Caregiver, Ms C

Caregiver, Ms D

Care Coordinator, Ms E

Spectrum Care Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC04441)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms C	Provider/Caregiver
Ms D	Provider/Caregiver
Ms E	Provider/ Care Coordinator
Ms F	Spectrum Care Trust, Team Leader
Mr G	Spectrum Care Trust, Senior Manager
Ms H	Spectrum Care Trust, Service Manager
Ms I	Caregiver
Ms J	Caregiver
Mr K	Resident at George Street home
Spectrum Care Trust	Care facility

Complaint

On 31 March 2006 the Commissioner received a complaint from Mr Allan McEvoy about the services provided to Mr A by Spectrum Care Trust (Spectrum Care). The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by caregiver Ms D on 3 March 2006.*
- *The appropriateness of the care provided to Mr A by caregiver Ms C on 3 March 2006.*
- *The adequacy of the service provided to Mr A by coordinator Ms E in March 2006.*
- *The adequacy of the service provided to Mr A by Spectrum Care Trust in March 2006.*

An investigation was commenced on 13 October 2006.

Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Information reviewed

Information was received from:

- Mr McEvoy
- Ms C
- Ms D
- Ms E
- Ms I
- Ms F
- Mr G
- The Chief Executive, Spectrum Care Trust
- The Ministry of Health

Relevant Spectrum Care policies and procedures were reviewed.

Information gathered during investigation

Background
Mr A, who is aged 45, has been in care since he was three years old. He has been totally blind and partially deaf since birth, and exhibits behavioural difficulties and a tendency towards self-injury. He is fearful of new physical surroundings. This can cause him to rip and tear his clothing and strike out at people, and increases his tendency to fall. Mr A requires 24-hour supervision and monitoring.

When the Mangere Psychopaedic Hospital was closed in 1995, Mr A was moved to Spectrum Care's residential home, Pear Tree Cottage in Weymouth. In 1997 it was closed and Mr A moved to Spectrum Care's residential home at George Street, Papakura. Mr Allan McEvoy cared for Mr A at the hospital from 1990–1994 and has acted as his Welfare Guardian since 1995.

On 29 August 2006, Mr A was transferred to his new home in Manukau. Mr McEvoy advised that the new home is a high-dependency unit managed by an umbrella trust. A number of ex-Spectrum Care caregivers staff this unit. Ms F has resigned from Spectrum Care and is now the House Leader at these premises.

Showering incident — 3 March 2006
On 3 March 2006 Ms F, Ms C and Ms D were on duty at Spectrum Care's George Street house. The George Street house provides accommodation for five men with a variety of longstanding intellectual disabilities.

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Ms F was the house leader at George Street. The caregivers' daily duties were food preparation, assisting the men with their meals, showering and toileting, and monitoring the men and engaging them in a variety of activities. At the beginning of each shift the staff would divide up the duties. George Street practice at the time excluded the staff member undertaking the kitchen duties from hands-on care of the men, such as toileting and showering, but that staff member could help with the bedmaking, general tidying round the home and outings.

Mr A was viewed by staff as the more challenging of the men in the George Street home, because of his habit of repeated digital bowel evacuation and smearing of faecal matter, occasional aggression and dislike of wearing clothing. Mr A enjoyed being in the shower and this was used to soothe him when he became agitated.

On the morning of Friday 3 March 2006, Ms F had left early in the morning to purchase groceries for the house, leaving Ms D to take the kitchen duties, and Ms C the general care of the men. Arrangements had been made for that day for three of the men to be taken to a disability activity centre (the activity centre) at 1pm. Ms D started lunch for the men at 11.30am, conscious of the need to have the meal finished in time for the men to be conveyed in the house van to the activity centre. Ms D and Ms C had a conversation about the arrangements, but had not been given the names of the men going to the activity centre that day, and decided to wait until Ms F returned. Ms D was in the kitchen preparing the meal. Ms C was working in the bedroom and bathroom areas.

Ms D and Ms C gave all the men, except Mr A, their lunch. Mr A is usually given his meal separately as he has a habit of knocking the other men's food off the table. Mr A was in his room at this time. After the men had their lunch, Ms D made a sandwich for herself and Ms C. While she was tidying the kitchen and making the sandwiches, Ms D was aware that the shower was running but she did not see who Ms C was showering.

Ms C stated:

> "After the shower and the breakfast and the tidying up, sometime after that, [Mr A] had another bowel motion and smeared and needed to be put back into the shower again, which was around about the end of lunch time. … He can just shower himself. … He loves the water, shower on top of his head. He'll sit there or he'll stand and he is quite safe in there because there is nothing in there. It's just a flat floor and a hose."

At this time Ms F arrived back with the groceries. Ms D helped to put the items away and reminded Ms F that they needed to leave with the men if they were to get to the activity centre in time. She then took one of the men to the van, but had to stay with him there to prevent him running away. Ms C came into the lounge to assist in loading the two other men into the van.

Ms D said that she was aware that they were running late in getting the men to the activity centre. She said that she "yelled out" to Ms C that they needed to hurry up. Ms D stated:

> "I remember ([Ms C]) saying to [Ms F], '[Mr A] is in the shower'. … I went to take, I'm not sure who it was, [one of the residents], into the van. And because when [one of the residents is] out in the van you're not to open the gate because he … runs away and you have to watch him. So I had to stay out in the van. … But I know [Ms C] told [Ms F], [Mr A] was in the shower and that was 10 to one. … [B]ecause I was sitting in the van … the door was open and you can … hear them talking."

Ms C stated that before she left she informed Ms F that Mr A was in the shower.

Ms C said:

> "We were off the grounds by about two minutes past one and when we left I said, '[Ms F], [Mr A's] in the shower', and that was the last. We'd gone."

Ms F stated that upon being told that Mr A was in the shower she went to check on him and found that he was in a cold shower. His body was very cold and his lips and feet had a bluish appearance. Ms F turned the shower on to a warm temperature and then dressed Mr A and massaged him until his colour returned.

Ms F initially recalled that she spoke to Ms D before she and Ms C left for the activity centre, and asked why Mr A was in a cold shower. Ms D told her that Ms C was supporting Mr A and that they were about to leave to go to the activity centre. Ms F said that she would catch up with them when they returned. However, Ms F later recalled that she waited until Ms C and Ms D arrived back at George Street from the activity centre at about 4pm to "find out what had happened".

