IDEA Services Limited

Disability Service 2

A Report by the

Deputy Health and Disability Commissioner

(Cases 21HDC00680 & 20HDC01824)

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Executive summary

1. This report addresses the concerns raised in two separate complaints about the care provided to a man (aged in his forties at the time of the events) by two different disability service providers. The man has intellectual, physical, and developmental impairments and is dependent on others for his care. The circumstances of each complaint are distinct, but both demonstrate the responsibility disability service providers carry for maintaining the safety and wellbeing of vulnerable consumers within their care.

2. The first complaint focuses on a provider's assessment of the man's strengths and weaknesses, and the provider's knowledge and understanding of the man's condition prior to undertaking a range of physical manipulations.

3. The second complaint relates to a combination of inadequate care planning by the provider to manage risk, the man's placement with another resident who exhibited inappropriate behaviour that escalated to violence, and poor management of incident reporting, which put the man in a particularly vulnerable position. It was found that the care provided to him fell short of the accepted standard. The provider is to be commended for the work it has since undertaken to implement a tool that assesses the compatibility of the people it supports and considers the person's wishes and preferences for flatmates.

Complaints and investigation

4. The Health and Disability Commissioner (HDC) received two separate complaints from Mrs B about the services provided to her son, Mr A, by IDEA Services Limited and Disability Service 2. Both complaints are discussed in this report. The following issues were identified for investigation:

   - *Whether IDEA Services Limited provided Mr A with an appropriate standard of care in 2020 and 2021.*
   - *Whether Disability Service 2 provided Mr A with an appropriate standard of care in August 2019.*

5. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

6. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs B	Complainant
IDEA Services Limited	Provider
Disability Service 2	Provider

7. Further information was received from ACC.

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Information gathered during investigation

Introduction

8. This report considers two separate issues. The first relates to an assessment of Mr A performed by Disability Service 2,[1] following which he was unable to use his right arm. The second relates to the circumstances surrounding Mr A being assaulted by another resident at the house where he lived, which is operated by IDEA Services Limited (IDEA Services).[2]

9. Mr A, aged in his forties at the time of the events, has cerebral palsy,[3] echolalia,[4] a significant intellectual disability, increased tone and contractures[5] in all four limbs, limited movement in his lower limbs, and weakness in his upper body. He is unable to weight bear and requires full 24/7 support with his daily living cares. He is supported to use an electric wheelchair, and is hoisted for toileting, showering, and getting in and out of bed. His mother, Mrs B, is his welfare guardian.

10. IDEA Services began to support Mr A in 2006, initially via respite care, and from 2008 in disability residential support. At the time of the events, Mr A was residing at a residential supported living home with five other disabled residents.

11. IDEA Services said that the residence had double staffing throughout the day to support the needs and safety of all service users, but some service users attended other facilities during the day and so single staffing was deemed appropriate during these hours. Sleepover shifts were performed by staff at the house at night, which meant that a staff member was available should issues arise, but there was no one-to-one oversight. IDEA Services had a 24/7 manager on-call system to provide support to staff if required. IDEA Services stated that it had procedures in place to notify community emergency services as required to ensure service users' safety.

12. IDEA Services provided support to Mr A under a Ministry of Health Outcome Agreement for Residential Disability Support Services. Mr A was last assessed by the Needs Assessment and Service Coordination (NASC) agency on 16 July 2019.

13. IDEA Services told HDC that Mr A had regular medical assessments, in particular for urinary tract, eye, and toenail infections, and he had a daily exercise/physiotherapy regimen. Prior to the COVID-19-related lockdown in March 2020, he attended IDEA Services' vocational day base five days per week, and subsequently he was supported with daily activities from his home.

Complaint one (20HDC01824): Disability Service 2 assessment

14. In 2019 Ms C was the Service Manager for the residence and had oversight of Mr A's support. IDEA Services said that Ms C became aware of Disability Service 2 through a presentation

[1] Disability Service 2 is incorporated as a charitable trust under the Charitable Trusts Act 1957.
[2] IDEA Services Limited is a fully owned subsidiary of IHC New Zealand Limited.
[3] A congenital disorder of movement, muscle tone or posture.
[4] Repetition of words spoken by another person.
[5] The tightening or shortening of muscles, tendons, joints, or other tissues.

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she attended. Ms C understood that the services were undertaken by experts in neurological conditions and could be of potential benefit to service users such as Mr A, possibly resulting in improvements in their physical health and range of motion.

15. On 5 August 2019, Ms C emailed Mrs B enquiring whether she would be interested in Mr A attending a free assessment. Ms C posted Mrs B an information booklet about the services. Mrs B responded by email on 6 August 2019 confirming that she agreed that it would be good for Mr A to attend. Mrs B's email stated: '[W]e received the booklet you sent by mail today …. I think it would be a great idea to give it a try and see how [Mr A] reacts.' Ms C made an appointment for Mr A to have the assessment on 15 August 2019 at 9.30am.

16. Mrs B told HDC that she agreed to the assessment on the condition that both she and her husband (Mr A's stepfather) were present at the assessment. Mrs B sent an email to Ms C on 13 August advising that she would be attending the assessment.

Disability Service 2 assessor

17. The Disability Service 2 manager, Ms D, told HDC that a senior assessor, Assessor E, undertook Mr A's assessment.

18. Ms D said that after graduating overseas, Mr E worked in various countries before moving to Aotearoa New Zealand in 2015. Ms D stated that Mr E had worked with Disability Service 2 for around four to five years, and 'is an exemplary employee'.

Informed consent

19. Disability Service 2 told HDC that the assessment process involves discussions about the person's current state and any known issues that Disability Service 2 would need to be aware of. Any physical facilitation, which is kept to a minimum during the assessment process, is used to determine the person's range of mobility, along with strengths and weaknesses that they and their family/whānau want Disability Service 2 to assist with.

20. The only medical information about Mr A on the Disability Service 2 enrolment form is that he chokes on bananas. Ms D said that prior to any physical facilitation, a full explanation of what is going to occur is provided, and permission is requested of the person involved as well as from any support people present. Ms D stated that with every aspect of the assessment, the assessor always checks by asking, 'is it ok', and that it is a backwards and forwards discussion.

21. Mr and Mrs B were not present at the beginning of the assessment as it commenced early. Ms D said that primarily they talked to Mr A to seek his consent. Ms D stated:

> 'All present are inherently involved in the process, with [Mr A's] carer from Idea Services saying "that is ok", and [Mr A's] parents saying "that is ok". If any of the suggested physical facilitation causes concern of risk due to circumstances we are not aware of, in our experience this is usually identified by the person or one of their support people during this verbal consent process.'

