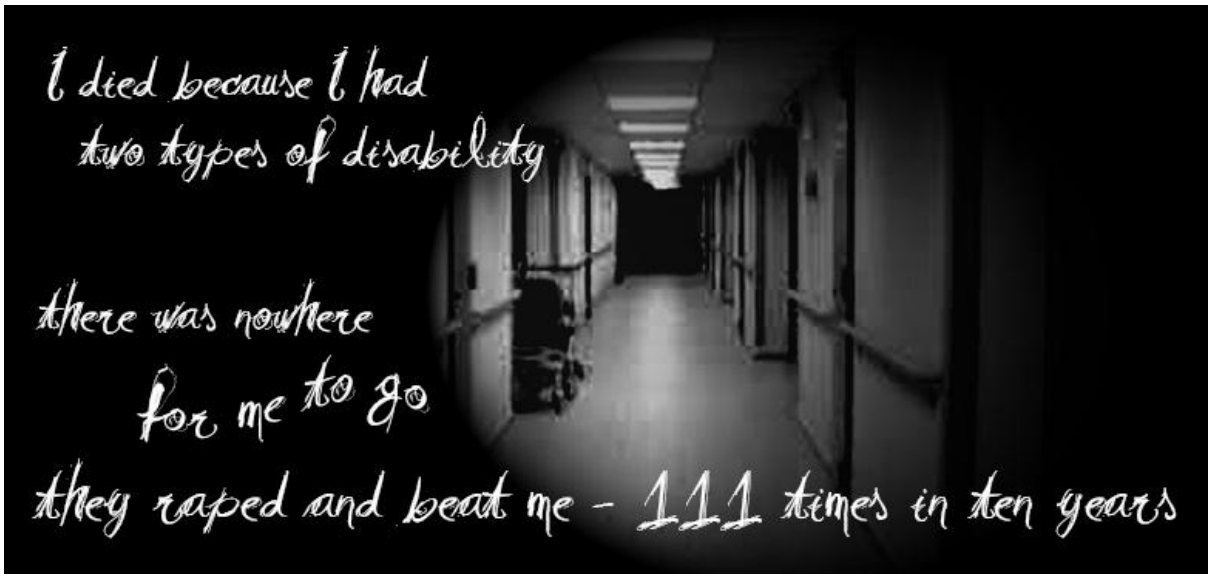

Image description: An image of a darkened hospital hallway with many doors. A wheelchair stands alone in the hallway. The text says, 'I died because I had two types of disability. There was nowhere for me to go. They raped and beat me – 111 times in ten years.'

Name	Amanda Gilbert
Location	WA
Date	2010
Type of abuse	Institutional neglect, systemic failure, abuse and passive neglect
Disability type	Mental health condition/ABI
Outcome	Death

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19. 111 Assaults

There was nowhere for Amanda to go after she tried to hang herself, because she acquired a brain injury as well as a psychiatric illness. Amanda was only young - and Graylands is where she stayed, from 1987. Shenton Park and other facilities 'couldn't accommodate her' - the report says that she was impulsive, labile, sometimes aggressive, provocative and interfering with other patients.

The Coroner's report talks about Alison's downhill spiral in institutional care. She had an unsteady gait, and started to fall, over and over. She was assaulted repeatedly. From the report -

'Alarmingly, the deceased suffered frequent and regular assaults from other patients. Most were minor in nature, but some were sufficiently serious to require treatment. There were at least 111 incidents of assaults on the deceased from March 1988 to July 1997. A large proportion of these incidents were provoked by the deceased intruding or interfering with other patients or their property. Many were also unprovoked, being the result of other patients' mental states. As time went on, the deceased also became aggressive to other patients and to staff. Staff regularly placed the deceased in seclusion as a means of settling her down.'

Graylands didn't want her either, so they tried to place her in a nursing home. She went through a gerentology assessment and was refused because they believed she was not disabled enough. Doctors wrote to the Minister for Health, arguing - she was still reasonably young and they thought a nursing home would provide better protection from assaults. The doctor said she needed a small, structured, intensive rehab program, but didn't know anyone in WA who would provide it. They applied to the Disability Services Commission, who told them that it was their responsibility - health, not disability. The cracks Alison fell between were more like a yawning chasm.

And in the meantime she fell, and fell, and they gave her more and more lithium to keep her quiet and calm. They stopped when they realised it was harming her, but her kidneys had begun to shut down. She stopped eating, and she fell, over and over. And eventually she died of renal failure from lithium toxicity.

'Unfortunately', they said.

Alison was 47 years old at the time of death. Her story is attached.

Image description: Two men hold down a man whilst another watches. The text says, 'After they raped me, I tried to hang myself. I told my mum and others I was going to do it again. But no one listened.'

Name	Chris Douglas, Fabian Long, Thomas Holmes, Laurence Santos, Jack Newman
Location	Risdon Prison Tasmania
Date	1999
Type of abuse	Various
Disability type	Various
Outcome	Deaths

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20. No Safe Place

They built a new mental health unit at Risdon jail, but that was only after community outrage that five disabled and mentally ill died within four months of each other at the maximum security penitentiary, which was combined with a hospital for violent prisoners who suffer acute mental illnesses.

If you commit a violent act in Australia, and you're mentally ill, it is a postcard lottery as to what happens to you, what treatment you receive. In WA, they are building Disability Justice Centres for people who can be 'indefinitely detained' under the Mentally Impaired Accused Act. In many states, people with disability and mental health conditions are detained together. Your treatment – and sometimes survival - depends on which state you are incarcerated in.

Chris, Fabian, Thomas, Jack and Laurence all died in Risdon within a few short months. Some died at their own hand – one man died after being administered high dosages of prescription medication. Chris, who was only seventeen when incarcerated, had been sexually assaulted in the past few days before taking his own life. He had an intellectual disability.

The Coroner's report says, '(there were) a number of ill defined yellow bruises on the buttock area. These are consistent with the buttocks having been forced apart. Subcutaneous tissues of the arms and legs were examined and have revealed further bruising, particularly on the inner aspect of the right thigh confirmed histologically. Rectum examined, bleeding was noted in the deep muscles of the rectum…this was a finding that would be consistent with some form of anal intercourse, or something being placed in the rectum, and there are definite bruises that look like fingertip marks on the buttocks and there is bruising on the inner aspect of the thigh. One mechanism which you could purport is that the legs had been forced apart, say by a knee, which would lead to this type of bruising.'

An article published shortly after outlines the circumstances of their deaths. The Coroner's report is attached.

Questions raised after five mentally-ill prisoners die in Australia

By Dragan Stankovich

21 August 2001 The five inmates died in late 1999, just months after Tasmania's Labor Party government rejected any review of the prison following a riot by 100 prisoners. Risdon is Tasmania's main jail, built in 1960, based on a stark open-air design from the American South. Simon Copper, a lawyer interviewed by Four Corners, described Risdon as "cages with yards" with "concrete steel floors washed away by repeated scrubbing so they are down to the stone". He concluded: "Just the whole environment was an appalling one... Just nothing about it is conducive to proper housing of people, and, I suppose, rehabilitation."

From the details unearthed by Four Corners, the five dead men were in prison because they were unable to obtain the psychiatric treatment they needed. Moreover, once inside Risdon, they were not only denied proper assessment and treatment, but were also placed in life-threatening environments.

At least two of the men were previously homeless, living on the streets of Hobart—Chris Douglas, 18, and Fabian Long, 21. Douglas was the first to die. Considered borderline intellectually disabled, he committed suicide after being sexually assaulted. He had been placed in a protection yard with paedophiles and sex offenders. A coroner's report noted that he was slightly built.

The day Douglas killed himself, he had asked to see a psychiatrist but none were available. When a guard discovered him hanging in his cell, it took five minutes to obtain a key to the cell door. Douglas may have died during that time.

That morning, Douglas had phoned his mother Vickie to tell her that he had already tried to kill himself once that day. He "tied his television cord around his neck and woke up on the floor shaking," Vickie Douglas told Four Corners. Asked why she hadn't reported this to prison officials, she replied: "Trying to tell the prison officials about anything is just hopeless."