There is a discrepancy in the recollections about the time Ms D and Ms C arrived back at George Street, as they believed it was about 3pm. As soon as they arrived at George Street they toileted the three men. Ms D finished her duty at 3pm but Ms C was rostered on until 4pm.

As Ms C was leaving, Ms F asked her to settle the pharmacy accounts on her way home. Ms F was busy in the office and kitchen at the time and asked Ms C to wait until she had the documents ready. Ms C recalled that she waited for 20 to 25 minutes for Ms F to give her the accounts, but finally said that she had to leave and would go to the pharmacy the following day. As she got to the door, Ms F addressed her and said, "Do you know you left [Mr A] under the cold water?" Ms C denied doing so and then left.

There is also a discrepancy about how the showering incident was reported to Ms F's line supervisor, Coordinator Ms E. Ms F stated that she did not report the incident

immediately when she discovered Mr A under the cold shower as at that time she was unaware who had placed him in the shower and wanted to wait until Ms C and Ms D arrived back from the activity centre, so that she could speak to them.

Ms E stated:

> "[On] 3rd of March, on my way home I called into George Street at approximately ten past five. I know it was after five. [I called in] to pick up something and I don't recall what it was. [Ms F] was stressing out, she goes, 'Oh I got to tell you something.' And I say to her, 'OK, OK, but I am really off shift.' Coz I had finished at five that's why I called in at that time. … And she told me … that she went into the shower after the two staff had gone to the [activity centre] and found [Mr A] in a shower that was running. The water was cold. …
>
> [M]y role, if something is reported to me and I'm not actually on shift, it should be reported to the 'on-call' coordinator and they deal with the situation. … So, when [Ms F] told me, I have to use these strong words,… because of [Mr McEvoy's] record within Spectrum. … [A]nd she goes, 'Yes, Yes, Yes.' and I says, 'Well, I can't do nothing about it, I'm not on shift, but you know the procedure'. Then I proceeded to ring [Mr McEvoy] and I went home."

Ms E stated that she telephoned Mr McEvoy because there was a history of Mr McEvoy complaining about the care being provided to Mr A. Ms E said, "I was unsure of what had actually happened, so I said to him, tepid water, coz the investigation had to proceed and I wasn't going to make any more assumptions because we had been down that track before with Allan," and she wanted to "safeguard [Ms F] and myself".

Ms F stated that Ms E did not call into George Street on the evening of Friday 3 March 2006. Ms F stated that she telephoned Ms E at about 5pm to inform her of the incident and was "really pleased" when she answered her mobile phone because she was concerned that Ms E would have finished for the day. Ms F said that if Ms E had not answered she would have had to contact the on-call manager. She recalls that when she told Ms E what had happened, she was told to complete the incident report on Monday (6 March). Ms E would then follow it up. Ms F assumed that Ms E would make arrangements to replace Ms C, who was rostered to work the weekend.

Mr G believes that Ms F's recollection that she telephoned Ms E on the evening of 3 March is incorrect. He stated that he checked the telephone records for George Street for 3 March 2006 and the only three calls made from the house landline to Ms E's mobile that day were at 9.29am, 6pm and 6.06pm.There is no record of a call having been made at around 5pm.

6 March 2006
Ms E arrived at George Street early on the morning of Monday 6 March to speak to the staff about the shower incident.

Ms C stated:

> "Monday morning I got to work, seven o'clock my usual starting time, I was only there it might have been even five minutes, four minutes, and I looked out the window, looked down the driveway and I saw [Ms E] coming and I thought, 'Gee, what's she doing here this time of the morning?' …
>
> [Ms E] said to me, 'Oh, I need to talk to you. We need to go down to the office'. … I knew straightaway and I said, 'Oh yeah, is it the cold water incident?' and she said, 'Yes I have to suspend you'. …
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> She said to me that I was suspended and that I can make the date for myself for the investigation. You know, I could put in a date and I could bring in my support person for me and I said to [Ms E], 'Why can't I just have it now,… make the meeting now, today, get it over and done with. '[Ms E] said to me, 'Are you sure?' I said, 'Yeah, because I have nothing to hide. I'll have it today. 'So she rang [Ms H], but [Ms H] wasn't available."

Ms F completed a "Client Incident Accident Form" on 6 March 2006, noting the time as 12.50pm. It is unclear whether this was the time Ms F completed the form or whether she was referring to the time of the incident. Ms F noted the circumstances as follows:

> "03-03-06. [Mr A] in shower area on crossing over staff cares. Staff [Ms F] entered the shower room to assist [him]. Found shower water control on straight cold water. Turned control back to hot to check water temp. Water temp supply hot. Showered [Mr A] to remove hard faeces on face and warm up his body. When finishing shower (approx 10 mins), dressed [him] warmly and supported [him] with his lunch.…
>
> On staff return from [activity centre], enquired with staff on duty who was giving support to [Mr A] re shower. [Ms C] acknowledged she was supporting [Mr A]. Informed [Ms C] of the above. [Ms C] gave no explanation at the time."

Mr McEvoy's recollection of when Ms E telephoned him about the showering incident differs from her version of the event. In his letter of 20 March 2006 to Spectrum Care he stated:

> "Approximately two weeks ago, [Ms E] the Coordinator of the Spectrum Care Trust [home] telephoned me at work to report to me that a complaint had been received from a member of the [Home] staff, claiming that another staff member had showered [Mr A] in 'tepid water'. [Ms E] assured me that [Mr A] was 'OK',

> the staff member involved had been suspended on full pay while an investigation took place, and that the incident would be thoroughly investigated and I would be informed of the result."

Mr McEvoy also stated that it was his understanding at the time that Mr A was not supposed to be left in the shower on his own.

Ms E remains certain that she telephoned Mr McEvoy from George Street on the evening of 3 March. She does not recall advising him about the suspension of the caregiver and the process of the investigation. She said that she would have been apprehensive about the consequences of not advising Mr McEvoy "straight away".

Follow-up actions
Spectrum Care stated that Ms E was performance counselled by Ms H on 6 March immediately after it became apparent that she had not reported the incident as per the Spectrum Care policy. A written record of the matter was placed on Ms E's file.