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22. Ms D told HDC that Mr E explained to all present that he would like to assess Mr A's core trunk flexibility and range of motion by assisting him to sit in a more upright position. Ms D said that verbal consent was requested prior to beginning this facilitation, with no concerns raised about this by Mr A, his carer, or his parents.

Assessment

23. Support worker Ms F told HDC that she accompanied and supported Mr A to the Disability Service 2 appointment. Ms F said that she and Mr A travelled there by taxi and arrived early. They met with Mr E and, although Mr A's parents had not arrived, Mr E started the assessment. Ms F said that Mr E was friendly and spoke to Mr A throughout the session. She stated that Mr E assessed what Mr A was capable of doing, such as kicking a ball, and made an attempt to lift Mr A from behind but realised that this was not possible. She said that Mr E did some arm lifting exercises with Mr A, and Mr E was sure that his treatment would enable Mr A to stand.

24. Ms F stated that she remembers wondering during the session whether the Disability Service 2 staff present had read any notes on Mr A, as she found a lot of what the assessor said was unrealistic, such as getting Mr A to stand or lift his arms. Ms F invited Mr E to visit Mr A in his home to point out the severity of his cerebral palsy and show him the equipment that Mr A used and the environment that he lived in. Ms F stated that the invitation came about because of the suggestion that Mr A would be able to straighten his legs. Ms F said that not long after that conversation Mr A's family arrived.

25. Mrs B said that when she and her husband arrived at 9.20am, they were upset to see that the assessment had started early, at 9.15am, without them. Regarding the assessment session having started early, IDEA Services told HDC that this decision was made by Disability Service 2. However, IDEA Services acknowledged that its staff were aware that Mr A's family were planning to attend and said that it would have been useful for Ms F to have suggested that Disability Service 2 wait until Mr and Mrs B arrived before starting the assessment.

26. Mrs B told HDC that the assessor bent Mr A over in his wheelchair with 'tremendous force' and then picked up Mr A's left hand to move it, at which stage Mr A indicated that he had had enough.

27. Ms D told HDC that she arrived shortly after Mr A's parents, and that Disability Service 2 disagrees that tremendous force was used. Ms D said that during the assessment, Mr E physically supported Mr A to sit in a more upright position in his wheelchair to assess his core trunk flexibility and range of motion, and that during this exercise, Mr A used his right arm to steady himself using a parallel bar. Ms D said that towards the end of the assessment Mr E also assessed Mr A's ability to utilise his left arm and hand, but Mr A indicated that this was not comfortable and that he would like to finish the assessment.

28. Ms D stated:

> '[Mr A's] request to finish the assessment was complied with immediately. We are aware that some of the people who attend our centre have very limited means of

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communication, so are acutely conscious of any signs we see of discomfort or distress. None of which were seen.'

29. Ms D told HDC that there was no indication at any point of the assessment, either from Mr A, Mr and Mrs B, or the support worker from IDEA Services, that Mr A had experienced any issues or distress. Ms D said that there was also no indication that anybody present was uncomfortable with how the assessment had been performed, and she did not see anything occur that would indicate that an injury had been, or could have been, sustained.

30. The Disability Service 2 assessment record states:

'At the assessment I asked him and helped hands-on to lean forwards in the chair into an upright position, and that was a real challenge. It seems that he has been accustomed to being tilted backwards in his regular motor wheelchair (having had it for about three years so far as the mum stated). The trunk/back anti-gravity support is a very essential component in most of gross motor activities along with the basic positioning. Hence, I see working on the trunk function, such as Motor control, range of motion, postural support, etc. would be one the primary targets at this stage in order to provide the basic muscular-skeletal for improved motor function (maintenance of upright positions such as leaning forwards/backwards in the chair, standing, etc …) At this stage, [Mrs B] stated that there is a suspicion for [Mr A's] hip joint dislocation/weakness. We agreed that X-Ray would be provided to adjust the programme for [Mr A].'

Inability to use right arm

31. Immediately after the appointment, Mr A left with Mr and Mrs B to spend the weekend with them. Mrs B told HDC she noticed that Mr A was unable to use his right arm before they started the vehicle to leave the appointment, as he could not lift it to hold onto the bar inside the car as he would usually do. Mrs B said that when she assisted Mr A with lifting his arm he winced in pain. She said that she immediately rang IDEA Services and asked whether Mr A had been able to use his arm to eat his breakfast that morning and the staff member replied that he had been able to feed himself unassisted.

32. However, IDEA Services said that on 15 August 2019 its staff were not aware, either during or following the appointment, that Mr A's arm had been injured. Ms F noted the visit in Mr A's health appointment file in his diary, stating that the appointment 'went well'. She also noted that the next session was booked for 22 August 2019, with Mr A's parents having confirmed that they were happy for it to go ahead.

33. On Friday 16 August 2019, Ms C received a phone call from Mrs B, who said she believed that Mr A may have injured his arm at the assessment the previous day. IDEA Services stated that this was the first time it became aware that Mr A may have been injured. Mr A returned to the home on the afternoon of Sunday 18 August 2019.

34. On Monday 19 August 2019, Ms C wrote a memo to staff to advise them of Mrs B's concerns and that a physiotherapy appointment had been made for Mr A on 21 August 2019.

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35. On 21 August 2019, Mr A attended the physiotherapy appointment. The follow-up email from the physiotherapist suggested that Mr A might have a tear in his shoulder. The physiotherapist provided advice for ongoing support and confirmed that there would be no further benefit from physiotherapy treatment for Mr A.

36. On 23 August 2019, Mr A visited his general practitioner (GP), Dr G, who noted that Mr A had a full range of motion in his right shoulder, which suggested that he had a simple sprain or muscle injury that should improve in one to two weeks. The Accident Compensation Corporation (ACC) provided cover for this injury. Dr G ordered an X-ray, which showed nothing of concern.

37. Mrs B stated that the injury changed Mr A's life dramatically, as he can no longer use his right arm, so he cannot feed himself, use his electric chair properly, or lift himself for others to manage his toiletry needs.

38. On 18 March 2020, a nerve conduction assessment was performed.[6] The neurophysiology report found that there was denervation[7] of both the right deltoid C5 and biceps brachii (C5/6[8]), which suggested a C5 nerve root injury. However, the report also noted that the study was limited, due to Mr A's cerebral palsy.