The next to die was Thomas Holmes, 29, who suffered from paranoid schizophrenia and had been in and out of hospitals. He was arrested after burning down a hotel. His family did not apply for bail because they thought that he would be given the help he needed inside Risdon. The jail's clinical director, Dr Alan Jager, had examined Thomas and made notes of his delusional tendencies but did not mention the possibility of suicide.

A nurse had put Holmes on suicide watch but in the lowest category. The hospital staff had no idea of his previous history. He hanged himself with his shoelaces after

he had been in prison for less than a week. A previous coroner's report had warned about hanging points in cells and revealed that warders were not trained to deal with suicidal prisoners. But authorities took no action.

Carol Rue, a friend of Holmes, commented: "Here's a person who's schizophrenic, who's burnt a pub because he believes aliens are entering Earth through it, a highly delusional person who's there for psychiatric assessment, who's been diagnosed as a schizophrenic, who is left in a cell for two days with his shoelaces. I don't know whether anyone talked to him or made sure he was OK because no one has written any notes anywhere.

"We didn't know how big a failure that special institution was going to end up being. We would've been better off bringing him here and padlocking him in my bedroom and making sure he took his drugs."

Jack Newman, 57, was also found hanging in his cell. A former government scientist, he had been found insane by a jury in 1983 after he brutally murdered his wife. Detained indefinitely, there were clear signs that he became suicidal after losing all hope of release. The coroner criticised Dr Jager's handling of Newman as "not adequate", noting that he ignored a senior psychiatrist's diagnosis that Newman suffered a major depressive disorder.

Laurence Santos, 20, died suddenly in his prison bed after receiving high drug dosages. The young man had developed schizophrenia after a bike accident, which he blamed on aliens. His parents had asked the police to take him to hospital for psychiatric assessment and care. His illness was diagnosed and he was released a month later when his condition stabilised.

Santos stopped taking his medication, however, and went into the bush for 10 days without food or shelter, suffering delusions that his parents were trying to kill him and his dog. When he returned, he murdered his father with a butcher's knife and attempted to kill his mother. He was also detained indefinitely after being found not guilty on grounds of insanity.

In Risdon, he was given Clozapine, a drug that can have fatal side effects if given in high dosages and without close monitoring. Despite the known dangers of convulsions, the treatment began at 100mg a day and went rapidly to 900mg a day, the maximum recommended dosage. The coroner could not determine the precise reason for his death but pointed to the possibility of suffocation from sleeping face down or heart failure, both of which could be caused by the high dosage of Clozapine. "There was inadequate monitoring of the effects of the drug on Laurence Santos, in particular, the dangerously high blood Clozapine levels," she said.

Fabian Long was found dead with a piece of torn sheet around his neck. The precise cause of death was uncertain but he had been sexually abused. Diagnosed as suffering severe schizophrenia, with hallucinations, he had been jailed after stabbing several people in the street. In Risdon, he was re-diagnosed as suffering from a personality disorder and placed in the general prison population.

“Look at the system”

No Safe Place tended to focus on the jail’s clinical director, Dr Jager. He had been the only applicant for the post when it was advertised following Chris Douglas’ death. Jager had trained under Professor Paul Mullen, his referee, who is a leading authority in forensic psychiatry, but he had not fully qualified as a psychiatrist.

Dr Jager had only 15 months’ clinical experience, all of which was supervised. The job specifications required eight years’ experience, including treatment of chronic mental illnesses that can sometimes cause violent behaviour. Inadequately trained for the position, Dr Jager treated Laurence Santos in a way that the coroner considered dangerous.

In the case of Fabian Long, the coroner criticised Dr Jager for placing him in the general prison population, ignoring the diagnoses of four other psychiatrists, and being aware of the risks of sexual assault and suicide. The coroner recommended that the clinical director’s position be reviewed.

The five men who died had mental illnesses that required specialist care and decent facilities. As Professor Mullen told Four Corners: “I think it’s very easy to point a finger at one vulnerable doctor, and assume all of the difficulties that occur are due to him, when, it seems to me, you have got to look at the system.” Mullen described forensic psychiatry services in Tasmania as “unacceptable”.

There is just one secured medical facility able to handle people with mental illness who present a risk to themselves or others—a closed ward at Hobart’s Royal Derwent Hospital. Specialist units have been shut down, leaving only three major hospitals providing services for the mentally ill, and some small services at Royal Derwent.

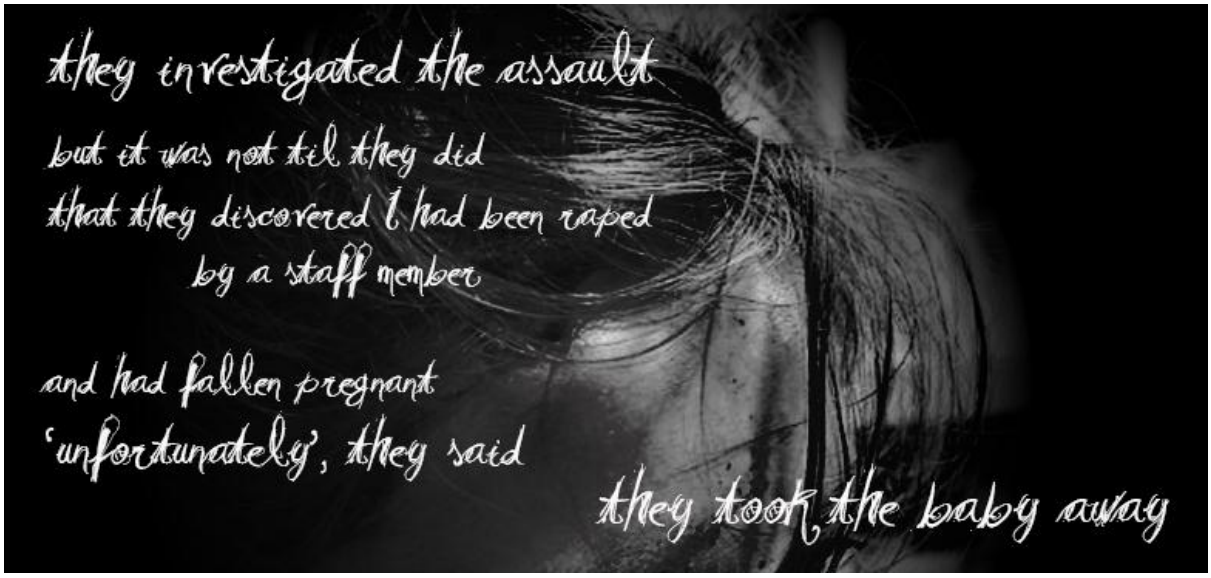
Over the past 15 years, both Labor and Liberal governments in Tasmania have savagely cut spending to social services—perhaps more than in any other Australian state. Mental health services were among those targetted. Throughout the 1980s and 1990s, the number of psychiatric beds was cut by 30 percent, without any adequate community facilities to replace them. Hundreds of mental health services staff lost their jobs. One result is that many mentally ill people have become homeless.

Once incarcerated, the treatment given to mentally-ill prisoners is in line with deliberately brutal conditions for all prisoners. After the 1999 Risdon riot, Tasmanian Attorney General Peter Patmore was asked why money was not spent to improve jail conditions. “I feel no sympathy for the prisoners of Risdon,” he replied.

The government has boasted of cutting costs in the jails. Tasmania’s prison population has doubled in recent years, but the Justice Department website declares that despite the increase, “cost efficiency has been substantially improved, staff numbers reduced and costs contained”.

The barbaric conditions inside Risdon only came to light because five men died in such a short time, giving rise to coroner’s reports and, eventually, to national television coverage on Four Corners. Since the publicity over the Risdon deaths, the government has moved Dr Jager to the University of Tasmania until his contract runs out.

It will not close Risdon prison, however. Instead, it has promised to spend $53 million over six years to develop the jail and provide a separate mental health facility. Even if this promise is kept, spending $9 million a year will do little to improve the prison’s conditions, and the underlying lack of mental health services in the community will remain.



Text description: A girl with a slashed and bloodied head. The text reads, 'They investigated the assault, but it was not until they did, that they discovered I had been raped by a staff member and had fallen pregnant – 'unfortunately', they said. They took the baby away.

