NSW Ombudsman

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Ombudsman's press statement

Report on Reviewable Deaths in 2005 Volume 1: people with disabilities in care

This morning I tabled my report on reviewable disability deaths. This report focuses on the deaths in 2005 of 67 people with disabilities who lived in residential care provided by disability services or licensed boarding houses. Of the 67 people who died:

- 26 lived in accommodation provided by the Department of Ageing, Disability and Home Care, known as DADHC;
- 28 people lived in accommodation provided by non-government services funded by DADHC; and
- 13 people lived in licensed boarding houses.

Many of the people with disabilities whose deaths we review are highly vulnerable. In the main, they are heavily dependent on accommodation and support services to meet their day-to-day needs and to link them with activities and services that many of us take for granted, including health care, and access to the community.

Our reviews this year have highlighted a number of areas for improvement in the delivery of services to people with disabilities in care. These areas include the need for:

- Better identification and management of risks facing individuals in care, including risks associated with swallowing and nutrition;
- Improved planning by services to meet the needs of individuals, including needs related to serious health issues;
- More effective responses to critical incidents, including the provision of first aid; and
- The maintenance of accurate and up-to-date records to indicate how services support the people in their care.

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Our reviews also highlight the importance that the NSW health system plays in the lives of people with disabilities in care. Many of the people whose deaths we review have multiple and complex health needs that require ongoing support, treatment and review, and more than half of the people who died in 2005 had at least one hospital admission in the 12 months before they died. Our work has raised questions about how well the health system is responding to the needs of people with disabilities in care.

Some of our reviews identified concerns about:

- How effectively hospitals planned for the discharge of people with disabilities from their care. A number of people were readmitted to hospital either the same day they were discharged or the day following discharge, sometimes on more than one occasion.

- End-of-life decision-making for people with disabilities admitted to hospital. We reviewed cases where there were no reasons documented to explain why a decision had been made not to resuscitate the person with a disability, and where the perceived 'quality of life' of the person played a role in decisions to limit treatment.

Significant consultations across NSW with services and people involved in the care of those with disabilities have raised concerns about access to some health services, and about the quality of those health services, including hospitals, therapy, mental health and dental services.

People we spoke with told us about physical barriers that reportedly make it difficult or impossible for people with physical disabilities to access examination tables and screening equipment. We were told that the barriers also include long waiting lists for public services, the high cost of private services, and some lack of clarity about whether NSW Health or DADHC has responsibility for providing therapy and mental health services to people with disabilities in care.

Many of the issues we have highlighted in this report are not new. Indeed, most have been the subject of recommendations in our previous two reports.

We are pleased to note the development of agency initiatives and departmental policies that have the potential to improve the adequacy and quality of services for people with disabilities in care. This includes the whole-of-government 10-year plan for the direction of disability services, and the joint work currently underway by DADHC and NSW Health to develop a Service Framework for the Health Care of People with an Intellectual Disability.

While these developments are positive, they are still in the initial stages, and will need to be properly put in place and evaluated. The issues identified in this report emphasise the need for significant and sustained work to be done to ensure that people with disabilities in care receive a fair go and obtain the range of health care and support services that they need, when they need them.

We have made 28 recommendations this year to DADHC and NSW Health. We will closely monitor the progress of both agencies towards meeting our recommendations and working together to improve services for people with disabilities in care.

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