ACC medical advice

39. On 16 November 2020 ACC obtained medical advice from Medical Advisor Dr H, who concluded that the C5 nerve root injury reported on the nerve conduction studies could not be linked as an 'injury by accident' to the single assessment/exercise activity done at Disability Service 2 on 18 August 2019.

40. Dr H noted that the caregiver who had accompanied Mr A to Disability Service 2 had stated that some lifting exercise was done, but she did not suggest that there had been a sudden and/or significant traumatic forceful event, and nor did she state that Mr A had a sudden onset of acute pain or symptoms suggestive of some acute injury event. ACC declined cover for the nerve injury.

Assessment by Dr I

41. On 19 February 2021, Mr A was seen by neurosurgeon Dr I, who reported to Dr G that Mr A had been 'subjected to some experimental … therapy without the presence of his parents which resulted in complete weakness of his deltoid'. Dr I noted that Mr A had stopped feeding himself, which he had been able to do prior to the assessment at Disability Service 2, that he was able to move only his fingers, and that he was unable to lift his hand off the chair or raise his shoulder.

42. On 26 March 2021, Mr A underwent an MRI scan. On 21 April 2021, he was reviewed by Dr I, who reported to Dr G that the MRI scan showed a very tight spinal canal at multiple levels, worse at C4/5 and C5/6. Dr I said that Mr A required surgery to decompress him anteriorly

[6] A study that measures electrical impulses as they move through the nerves to help identify nerve damage.
[7] Loss of nerve supply.
[8] The C5 C6 segment is located in the lower portion of the cervical spine. It provides neck flexibility.

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with C4/5 and C5/6 anterior cervical discectomies (removal of damaged discs through the front of the throat) and following that he might need a laminectomy (removal of part or all the vertebral bone). Dr I noted that the changes in Mr A's spine were longstanding, but he opined that the manipulation of Mr A's neck and spine by Disability Service 2 was the action that had caused Mr A to lose the function of his right arm, which he considered should be covered by ACC.

Further ACC advice

43. Dr H provided ACC with a further report on 19 May 2021. Dr H stated that based on the clinical findings and MRI report, the cause of Mr A's C5 nerve root problem was compression of the nerve roots due to severe cervical spondylosis[9] as reported on the MRI. Dr H noted that Dr I had reported the following: 'The MRI scan shows a very tight spinal canal at multiple levels, worse at C4/5 and C5/6. The changes are longstanding in his spine.'

44. Dr H concluded that based on Mr A's clinical symptoms, the nerve conduction studies, and the MRI findings, the severe degenerative changes in the cervical spine (spondylosis) causing narrowing of openings leading to nerve root compression were the cause of Mr A's symptoms and condition. Dr H said that the narrowing of the spine foramen (the opening through which nerves pass in the cervical spine) leading to the nerve root compression was due to Mr A's longstanding changes in his cervical spine that had occurred gradually over time, and the changes could not be attributed to the Disability Service 2 assessment on 18 August 2019.

45. Dr H acknowledged that Mr A's loss of function of the right arm was noted after the Disability Service 2 assessment, which had unmasked and rendered symptomatic the cervical spondylosis with symptoms of cervical nerve root compression and injury of the C5 nerve root.

Cervical spondylosis

46. Dr H explained that cervical spondylosis is a term that encompasses a wide range of progressive degenerative changes that affect all the components of the cervical spine. Dr H stated that although the causes of spondylosis have not been well defined, it is considered to be a natural process of aging and presents in the majority of people after the fifth decade of life, but it can occur in some individuals at an earlier time.

47. Dr H stated that in the cervical spine, this chronic degenerative process affects the intervertebral discs[10] and facet joints (the connections between the bones in the spine), and may progress to disc herniation, osteophyte (bone spur) formation, vertebral body degeneration,[11] and compression of the spinal cord and/or compression of cervical spinal nerves due to the narrowing of the foramen.

[9] Age-related wear and tear affecting the spinal disks in the neck.
[10] Discs that lie between adjacent vertebrae in the vertebral column helping to allow slight movement of the vertebrae.
[11] Gradual loss of normal structure and function of the spine over time.

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Further comment by Dr I

48. On 23 May 2022 Dr I wrote to Mrs B stating:

> 'I do believe that [Mr A's] manipulation of his neck has caused the damage to his C5 nerve root. Having degenerative spinal disease does not stop people from having injuries, especially if there is a tightness around the foramen where the nerve root exits. The manipulation would no doubt cause injury to a nerve. Especially if the nerve is already compromised in an area where it has no room for movement. We do advise that patients who have tightness, or canal stenosis to avoid any manipulation for the neck because we have seen this many times.'

Complaint two (C21HDC00680): Assault

Opening remarks

49. The provision of appropriate support services in the community can be a challenge for disabled people and their family/whānau. People in residential supported living homes sometimes have limited choice in where and with whom they live and the daily activities they undertake. The priority is to ensure that people have choices. Where there are limited options, situations can arise where service users who are not compatible are living proximate to each other. In situations like this, the onus is on the provider to put arrangements/safeguards in place to accommodate the needs of all the residents and keep them safe. This report highlights the difficulties experienced by disabled people when they are living in a home with people with whom they are not compatible.

50. This complaint relates to Mr A being assaulted by another resident, Mr X, on 19 March 2021. To determine whether IDEA Services provided services that minimised the risk of harm to Mr A, it is necessary to examine previous incidents where Mr A's safety was jeopardised, most of which involved Mr X.

Mr X

51. Mr X moved to the house in 2018. The move occurred following a brief admission to hospital after a serious incident in early 2018 at another IDEA Services' residence, involving Mr X and a staff member.

52. IDEA Services stated that Mr X has an intellectual disability and autism spectrum disorder, and is non-verbal. Mr X has ongoing behaviour challenges and previously had been supported via Disability Service 3, with specific plans for staff to follow to provide support to him.

Previous incidents

53. An IDEA Services' incident form states that on 25 November 2018, Mr X was found in Mr A's room and ran out when staff arrived. The form states that Mr A looked scared, and the staff member asked him if he was OK. Mr A was lying in bed and the staff member noticed that Mr A's bed had been raised higher than it had been previously. When Mr A was asked who had moved his bed, he replied, '[Mr X],' and said, 'no more [Mr X]'. The form states that a door alarm was fitted to Mr A's door in response to this incident.