Name	Various
Location	Queensland
Date	1968 to present
Type of abuse	Various
Disability type	Various
Outcome	Death, neglect, violence and abuse

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For the Senate inquiry, we have chosen a representative number of accounts which demonstrate violence, abuse and neglect against persons with disability in institutional settings.

21. The State of Inquiries

'Client 1 had been physically assaulted by an RCO in late 1986. That matter was reported and investigated, but it did not result in any action being taken against the RCO.

She was raped by a staff member and the child was taken away.

On the morning of Saturday, 22 August, 1992, Client 1 was reported to have sustained an injury to her head. A particularly ugly wound to the top of her head, the injury is shown as an open bloody gash running down the centre of her scalp from crown to hairline and was about one cm wide and five cms long...this horrible laceration had all the appearances and was consistent with her having been delivered a brutal blow to the head…it was during that investigation that the written evidence about her having fallen pregnant was revealed.'

And on and on it went, the abuse at Basil Stafford. Over and over.

If you investigate any institutional abuse and neglect in any state, it usually goes this way.

- A person with a disability is raped or abused or killed and there is enough evidence to ascertain that this has occurred.
- The police or justice system are unable or unwilling to act, for a variety of reasons.
- A parent of a child or adult with a disability manages to garner enough interest (usually via a sympathetic journalist, after much letter writing and pleading to Ministers) to get public attention.
- The relevant Minister is forced to respond.
- A review is announced.
- After some lengthy time, the review is conducted.
- Occasionally an institution is closed. Sometimes changes are made. Often, nothing really happens at all.

Client 1 remained just as raped, just as beaten, if you consider the 'reviews and inquiries' that were carried out over the next few years after the investigation about her and 122 others at Basil Stafford during the 1990s.

1995 - Report of an inquiry into allegations of official misconduct at the Basil Stafford Centre — Crime and Misconduct Commission Queensland

1999 - Forde Inquiry Report - Commission of Inquiry into Abuse of Children in Queensland Institutions

1999 - Response - Queensland Government response to the recommendations of the Commission of Inquiry into Abuse of Children in Queensland Institutions

2000 - The Basil Stafford Centre Inquiry Report: Review of the Implementation of the Recommendations

2001 - Final Progress report - Queensland Government response to recommendations of the Commission of Inquiry into Abuse of Children in Queensland Institutions

2003 - Queensland Government Submission to [federal] Senate Inquiry into Children in Institutional Care

2006 - Challenging Behaviour and Disability - a Targeted Response (Carter Report)

2007 - Investing in positive futures: The Queensland Government's response to a report by the Honourable WJ Carter QC, Challenging Behaviours and Disability — A Targeted Response

Client 1, who was at the time of the sexual assault 22 years of age, was 'profoundly disabled' with a 'mental age equivalent to an infant of five months'. She understood simple commands like 'come here'. She had physical disabilities as well as intellectual disability. In a letter to the centre a consultant gynaecologist noted that Client 1 was 'unfortunately pregnant'. In September 1990, her child – which was born with microcephaly – was taken away. But it was not until 1991 that the offender was jailed for carnal knowledge. The sentence was so short that the Attorney General had to appeal for an increase in his sentence of imprisonment.

Another offender was arrested about the same time, but the Crown Prosecutor decided not to proceed with the prosecution. The offender was an RCO and the victim was a resident – there was a constant 'raining of blows' on him and a fellow RCO intervened to stop him being hit. The 'intellectually handicapped person' is described as having a mentality of two years of age. He received a fractured jaw, but they decided not to proceed.

The Commission proved the change, but instead of returning to court, the RCO's charge was heard at a misconduct trial. He was fired.

Lenient sentencing seemed to be the order of the day when it came to residents of Basil Stafford. A third RCO had assaulted a 17 year old boy with a severe intellectual disability. He was trying to get the boy into bed when the young man

grabbed onto him. He lost his temper and punched him in the face, over and over…the boy required six stitches to the inside and outside of his mouth. His two front teeth were knocked out and another tooth was broken.

The RCO said he was under stress because of a custody battle, and his mother was ill. In 1991, he was convicted and ordered to carry out 150 hours of community service.

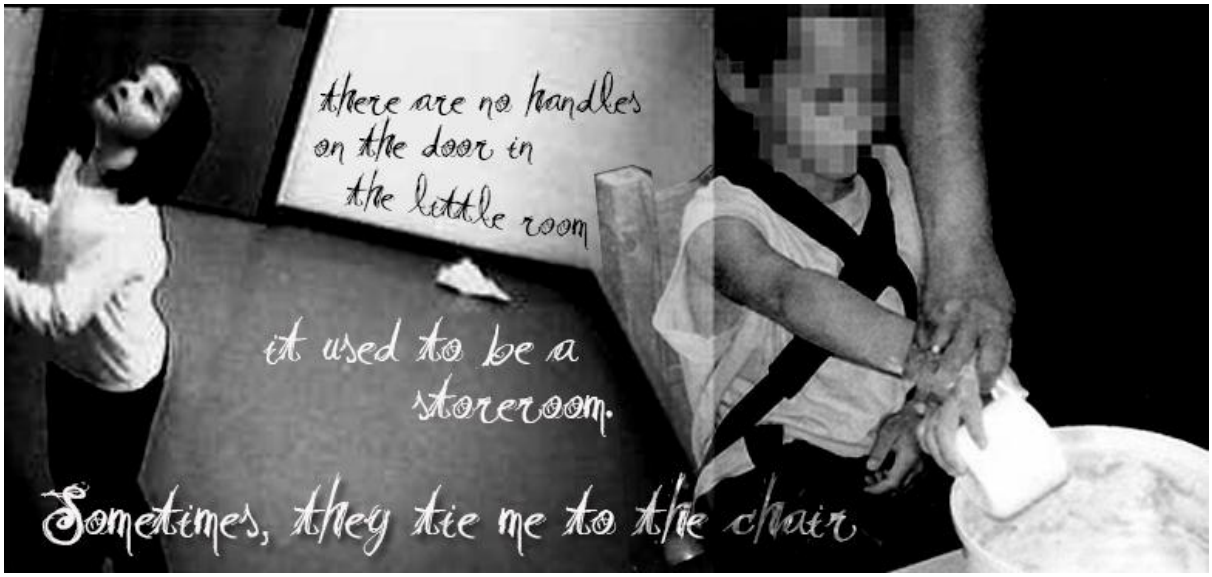
Yet another RCO, a woman, stood trial in the Magistrates Court in 1991, accused of four charges of aggravated assault against two intellectually and physically disabled female clients and one intellectually disabled male child. She was found not guilty of each count. During the course of the trial, the Magistrate remarked, 'Some interesting observations can be made of the witnesses…the two fellow RCOs who gave evidence for the prosecution in relation to two of the alleged assaults…they, if they are to be believed, were aware of an assault committed by a fellow workmate and chose to take no action or report same for the reason of fear of the defendant. One RCO not only did not report the incident to her superior but first lied to the police before later implicating the defendant…it is all very well to come to this court and say that in hindsight they should have reported the incident…I was not satisfied as to their explanation of fear as to why a report was not made. Fear coupled with whatever else may have been involved but I do not accept fear alone. I find I cannot place reliance upon the evidence of the two RCOs to satisfy me beyond a reasonable doubt.'

There were many, many complaints put before that inquiry, but only six were investigated. You can read the initial inquiry here.

http://www.ccc.qld.gov.au/research-and-publications/report-of-an-inquiry-into-allegations-of-official-misconduct-at-the-basil-stafford-centre

Basil Stafford remains open, and the complaints keep rolling in.

http://www.couriermail.com.au/news/queensland/troubled-teen-still-held/story-e6freoof-1111113078047



Text description: A girl looks up and is trying to get out of a room. A boy is superimposed on the image, strapped to a chair. A staff member is restraining his hands. The text reads, 'There are no handles on the door in the little room. It used to be a storeroom. Sometimes, they tie me to the chair.'

