Learning from reviews of incidents and deaths: strategies for preventing abuse and neglect

Steve Kinmond
NSW Community and Disability Services Commissioner
Deputy Ombudsman

Ombudsman
New South Wales

12 September 2017

The NSW Ombudsman and serious incidents

1. The Disability Reportable Incidents scheme

2. Reviewable deaths of people with disability

3. Inquiry into the abuse and neglect of people with disability in the community

Disability Reportable Incidents scheme

- Legislated scheme – started 3 December 2014
- Focuses on people with disability living in supported group accommodation
- Applies to the Department of Family and Community Services and funded providers
- Head of agency is required to notify the Ombudsman within 30 days of becoming aware of the incident/ allegation
- Allegation-based scheme

Reportable incidents

- Employee to client incidents
  - any sexual offence, or sexual misconduct
  - assault
  - fraud
  - ill-treatment or neglect
- Client to client incidents
  - sexual offence
  - assault that causes serious injury, involves the use of a weapon, or is part of a pattern of abuse
- Unexplained serious injury
- Breach of an Apprehended Violence Order

Notifications 3 Dec 2014 – 30 June 2017

Incident category	Number of notifications	Percentage
Employee to client	800	49%
Client to client	582	35%
Unexplained serious injury	253	15%
Breach of AVO	6	<1%
Total	**1641**	**100%**

Employee to client incidents

Conduct	No. Notifications received 3/12/14 – 30/6/17	% Received	% Sustained
Physical assault	303	38%	22%
Neglect	240	30%	60%
Ill-treatment	139	17%	38%
Sexual offence	60	8%	3%
Sexual misconduct	35	4%	18%
Fraud	21	3%	60%
Reportable conviction	2	<1%	100%
Total	**800**	**100%**	34%

Client to client incidents

Conduct	No. notifications 3/12/14 – 30/6/17	Percentage
Pattern of abuse	276	47%
Sexual offence	128	22%
Assault causing serious injury	116	20%
Assault involving use of a weapon	59	10%
Breach of AVO	2	<1%
Reportable conviction	1	<1%
Total	**582**	**100%**

Significant outcomes – employees

- Criminal charges – 23 (18 individuals)
- Management action has been taken in 72% of cases, including (but not limited to):
  - Dismissal – 67
  - Permitted to resign – 45
  - Formal performance monitoring – 63
  - Issued with a warning – 58
  - Restricted/changed duties – 43
  - Counselled – 39
  - Training – 108

Significant outcomes – client SOAs

- Action has been taken in 94% of cases, including (but not limited to):
  - Development/ review of behaviour support plan – 158
  - Increased behaviour support – 39
  - Increased supervision – 94
  - Change of accommodation – 63
  - Action to meet clinical/medical needs – 40
  - Action to meet psychological support needs – 35
  - Education provided to client – 17

Significant outcomes – alleged victims

- Action has been taken in 83% of cases, including (but not limited to):
  - Increased supervision – 293
  - Review of behaviour support needs – 229
  - Change in behaviour support – 162
  - Review of health/medical needs – 152
  - Change of accommodation – 107
  - Review of psychological support needs – 91
  - Change in health support – 77
  - Change in psychological support - 65

Reporting Sources

- Staff 58%
- Alleged Victim or Agents 24%
- Other 18%

Reviewing the deaths of people with disability

- Legislated scheme – started December 2002
- Focuses on people with disability living in, or temporarily absent from, residential care
- Applies to FACS and funded providers, including NDIS providers
- FACS, providers and the Coroner are required to notify the Ombudsman of the person's death within 30 days

Reviewing the deaths of people with disability

- On average, there are 100 deaths per year.
- On average, people in disability services in NSW die at 53 years of age – almost 30 years younger than the general population.
- Vast majority die of natural causes
- Main underlying causes of death include respiratory diseases, heart diseases, nervous system diseases, and choking on food

Reviewing the deaths of people with disability – examples of outcomes

- Introduction of minimum requirements relating to first aid qualifications across all residential care environments
- Development and implementation of minimum requirements for identifying and addressing nutrition and swallowing risks
- Audit of the use of psychotropic medication for behaviour management purposes (restricted practice) in disability services, and development of a practice improvement initiative
- Development of a Joint Guideline relating to support for people with disability in hospital
- Development of improved guidance and practices in Local Health Districts, including on the diagnosis of fractures in people with communication difficulties

What have we learnt?

For disability services, the following elements are critical:

- Knowing the people with disability you are supporting
- Effectively identifying and appropriately managing risks
- Educating and empowering people with disability
- Investing in, and empowering, staff
- Developing and maintaining good professional relationships with mainstream services

Knowing the people with disability you are supporting

- Key to preventing and effectively responding to serious incidents
- Major factors in client to client incidents include compatibility issues, inadequate actions to meet needs, and poor staff awareness/ understanding of the person and required actions
- Staff must know the person to be able to recognise and respond to changes in their health or behaviour
- Important considerations in relation to induction, handover/communication, use of agency staff

Identifying and managing risks

- Effective incident reporting systems, analysis, and action to prevent recurrence
- Identifying and mitigating risks to the health and wellbeing of individuals
- Enhancing systems for reducing risks posed by employees – probity checking, contracts of employment linked to codes of conduct
- Employee screening system
- Exchange of information relating to safety
- After an incident – initial risk assessment and ongoing risk management; investigation; internal review

Ombudsman
New South Wales

Educating and empowering people with disability

- Awareness and understanding of their rights and options
- Speaking up about abuse and neglect
- Enabling effective access to justice
- Enabling effective access to community-based and preventive health supports

Investing in, and empowering, staff

- Importance of staff culture and zero tolerance
  - Setting the culture and expectations at the outset
  - Staff need to see action being taken
- Empowering staff to report and take action
  - Support for staff who report
  - Taking action in response to changes in health and/or behaviour

Relationships with mainstream services

- Important to have strong professional relationships with mainstream services – particularly police, and health services
- Not a one-way street – the best outcomes are achieved where parties work cooperatively, and with the person with disability at the centre

Effective collaborative work requires broader system reform – eg: police

- Reportable incidents – reforms required in relation to police investigative practice and in the broader criminal justice system
  - Upskilling police in relation to people with cognitive disability
  - Communication intermediaries

Ombudsman New South Wales

Effective collaborative work requires broader system reform – eg: health

- Support for people with disability in hospital – reasonable adjustments
- Coordination and transfer of care
- Response to complex needs
- Access to community-based health care and programs
- End-of-life care and decision-making
- Data and reporting on performance
- NDIS and mainstream health services

Effective collaborative work requires broader system reform – eg: the case for a Public Advocate

- Inquiry into the abuse and neglect of people with disability in community settings
- Abuse in the community – importance of having a coordinated and informed approach

Ombudsman
New South Wales

Contact us

NSW OMBUDSMAN

- Phone (02) 9286 1000
- Toll free (outside Sydney metro area) 1800 451 524
- Facsimile (02) 9283 2911
- Telephone typewriter (TTY) (02) 9264 8050
- Email nswombo@ombo.nsw.gov.au
- Web www.ombo.nsw.gov.au