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54. On 16 December 2019, Ms F completed an incident form that states that she went to check on Mr A that evening and found that Mr X had played with the remote control of Mr A's bed and had lifted the bed high, leaving Mr A in 'midair'. The incident form states that Mr A showed no distress and said he was OK when asked by staff. Ms F recorded that she lowered Mr A's bed, pulled out the power plug to the bed to prevent the incident reoccurring, and made sure that Mr A was comfortable before leaving. There is no mention of whether the door alarm was being used at the time of this incident.

55. An incident form dated 22 June 2020 records that staff saw Mr X coming out of Mr A's bedroom when they went to check on Mr A, and they found that his power chair had been tilted right back. Staff asked Mr X not to go into Mr A's room. The incident form states that the alarm in Mr A's room had not alerted staff to the fact that someone had entered his room. The form states: 'The alarm needs to be used at all times when [Mr A] is alone in his room.'

56. An incident form dated 17 August 2020 states that a staff member was putting away washing and she could hear loud music from Mr A's room and noticed that his door was shut. When she entered Mr A's bedroom, his wheelchair was up against the ranch slider, and he was tilted back as far as it could go. Mr A was very upset and started to cry. The staff checked to see why the alarm was not working and found that it needed new batteries. Mr X was not found in the room, but it was thought that he had been involved because Mr X had ripped the pocket off his jeans and there was a small rip on the side of his leg. The incident form notes that this indicated that Mr X may have got caught on the wheelchair, as the control panel was pushed out from the chair.

57. The form states:

> 'The door alarm needs to be on at all times so that staff can be alerted to anyone going into [Mr A's] room when he is in there. This is a risk and it is in [Mr A's] support notes and this needs to be followed at all times.'

58. An incident form completed on 31 December 2020 records that staff member Ms J found Mr X sitting on Mr A, who was in his wheelchair in his bedroom. When Ms J asked Mr X why he was sitting and leaning back on Mr A, Mr X jumped up, stormed past her, and proceeded to slam his door continuously. Ms J assessed Mr A regarding having had the weight of Mr X on his legs, and she recorded that Mr A said that 'he was ok but [Mr X] was a bitch'. Ms J recorded that Mr A seemed stressed about the whole incident. There is no mention of whether the alarm was in use at the time of this incident.

59. None of the incident forms refer to IDEA Services having contacted Mrs B to inform her of the incidents.

60. Mr A's support plan states that the door alarm was to be used at all times when Mr A was in his room by himself, and staff were to check on him when the alarm was activated. The plan states that the alarm can be switched off when staff are in Mr A's room but must be

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switched back on as soon as staff leave his room and he is left in there. Mr A's support plan does not refer to any risk posed by other residents in the house.

61. IDEA Services stated that it was known that Mr X was keen on a particular item of clothing that was in Mr A's room and that Mr X repeatedly went into the room to find it. IDEA Services said that a privacy lock was installed on Mr A's door on 26 September 2019 to provide Mr A with his own privacy away from other service users, and staff ensured that it was used regularly so that nobody could access Mr A's room from the internal hallway. However, IDEA Services also said that Mr A preferred to have his door ajar, but the privacy lock was used when Mr X was having a behavioural incident and Mr A did not want to leave the house. IDEA Services said that there is an alternative external glass door in Mr A's bedroom that could be accessed by both staff and Mr A but not the other service users.

Management of Mr X

62. In January 2021 Ms C referred Mr X to Disability Service 3 for behavioural support. The referral states:

> '[Mr X's] flat mates fear him, his staff are very weary of him and the behaviours. The house is not a home for those that live there. There are health and safety concerns for all involved … Another flat mate is in a wheelchair and [Mr X] has started to go into his room again (he has done this in the past), and he will play with the door alarm (to let staff know if anyone is going into the room), he has been seen by staff doing this. In the past [Mr X] has gone into his room and played with the electric bed controls while the flat mate has been in his bed. [Mr X] will play with the wheelchair controls. We are all concerned if [Mr X] does play with something that his flatmate may get hurt (hence the door alarm).'

63. An updated three-stage support protocol for Mr X was put in place on 23 February 2021. IDEA Services told HDC that, at that time, some events had occurred involving Mr X displaying agitation and aggression towards property in the home. This was characterised by him slamming his own bedroom door repeatedly, for up to an hour in some cases, moving his own bedroom furniture aggressively, throwing things aimlessly in the home, and upending furniture in the common areas of the home such as the dining room.

64. IDEA Services said that Mr X's behaviour was managed using several strategies. One was to remove the staff and other residents from the environment to reduce the stimulation and de-escalate the event quickly. The staff would take the other residents to a separate residence on the property until Mr X calmed down. Mr A was offered the option to go to the other residence during events of this nature, but often he declined to leave his bedroom and so the privacy lock was installed to support Mr A to remain in his room during these events. Staff were instructed to check on Mr A at regular intervals by way of the ranch slider in his room, to check whether he was ok as he was likely to be able to hear Mr X slamming his own bedroom door or tipping furniture.

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Assault 19 March 2021

65. Mrs B told HDC that on 19 March 2021 she and her husband drove to collect Mr A to take him home for the weekend. When they arrived at the residence, Ms C was waiting outside the front door, and she told them that Mr A had been assaulted by Mr X. Ms C said that one of the house staff had gone into Mr A's room to get him out of bed and found Mr X sitting on Mr A's chest hitting Mr A's genitals with a closed fist.

66. IDEA Services told HDC that the staff member directed Mr X to stop and move away, which he did, and he then went into his own bedroom, where his behaviour remained elevated for approximately 1.5 hours.

67. The incident form states that Mr A had laboured breathing, was crying, had graze marks on his chest, and the area was red. Mr A was wearing an incontinence pad and there was no apparent injury to his genitals, but he had scratches on his arms.

Alarm

68. IDEA Services said that on 19 March 2021 there was an operating alarm at the door of Mr A's bedroom, but it was turned towards the wall at the time of the incident. Staff had turned the sensor around earlier that morning when showering Mr A, as at that time staff were going in and out of his room constantly, and they had then forgotten to turn it back around afterwards.

69. IDEA Services told HDC that if the door alarm had been operating as expected, the staff would have been alerted when Mr X entered Mr A's bedroom, and the incident could have been prevented.

Action taken

70. IDEA Services did not report the incident to the Police. Mr A, accompanied by his parents, was taken to a general practitioner (GP), who examined Mr A and took his blood pressure. The GP felt that Mr A had been through a serious situation, but he had no broken bones, and his blood pressure was normal. The GP confirmed that there were no serious injuries (there were small abrasions and Mr A had a red chest). Mrs B decided to continue with the plan to take Mr A to her home for the weekend, and Mr A returned to the residence on the Sunday afternoon.