Name	Various
Location	Australia wide
Date	Past and present
Type of abuse	Restrictive practices, solitary confinement
Disability type	Various
Outcome	Violence, torture and abuse

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22. Time Out

Children with disability are routinely strapped to chairs and locked in time out rooms in schools across Australia.

The outdated practice is regarded as standard in most Australian schools, although in some states there are guidelines around the use of restraint rooms and other places used for confinement and punishment.

Often, the rooms are renamed. ‘Sensory’ rooms or ‘quiet’ rooms rather than ‘time out’ rooms. Parents are asked to agree to restraints being used on their children or children being isolated and segregated without access to a school curriculum.

Reported incidents include –

- Autistic children being repeatedly locked in a darkened room for misbehaving
- Teachers sitting on unruly students (Victoria)
- Court actions being launched separately against [redacted] School in [redacted] over restraint, seclusion and other issues.
- Staff leading children around on wrist straps, physically restraining students who won’t sit still and locking children in an -outdoor courtyard alone as punishment.
- [redacted] has photos of her [redacted] strapped to chairs at [redacted] Special Developmental School in Melbourne
- [redacted] says her son [redacted] was strapped to a chair and locked up at [redacted] Primary, in [redacted]
- [redacted] claims her son [redacted] was locked up at [redacted] School, in [redacted] and left 'screaming for help' at the age of nine
- In 2011, a five year old student was allegedly tied to a chair at [redacted] Primary School, [redacted] to punish him for misbehaving
- In 2015, a student in Canberra was locked in a two metre by two metre ‘cage’ in a classroom. It was labelled a ‘withdrawal space’.
- In 2015, six year old [redacted] received severe bruising at school – the hospital said it was ‘from a hand’. He also escaped from school on two occasions and was found wandering unsupervised, had panic attacks and nightmares and began to repeat the word ‘retard’, which his father said he could only have heard at school

- In 2015, video of a child with a disability being forced into a small room by an education assistant went viral. The staff member appeared to force the boy into the room with her foot in order to close the door, which she then locked
- Most parents of children in special schools report the widespread use of restraint and seclusion, some in specially designed 'padded cells'
- Some parents report that children are being locked in storage cupboards and small modified storerooms from which the handles have been removed on the inside of the doors

Perhaps the most alarming aspect of the routine confinement of children with disability is the response – in the case of the Autistic child who was caged, the Principal was suspended and an investigation was launched into how a primary school student was placed in the purpose built two by two metre structure made of metal pool fencing. The structure was built on March 10 to confine one student, and it was only after a formal process via the ACT Human Rights Commission, a formal complaint by the Children's and Young People's Commissioner on March 26, when the cage was removed. But there are no reports of police involvement or widespread inquiries into the routine restraint of children with disabilities in the education system.

The ACT Education Minister announced yet another inquiry. She made the announcement on World Autism Awareness Day. [1]

[1] http://www.theaustralian.com.au/news/violent-kids-in-cells/story-e6frg6n6-1226552745216

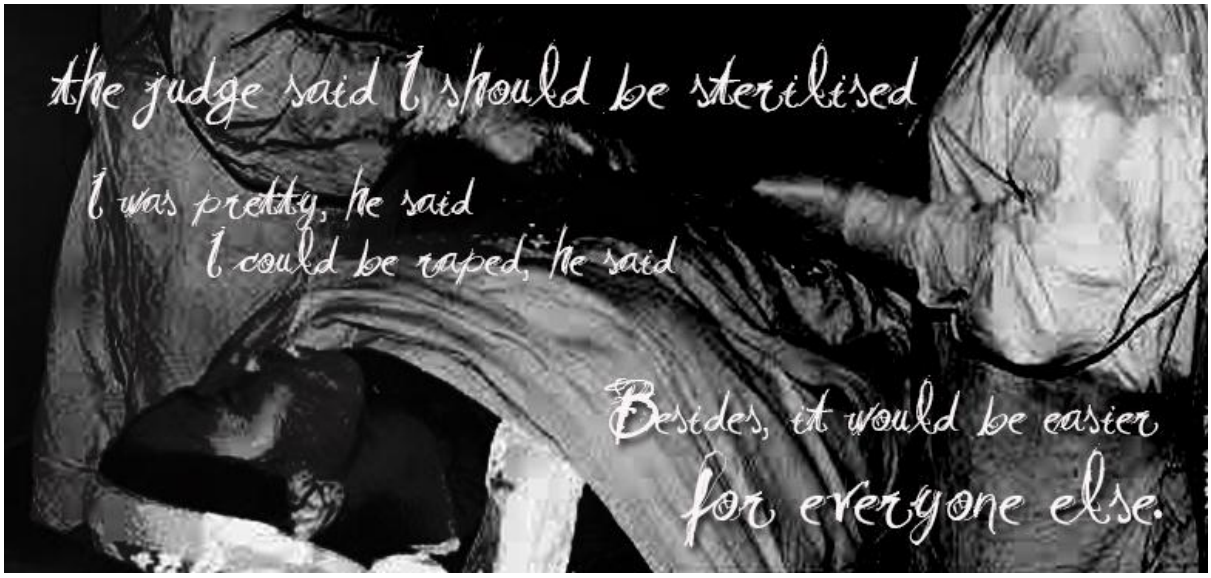

Image description: A surgeon is operating on a woman, below her waist. The woman is lying under a sheet. An assistant is helping. The text reads, 'The judge said I should be sterilised. I was pretty, he said. I could be raped, he said. Besides, it would be easier for everyone else.

Name	Various
Location	Australia wide
Date	Past and present
Type of abuse	Torture and abuse
Disability type	Various
Outcome	Violence, torture and abuse

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23. Inhumane and Degrading Treatment

The judge didn't mince his words.

"It is highly unlikely that Katie will ever have the capacity to understand and voluntarily enter into a sexual relationship..... It is however well documented that disabled children are particularly vulnerable to sexual abuse and Katie is quite an attractive girl."

That was the reason for Katie being sterilised at the age of sixteen, despite the UN unequivocally stating that involuntary sterilisation is a form of torture.

'Forced interventions [including involuntary sterilization], often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment,' says the UN Special Rapporteur on Torture

But in Australia, we routinely sterilise young women for no other reason than the presence of disability. Having a disability means that women, especially women with intellectual disability, are more likely to be raped and have unwanted pregnancies, and it is a costly business providing personal care to someone who menstruates on a monthly basis. Cost and convenience, couched in 'best interests'.

In another case, where the Court authorised the sterilisation of a 14 year old girl prior to the onset of menstruation, the judge said; *"it is unlikely she will have any form of relationship involving sexual intercourse. She could, of course, be the victim of a sexual assault and with her normal physical development and attractive looks that cannot be discounted."*

Sometimes the rationale for sterilisation is the consideration that a child's 'behaviour' may incite 'unwanted attention'.

"Ever since Elizabeth was a very young child, she was prone to run to men. If her mother takes her out she will go to any man, including strangers. On many occasions in public when the mother has not been holding Elizabeth tightly, she has run over to a man who is a complete stranger and taken his arm. She shows no fear and would happily go off with any man. She has to be physically restrained from chasing after men in public and throwing her arms around them."

But whose best interests are we addressing? When looking at the applications to Courts and Tribunals for sterilisation, it is clear that the best interests are far less likely to be about the girl or woman and more likely to be about the interests of others.

- *"The interests of Katie are inextricably linked with the ability of her parents to cope with the burdens of Katie's care."*
-
- *"The operation would certainly be a social improvement for Angela's mother which in itself must improve the quality of Angela's life."*
-
- *"Not only would S be unable to care appropriately for herself it would also be difficult for others to care for her as a result of menstruation."*

Women with Disabilities Australia have carried out a large body of work on this subject and the information above is from their report, "The Sterilisation of Women and Girls with Disabilities in Australia: Violating the Human Right to Health" (Frohmader, 2013)

Women with disability routinely express their deep sorrow about sterilisation and other violations of their reproductive rights, but it seems that in Australia, nobody is listening.

You can download the full report here
http://wwda.org.au/issues/sterilise/sterilise2011/

Image description: A man is in shadow behind chain link. A wheelchair is superimposed on the image. The text reads, 'All I want to do is hug my wife'.

