Ombudsman
New South Wales

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Ombudsman report of the deaths of people with disability in residential care 2014-2017

Embargoed until 12pm, 31 August 2018

The NSW Ombudsman, Mr Michael Barnes, tabled a report in Parliament today on the deaths in 2014-2017 of 494 people with disability who lived in residential care.

Residential care includes group homes and residential centres operated by the Department of Family and Community Services (FACS) and non-government providers funded by FACS or the NDIS, and assisted boarding houses.

The report identifies a range of actions by disability providers and health services that are required to reduce preventable deaths. In particular, the Ombudsman's reviews identified deaths of people with disability in residential care in 2014-2017 that may have been prevented if the individuals had received:

- timely medical assistance and effective first aid
- support to minimise their resistance to health assessments and treatment
- help to address significant risks associated with obesity, smoking and other lifestyle factors
- effective supervision and support to manage choking risks
- appropriate support in hospital.

'Our work consistently shows that people with disability in residential care die at a much earlier age than the general population,' said Mr Barnes. **'It is critical that they get the support they need to minimise their health risks, access health services, and receive necessary treatment. We have found that this does not consistently happen, and the consequences for individuals are dire.'**

The report identifies that there have been key developments to improve support for people with disability in mainstream health services, including recent additional funding by the NSW Government to increase the number of intellectual disability health teams. However, the Ombudsman advises that **'significant change is still needed to make a fundamental difference to the health outcomes of not only people with disability in residential care, but to people with disability generally.'**

The Ombudsman has made seven recommendations to NSW Health, aimed at improving health supports and services for people with disability, including access to community based health programs, and support in hospital.

Following the start of the NDIS Quality and Safeguarding Commission on 1 July 2018, the Ombudsman is working with the Commission on a joint approach to examining the deaths of people with disability in residential care in 2018/19. The arrangements will include the NDIS Commission examining the involvement of NDIS providers, while the Ombudsman's office maintains its ongoing review of the health and other service systems in NSW.

The report will be available on the NSW Ombudsman's website after 12pm.

General inquiries contact: Anita Whittaker | 02 9286 1037 | 0477 724 835 | media@ombo.nsw.gov.au