71. IDEA Services' Area Manager (Ms K) and Ms C met with Mr and Mrs B on 26 March 2021. Also in attendance was an advocate. Mrs B was concerned about Mr A's ongoing safety. The managers apologised again for what had occurred and assured Mrs B that they believed that IDEA Services could continue to support Mr A as required.

72. Mrs B told HDC that Ms K told them that there was no night supervision of Mr X and, as they had nowhere else to move him to, they suggested that Mr A go to another IDEA Services' house for a holiday. Mrs B stated that when she asked why Mr X was not being sent to another house, she was told that this was not possible.

73. IDEA Services told HDC that the reason why Mr X was not moved to a different property, and it was suggested to Mrs B that Mr A move out on an interim basis, was because finding

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a flat quickly for Mr X was a challenge given the significant shortage of available suitable accommodation, as IDEA Services considered that Mr X needed to live in a flat on his own. IDEA Services did not have a suitable bed space in another house for Mr X at that time, but it could safely accommodate Mr A temporarily in another home.

74. In response to the provisional opinion, IDEA Services stated that it presented various options available at that time (one of which was that Mr A could move to another home for a short time), and that its stated preference was that Mr A could stay in the home. It said that the options were presented to Mrs B so that she was fully informed and could then choose her preferred plan. IDEA Services stated that it was necessary to consider all the options in light of its requirement to take reasonably practicable steps to minimise health and safety risks in the circumstances.

75. Mrs B decided that moving Mr A would be extremely disruptive and unsettling for him and would upset him, and he would perceive it as him being punished.

76. IDEA Services said that Mr X was moved that same day to an adjoining flat at the back of the house (which was made available after a person was moved from the flat to a bedroom inside the house). IDEA Services made an urgent request to the landlord to get the flat modified with new safety glass and locks.

77. Mrs B said that she was told that Mr X would be under 24-hour surveillance while the flat at the back of the house was made secure. However, that did not happen, and Mr X was watched only in the daytime, with no surveillance at night. Consequently, Mrs B felt that she had to take Mr A home to be cared for until such time as she was satisfied that he was safe.

78. IDEA Services said that Mrs B wanted to know what support would be available if she took Mr A home on an ongoing basis. IDEA Services' managers discussed the logistics of that, including sharing their concerns about whether Mr and Mrs B would be able to do this (given their age). IDEA Services said that they were assured that the family could care for Mr A if support workers came to the house to assist. It was suggested that Mr and Mrs B might need to get an electric hoist rather than the current manual hoist, and that IDEA Services could support Mrs B to access such equipment. The managers discussed possible local community disability services providers in the area, which would need to be contracted if Mrs B were to withdraw Mr A from IDEA Services' residential care.

79. Mrs B told HDC that she became aware that there had been two other incidents in the house involving Mr X about which she had not been informed at the time, and after the incident on 19 March 2021, she found out that Mr X had a history of at least one other major incident about three years previously (discussed above), which was why Mr X was transferred to the residence. Mrs B was never informed of the risk Mr X posed to Mr A. In response to the provisional opinion, IDEA Services stated that it would not have been appropriate to inform Mrs B of that information as it is not able to share information about other people with family members.

80. IDEA Services said that the two previous incidents referred to by Mrs B were when Mr X sat on top of Mr A when he was in his wheelchair in December 2020 (no harm was caused), and

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earlier when Mr X was seen to grab the control on Mr A's wheelchair (no harm was caused). IDEA Services has not provided an incident form for the second of these incidents. IDEA Services agreed that Mrs B was not informed about the previous incidents involving her son and Mr X and said that this was because they were not considered sufficiently serious, and no harm had occurred. IDEA Services stated that the requirement for notification relates to where the incident is considered serious and, at the time, it was open to management to form the view that the incidents did not meet the threshold requiring notification.

81. IDEA Services told HDC that the NASC did not agree to increase Mr X's level of support and funding until after the March 2021 incident. At that time, upon review, the NASC finally agreed to increase his level of assessed support, and IDEA Services was able to move him into a home where he could live by himself and receive one-to-one support.

Policies

82. The Incident Reporting and Response System Policy (2017) states that service managers must investigate all reported incidents and near misses and feedback must be provided to staff, service users, and others involved in an incident or near miss. This includes the service user's family/advocate. The policy states: 'The service manager will notify family/advocate if the incident is serious or there is agreement to call them after an incident.'

83. The Protection of Vulnerable Children and Adults Policy (2017) states that when a service user discloses abuse or neglect, or staff have grounds to believe that abuse or neglect has occurred, the safety and best interests of the service user are paramount. The most immediate concern is to ensure that the service user who is the alleged victim of abuse is safe.

84. The policy requires that the Police must be notified if any type of abuse has occurred within a Regional Intellectual Disability Supported Accommodation Service. It states that section 195A of the Crimes Act 1961 requires that all instances of actual or suspected abuse and neglect where the vulnerable person is at risk of 'death, grievous bodily harm or sexual assault' must be reported to the Police.

85. The policy states that the Police are responsible for investigating the allegation, and the manager liaising with the Police is to clarify with them the responsibilities for communication with caregivers and family/whānau and to provide any contact details requested.

Further comment from IDEA Services

86. IDEA Services told HDC that there were appropriate protocols in place to ensure Mr A's safety. The alarm on Mr A's bedroom door was there to alert staff to attend to him immediately if someone entered his room. However, on the day of the incident, a support worker had not remembered to reactivate the alarm as expected, and this resulted in Mr X entering Mr A's bedroom without the knowledge of staff.

87. IDEA Services said that there had been repeated reminders to staff regarding the expectation that they return Mr A's bedroom door alarm to the correct position after

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providing support to him in his bedroom. IDEA Services noted that the alarm was overly sensitive when support workers were providing support around Mr A's bed, and it sounded loudly and repeatedly — so staff typically turned the alarm inwards or covered it whilst providing cares and reinstated the alarm to its proper position on finishing Mr A's cares. A hard-wired magnet alarm was considered but was not deemed appropriate as Mr A wished to have his bedroom door ajar and not closed, therefore a sensor-based alarm was chosen.

Response to provisional opinion

Mrs B

88. A copy of the 'information gathered during investigation' section of the provisional opinion was sent to Mrs B, and she was invited to comment. Her comments have been incorporated into this report where relevant.