(The Spectrum Care "Complaints Management Procedure" is attached as **Appendix 1** and "Detecting and Reporting Abuse or Neglect" as **Appendix 2**.)

Ms C stated that the meeting at which she was spoken to about this incident took place on Thursday 9 March 2006. She said:

> "At the meeting, I said to [Ms H], 'Well [Ms H], first of all you know I'm looking at the time this Incident report was written on the 6th. It happened on the 3rd. I'm looking at the time it was written. I got suspended that morning at 7 o'clock. That's in the report as written at ten to one. I'm looking at this Incident [Report], it doesn't even show what time she took him out of the shower. So, how do I know, she might have left him in there for a long time. I don't know. So, I've got no idea. … How can you call me in when there's no time here?' "

On 17 March 2006, Ms H wrote to Ms C thanking her for meeting with her and the Human Resource Advisor on 13 March (not 9 March as Ms C believes) to discuss the incident concerning Mr A being found in a cold shower. Ms H noted: "As I advised you verbally by phone, we considered your response and have decided that no further action will be taken in regard to this matter."

On 17 March, when Mr McEvoy had heard nothing further from Spectrum Care about the incident, he contacted Ms H. She confirmed that they were investigating an incident where Mr A had been left in a cold shower. Ms H stated that Spectrum Care management had concluded that the "balance of probability" was that the accused member of staff did not deliberately mistreat Mr A. Mr McEvoy expressed his concern that Ms E had misrepresented the circumstances of the incident.

On 20 March Ms H wrote to Mr McEvoy to advise him of the outcome of her investigation. Ms H stated:

> "Disciplinary investigations are a fairly exhaustive process, to ensure that the outcome is based on fair and objective information. As I discussed with you [on] the phone, in employment law, disciplinary action is based on the 'balance of probability', rather than 'beyond a shadow of a doubt'.
>
> The reasons I did not proceed with disciplinary action included:
>
> - [Ms C] informed [Ms F] that [Mr A] was in the shower before she left. If she had intended [Mr A] to be in there with cold water on him, she would have known that a complaint would have been laid.
> - There is a history in the house of other clients on occasion going into the other's space (i.e bedrooms, the shower room) and 'playing' with items. Although remote, there is a possibility that one of the other men had gone into the shower. Once again, although slim, there is the possibility that [Mr A] may have turned the tap himself, as he does have access to the control as well as the shower handle itself.
> - The third staff member corroborated the information that the staff member had about times and activities.
> - The complainant was very vague on when activities took place, she could not be sure of how long [Mr A] was in the shower, for example.
> - [Ms C] has a history of providing excellent support for [Mr A], there is no other evidence that she would intentionally harm [Mr A]."

Ms H made a number of recommendations, which were implemented, for change to Spectrum Care's systems, including showering procedures and handover, to ensure that this situation did not recur.

On 30 November 2006, Mr G, stated:

> "[Ms F] should have contacted [Ms E] well before their 5.00pm finishing time, which in turn, would have given [Ms E] the opportunity to inform [Ms H] before 5.00pm. If [Ms F] was concerned that she was unable to contact [Ms E], then it would have been appropriate for her to have contacted [Ms H] directly. Failing that, and given that she had elected to stay at work after 5.00pm, [Ms F's] next best course of action would have been to express her concerns to the on-call Service Coordinator, who in turn would have contacted the on-call Service Manager, to determine the appropriate action to take with respect to [Ms C] [who was rostered to work the weekend]. It is accepted, however, that [Ms E] should have contacted the on-call Service Manager to apprise them of the situation on Friday evening. This would have created the opportunity for [Ms C] to have been immediately suspended until the incident had been investigated and an appropriate response formulated."

Mr G advised that the George Street home is a normal residential home and has a standard 180 litre electric hot water cylinder. Mr G had earlier stated that the hot

water cylinder is fitted with a thermostatic mixing valve which limits the water temperature at the tap to be no hotter than 55 degrees. Mr A is limited to having three half-hour showers a day. Mr G advised that the staff have been able to ensure that there is sufficient hot water for all the men's needs by scheduling showering and laundry times. However, a routine check of the hot water cylinder conducted in March 2006 found that the cylinder "had recently been drained of hot water". Mr G later advised: "There is no evidence that the men's needs have ever been compromised through insufficient hot water."

Other matters of concern

While the initial focus of this investigation was the events of 3 March 2006, during the investigation other issues of concern regarding the services provided to Mr A over this period were also identified.

Mr A confined to his bed
One of Mr McEvoy's concerns relating to the care provided to Mr A at George Street was that he had been "under-stimulated as a punitive measure by some of the staff". Caregiver Ms I advised that Mr A was confined to his bed on a number of occasions. She stated that on these occasions staff were rostered to sit in Mr A's room for two-hour periods to watch him and keep him in bed. They played his CDs to divert him. She was told that this was his choice, but she was uncomfortable with this, especially as his care plan included activities such as walks and rides in the van. Ms I stated that this practice was still occurring when she ceased working at the George Street house in April 2006.

Mr G stated that Mr A has "never been confined to or prevented from leaving his bed", but he "often preferred to spend time in his room". Ms E and Ms C supported Mr G' statement that Mr A was not confined to his room. Ms E said that it was Mr A's choice to be in his room. In response, Mr McEvoy queried why Mr A would choose to remain in his room and stated that in his current home the only time Mr A spends in his room when he is sleeping.

Mr McEvoy had brought in a radio and a tape for Mr A to listen to, but staff believed that Mr A was lonely because if he was left alone he would scream. Staff were assigned to keep him company in three-hour shifts. They would do paperwork or throw toys to him while he listened to the tape. Ms E was unsure who had authorised this activities plan for Mr A, but thought the plan might be in the psychiatrist's report. Ms C said that she ordered audio material from the Foundation of the Blind, and that staff would read to Mr A and sing with him to the tapes. She considered that this was stimulation for Mr A, and said that he seemed to enjoy it.

Mr G stated that although Mr A spent a lot of time in his room, he was always free to move about the house and garden at will. He was provided with additional staff to keep him company and provide him with extra stimulation.

