The Public Advocate
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30 June 2020

Ms Melissa Sailsbury
A/Committee Secretary
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George Street
Brisbane Qld 4000

Via email: health@parliament.qld.gov.au

Dear Ms Sailsbury,

Inquiry into the Queensland Government's health response to COVID-19

I am writing in response to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's call for submissions in relation to the Queensland Government's health response to COVID-19.

In the first instance, it is important to note that the COVID-19 pandemic has been a critical time for government and communities right around the world, where there have been few precedents to follow and decisions have had to be made quickly, often followed by the retrospective development of complementary policies and programs.

During this time, Australia has seen a level of co-operation between levels of Government that has been unprecedented outside of war time, which has allowed key decisions to be made and implemented swiftly, efficiently and consistently. This response has been important to ensure that vulnerable members of the community, particularly older people and people with disability, receive appropriate care and supports along with necessary health protections.

As the Public Advocate for Queensland, I am appointed to undertake systemic advocacy to promote and protect the rights and interests of people with impaired decision-making capacity.

To date, the Queensland Government's health response to COVID-19, led by Queensland Health (QH), has been an unquestionable success. In addition to its frontline health response, the government's approach included targeted responses for key cohorts, including people living with disability and mental illness, as well as older Queenslanders, particularly those living in residential aged care facilities.

To inform and facilitate its COVID-19 response for these different groups, QH convened a number of inter-agency working groups with membership from key stakeholders representing government agencies, service providers, community service and advocacy organisations. I am currently a member of the Aged Care COVID-19 Working Group and the Disability Support COVID-19 Working Group, which, until recently, had been meeting on a weekly basis.

I would like to commend QH for taking the initiative and establishing these working groups. They have been invaluable in ensuring cross agency co-operation and feedback on key

issues in a time of crisis. The regular meetings of the working groups supported information sharing and an issue identification process that was used to develop and adjust the health responses to the pandemic for these cohort groups. They also kept key stakeholders abreast of key developments with sector wide ramifications in a timely way. This also contributed to improved communication and acceptance and support of the new measures or procedures to support those changes. The working groups were also instrumental in identifying gaps in information and guidance to the community and service providers about the virus and the health directives, as well as actioning some issues that were long-standing challenges for the health system in the pre-COVID-19 environment.

One of the issues that was escalated during the pandemic was the discharge of patients with disability who are medically ready for discharge from hospital to safe and supported accommodation in the community.[1]

In September 2019, Queensland Health advised my office that there were still 412 Queenslanders medically ready for discharge residing long term in public health facilities.[2] The needs of these patients were being addressed, but very slowly. In 2018-19 only four people in this cohort discharged from health facilities, with the commencement of the NDIS in Queensland, and the Queensland Government's *Joint Action Plan – Transition of long-stay younger people with disability from Queensland public health facilities.*[3]

The Department of Communities, Disability Services and Seniors (the lead agency for the transition plan) advised my office (DCDDS), that the Joint Action Plan would not be extend beyond the end of June 2019.[4]

In its brief to this Committee on the emergency response to COVID-19, QH advised that 273 long stay patients were discharged from QH facilities in a little over two months, between 25 March and 27 May 2020. Further work to discharge another 199 patients is currently underway, with Queensland Disability Network (QDN) engaged to provide 'independent support and advocacy for patients, their families, and guardians'.[5]

I applaud this initiative and the concerted effort by multiple government agencies to fast-track discharges and transition people to community living.

It was also noted by QH (again in the brief to this Parliamentary Committee) that the 'flexibility in the implementation of scheme policy by the National Disability Insurance Agency (NDIA) has been a major input to the success of this hospital discharge strategy'[6].

Many of the people involved in the discharge program have a disability and complex health conditions, which are the principal reasons they have resided long-term in a Queensland health facility prior to the fast track program implemented in response to the pandemic. This is because it has been difficult to put in place an appropriate model of

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[1] Queensland Health, *Inquiry into the Queensland Government's health response to COVID-19* Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Health written submission to Committee,16 June 2020, accessed online 23 June 2020 <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2020/COVID-19/bp-17Jun2020.pdf>.

[2] Letter from Ms Bronwyn Nardi, Assistant Deputy Director-General, Strategy Policy and Planning, Department of Health to Ms Mary Burgess, Public Advocate, 26 September 2019.

[3] Queensland Government, the *Joint Action Plan – Transition of long-stay younger people with disability from Queensland public health facilities* (17 September 2019) Public Advocate <https://www.justice.qld.gov.au/public-advocate/activities/past/people-with-disability-residing-long-term-in-health-care-facilities>.

[4] Letter from Ms Clare O'Connor, Director-General, Department of Communities, Disability Services and Seniors to Ms Mary Burgess, Public Advocate, 29 August 2019.

[5] Queensland Health, 16 June 2020.

[6] Queensland Health, 16 June 2020, p.28.

disability and health care to support this group of patients to safely transition to community living and maintain their health and wellbeing.

With that in mind, I would like to draw to the Committee's attention to the State's role in continuing to monitor the health and provide appropriate health supports over the longer term for the people who have been transitioned out of QH facilities during the COVID-19 emergency. While the NDIS is responsible for the provision of disability supports and some health supports directly related to a participant's disability, the State's responsibility for the provision of health care services requires a specific response for people with disability and complex health conditions.

In 2016, my predecessor, Jodie Griffiths-Cook, prepared a landmark report, tabled in this Parliament, that reviewed the deaths of 73 people with disability and complex health conditions that had died while in care in the community. This review found that more than half of these deaths (53%) were potentially avoidable, with people dying from incidents such as choking because they were fed the wrong types of meals or were not appropriately supervised while eating, and from treatable conditions that had progressed to the point that they required emergency treatment and they could not be saved. Some died from cancer that was undiagnosed.