IDEA Services Limited

89. IDEA Services was given an opportunity to comment on the relevant sections of the provisional opinion. IDEA Services' comments have been incorporated into this report where relevant.

90. IDEA Services stated that reference to the 2019 incident should be removed from the opinion because it had limited involvement in that incident.

91. IDEA Services advised that at the time of these events, sleepover shifts were occurring in this home, and a staff member was available at all times if something came up. However, no staff member was performing the sleepover in the particular service user's room (1:1 surveillance), and this would be a very non-typical arrangement.

92. IDEA Services said that since 2022 there have been no further complaints from Mr A's family, and any concerns are discussed and addressed. IDEA Services stated that communication with Mr A's family continues to be open and positive.

Disability Service 2

93. Disability Service 2 was given an opportunity to comment on the relevant sections of the provisional opinion. Disability Service 2's comments have been incorporated into this report where relevant.

Opinion: IDEA Services Limited — breach

Introduction

94. As a provider of disability support services, IDEA Services was responsible for providing services to its clients in accordance with the New Zealand Health and Disabilities Sector (Core) Standards and the Code of Health and Disability Services Consumers' Rights (the Code), and this included responsibility for the actions of its staff.

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95. Mr A entered IDEA Services' residential service in 2006. He has intellectual, physical, and developmental impairments and is dependent on others for his care. IDEA Services had a responsibility to ensure that he received services of an appropriate standard. IDEA Services also had a responsibility to protect him from being harmed by other clients.

96. In my view, there were deficiencies in the care provided to Mr A by IDEA Services' staff, and these were systemic issues for which IDEA Services Limited bears responsibility.

97. I consider that a combination of inadequate care planning in relation to risk management, placement with a resident who exhibited inappropriate behaviour that escalated to violence, and poor management of incident reporting, placed Mr A in a position of vulnerability, and the care provided to him fell short of the accepted standard.

98. The New Zealand Health and Disabilities Sector (Core) Standards (NZS8134.1:2008) in force at the time state that the standards are to enable consumers to be clear about their rights, and providers to be clear about their responsibilities for safe outcomes. NZS8134.1 requires the following:

> '(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;
>
> (b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;
>
> (c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and
>
> (d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.'

99. NZS 8134 provides (amongst other things) the following: 'Standard 2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.'

Failure to provide a safe environment — breach

Mr X's conduct

100. Mr X moved to the house in 2018. The move occurred after a serious incident in early 2018 at another IDEA Services' residence, involving Mr X and a staff member. Mrs B was not informed about this incident or of the risk Mr X posed to Mr A. In response to the provisional opinion, IDEA Services stated that it would not have been appropriate to inform Mrs B of that information as it is not able to share information about other people with family members.

101. It is clear from the information available that on several occasions Mr X's behaviour impacted negatively on Mr A's privacy, safety, and wellbeing. Apart from the distress caused by Mr X repeatedly slamming his bedroom door and throwing furniture and other objects, there were repeated incidents when Mr X directly put Mr A at risk, as detailed above.

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102. None of the incident forms refer to IDEA Services having contacted Mrs B to inform her of the incidents. IDEA Services said that this was because the incidents were not considered sufficiently serious, and no harm occurred. In my view, that is not the point. The Incident Reporting and Response System Policy states that service managers must investigate all reported incidents and near misses, and feedback must be provided to staff, service users, and others involved in an incident or near miss, including the service user's family/advocate. The policy states: 'The service manager will notify family/advocate if the incident is serious or there is agreement to call them after an incident.' In response to the provisional opinion, IDEA Services stated that the requirement for notification relates to where the incident is considered serious and, at the time, it was open to management to form the view that the incidents did not meet the threshold requiring notification.

103. I remain of the view that psychological harm can be serious. The incident forms indicate that Mr A was distressed and crying after some of the incidents. Mr A was also at risk of physical harm when he was assaulted, sat on, and his chair and bed were moved and tilted. Mrs B was closely involved in her son's welfare, and she should have been informed of each incident so that she could discuss them with her son and satisfy herself that he was safe.

104. In my view, the door alarm was insufficient to keep Mr A safe. Although an alarm was installed, on at least one occasion the batteries were flat. In addition, at times the alarm was turned off or turned around. Consequently, the alarm was not effective to keep Mr A safe, and incidents continued to occur.

105. Although staff were reminded to use the alarm, the management plan did not consider the incidents adequately and respond to them appropriately, and IDEA Services did not identify the risk posed by Mr X adequately and prepare an adequate safety plan for Mr A.

106. Mr A's support plan states that the door alarm was to be used at all times when he was in his room by himself, and staff were to check on him when the alarm was activated. However, the plan also states that the alarm could be switched off when staff were in Mr A's room but must be switched back on when staff left his room if he was still in the room. Mr A's support plan does not refer to any risk posed by other residents in the house.

107. IDEA Services was aware that Mr X's escalating behaviour was impinging on the quality of life of Mr A and the other residents. In January 2021, Ms C referred Mr X to Disability Service 3 for behavioural support with the referral acknowledging the incidents with Mr A and the health and safety risks that Mr X's behaviour posed for staff and service users.

108. An updated three-stage support protocol for Mr X was put in place on 23 February 2021. Mr X's behaviour was managed using several strategies, including staff taking the other residents to a separate residence on the property until Mr X calmed down. Mr A often declined to leave his bedroom and so a privacy lock was installed to support Mr A to remain in his room during these events, with staff instructed to check on Mr A at regular intervals.

109. Following the escalating pattern of incidents, on 19 March 2021 Mr A was assaulted by Mr X, with a staff member finding Mr X sitting on Mr A's chest hitting his genitals with a closed fist. Mr A had laboured breathing, was crying, had graze marks on his chest, and the area

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was red. Mr A had no apparent injury to his genitals, but he had scratches on his arms. The alarm on Mr A's door was not working because staff had turned the sensor around earlier that morning when showering Mr A and had forgotten to turn it back. In light of the multiple previous incidents, this was unsatisfactory.

110. In my view, there was a concerning pattern of Mr A being subjected to unsafe and inappropriate behaviour by Mr X, which escalated to violence. I note that IDEA Services said that it was actively working with various services to manage Mr X's inappropriate behaviour and had put in place plans to minimise harm. However, Mr A was particularly vulnerable to Mr X's behaviour.

111. I am concerned that IDEA Services responded inadequately to multiple incidents involving Mr X's behaviour towards Mr A. It is apparent that reminders to staff to ensure the alarm was functioning were inadequate and ineffective, putting Mr A at risk of suffering further harm.

