NSW Ombudsman

MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE MEDIA RELEASE

Embargoed until 3:30pm 7th December 2005

Report of Reviewable Deaths in 2004

The NSW Ombudsman, Bruce Barbour, tabled his second report of reviewable deaths in Parliament today.

The report identifies problems and recommends solutions based on scrutiny of the deaths last year of certain children and people with disabilities in NSW.

The problems include the quality of risk assessment by the Department of Community Services and the quality of health care planning in disability services.

The reviews examined the deaths of 195 people.

They included 93 people with disabilities who were living in residential care or licensed boarding houses.

They also included 104 children, most of whom were known to the child protection system. Aboriginal children continued to be over-represented, comprising about 3.5% of the State's children but 19% of reviewable deaths.

"**People with disabilities living in care and children who may be at risk are among the most vulnerable members of our community**," Mr Barbour said.

"**Child protection and disability service provision is often complex, difficult work that places great demands on systems and individuals. Our role, under the legislation, is to contribute to service improvement by identifying ways to prevent or reduce untimely deaths**."

Analysis of the deaths in 2004 has provided the basis for a total of 45 recommendations in the report. These are directed to the Department of Ageing, Disability and Home Care (DADHC), Department of Community Services (DOCS), NSW Health, and NSW Police.

Reviewable disability deaths

There were reviews of 93 people with disabilities who died in care in 2004. They included:

- 34 residents of services run by DADHC
- 35 residents of services funded by DADHC
- 24 people living in licensed boarding houses

Media contact: Lisa Du, Public Relations Officer, telephone: 9286 1008 or 0417 233 320

The reviews revealed problems in health care co-ordination and generally poor quality of health care planning. Specific concerns included a lack of health screening and delays in acting on referrals for medical treatment.

There were also problems identified in areas including management of medication and end-of-life issues for patients with disabilities.

"**The people whose cases we reviewed not only had complex and continuing health needs**," Mr Barbour said**, "many were also restricted in their ability to communicate about their needs, making it even more vital that their carers properly plan and co-ordinate ongoing health care."**

Most of those living in disability services had an intellectual disability and at least one other disability, as well as a high number of ongoing health conditions. For boarding house residents, the most common disability was psychiatric disability, followed by acquired brain injury. More than half of the boarding house residents had some form of cognitive impairment.

There were a high number of deaths related to respiratory illnesses, such as pneumonia, as well as cardiovascular disease and sepsis.

The report considers people in licensed boarding houses separately from those in the disability services. This is because boarding houses are not covered by the statutory standards that apply to disability services.

The report notes the importance of ensuring adequate safeguards for people with disabilities living in boarding houses.

There are 23 recommendations directed to DADHC and NSW Health.

Reviewable child deaths

The report covers 104 of the 540 children who died across the State last year.

Many of the reviewable deaths had no connection to child protection concerns.

However, the Ombudsman's responsibilities include identifying ways to prevent or reduce the deaths of children who are *at risk* of death because of abuse or neglect. This necessarily involves considering the child protection histories of children who died, together with the responses of the child protection system.

Of the 104 child deaths, 96 were reviewable because either they or a sibling had been the subject of a report to DoCS in the three years before they died.

The remaining eight cases did not feature any reports to DoCS. Seven were reviewable because the children died from abuse or neglect, or in suspicious circumstances. One child died in care from natural causes.

Media contact: Lisa Du, Public Relations Officer, telephone: 9286 1008 or 0417 233 320

The report identifies examples of poor assessments of risk for children. It also raises concerns – as with the previous report – about the DoCS policy of closing cases based on competing priorities and availability of resources.

At times, high-risk cases were closed without allocation to a local DoCS office for a full risk assessment.

The report focuses on DoCS responses to certain issues, including risk of harm reports about:

- unborn children
- children involved in domestic violence incidents
- adolescents

A high number of reports for these three groups were closed without an assessment at a local DoCS office.

The department's significant reform program is due to be completed in 2008.

" **It will be important for DoCS to be able to demonstrate how new approaches, combined with its additional funding, will result in adequate risk assessment and appropriate, effective responses at the local level,**" Mr Barbour said.

The Ombudsman is required to review the deaths of people with disabilities who reside in disability services or licensed boarding houses, and children who die

- in care
- within three years after being reported to DoCS
- within three years after having a sibling reported to DoCS
- because of abuse or neglect
- in suspicious circumstances
- in detention

Media contact: Lisa Du, Public Relations Officer, telephone: 9286 1008 or 0417 233 320