Mr G stated that Spectrum Care had increased the staffing levels at George Street beyond what Mr A's funding allowed. The increased staff hours provided one-to-one support with the aim of distracting him from faecal smearing. Mr G stated that Mr A had a full activities plan and that many of his supervised activities were undertaken in his room. Spectrum Care provided a copy of Mr A's activities plan for July 2006. The plan lists his activities as a weekly outing for swimming, and a drive in the van. The majority of his activities are centred at the house, such as "backyard walk, lounge visit 2hrs — sat on sofa, relaxation — listening to music". Visits by Mr McEvoy, a doctor's appointment and a haircut were also written up as planned activities.

Replacement mattress

Ms I stated that over a period of three weeks, when she was on night duty, Mr A was sleeping on a urine-soaked and faeces-smeared mattress, because he had removed the plastic cover from the mattress. She said that the smell was so bad that she took the mattress off the bed, put it outside on the deck and settled him on the mattress base for the night.

Mr G stated that Mr A was provided with a customised mattress because of his ability to rip the plastic covers off regular mattresses, and he was also able to rip the cover from the customised mattress. Mr G stated that a replacement was immediately ordered, but because the mattress cover was customised there was a delay in delivery. Apparently there were factory staff shortages at this time as well, which contributed to the delay. He advised that the mattress was ordered on 13 March 2006 but the exact date of delivery is not certain.

Ms E stated that the normal reporting procedure for replacement or repair of furniture and fittings is for the staff to report the matter to her. In the case of Mr A's mattress cover, the difficulty arose because they could not use any particular plastic because Mr A would rip the cover "straightaway".

Ms E said that while they were waiting for the new customised cover to be delivered they purchased a car-cover which was long and wide enough to cover the mattress, but Mr A threw it off. She agreed that the situation was not ideal but the circumstances of replacing the mattress and cover were beyond their control.

Spectrum Care management

A number of the staff, past and present, spoken to in the course of this investigation were critical of the Spectrum Care management. There was a general feeling that staff were not expected to complain and, if they did, they would not be supported in their concerns. A number of the staff reported tensions within the middle management, which impacted on the overall culture in the George Street home.

Caregiver Ms D was interviewed about the circumstances of the showering incident on 3 March 2006 and other issues relating to the service provided to Mr A at George Street. She stated that all the staff were aware of the allegations that had been made about the care at George Street. She said that one day when she was new at George

Street Mr McEvoy approached her. She said, "He was asking me all these questions … and I go, 'Huh. You shouldn't be asking me. You should be asking [Ms F] or [Ms E] or [Ms H].' "

Ms D stated that staff felt unable to report to management if they had concerns about the practice of any of the other staff. She stated:

> "Coz you felt that nothing's gonna get done really. You know, because when I was at IHC, if anything like that happened, you guarantee you knew who to go and see. … But I didn't feel that at Spectrum. You know, it felt as though you just do your job. That's it you know. You are not allowed to complain."

Ms D stated that there were difficulties between certain sections of the management staff. She said:

> "[T]hey didn't actually make it unpleasant, but you felt it. You know, you felt something's not right. You know, like coz if [Ms E] walked into the room, [Ms F] walked in the room, [Ms H] walked in the room — you know you can feel that … vibe."

Ms F also stated that she felt that she would be "in trouble" for reporting the showering incident and that the coordinator would not like it because there was so much pressure in the house.

Ms E acknowledged that there had been tensions among the staff at George Street. She said that not long after she took the position as Coordinator, she attended a team meeting at George Street, and Ms D, Ms C and another staff member told her that they felt there was "racial tension within the house and at management as well". She told the staff that they knew there were proper procedures to follow when they had concerns of this nature. However, she spoke to Ms H about the concerns expressed by Ms D and Ms C. She recalled that Ms H replied, "Oh, for goodness sake." Ms E went back to the staff and advised them that she had raised their concerns with Ms H, and told them that if they wanted to take it further it was up to them to do so. Mr G stated that the allegations of racial discrimination were followed up directly and confidentially with all staff employed at George Street at the time.

Ms E said that occasionally staff members report that they find looking after a particular resident is too stressful. She said that this is discussed with the house leader and the coordinator. The advised action is to remove the staff member from the situation and assign another key worker. However, it is not always possible to do this owing to staff shortages. The expectation then is that the house leader will take over the role of key worker for the resident.

Ms E stated that she was unaware of any tensions at any of the other houses she was responsible for. She said that Mr A is no longer at George Street and, as a result, "it's changed the dynamics a wee bit".

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Mr G stated that prior to the events in question, Spectrum Care had taken steps to encourage the raising of concerns. During 2005, senior Spectrum Care managers "encouraged staff to make their concerns known as part of the process of continuous quality improvement of the service". In July 2005, an 0800 OUTLOUD telephone line was set up to give Spectrum Care staff an opportunity to express concerns, anonymously if they wished, without being constrained by the line management reporting requirements.

Anonymous allegations

On 4 April 2006, Mr McEvoy was provided with information from an anonymous email correspondent who outlined concerns about the care provided to the residents at the George Street home, in particular Mr A.[1] The writer, who it appears was or is employed by Spectrum Care, stated:

> "There is so much abuse going on in the house that it just makes me cry. All targeted mainly at [Mr A]. [Ms E] gave instructions to the staff to give [Mr A] a coldest shower due to him [soiling] himself. … [Mr A's] file has been removed from George Street so staff cannot contact Allan [McEvoy] for any issues with [Mr A]. … The abuse ranges from leaving him in the shower on his own (highly dangerous and [Mr A] has ripped off two doors since the staff have been leaving him in the shower on his own), manhandling, isolation, not feeding him, refusing [Mr A] not to do anything he wants and generally ignoring him and not taking him anywhere. Constant medication errors. …
>
> Management refuses to come to George Street to sort the issues out. … The house leader [Ms F] has now put in her resignation and told us that she was leaving. I was very upset because she tried everything to prevent the abuse but [Ms E] & [Ms H] won't stop it."

Ms I described an incident she witnessed when Mr K (another resident at the house) ran away from the home and was located a short time later (the date was not provided). She stated:

> "I said to [a caregiver], I've showered [Mr K] because he was wet. And then she come in when I take it off [Mr K's] clothes. And she came in and she said, 'Give him a cold shower'. So I didn't say anything. Plus I'm not stupid. You know, I'll just shower him and I'll say myself, 'Oh, I think that's the way they [are]. You know most of the time I'm not working with them.'"

