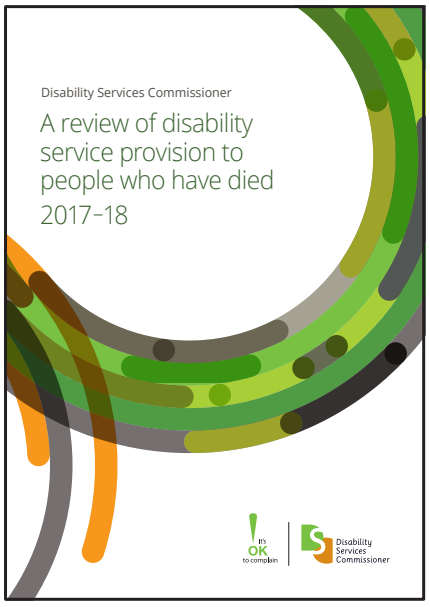
Disability Services Commissioner

It's OK to complain

Plain English

A review of disability services to people who have died in 2017 - 2018

This is a Plain English report of a longer report.
The long report is called A review of service provision to people who have died 2017-2018.



This report is about the work done by the Disability Services Commissioner. It is about disability services given to people who died in Victoria in 2017 and 2018.

In the report, we will tell you:

- why we had to do the report
- how we went about finding out about the people – this is called the investigation
- what we learnt about why people died
- what we think needs to happen now.

Why we had to do the report

In 2015, the Victorian Parliament did an Inquiry into abuse in disability services.

The people at the Inquiry talked about people dying while living in disability accommodation.

They found out that:

- some people may have died because of abuse or neglect in disability services
- no one was looking at why people had died.

Because of this Inquiry, the Minister asked the Disability Services Commissioner to:

- investigate the services that had been given to the person who died
- make a report and suggest where disability services could improve.

The Minister asked the Department of Health and Human Services (DHHS) and the State Coroner (the Coroner) to help us. They gave us information about people who have died and the name of the disability service.

Our investigation process

DHHS told us about people who had died who were receiving disability services. DHHS told us the name of the disability service. They told us if they thought the death was expected (the person had been sick for a while) or unexpected. The Coroner told us about people who had died that have been reported to the Coroner's office . A Coroner decides why people die.

In 2017-18, we were told about 88 people who had died while receiving disability services. Nearly half of the people were seen by the Coroner.

The next step was to ask disability service providers:

- questions about the person who had died
- to give us information and documents about the person.

The information included:

- support plans
- health assessments
- staff notes and rosters
- incident reports.

We reviewed their answers and documents. We made decisions about what to do next.

- Sometimes we took action straight away to make sure other people with disability were safe.
- Sometimes we told Victoria Police.
- Sometimes we ended the investigation because we thought the service was doing the right things.
- Sometimes we continued to investigate. We visited the disability service to do an inspection. We interviewed staff members, family and friends of the person who died.

After the investigation, we wrote a report about what we found.
We gave the report to:

- The disability service provider
- DHHS
- the Minister
- the Coroner, if they had been involved.

We are still doing investigations now. We use the same steps for all of our investigations.

What did we find

In 2017-18, we completed 20 investigations.

Sometimes the service provider needed to take action and improve their service straight away. This is called a Notice to Take Action. There are special rules when a service has a Notice to Take Action.

We gave eight Notices to Take Action to make changes in the way services do things.

Sometimes we saw that changes should be made across all disability services in Victoria. We asked DHHS and Disability services to make these changes, so that services can be safer for everyone.

About the people who died

Most of the people who died were living in disability accommodation when they died.

We learnt that Victorians with disability died almost 29 years younger than other Australians. People who had severe or profound levels of intellectual disability died four years younger than those with a mild or moderate level of intellectual disability.

Most of the people who died had multiple complex physical and mental health conditions. Most people had around four different health conditions to manage.

Problems that we found

We looked at the information for the 88 people who died. Some problems happened for lots of the people.

Communication. Some people who needed communication plans did not have them. This meant they couldn't let people know if they were not feeling well.

Meal Times. Some people died from choking on food. Some people died because of aspiration pneumonia. This is an infection that is caused when food, drink, saliva or vomit goes into the lungs. Aspiration pneumonia is more likely to happen when someone isn't supported to eat and drink safely.

We found that some disability services did not always provide good support to people during mealtimes. They did not follow advice and guidelines even though speech pathologists had told staff that these people needed special support.

Heart disease. The number of people who died of heart disease was almost equal to the number of people who died from lung diseases. Most people had an intellectual disability and half of them had not seen a cardiologist or dietician in the previous 12 months.

Safe and well. Some service providers hadn't done everything they should have been doing to make sure that people with disabilities were safe and well.

Following rules. Some service providers hadn't followed the law or human rights guidelines.

Keeping notes. Some service providers hadn't been keeping good notes and records about how to support people with disability.

What happens now

We are making disability services safer for everyone.

We told some service providers to do things like:

- look carefully at all their notes and records and make sure they are up-to-date
- look at the rules around providing support during meal times
- look carefully at health plans and ensure they are up-to-date
- provide training and education to all their staff.

We told all Victorian disability service providers about things they need to improve in their services.

We will keep investigating how disability services have been provided to people who have died until June 2019. We will share what we find and how services can improve.

After June 2019 any deaths that occur in disability services will be reported to the NDIS Quality and Safeguards Commission.

Disability Services Commissioner

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April 2018