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Review raises alarm on disability deaths in care

Queensland's first report on deaths in care of people with disability has found more than half (53%) of those reviewed were potentially avoidable.

Most (59%) were unexpected 24 hours earlier and many involved relatively young men and women with nearly half (47%) dying in their 20s, 30s and 40s.

The grim findings have been reported to the Queensland Government by Public Advocate Jodie Griffiths-Cook who led an expert review into the deaths of 73 people living in supported disability accommodation and accredited residential services between 2009 and 2014.

The landmark report tabled in State Parliament today warned that the situation could worsen under the National Disability Insurance Scheme (NDIS) unless urgent action was taken to improve health care, minimum service standards and official reporting.

"As we learned from the pink batts program, good intentions are no protection against tragic outcomes if you don't get the framework right," Ms Griffiths-Cook said.

"The number of people accessing disability support will more than double under the NDIS, so that will obviously magnify our existing problems if they're not fixed.

"On the other hand, transition to the NDIS presents a timely catalyst for change, so we urge the government and service providers to use this window of opportunity wisely and act on the recommendations informed by this review."

Ms Griffiths-Cook said risk factors and vulnerabilities for people with disability were often poorly understood, even among health professionals and support staff.

"There were several cases of people with known swallowing difficulties choking to death simply because they were served the wrong meals," she said.

"They were supposed to be given soft moist food cut into small pieces, but one man died after being given a burger and chips, another died after being given a piece of cake and another died after eating a sausage.

"These deaths should never have happened and the remedy is relatively inexpensive – enhanced awareness through better information and training."

The review found other people died from serious diseases that should have been identified and treated earlier, but the symptoms were missed or misdiagnosed.

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"One woman had health issues for years and was thought to have asthma. When she was eventually taken to hospital, x-rays found multiple advanced cancers throughout her chest and she died two days later," Ms Griffiths-Cook said.

"Greater priority needs to be given to primary health care for people with disability, including preventative care such as annual check-ups and regular medical reviews."

Ms Griffiths-Cook said health care was not only inadequate in many cases, but seemed overly reliant on medication.

"Very few of those who died had a diagnosed mental illness, yet nearly half (49%) were being given psychotropic medication, including antipsychotics," she said.

"Many were receiving multiple medications even though polypharmacy is known to increase health risks, particularly for people with disability."

Ms Griffiths-Cook said the problems identified by the expert panel had largely been hidden from public view because there was no systemic reporting in Queensland.

"The State Coroner does investigate all reported deaths in care, but only on an individual basis and rarely by way of public inquest," she said.

"We've recommended that the State Coroner report annually on deaths in care, with systemic reviews by an appropriate agency every two years. This was the first review of its kind in Queensland and we need to ensure it's not the last.

"The review also recommends improved education on reporting requirements for disability service providers and health professionals because the total number of deaths in care is almost certainly under-reported at the moment."

The report – Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland – has been published online at www.publicadvocate.gld.gov.au

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