On 7 April, a further communication by the anonymous email writer stated that there are locks on the bedroom doors at Home "as a preventative measure". The writer alleges that there are two residents who like to roam and, because the staff do not like

[1] The information was initially sent to a journalist at the *Herald on Sunday*, who then sent it to Mr McEvoy.

this to occur, they lock the residents in their rooms. Ms E writes risk assessments for the house that authorise the staff to keep clients in their rooms for "safety". The email writer stated that the clients' "safety and well-being are diminishing greatly". Staff manhandle the clients and shove them into their rooms and lock the door. They "bullshit" to the doctors, especially if bruising results from this treatment. The writer alleges that one doctor refused to accept the staff explanation for a client's bruising and reported his concerns in writing to Spectrum Care management. The writer stated that the management did not accept the doctor's findings.

Mr G denied the allegations made by the anonymous informant, stating that Mr A's file was not removed from George Street to prevent staff from contacting Mr McEvoy. Mr G said that it was not "highly dangerous" or "abusive" to leave Mr A in the shower by himself. Showering was the one activity where Mr A could be given the freedom to independently engage in an activity he enjoyed. Mr G stated that there is no evidence that Mr A was "man-handled" or "isolated", and not fed or provided with appropriate activities. Mr G also stated that there is no evidence that clients were locked in their rooms.

Mr McEvoy's anonymous informant also stated that Ms E was destroying all three carbon copies of incident reports submitted by staff, and has now removed all the Incident and Accident books from the house.

Mr G stated that in September 2006, there was a review of the George Street incident forms for the period January to August 2006, which found that there were a small number of instances where the pink copy of the report (the copy that is to be retained in the Incident book) was missing. Spectrum Care management was unable to determine why the forms were missing, but believe that the claim that Ms E had destroyed this information is unsubstantiated.

On 26 April 2006, Ms H advised Mr McEvoy that she had requested that locks be placed on all the bedroom doors at George Street "to deter one of the men from entering into the other men's rooms and damaging their personal items". She stated that the locks were the type that can easily be unlocked from both sides, with the "outside able to be locked or unlocked by a simple implement such as a coin or spoon handle. Unfortunately, the contractors installed an external unlocking mechanism which required a key rather than any handy implement". She stated that the door handles and their locking assemblies have now been removed, but it is not uncommon for simple easy-release privacy locks to be installed at Spectrum Care facilities.

Medication issues
The anonymous writer also stated:

> "Any medication errors, [Ms E] has authorised staff to get rid of the medication and not file an incident report. Some cases, staff don't give the meds, just put it down the drain and then sign the medication sheets. … [One weekend in May 2006] the staff deliberately didn't give [Mr A] his medication for all day Saturday

> and [were] laughing about him cos they didn't like [Mr A] trying to attack them, so they didn't feed him either. [Ms E] is blocking it from management again, although [a caregiver] reported to On Call."

Ms I stated:

> "[S]ometimes I do night. I found about three medication on [Mr A]'s bed. … If I give [Mr A] medication at night I just make sure I put it in his mouth and I stand there and watch to make sure he's taking his medication. But I'm talking about morning because I don't know which one is which. So at night, if I toilet him in the middle of the night, I found about two medication on the bed or under the blanket or on the floor. So I give it to one of the permanent staff. They said to me to throw away. Just throw in the rubbish, even the shower. … Once when I found two medication, the white one and the purple one. … [S]o I did write it down and when I do a handover, I let staff know and they say 'Oh well, don't worry about it. … Just throw it in the rubbish.' "

Mr McEvoy confirmed that he had also found medication on the floor of Mr A's room when he had visited.

Ms E advised that there is a procedure for staff to follow when administering medications to residents. Staff take the blue medication folders containing the doctors' prescription sheets and administration forms from the locked cupboard to the person who is to be given the medication. The drugs are given with either water or yoghurt depending on the resident's preference. The administration form is signed off after the drug has been administered. Ms E said that Mr A had a "great" appetite and there was never any problem with him taking his medications. She said that she cannot accept that the full-time staff would have advised Ms I to throw away any medication she found in a bed or on the floor. The proper procedure is that such an occurrence is reported immediately to the coordinator or the on-call supervisor, and an Incident Report completed.

Mr G stated that there was no evidence of medication errors being unreported. He noted that two errors were recorded for Mr A for the period January to June 2006, and that this indicated that such errors were reported and were few in number.

Ministry of Health audit

Between 21 and 23 June 2005 the Ministry of Health carried out an issues-based audit of the George Street house in response to concerns being raised about the standard of care there. The report found that some of the concerns could be partly or wholly substantiated. It was found that there were a significant number of medication errors and no documented evidence of remedial action or retraining. Concerns regarding incident management and a culture of under-reporting were found, in part, to be substantiated. The Ministry of Health confirmed that all the requirements from this audit were completed by Spectrum Care and signed off by the auditors on 18 August 2005.

Responses to provisional opinion

Mr McEvoy
In his response to the provisional opinion Mr McEvoy noted that Ms E's statements seemed to confirm that she had deliberately downplayed the showering incident when discussing it with him. He also expressed concern at Ms C's statements to Ms H, stating that it seemed to suggest that the incident should not be investigated because specific times were not noted on the incident report.

Ms E
A representative from the Public Service Association responded to the provisional opinion on behalf of Ms E. She expressed concern that information from an anonymous source had been accepted, and stated that Ms E had not been given an adequate opportunity to respond. In relation to compliance with the policy for reporting abuse, she stated that Ms F did not comply with this policy and questioned the reliance on her statement over that of Ms E.

She also stated:

> "[Ms E] is concerned about the statements in your report regarding her obligations after she had ceased work. While your perspective is understood it makes no allowance for the importance of appropriate systems to manage responsibilities beyond and outside an individual's work hours such as the on-call coordinator system. Systems for managing responsibilities beyond and outside an individual's hours of work are fundamental to ensuring a safe and healthy workforce. Statements from the Office of the Health and Disability Commissioner that do not reinforce and support the use of these systems have the effect of undermining these systems and placing onerous responsibility and potentially excessive hours on workers.
>
> [Ms E] is not disputing the remedies sought and is willing to provide an apology to [Mr A] and Mr McEvoy. However, you are requested to … amend your report to acknowledge and support on-call outside of hours procedure."