Name	Mr M
Location	Detention in WA
Date	2015
Type of abuse	Solitary confinement, neglect
Disability type	Physical disability
Outcome	None

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24. All I Want To Do Is Hug My Wife

Mr M is being detained just down the road. Like me, he uses a wheelchair.

But his carer – his wife – is being held some distance away. He is unable to be with her, except for limited visiting periods. 'All I want to do is hug my wife,' he says.

A refugee advocate wrote this account.

"Mr M presents as a frail and pale middle-aged man much older than his chronological age. He is currently detained at XXXX IDC and uses a wheelchair. He is currently being held separately from his wife and caregiver.

I believe the detention of this man at XXXXX is highly inappropriate as the centre is not adequately equipped for a person that is disabled and he is at risk of a fall, and of inadequate nutrition.

1) He is detained without his wife in the single male section of XXXXX. His wife is his caregiver and he is reliant on her for his activities of daily function. It is my conclusion that he either requires a permanent and constant nurse's aid to assist with those functions or he needs to be moved to a facility where his wife can provide the necessary assistance.

2) Mr M has significant blisters and abrasions on his hands from his wheelchair. He complains of difficulty in pushing it uphill, and it is uphill to the mess hall. The hilly terrain and rough paving in some areas of XXXXX make his manoeuvring difficult. The ramps provided are very steep and he has problems getting up a number of them. Other asylum seekers at XXXXX confirm this. They also confirm that staff do not assist him in moving about the compound.

3) Meals: Mr M and his friends at XXXXX believe he is losing weight due to skipping meals, most notably lunch. He and his friends indicate it takes him about a half hour to get from his room to the meals area and often by then he is very tired and the food service is nearing completion, selection limited and food is cold. Because staff neither assist nor allow him to have any food brought back to his room he is now missing meals and suffering from lack of adequate food intake. This is not assisting in his recovery. It is suggested that his weight be monitored to see how significant an issue this might be. Being in an alternative facility or with his wife would assist in ensuring he was getting adequate nutrition. Again a full time carer would also alleviate this problem.

4) Toilet: The toilet is located outside his bedroom. This is due to him being considered a high risk detainee (self harm risk). Unfortunately as his wife previously assisted him with toileting he finds this difficult as well and reports falling on one occasion. Mr M says that there are no disabled supports or bars in the toilet and he must use it unassisted. He reports that he has fallen on one occasion getting back into his wheelchair. He reports there is no distress or emergency button in the toilet. It is unclear if the issues with toileting are impacting on his need to see a urologist. He says an appointment has been booked.

5) Showering. Mr M's wife assisted him previously with showering and bathing which he was in the habit of doing daily with her help. Mr M reports he sits on a chair to shower but finds it difficult to turn the water on or get it to the correct temperature. He reports there are no hand rails or distress buttons in the shower. He fears suffering a fall while getting in or out of the shower. Due to his fear and the lack of adequate disabled support he is limiting his showers to once/week. Mr M requires an aide to assist with showering as the risk of a fall is quite considerable in a wet location. This ought to be either a paid caregiver or his wife who is able to assist him. He also needs to be in a facility with the proper hand rails and equipment for a disabled person.

6) Bed. His wife previously assisted him in getting in and out of bed. Again he notes no hand rails or other devices to assist him getting in and out of his wheelchair.

7) Mr M reports that due to his difficulty in physically getting around the facility he also avoids going to the activities and thus misses out on both the benefit of the activity and the associated points. He feels this is discriminatory as he would attend if he had an assigned care giver or his wife to take him."

Mr M has been in detention as follows since he and his wife fled their home: 6 month in Christmas Island (after arriving via a people smuggler boat from Indonesia), 14 months in Nauru, three months in Darwin and now one month in Northam. This is the only place that separates him from his wife and carer. He is a Mechanic by profession and his wife an accountant. He is 34 but looks 50+.'

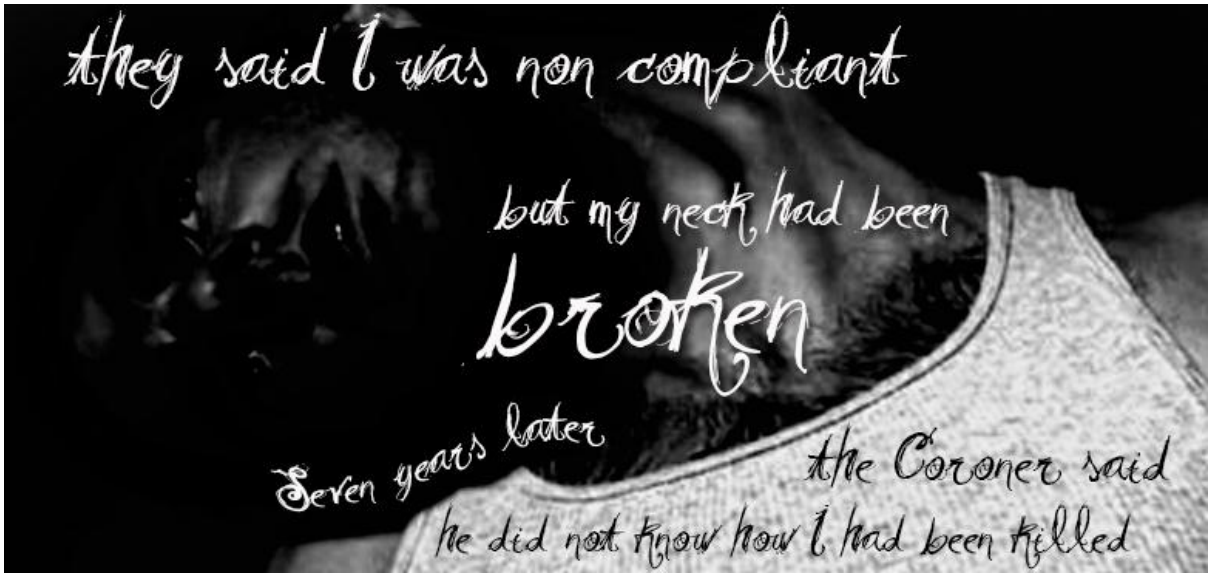

Image description: A shadowy image of a man whose neck has been broken…it is twisted to the side. The text reads, 'They said I was non-compliant, but my neck had been broken. Seven years later, the Coroner said 'he did not know how I had been killed'.

Name	Darren Kingma
Location	Victoria
Date	2007
Type of abuse	Neglect, systemic failure
Disability type	Coffin-Lowry Syndrome
Outcome	Death

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25. Non-Compliance

Darren was 29 when he died. He went off to respite and had a fall. Darren had an intellectual disability and a condition called Coffin Lowry Syndrome. He fell over and broke his neck - but nobody knew he broke his neck. For an hour - and Darren had broken his neck so sufficiently that he became a ventilator assisted quadriplegic - his support person tried to get him up off the floor, but Darren was being 'non-compliant'. Eventually she texted for help - to say Darren had 'cracked it'. And eventually, several hours later, somebody noticed.

Darren ended up in hospital and had an MRI three hours later, when he was diagnosed as having a broken neck.

They said you'd have to fall from three metres to fracture your neck at a C5/6 level, but they later agreed that Darren could have fallen from height, a sudden drop to the ground, a hit to his head as he dropped to the floor, or he could even have been assaulted. But no one ever investigated.

The support workers said that they didn't know much about the syndrome Darren suffered from. The woman who found him said that she moved Darren by sitting him up, dressing him, laying him down, sitting him back up again. And after the ambulance was called, she left the respite facility.

Darren couldn't tell him what was wrong, and neither could the second support worker, who was called in hours later. She couldn't answer questions about what position Darren was found in, what state the room was in, whether any furniture had been upturned or out of place, when Darren had been found, whether he was conscious and alert at the time, and whether there was any indication of injury. Counsel for Ambulance Victoria submitted later that firsthand information is crucial in their ability to make an accurate assessment.

That might have been while he was transferred to the wheelchair without head and neck support. The ambulance officer held his head because it was 'floppy'. She put her hand on his chest to support him and keep him from falling forwards. Nobody was supporting his head.

