Disability Services Commissioner

MEDIA RELEASE

Thursday 20 December

Poor disability support practices highlighted in review of deaths of people with disabilities in Victoria

A Victorian review of disability service provision to people receiving these services at the time of their deaths has revealed significant failures by some providers to meet their obligations under the *Disability Act 2006* (the Act).

The report on the findings of the inaugural review conducted by the Disability Services Commissioner (DSC) – *A review of disability service provision to people who have died 2017-18* – was tabled in Victorian Parliament yesterday, Wednesday 19 December.

It has found evidence of poor practices by some disability service providers and the need for action at both state and national levels.

With assistance from the Coroners Court of Victoria, DSC obtained information about the cause or preliminary cause of death for 48 of the 88 deaths that were in scope for the Commissioner's review.

The preliminary cause of death for three of the 48 deaths was attributed to the person choking on food and a further seven deaths to aspiration pneumonia - a life-threatening but often avoidable infection caused by inhaling food, fluid, saliva or vomit into the lungs.

"This important review tells us that some Victorian disability service providers are not meeting their obligations under the Act to uphold the rights, safety and wellbeing of people with disability," said Disability Services Commissioner Arthur Rogers (the Commissioner).

The Commissioner's increased powers and functions to undertake this work arose from some of the findings and recommendations of the 2016 Victorian Parliamentary Inquiry into Abuse in Disability Services which reported widespread abuse and neglect of people with disability and shortcomings of essential safeguarding and oversight systems in Victoria.

"The Victorian Government is to be commended for enabling us to highlight these practices at such a crucial time for funding, policy and oversight of disability services, with the rollout of the National Disability Insurance Scheme (NDIS)," Commissioner Rogers said.

Among major concerns, the report highlights:

- A high number of cases in which expert advice about implementing modified diets was not followed by the disability service, thereby placing people with disability at significant risk of health complications or death.
- A lack of communication assessments and communication plans to support people with a disability to communicate their specific needs, notify others of their deteriorating health, and exercise choice and control over their lives.

- Poor record keeping by disability services, including missing and illegible case notes and inaccurate and outdated information, resulting in gaps in critical information to ensure that all staff provide appropriate and safe support. Some had good policies and procedures but they were not consistently followed.
- Half of the people whose deaths may be related to heart conditions had not seen either a cardiologist or dietitian in the previous year.

As a result of the investigations, the Commissioner has issued Notices to Take Action to some disability service providers to rectify practices that did not meet their obligations under the Act, issued a Notice of Advice to all Victorian disability service providers, and notified Victoria Police and the State Coroner about concerns in individual cases.

“These outcomes are relevant for all disability service providers, not just those subject to our investigations. They will inform the refinement of planning and practice approaches and safeguarding arrangements as the disability sector transitions to the full roll-out of the NDIS."

"We believe our review should inform the implementation of the NDIS, particularly with a focus on appropriate assessment and planning for people who require communication, dietary or mealtime assistance. We would also expect service providers to respond to this report by increasing their focus on identifying and implementing appropriate supports for the people they support.” Commissioner Rogers said.

Commissioner Rogers encourages people with disability, their friends and family, and staff in disability services to check that the right support is being provided and to raise any concerns if they have them.

Media please note:

The report – A review of disability service provision to people who have died 2017-18 – is available online here.

Disability Services Commissioner Arthur Rogers and a person with disability who is able to speak to lived experience are available for media interviews.

To arrange an interview or for more information, please contact Amanda Chan on 0429 303 362.

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Snapshot of the review

- 88 deaths were in scope for investigation. Half of the notifications investigated related to people receiving disability services from DHHS and half from non-government disability service providers.
- Of the 88 investigations commenced, 20 investigations were completed in the seven months since the Commissioner commenced the review under newly provided powers.
- Ten completed investigations resulted in adverse findings about the service provider and either a Notice to Take Action or advice was issued to rectify practice deficits including swallowing and choking risks, health plans, bowel management, record keeping and incident reporting, duty of care training, the need to promote healthy eating and physical activity and the effective administration of medication.
- Advice and recommendations were made to the Secretary to DHHS in her role as funder and regulator of Victorian disability services, as a consequence of significant practice deficits identified in two completed investigations.
- Most deaths (83%) involved people with disability who resided in shared supported accommodation.
- Eight of the ten people whose preliminary cause of death was either choking or aspiration pneumonia were people with an intellectual disability.
- Many were not afforded their right to be able to communicate: 11 of 35 (31%) people described as being non-verbal but able to communicate with aids or gestures were not provided with a communication plan by their disability service provider.
- Median age of death was 52 years for males and 54 years for females – 29 years less than the median age at death for the general Australian population.
- Analysis of the practice issues identified in the completed investigations is consistent with findings in the literature and in reviews conducted by other jurisdictions in Australia and the United Kingdom.