112. In my opinion, IDEA Services should have made greater effort earlier on to address this situation. While I acknowledge that IDEA Services was reliant on the NASC agreeing to increase Mr X's level of assessed support, which would enable IDEA Services to move Mr X into a home where he could live by himself and receive one-on-one support, in the meantime, and as noted above, behaviour support assistance was not sought for Mr X until January 2021, some three and a half years after Mr X first moved to the house. Noting the incidents that occurred in the intervening period, IDEA Services made a referral to Disability Service 3 only when the situation had deteriorated to the extent that 'the house was not a home for those that lived there' and there were health and safety concerns for all involved, with Mr X's flatmates fearing him and staff being weary of him and his behaviours. The situation facing Mr A and his flatmates was untenable.

113. I am also critical that IDEA Services failed to contact the Police following a serious assault on Mr A on 19 March 2021 given that the Protection of Vulnerable Children and Adults Policy specified that Police must be notified if any type of abuse has occurred within a Regional Intellectual Disability Supported Accommodation Service.

114. I consider that the incident reports show that IDEA Services failed to provide Mr A with a safe environment. I am highly critical of this failure.

Change of residence

115. Following the incident on 19 March 2021 during which Mr A was assaulted, his parents took him home for the weekend. On 26 March 2021, they met with Ms K and Ms C. Mrs B was concerned about Mr A's ongoing safety.

116. Ms K told Mr and Mrs B that there was no night supervision of Mr X and, as they had nowhere else to move him to, they suggested that Mr A go to another IDEA Services' house for a holiday. Mrs B stated that when she asked why Mr X was not being sent to another house, they were told that this was not possible.

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117. IDEA Services said that the reason it was suggested that Mr A move out on an interim basis was that finding a flat quickly for Mr X was a challenge given the significant shortage of available and suitable accommodation, as they considered that he needed to live in a flat on his own.

118. Mrs B did not think moving Mr A would be appropriate, so IDEA Services moved Mr X to an adjoining flat at the back of the house and made an urgent request to the landlord to get the flat modified. I agree that moving Mr A from his home of 17 years was not reasonable. In response to the provisional opinion, IDEA Services stated that it presented various options available at that time (one of which was that Mr A could move to another home for a short time), and that its stated preference was that Mr A stay in the home. IDEA Services said the options were presented to Mrs B so that she was fully informed and could then choose her preferred plan. It said that it was necessary to consider all of the options in light of its requirement to take reasonably practicable steps to minimise health and safety risks in the circumstances.

119. Mrs B said that she was told that Mr X would be under 24-hour surveillance while the flat at the back of the house was made secure. However, that did not happen, and Mr X was watched only in the daytime, and there was no surveillance at night. Consequently, Mrs B felt that she had to take Mr A home to be cared for until such time as she was satisfied that he was safe.

120. I accept that as Mr X was difficult to manage and needed a secure environment, there was a need to modify the flat. However, the initial suggestion to move Mr A rather than Mr X was inappropriate, and the subsequent lack of oversight of Mr X meant that Mr A remained at risk.

Conclusion

121. Mr A is a vulnerable man with high needs who relied on IDEA Services to provide him with safe services of an appropriate standard. In my view, IDEA Services did not meet that standard, and several factors contributed to this. These included the following:

- Risk planning was insufficient. Risks were not identified satisfactorily, and adequate risk prevention strategies were not put in place.
- IDEA Services was aware that the alarm on Mr A's door was not used reliably and was insufficient to alert staff when Mr X entered Mr A's room but took no action other than reminding staff to engage the alarm.
- Mr A was placed with another resident who exhibited inappropriate behaviour towards him that at times escalated to violence.
- IDEA Services did not make a timely referral to Disability Service 3 for assistance with managing Mr X's inappropriate behaviours.
- Following the assault, it was suggested that Mr A be moved to an unfamiliar residence.
- IDEA Services failed to inform Mrs B of the concerning incidents. As a result, she was not able to support her son or advocate for him.

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- IDEA Services failed to report the assault to the Police, as required by its policy.

122. Noting the above, I consider that IDEA Services failed to provide services to Mr A that minimised the potential harm to him and optimised his quality of life, and I find that IDEA Services breached Right 4(4) of the Code.[12]

Disability Service 2 assessment — adverse comment

123. On 5 August 2019, Ms C emailed Mrs B enquiring whether she would be interested in Mr A attending a free Disability Service 2 assessment. Ms C posted an information booklet about Disability Service 2 to Mrs B, who responded by email on 6 August 2019 confirming that she agreed that it would be good for Mr A to attend. Ms C made an appointment for Mr A's assessment on 15 August 2019 at 9.30am.

124. Mrs B said that she agreed on the condition that both she and her husband were present at the assessment, although her email of 6 August 2019 does not express this condition. On 13 August, Mrs B told Ms C in an email that she would be attending the assessment.

125. Ms F accompanied Mr A to the assessment, which began at 9.15am. Mrs B said that when they arrived at 9.20am, they were upset to see that the assessment had started early, without them. IDEA Services told HDC that the decision to start early was made by Disability Service 2; however, IDEA Services acknowledged that its staff were aware that Mr A's family were planning to attend and said that it would have been useful for Ms F to have suggested that Disability Service 2 wait until Mr and Mrs B arrived before starting the assessment.

126. I agree. Mr A has limited communication ability, and his mother has been a conscientious advocate and supporter for him. It was not appropriate to proceed on the basis of Mr A's consent, particularly as he has echolalia. Mrs B is his welfare guardian, and regardless of whether her consent to Mr A's Disability Service 2 was conditional on their presence, Ms F should have told Mr E to wait until Mrs B arrived, especially as Mr and Mrs B were not late for the appointment. I note that Ms F thought that Mr E lacked understanding of Mr A's condition, and this was information that his parents could have provided.

Opinion: Disability Service 2 — adverse comment

127. On 15 August 2019 Mr A attended an assessment at Disability Service 2. Immediately after the appointment Mrs B noticed that Mr A could no longer use his right arm. Mrs B said that the injury to Mr A's right arm has changed his life dramatically, as since then he has been unable to feed himself, use his electric chair properly, or lift himself for others to manage his toiletry needs.

[12] Right 4(4) of the Code states: 'Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

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128. Mrs B believes that Mr E's actions caused Mr A's inability to use his arm. It is not the role of HDC to determine the cause of Mr A's symptoms. The role of HDC is to determine whether the assessment undertaken by Disability Service 2 was of an appropriate standard. In assessing this, I have taken into account the views of Dr H and Dr I, acknowledging that neither is a peer of Mr E.