He sat in the ambulance in a ‘semi recumbent position’ throughout the journey to hospital, and his sister supported his head as they went around corners in the ambulance.

And five days later, his family made the decision to turn off the respirator. Darren died at two o'clock in the morning.

Nobody ever ascertained how Darren was injured…and, it seemed, nobody was able to investigate. The police were never called, and the inquest held by Coroner Hendtlass was carried out over a long period of time - between August 2008 to December 2010. Coroner Hendtlass retired on 31 December, 2013, without making an inquest finding in this investigation. The finding was handed down in March, 2014, seven years later.

Although the Coroner said that he was ‘unable to determine the timing and mechanism of the injury’, the first paragraph of the inquest summary announces that Darren died ‘in a fall’.

The Coroner does not make note of police involvement, nor the other inhabitants of the respite facility.

At the time of his death at the Austin Hospital, after suffering a spinal injury at the Phillip Street Respite Facility (run by the Department of Human Services), Darren was 29 years old.

Darren’s story is attached.

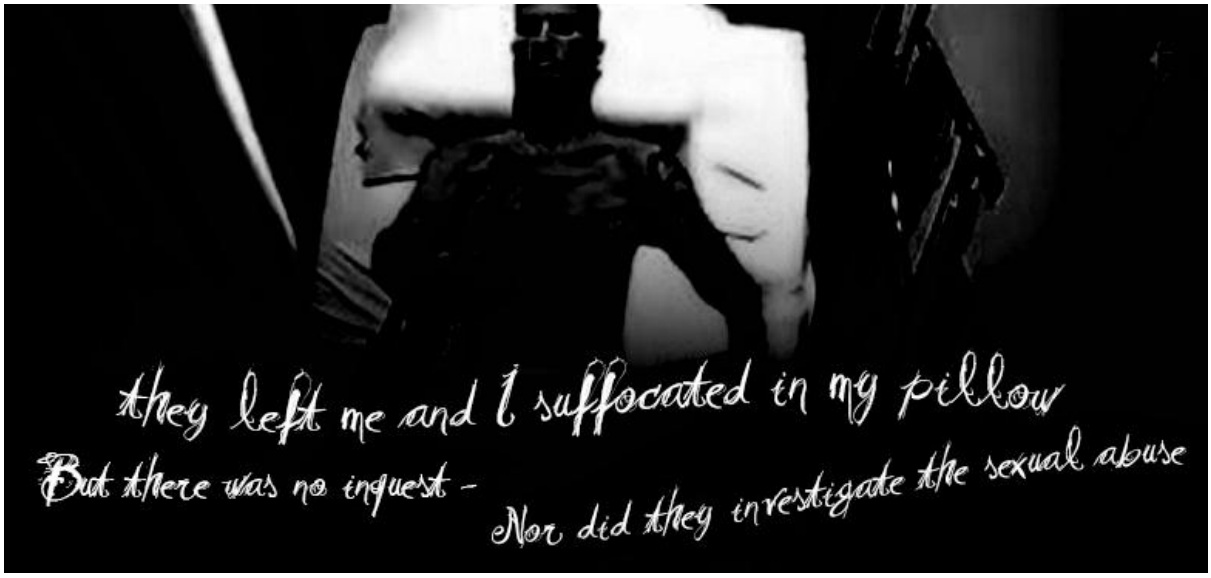

Image description: A shadowy image of a man whose neck has been broken…it is twisted to the side. The text reads, 'They said I was non-compliant, but my neck had been broken. Seven years later, the Coroner said 'he did not know how I had been killed'.

Name	[redacted]
Location	Tasmania
Date	2009
Type of abuse	Neglect, Sexual Abuse
Disability type	Quadriplegia
Outcome	Death

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26. Suffocation

[redacted] suffocated to death in a bed at the [redacted] Centre.

In 1998, [redacted] was injured in a motor vehicle accident. He received a brain injury that rendered him a quadriplegic, but could communicate by means of moving his eyes. [redacted] needed round the clock care, and it appears that this is where it all went wrong.

The Coroner decided not to hold an inquest. He notes that he saw 'no need to further investigate a complaint of sexual misconduct made by [redacted] against a different staff member a few weeks before [redacted] death'. He was satisfied that there was no relationship between [redacted] death and the allegation, and there is no evidence that the sexual misconduct case was ever investigated.

They didn't check [redacted] He was given a suppository and positioned, and at some point he rolled, with his face buried in the pillow or bed. He suffocated and was found some time later.

When [redacted] died, his complaint died with him. He was twenty nine years old.

The record of the investigation – dated 2012, three years after [redacted] death - is attached.

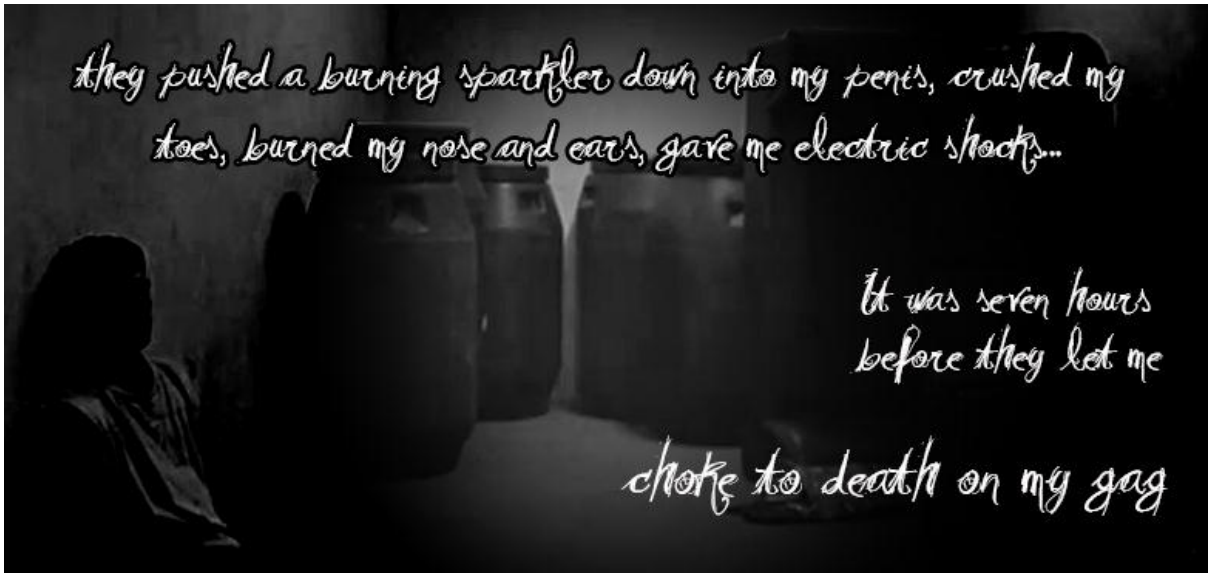

Image description: An image of a man slumped against a wall, with plastic barrels in the background. The words say, 'they pushed a burning sparkler down into my penis, crushed my toes, burned my nose and ears, gave me electric shocks…it was seven hours before they let me choke to death on my gag.'

Name	Ray Davies, Thomas Trevilyan, Gary O'Dwyer, Frederick Brooks
Location	Snowtown, South Australia
Date	1992 - 1999
Type of abuse	Murder, Torture
Disability type	Intellectual disability, schizophrenia
Outcome	Death

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27. A Culture of Hate

In Australia, we don't talk about hate crime. We don't even have words for it.

That's not the case in other countries, where hate crime is recognised for what it is.

'It is not just that these crimes appear more horrific because the victims are disabled. But rather the abuse is often more horrific because the victim is disabled. Research shows that disabled people are more likely to experience 'particularly sadistic' treatment: sustained attacks that involve dehumanising humiliation, torture, and degradation," writes journalist Frances Ryan in a powerful opinion piece for The Guardian.

Are there cases of hate crime in the many cases of interpersonal violence in Australia today? Absolutely there are. One of the clearest cases of hate crime – which has never been painted as such – was the series of homicides committed by John Bunting, Robert Wagner and James Vlassakis between August 1992 and May 1999 in South Australia. The victims were targeted because they were alleged to be 'paedophiles, homosexuals, or 'weak''. And in the case of the Snowtown murders, 'weak' equated to 'disabled'.