The report recommended a coordinated response, to ensure that people with disability and complex health conditions do not die a preventable death while living in the community. With the rollout of the NDIS, that coordinated response should involve the NDIS (when people are participants in that scheme), GPs, primary health networks, and hospital and health services (HHS).

Ideally, people with disability and complex health conditions should be identified by the State health system, so that they can receive appropriate and responsive health care, that takes into account their disability care needs. They should have an annual health assessment that should inform an annual health care plan, which should include the coordination of their health care between a GP, private medical specialists or a plan for and the provision of emergency and specialist care via the local Health and Hospital Service (HHS). The plan should include an annual Fluvax, and eventually a COVID vaccination, along with other appropriate specialist appointments, depending on the person's health conditions. I would also suggest that for people with disability with particularly complex health conditions, consideration should be given to establishing health liaison or health coordination positions within HHSs, whose role it would be to ensure that the health care plans of this vulnerable cohort of people are being implemented and reviewed.

To provide the necessary health supports and maintain the health and wellbeing of people with disability and complex health conditions who were discharged from health facilities through this fast-tracked process, QH needs to lead and coordinate the development of the type of specific health response outlined above. While these vulnerable members of our community are now residing in the community, their health needs continue to be the responsibility of our mainstream health system. We now clearly understand the health risks for this group and should put in place an appropriate strategy to support their healthcare over the long-term. A more proactive approach to this issue should significantly improve the quality of life and health of this cohort and reduce demand on emergency rooms and hospital beds.

Indirect measures associated with the health response to COVID-19

While not directly initiated by QH or the Health Minister in response to the COVID-19 emergency, there have been some actions by government associated with the pandemic

that have directly and negatively impacted the rights of people with disability, without demonstrating the need to protect their health and wellbeing.

These actions include the recently passed *Justice and Other Legislation (COVID-19 Emergency Response) Amendment Act 2020* (the Act). This Act introduced a range of amendments to various pieces of Queensland legislation, including the *Disability Services Act 2006* and the *Forensic Disability Act 2011*.

I have serious concerns about the approach taken to the development of these amendments and whether there was any demonstrated risk that could justify them. In my view, the amendments were not consistent with a 'disability inclusive' response to the COVID-19 pandemic and have the potential for Queensland adults with disability affected by the amendments to be more vulnerable to violence, abuse, neglect and exploitation.

The amendments to the *Disability Services Act 2006* provide for the locking of gates, doors and windows by disability service providers to ensure a person with disability complies with a public health direction. It provides immunity from criminal and civil liability for disability service providers if they act (i) honestly and without negligence; (ii) in compliance with the policy made by the department; and (iii) takes reasonable steps to minimise the impact on a person living at the premises who is not a relevant adult with an intellectual or cognitive disability.

The amendments to the *Forensic Disability Act 2011* allow the Forensic Disability Service to prevent clients with disability from accessing certain services and to stop all 'community treatment' (i.e. external outings), if it is determined that it would pose a risk to the health, safety or welfare of the forensic disability client or another person.

It is concerning that such provisions restricting the freedom of movement of people with disability and their access to services and the community (necessary for their rehabilitation) should be introduced at a time when the Queensland Government was easing community restrictions on movement and social interactions under the COVID-19 Public Health Directive.

A key concern is the absence of any identified or demonstrated need for these amendments. Other than general statements about protecting the health, safety and wellbeing of people with disabilities and the broader community, there is no clear explanation in the explanatory notes or the statement of Consistency with Fundamental Legislative Principles of the purpose of the amendments and why they are needed. For example, had there been instances where people with disabilities or members of the community were at risk of harm because a service provider was unable to ensure they remained in their home? The authorisation of actions that would otherwise amount to criminal or tortious acts amounts to a significant infringement of the fundamental human rights of a group of vulnerable Queenslanders, and should only occur when they are supported by evidence of a specific problem which requires addressing.

Other concerns I noted in a letter to Minister O'Rourke on 1 June 2020 in relation to amendments to the *Disabilty Services Act* included:

- A lack of consultation with people with disability, disability advocates, service providers and the various agencies involved in promoting and protecting the rights of people with disability when preparing the amendments;
- The potential stigmatisation of people with disability;
- The potential negative effects of social isolation on people with disability;
- The commencement of the amendments before the departmental policy directing how the locking of gates, doors and windows should be applied were finalised; and
- An absence of requirements for reporting, monitoring or oversight.

These concerns clearly demonstrate the potential for this amendment to expose people with disability to a greater risk of violence, abuse, neglect and exploitation.

In relation to the *Forensic Disability Act* amendments, I am concerned about the unnecessarily broad and ambiguous wording of the discretion to restrict clients' access to services and the community, and its potential to infringe the rights of people with disability to access rehabilitation and community supports.

I understand that the scope of this Parliamentary Committee Inquiry may not allow for consideration of some of the issues I have raised. However, I consider it important to raise these matters with the Committee as examples of how emergency responses to pandemics – with the best intentions to protect the most vulnerable in our community – can be misguided. It is in these emergency circumstances that we should continue to carefully consider and scrutinise these types of measures to ensure that the actions we take to protect vulnerable people do not cross the line of paternalism and ultimately breach the human rights of those people they are designed to protect.

I would suggest that we should learn from these experiences and ensure that these few misguided actions are not repeated in any future responses to a resurgence of the COVID-19 virus in the community or any other health or public emergency.

I would be pleased to make myself available to the Committee or your staff if you would like to discuss any of the issues raised in this letter. I can be contacted on [redacted] or via email at [redacted]

I look forward to reading the final Committee report.

Yours sincerely

Mary Burgess
Public Advocate