129. On 26 March 2021 Mr A underwent an MRI scan that showed that he had a very tight spinal canal at multiple levels, which was worse at C4/5 and C5/6. According to Dr I, Mr A required C4/5 and C5/6 anterior cervical discectomies and might need a laminectomy. Dr I noted that the changes in Mr A's spine were longstanding, but he opined that the manipulation of Mr A's neck and spine by Disability Service 2 was the action that had caused Mr A to lose the function of his right arm. However, as discussed below, there is no evidence from those present during the assessment that Mr E manipulated Mr A's neck and/or spine.

130. Dr H advised ACC that based on the clinical findings and MRI report, the cause of Mr A's C5 nerve root problem was compression of the nerve roots due to severe cervical spondylosis. Dr H concluded that the nerve root compression was due to changes in Mr A's cervical spine that had occurred gradually over time and could not be attributed to the Disability Service 2 assessment on 18 August 2019.

131. Dr H acknowledged that Mr A's symptoms of loss of function of the right arm were noted after the Disability Service 2 assessment, which had unmasked and rendered symptomatic the cervical spondylosis, resulting in the symptoms of cervical nerve root compression and the injury of the C5 nerve root.

132. It appears from Dr I's comments that he considered that Mr E should not have manipulated Mr A's neck.

133. As stated above, neither Dr H nor Dr I is a peer of Mr E. However, in any event, the statements of the people present at the assessment do not refer to Mr E having manipulated Mr A's neck or his spine. Disability Service 2 said that its assessment process involves discussions about the person's current state and any known issues that Disability Service 2 needs to be aware of. Any physical facilitation, which is kept to a minimum during the assessment process, is used to determine the person's range of mobility, along with strengths and weaknesses that they and their family/whānau want Disability Service 2 to assist with.

134. Ms F said that Mr E assessed what Mr A was capable of doing and made an attempt to lift Mr A from behind, but Mr E realised that this was not possible. Mr E did some arm lifting exercises with Mr A and said he was sure that his treatment would enable Mr A to stand.

135. Ms D said that the assessment included Mr E physically supporting Mr A to sit in a more upright position in his wheelchair to assess his core trunk flexibility and range of motion while Mr A used his right arm to steady himself using a parallel bar.

136. The Disability Service 2 assessment record states:

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> 'At the assessment I asked him and helped hands-on to lean forwards in the chair into an upright position, and that was a real challenge. It seems that he has been accustomed to being tilted backwards in his regular motor wheelchair …'

137. Mrs B said that Mr E bent Mr A over in his wheelchair with 'tremendous force'. Disability Service 2 denied that 'tremendous force' was exerted. Given that the other people present do not refer to there having been tremendous force, I find that Mr E leant Mr A forward, but I make no finding about the extent of the force used to do so.

138. I note that none of the accounts of the people present at the assessment refer to neck or spinal manipulation having occurred. However, they do refer to Mr E having attempted to have Mr A lean forwards in his chair.

139. I acknowledge that it is extremely unfortunate that Mr A's symptoms worsened after the Disability Service 2 assessment. However, I am unable to make a finding that the conduct of the assessment was inappropriate. I note that Mrs B was sufficiently satisfied with the assessment to agree to Mr A having a further appointment.

140. It appears that Mr E had limited knowledge of Mr A's condition. Ms F stated that she remembers wondering during the session whether the Disability Service 2 staff present had read any notes on Mr A, as she considered that a lot of what Mr E said was unrealistic. I am critical that Disability Service 2 had limited information about Mr A's condition before undertaking the assessment.

141. Mr A has an intellectual disability and echolalia, and his mother is his welfare guardian. I consider that Mr E should have discussed Mr A's history, abilities, and condition with Mrs B before starting the assessment.

142. Furthermore, in my view, the Disability Service 2 assessment should not have involved applying any force to Mr A's spine without having first had a medical clearance to do so.

Changes made since events

IDEA Services Limited

143. IDEA Services has implemented a comprehensive Compatibility Tool to assess the suitability of the people it supports when moving into new living arrangements. The tool assesses both compatibility and the wishes of the people it supports and their preferences for flatmates.

144. IDEA Services advised HDC that since the events:

a) Mr A remains in the same home where he lives with four other people.

b) There has been a change in managers, with the current manager in an acting role since April 2024, which was made permanent in September.

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c) Mr A has been receiving increased support (a total of 66.5 hours per week) since his last three-yearly needs assessment review in June 2022.

d) Ceiling hoists have been installed in Mr A's bedroom to support him and his support team to ensure that transfers are completed safely.

e) An external audit of the residence was completed in 2024, which Mrs B participated in. Feedback from Mrs B indicated that she could see improvements in the service being provided to Mr A.

Disability Service 2

145. Disability Service 2 told HDC that it has amended its processes to ensure that when performing an assessment where an external agency is involved, it waits for family/whānau representatives to arrive, if applicable, before commencing the assessment.

Recommendations

IDEA Services

146. I recommend that IDEA Services Limited provide a written apology to Mr A and his family for its breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

147. I recommend that IDEA Services Limited complete the following actions and report back to HDC within six months of the date of this report:

a) Commission an independent review of:

i. whether the processes to identify risk arising from incidents is adequate; and
ii. the personal plans and risk management plans for each client in the residence to ensure that each has been reviewed and updated appropriately and contains clear information specific to that person;

and report back to HDC on the actions taken in response to the review.

b) Report back to HDC on the continuous development work it has undertaken on the Compatibility Tool since it was first introduced in 2019.

c) Conduct an audit, over a three-month period, of compliance with incident reporting procedures and timelines in the region and report back to HDC on the outcome of the audit.

Disability Service 2

148. I recommend that Disability Service 2 provide a written apology to Mr A and his family for the criticisms contained in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

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149. I recommend that with three months of date of this report, Disability Service 2 develop a policy requiring its assessors to have reviewed medical assessments of clients before undertaking any physical manipulations. The policy is to be provided to HDC.

150. I recommend that within three months of the date of this report, Disability Service 2 arrange for its staff who work with clients to complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/ — and provide evidence of each staff member having done so.

Follow-up actions

151. A copy of this report with details identifying the parties removed, except IDEA Services Limited, will be sent to Disability Support Services — Ministry of Social Development, Whaikaha|Ministry of Disabled People, the Office for Disability Issues, the Disability Support Transformation Team, the New Zealand Disability Support Network, Disability Service 3, and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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