Ray Davies, one of the first victims, was an intellectually disabled man. He was garrotted with a piece of rope and a tyre lever after being placed in a bath, attacked with clubs, repeatedly beaten about his genitals and having a toe crushed with a pair of pliers. He was murdered by the group and never reported missing.

Thomas Trevilyan had schizophrenia, would wear only army style clothing and who would at times run outside his house with a knife if he heard unfamiliar noises and who was known to regularly travel long distances on foot. His murderers described him as a 'risk' because he 'went mental' and so they forced him to stand on a box and fastened a noose around his neck, kicking out the box from under him. His death was initially treated as a suicide.

Frederick Brooks, 17, was another young man with an intellectual disability. He received electric shocks to his penis and testicles, and had a burning sparkler pushed down into his penis; after his toes were crushed and his nose and ears burned with cigarettes, he was allowed to choke to death on his gag.

29 year old Gary O'Dwyer, an intellectually disabled man with an ABI who lived alone. He was seen as an easy target after the killers asked if he had any family, and his body was found with burn marks which were inflicted using a variac machine to apply electric shocks.

Tellingly, one of the victims (Frederick Brooks), was the son of one of the perpetrators, Jodie Elliot. Bunting, the ringleader, called her the 'village idiot' (Jodie has a learning disability and was in a relationship with Bunting) and murdered her son after she was admitted to an Adelaide psychiatric ward suffering a nervous breakdown. Family ties were no barrier to punishing people for being different.

Of the 12 Snowtown victims, four had a disability or mental health condition.

What was the reaction of the Australian public? O'Dwyer's sister says that she and her family were targeted for being 'the sister of a paedophile', an allegation levelled against the victim by the killers. The commentary of others made no distinction between victim and perpetrator. *'Both the victims and those accused of murder are too tragic by half. Many are of low intelligence, have lived under the painful shadow of rape and sexual abuse, sharing houses with the mentally ill, living off invalid pensions and unemployment benefits in homes so putrid their neighbours never dared set foot inside'* (Stevenson & Gelastopoulous, 1999). Close to two thirds of the articles about Snowtown described the victims in sensational and emotive language that emphasised their socioeconomic disadvantage and marginal status. Collectively, they were described as: '[d]ispossessed' 'fringe dwellers' (Scott, 1999); 'misfits and drifters' (Penhall, 2004); 'life's losers … intellectually disabled or obese or paedophiles or … a transvestite' (Smith, 2002); people who lived in suburbs of 'creepy incestuousness' with lives of 'sickening squalor and stench' (Smith, 2002) and certainly not the kind of 'battlers' that Australians take 'to their hearts' (Smith, 1999). All eleven victims attracted negative media descriptions from media. Ray Davies, for example, was described as, 'Ray Davies: '*a mentally handicapped homosexual who,*

according to neighbours, masturbated in open view of them and committed acts of bestiality' (Smith, 1999)[1]

"Whether it is for the headline murders of people like Lee Irving or the hidden, daily assaults and verbal abuse of others, our repulsion should not stop at the individual perpetrators – but go all the way to the culture that portrays disabled people as liars or leeches," writes the Guardian.

"When a group is routinely dehumanised in this way, it is only a matter of time before their lives are seen to mean less."

There has been much controversy in Australia about how the concept of hate crime should be legally defined. To date, Australian jurisdictions have introduced far less hate crime legislation than the United States or the United Kingdom, nor do we carry out disability awareness raising campaigns. Articles 8, 15 and 16 of the United Nations Convention on the Rights of Persons with Disabilities clearly outlines our responsibilities under international law.

Snowtown is an extreme example, but an illustrative one. People with disability are painted as being 'less than' in Australian culture, and our lives are consequently regarded as less, and 'other'. [2]

Ray, Thomas, Frederick and Gary are amongst those who suffered the consequences.

[1] Hate Crime as a Moral Category: Lessons From the Snowtown Case - Gail Mason, 2009
[2] https://172430notohatecrime.wordpress.com/projects/hate-crime-awareness-week/

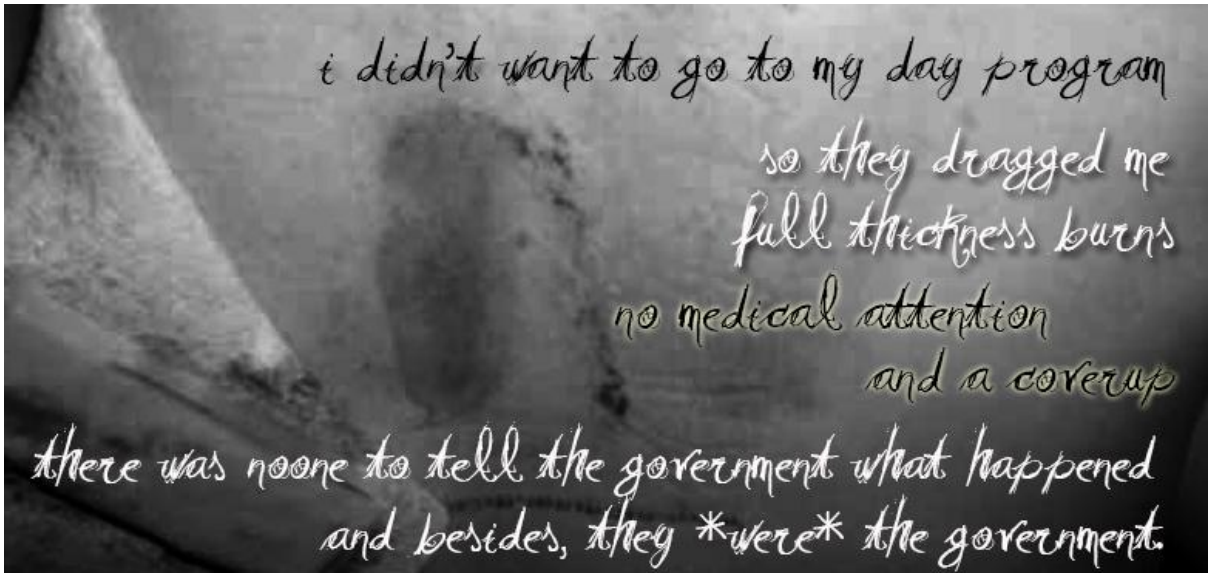

*Image description: An image of a full thickness burn on a man's back. The text reads, 'I didn't want to go to my day program, so they dragged me. Full thickness burns, no medical attention, and a coverup. There was no one to tell the government what happened, and besides, they *were* the government.'*

Name	Name redacted
Location	Victoria
Date	2008
Type of abuse	Physical abuse
Disability type	Intellectual disability, epilepsy, physical disability
Outcome	Full thickness second degree burns

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28. Dragged

'Mark' was 39 years old, and doesn't use spoken language. Mark has an intellectual disability, epilepsy and a physical disability. He uses gestures and body language to tell others when he is hot or cold, happy or sad. He can't advocate for himself and his parents are both deceased. In 2008, Mark was not in contact with any other members of his family.

There was nobody to notice when Mark got hurt. He didn't get hurt accidentally – two staff members dragged him along a carpeted hallway in the group home (CRU) where he was living. They dragged him out of the unit to force him onto a bus to take him to his scheduled day placement.

Mark's injuries were severe – he suffered a second degree carpet burn to the upper middle of his back, which required ongoing treatment. He still has a scar today. After dragging him along the floor, the staff member took him to his day placement without taking him to receive medical treatment. She showed the injury to day placement staff and advised them that she had dragged him along the unit floor.

A clearcut case of abuse, where a perpetrator or perpetrators should have been identified and fired, with compensation paid to the victim and an ongoing police investigation initiated immediately. That is not what happened.