Spectrum Care
Mr G responded to the provisional opinion on behalf of Spectrum Care and stated:

> "[S]pectrum Care sees merit in your recommendations and intends to follow them, it also concedes with the benefit of hindsight, its care of [Mr A] did not live up to its own expectations. But on the other hand Spectrum Care is troubled by some of your factual findings that lack solid evidential foundations.
>
> Spectrum Care accepts the need for accountability, and acknowledges the important place that the accountability process has in developing public confidence in quality of health and disability services. However, we also believe

> that it is important that this public confidence is not unnecessarily or unjustifiably eroded …
>
> We accept that the Health and Disability Commissioner is obliged to report on the results of its investigation into the 15 month old events at George Street, but we believe that this can be done in a way that avoids creating an unnecessarily negative or alarming perception about Spectrum Care. …
>
> Spectrum Care accepts all of the report's proposed recommendations and welcomes them as opportunities to improve our services. I also note that most of them have already been implemented, either fully or in part. We do not intend to challenge your provisional finding that Spectrum Care has breached the Code. Accordingly, apologies will be forwarded to both [Mr A] and Mr McEvoy in the near future and we will send you copies.
>
> By 31 August 2007, Spectrum care will report back to you with the strategies it will implement, or had implemented, to address:
>
> - incident investigations;
> - annual staff climate surveys;
> - management of on-the-job stress; and
> - environment enrichment activities for residents. …
>
> Spectrum Care underwent its three yearly certification audit and accreditation survey in May 2007 (which comprised visits to forty of its houses, including George Street).The findings were overwhelmingly positive. We received full three years certification and Spectrum Care was acknowledged for its leadership in supporting people with intellectual disability to have the best possible quality of life."

Mr G confirmed that Spectrum Care had already reviewed its practice prior to the provisional report. He stated that "Spectrum Care is confident that while the findings of the HDC report may reflect the circumstances that existed in one house some fifteen months ago, they are not representative of how Spectrum Care operated generally then, and certainly not now." Mr G advised that most of the staff involved were no longer employed by Spectrum Care, and that it had actively addressed George Street's organisational culture.

Mr G suggested that Ms I's credibility should be reconsidered, and stated that she was biased against Spectrum Care owing to the fact that it had apparently asked her agency not to place her at Spectrum Care houses.

Mr G stated that Spectrum Care is concerned about the inclusion of anonymous allegations in this report, and believes that it is unsafe and unjustified to rely on them.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 1
Right to be Treated with Respect

(1) Every consumer has the right to be treated with respect.

RIGHT 3
Right to Dignity and Independence

(1) Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
(4) 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.

Opinion

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

Opinion: Breach — Ms E

At about 5pm on Friday 3 March 2006 Ms E became aware of an incident involving Mr A. There are differing accounts as to how Ms E was advised of this incident. She states that she was off duty when she called into George Street to "pick up something" on her way home, and Ms F told her that she had discovered that Mr A had been left under a cold shower around lunchtime.

Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Ms E believes that she was clear in her instruction to Ms F that, as she was off duty, Ms F was responsible for complying with the policy and reporting the incident to the on-call supervisor. However, Ms F stated that she contacted Ms E by telephone at about 5pm and was relieved that she had caught her before she went off duty. Ms F stated that Ms E did not attend the house in person on 3 March 2006. Ms F did not complete the Incident Form that evening because Ms E had instructed her to complete the form on Monday, and said that the matter would be followed up then.

The next action taken in this matter was not until the morning of Monday 6 March, when Ms E called at George Street and spoke with Ms C. It was only after this interview that the Service Manager, Ms H, was made aware of the incident.

It is difficult to reconcile these conflicting recollections. In my view, the phone records would seem to support Ms E's description of events. However, even accepting her recollection of events, her response to the incident was inadequate. The fact that Ms E had just finished duty when this incident involving apparent abuse of a resident was reported to her should not have affected her actions. She was the coordinator responsible for the overall welfare and safety of the residents at George Street. If she is correct in her recollection that she called in at the home that evening and observed that Ms F was "stressing out", then, if pressing matters meant she could not stay on, she should have taken the time to assure herself that Ms F knew who the on-call supervisor was and how to contact her. I accept that Ms F should have reported the incident sooner and, in relation to this aspect, failed to follow the policy. This fact does not diminish Ms E's responsibilities in the matter.

I find it difficult to understand, given the apparent seriousness of the situation and the history of complaints about Mr A's care, why Ms E did not stay on duty to ensure that the Service Manager was advised. I do not accept her submission that there is an issue regarding the importance of appropriate systems to manage a staff member's responsibilities outside of work hours, and that undermining these systems places on the staff member an onerous responsibility and the potential need to work excessive hours. Ms E was the care coordinator. It was her responsibility first and foremost to ensure the safety of Mr A. Furthermore, by her own account she had been "off-duty" for only 10 minutes.

I am concerned that Ms E's first action in this situation was not to ensure the safety of Mr A, but to telephone Mr McEvoy to tell him that there had been an incident involving Mr A, and to downplay the seriousness of the matter to protect herself and Ms F. The fact that she apparently made this phone call while "off-duty" also seems to undermine her submission about the reasonableness of expecting her to take action despite having technically finished work 10 minutes earlier.

My initial view was that Ms E's visit to George Street early on the morning of 6 March appeared to support Ms F's recollection of being told that the incident would be followed up on Monday. However, Mr G stated that it would have been "prudent" for Ms E to call into George Street on Monday morning to find out what follow-up

action had been taken in respect of the showering incident, and that Spectrum Care would have expected her to make this check. Notwithstanding this explanation, it appears that one of Ms E's first actions was to talk to Ms C and suspend her. If Ms E believed that Ms F had informed the on-call supervisor on Friday evening, and the Spectrum Care policy had been followed, then Ms C should not have been on duty.