Within days of the injury occurring, a number of incident reports had been received by management within the department and a staff member at the unit had contacted management to express concerns about the resident's injury. Their response? They conducted an 'informal information gathering process' and did not take any disciplinary action in relation to the abusers. At interview, the Acting Area Manager who was employed at the time of the 'information gathering process' informed the Ombudsman that the department did not conduct a 'preliminary assessment' to determine if an investigation was required because of concerns involving the department's employee union. She also advised that when she left her role (in May 2008) the department 'had established that he [the resident] was dragged'. The Ombudsman established that there had been a coverup by the Department and that the Department showed a 'disregard for the resident's human rights

and the duty of care that the department has to exercise'. It was considered that the assault on the resident was clearly a category one incident, requiring the police and family of the victim to be notified. However, it was incorrectly classified and a number of department staff reviewed the report without rectifying the error.

A Community Visitor was told by a casual staff member that the resident's injury was self-inflicted. And the Ombudsman found that the then Acting Disability Accommodation Services (DAS) Manager covered up the incident and failed to provide truthful and timely responses to the Community Visitor about the resident's injury. Specifically she:
• failed to disclose that the department was aware staff had dragged the resident, causing his injury
• sought to emphasise 'non-compliant' behaviours displayed by the resident, implying the injury was self-inflicted
• stated that the department had investigated the matter when it had not
• said that she would investigate the false information provided to the Community Visitors by the casual unit staff member when she did not. She then fabricated a preliminary assessment report, and admitted signing and backdating the report.

The Ombudsman made recommendations to change the system and 'consider taking disciplinary action' against the staff involved in the assault and the managers who failed to ensure 'the incident' was appropriately responded to.

Disciplinary action and changes in policy. But no assault charges and in the absence of legislation that imposes sanctions against those responsible for breaches of care of people with disability, no accountability. In 2011, three years after the assault, it was reported that DHS still employs the two staff and one of them still continued to work directly with the victim.

The Ombudsman's report is attached.

Image description: An image of a crashed Piper Warrior aircraft. The superimposed text reads, 'They wouldn't let me go home, I ran away, and they forgot me, until I flew to God.'

Name	Bryan G
Location	Darwin
Date	2000
Type of abuse	Systemic neglect
Disability type	Schizophrenia
Outcome	Death

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29. Fly to God

There are literally dozens of suicides which are attributed to failure of the system to care for people with psychosocial disability, but few have as many suicides attached to them as the Cowry Ward.

The names are catalogued in the Northern Territory's Coroner's findings – Vincent, Claridge, Guarini, Higgins, Littlewood.

The Coroner tells of failures in the system and failures where systems intersect. But few people were failed like Bryan G was failed.

No secret that Bryan was mentally ill. Born in Perth, he spent most of his early life in psychiatric care. He could escape from any locked ward – Bryan was a talented lock picker – and refused medication. People knew to take extra care with him.

The notorious Cowry Ward was probably the worst place in the world for him. But when Graylands Hospital in Perth was contacted – it was recognised that Bryan would benefit from being closer to family – they didn't want him back.

This time, Bryan was yet again an involuntary patient. It wasn't entirely unexpected that Bryan should escape from the Ward. What was unexpected was the failure of anyone to look for him and retrieve him. Bryan left mid 2000, and nobody was sent to search. His order lapsed in September, which did not trigger anything to the Mental Health Review Board. The Coroner is damning about the systemic failures in his treatment and care.

So where was Bryan?

Bryan, who had long since expressed a desire to 'fly to God' was living out his obsession with accessing a plane. By December, nobody had found Bryan, because nobody looked.

And in December, Bryan flew to God.

Bryan's story is attached.

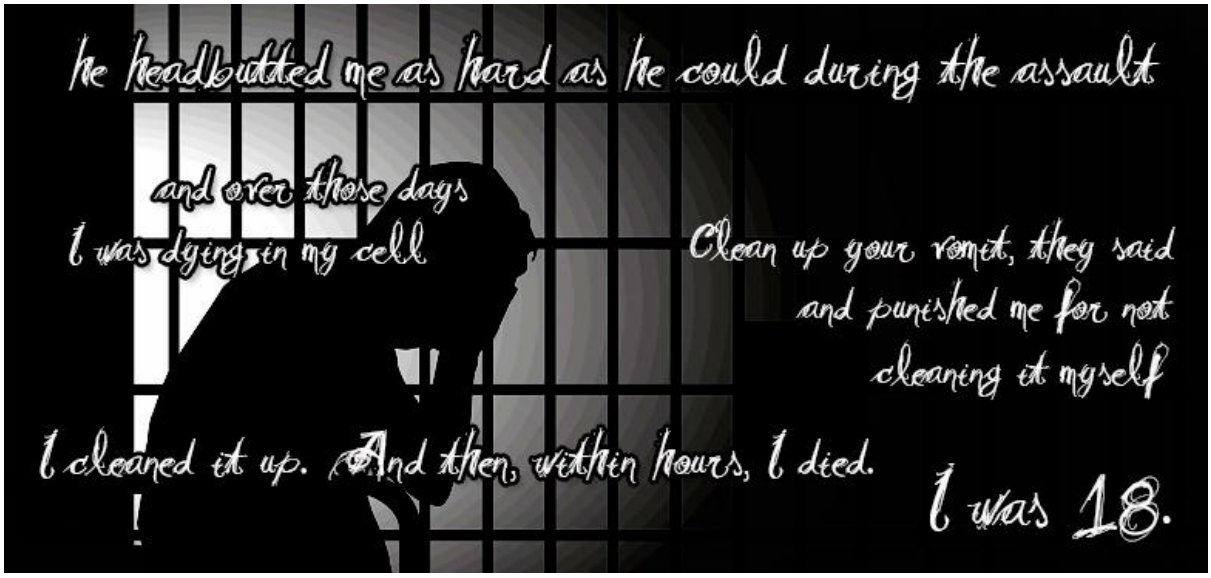

Image description: An image of a crashed Piper Warrior aircraft. The superimposed text reads, 'They wouldn't let me go home, I ran away, and they forgot me, until I flew to God.'

Name	Craig Sullivan
Location	Tasmania
Date	2010
Type of abuse	Systemic neglect and abuse
Disability type	Intellectual disability
Outcome	Death

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30. Clean Up Your Vomit

The youth detention centre's psychological reporting suggested that 'as a 13 year old he functioned at an extremely low level intellectually, with verbal and nonverbal reasoning, memory and processing of visual material'. Craig came from 'that type of family', too - his brothers had all spent time in the youth remand centre, and his family was known to police. Craig had a lengthy record, over 22 pages - he was first incarcerated at the age of 12. He spent most of his teenage years at the remand centre and was at the bottom of the residents' pecking order. Craig was subjected to intimidation and abuse at the hands of others at the remand centre.

Craig was charged with a driving offence just before his eighteenth birthday, and although he turned eighteen a few days later, he went back to the youth detention centre. A few days later, he was assaulted by another resident, and despite the fact that he was very ill over the weekend, Craig was not referred for medical treatment. He died in custody a few days later.

All that sounds fairly unremarkable, the failures of a stressed system who overlooked the needs of a detainee. But when you read the report you can read between the lines. Craig, who hated being away from his mother, had complained of a severe headache after the Friday assault, and leaned over and suddenly vomited from his bed at 8am on Sunday morning. An employee cleaned it up, but Craig did not eat breakfast, nor lunch. He came out for a drink of cordial, but that was it.

On Monday he complained again of a headache, but was not believed. The rest is a litany of disaster - the file note that reads 'Down in the dumps again today. Well behaved mostly but needs to remember he is 18 not a little boy.' - the other residents' comments about his gradual decline and his comments that he 'felt like he was dying'. A punishment for not cleaning his vomit up over the next weekend - it was left in the room - and removal of incentives like watching television were inflicted upon the very sick Craig. After two days, he cleaned up the vomit - about ten hours before he died from the rupture of a large brain abscess.

The Coroner's reports are filled with 'deaths in care' or 'deaths in custody', and all of these stories have patterns of disadvantage and vulnerability associated with the deaths, which are not painted as 'institutional deaths'. There are rarely any recommendations made around disability, and rarely does the Coroner note that the person with disability may be exceptionally vulnerable.

Craig's name was Craig Sullivan, and he died at the Ashley Youth Detention Centre on the 25 October 2010 in Tasmania.

The Coroner’s findings for Craig’s death is attached.