In my opinion, Ms E did not take appropriate action on the evening of 3 March to ensure Mr A's safety. As discussed above, Ms E did not take the time to assure herself that her "stressed out" house leader would notify the on-call manager about the incident. As a result, Ms F made the assumption that she had reported the matter, and no action was taken to address the fact that the caregiver who had left Mr A in the shower, Ms C, would also be supporting him during the weekend. Given that the showering incident could have been an abusive act, it was clearly inappropriate that the caregiver involved should continue to support Mr A until the matter had been resolved. Failing to take action when a serious situation has occurred, because of finishing duty 10 minutes earlier, is not acceptable practice in a manager. Furthermore, Ms E's actions on 6 March 2006 seem to suggest that she was aware that no steps had been taken to suspend Ms C from her caregiving duties at George Street.

Spectrum Care policy regarding reporting of abuse or neglect specifies that the staff member who suspects or witnesses abuse or neglect must first make sure that the resident is safe, and then immediately call the Service Coordinator. The Service Coordinator is then to contact the Service Manager, who will commence an investigation into the matter. Ms E did not contact the Service Manager. While Ms F may not have followed the policy either, it appears that Spectrum Care management were of the opinion that Ms E, as the senior staff member, had the greater responsibility in this matter. She was performance counselled by Ms H about her failure to report the incident to the Service Manager. A written record of this matter was placed on Ms E's personal file.

In my opinion, Ms E did not comply with the Spectrum Care procedure relating to the reporting of abuse and neglect. Additionally, she did not act ethically and accordingly breached Right 4(2) of the Code.

Opinion: Breach — Spectrum Care

Under the Code, Spectrum Care had an obligation to treat Mr A with respect and provide services in a manner that recognised his dignity and independence. Mr A also had the right to services of an appropriate standard. Overall I consider that Spectrum Care failed to meet these obligations.

Medication management
Mr McEvoy was provided with information from an anonymous source (who either had worked or still works at George Street) that frequently the men were not given their prescribed medication, and that medications were thrown away. Under normal circumstances I would not give great weight to anonymous and, therefore, unable to be verified, information. However, caregiver Ms I advised that she had also discovered medication in or under Mr A's bed. She stated that when she informed the staff about this she was told to throw the tablets in the rubbish. Mr McEvoy also reported finding discarded medication on the floor of Mr A's room.

An allegation was made that Ms E instructed staff to discard medication in such circumstances and that documentation of missed medication is not necessary. Ms E denied that this was the case. She said that if staff find that medication has been discarded by the resident, then they are to report to their supervisor and complete an Incident Report. She said that staff are aware of the procedures for medication administration, and does not accept that full-time staff would have instructed Ms I to simply throw medications she found on the floor or in a bed in the rubbish.

Mr G submitted that the evidence provided by the anonymous informer and Ms I is unreliable and should be discounted, "particularly as the evidence suggests medication errors were being reported, and as … the Ministry of Health conducted an audit on this specific point and confirmed that Spectrum Care had addressed the medication issues".

I accept that Spectrum Care had policies in place regarding the administration of medication. I accept that the errors found at the time of the Ministry of Health audit in July 2005 were addressed by Spectrum Care management. However, the medication errors that are the subject of this complaint occurred after this time, and I am of the view that the two unsolicited reports from staff and Mr McEvoy's observations are credible. It appears more likely than not that there were occasions when Mr A was not given his medication, and that this was not reported or acted upon.

Activities planning
Mr McEvoy also complained that Mr A had been under-stimulated. This concern was supported by Ms I, who was unhappy at being instructed to confine him to his room and bed for long periods with only music to divert him.

Mr G advised that an activities plan had been formulated for Mr A, which included walks and rides in the van. He said that Mr A preferred to spend time in his room. Staff stated that caring for Mr A was challenging. Mr A's psychiatrist noted that he had learned that he could gain attention and the pleasure of returning to the shower if he smeared faeces. When bored he ripped his clothing and bedding, and Mr A's blindness and mutism made communication difficult. Ms H noted that the Spectrum Care staff were "normal people carrying out an extraordinary and stressful job. Faecal smearing, biting and hitting take a toll on staff who agree that the George Street environment is stressful."

Despite Mr G's assurance to the contrary, I am not convinced that Mr A was provided at all times with the stimulation and activities he required. It appears that there were times when measures were put in place to restrict Mr A's activities. I acknowledge that coping with the behaviours Mr A exhibited is taxing on even the most experienced and capable staff. However, Spectrum Care is a specialist organisation providing care for people who cannot be accommodated in other residential facilities and, as such, should have systems in place to provide their staff with the resources and support required to provide their clients with a service appropriate to their needs.

Soiled mattress

During the course of the investigation into Mr McEvoy's complaint, caregiver Ms I reported that Mr A slept for three weeks on a urine-soaked and faeces-smeared mattress. Ms I was on night shift. She reported the state of the mattress and requested a replacement. When the mattress was not changed, she took it upon herself to remove the mattress to the deck because she did not believe it was acceptable for Mr A to have to sleep on it.

Mr G acknowledged that Mr A's mattress had needed to be replaced because he tore the plastic covering. Mr A's mattress was customised because of his tendency to rip the covering. A replacement was ordered when the condition of the mattress was noted, but because of the need to have it custom made, there was a delay in replacing it. There were also staff shortages at the factory, which further contributed to the delay.

In my view, it was unacceptable for Mr A to have to sleep on a soiled mattress for three weeks. I am not convinced that there was no alternative solution to providing him with temporary bedding while waiting for the customised mattress. I am disappointed that Spectrum Care did not seek assistance or support from Mr A's welfare guardian, Mr McEvoy. This shows a serious lack of judgement and lack of willingness to work with Mr McEvoy to provide Mr A the best care possible in the circumstances.

Mr G stated that Spectrum Care could have done more to have found a temporary alternative while waiting for Mr A's new mattress. He said, "With the benefit of hindsight, it would have been preferable to have had a standby replacement mattress manufactured."

In my opinion, Spectrum Care did not provide a service to Mr A that respected his dignity and well-being. The services provided were not consistent with his needs and did not optimise his quality of life. Therefore Spectrum Care breached Rights 1, 3, 4(3) and 4(4) of the Code.

Opinion: No Breach — Spectrum Care

Vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994, employing authorities are vicariously liable for any act or omission of an employee unless they can show that reasonable steps were taken to prevent the act or omission in question. Ms E is an employee of Spectrum Care. Therefore I must consider whether Spectrum Care is vicariously liable for her breach of the Code. I have some concerns about the extent to which Spectrum Care management supported staff to raise concerns and report incidents, and these are discussed further below. However, Spectrum Care did have a clear procedure for the reporting of incidents of possible abuse or neglect and, as the Coordinator, Ms E was well aware of this, and could be expected to follow it. There has been no suggestion that Ms E felt that she was discouraged from following this procedure, and indeed she took action on the matter the following week. In these circumstances I consider that Spectrum Care took reasonable steps to ensure that Ms E responded appropriately to reports of possible abuse, and is therefore not vicariously liable for her breach of the Code.

Opinion: No Breach — Ms D

Ms D was on duty at George Street on 3 March 2006. She was, however, assigned to kitchen duties and meal preparation that day, and therefore was not involved in the hands-on care of the residents. She assisted Ms C to transport a number of the residents to their activities programme at the activity centre just after midday. She did not witness Mr A being placed in the shower but heard Ms C report to Ms F as they left the house that Mr A was in the shower. There is no evidence that Ms D failed to provide care to Mr A or the other residents at George Street in accordance with the policies or residents' care plans. Accordingly, in relation to the concerns raised about the care provided to Mr A on 3 March 2006 and the general concerns about the care at George Street, Ms D did not breach the Code.

Opinion: No Breach — Ms C

Ms C was responsible for providing care to the residents on 3 March 2006. She advised that around lunchtime Mr A, who did not usually join the other residents at the dining table because of his disruptive behaviour, moved his bowels and smeared the faeces, and she placed him under the shower. Ms C and Ms D were waiting for Ms F to return from a shopping trip so that they could transport some of the residents to their activities programme.

When Ms F returned, Ms C assisted Ms D to load the men into the van. Immediately before leaving the house she called out to Ms F that Mr A was under the shower. Ms D, who was in the van with one of the men, stated that she heard Ms C call out to Ms F about Mr A being in the shower. Ms F stated that when she went in to see to Mr A, she found that he was sitting under cold water and had a bluish appearance around his lips and feet. The shower temperature control was set at cold. Ms F has not said exactly what time she found Mr A in the shower.

Ms C and Ms D returned to the house at about 4pm. Ms D went home and, about half an hour later, Ms F asked Ms C for an explanation of why Mr A had been left in a cold shower. Ms C denied that she had put Mr A under a cold shower. The incident was not formally reported until 6 March, when Ms C was informed of the allegation and suspended pending the outcome of an investigation. Ms C met with Spectrum Care management on 13 March to provide her version of events. On 17 March she was advised that no further action was to be taken and that she had been reinstated.

In my view, it is unlikely that Ms C had placed Mr A under a cold shower, a situation that she knew would be discovered and reported by the house leader (who she had told that Mr A was in the shower). It is not clear how much hot water was used that morning to shower the five men in the home, or how long Mr A was under the shower before he was found by Ms F. However, it does not appear that the hot water had run out, given that Ms F was able to turn the water temperature up to warm when she found Mr A.

The staff who were familiar with Mr A's abilities agreed that it was most unlikely that Mr A or any of the other men in the house would have intentionally turned the tap to cold. However, it is possible that Mr A, who was in the shower for an unspecified time, could have adjusted the controls himself. These issues are not able to be resolved given the conflicting information.

Of concern to me is that Ms F has stated that when she found Mr A under the cold shower he had dried faeces on his face, which she had to wash off. It would have made sense for Ms C to have washed Mr A thoroughly before having left him in the shower unattended. It seems reasonable to assume that it would not be in the best interest of Mr A's health and well-being to leave faecal matter on his face for any length of time.

There is insufficient evidence to conclude that on 3 March 2006 Ms C placed Mr A under a cold shower with faeces smeared on his face, or failed to provide him with an appropriate standard of care at any other time. Therefore, in my opinion, Ms C did not breach the Code.

Other comment

The allegations made by an anonymous person who appears to have worked at the George Street house are clearly concerning. However, the fact that the person wishes to remain anonymous constrains the action that I can take on these allegations. Some parts of the allegations have been supported by other people's accounts. Other allegations have been unable to be verified. While I cannot speculate on the reasons for the person wishing to remain anonymous, I have set out below my concerns regarding the approach taken by Spectrum Care in relation to incident reporting.

Follow-up of showering incident
The outcome of the investigation of this incident, the changes to the showering policy, does little to put my mind at rest that the same incident will not occur again with another resident. I suggest that an alarm mechanism or a timer would be a more reliable form of reminder to ensure that residents are assisted from the shower in a timely manner rather than relying on the memory of a worker in a busy residence.

Management of staff
My view is that there were staff working at George Street who were either insufficiently trained or otherwise unable to cope with the challenging behaviours exhibited by the men. When the caregivers, who were dedicated and caring, expressed their concerns about poor care, they felt unsupported by Spectrum Care management and believed that their complaints and concerns were discouraged.

I am concerned about the actions that were taken by senior staff in relation to the shower incident of 3 March 2006. It appears that the incident was discovered in the early afternoon and, although the House Leader spoke directly with the involved staff at the earliest opportunity — around 4pm, it was another hour (late on Friday afternoon) before the incident was reported by Ms F.

As previously stated, there is discrepancy in the information received about the reporting of this incident. Ms F recalls that she telephoned Ms E on her mobile at about 5pm and was relieved that she caught her before she went off duty. There is no record of this call being made. Ms E recalls that she visited George Street on her way home, found out about the incident, and instructed Ms F to report to the on-call manager. Whatever the facts of the matter, Ms F did not report the incident to the on-call manager. If Ms E's version of events is preferred, then Ms F failed to follow the policy. However, the Service Manager was not notified, and the policy states that this was the responsibility of the Coordinator, Ms E. Ms E was counselled about her failure to follow the policy.

Ms E did not follow Spectrum Care's complaint/abuse policy when she was advised of the alleged abuse. It appears that she was very concerned that there was another incident involving Mr A. She knew that an investigation had to proceed but was conscious of the need to "safeguard" herself and Ms F. I am of the view that this knowledge determined her actions.

I am concerned that there is a pattern of behaviour in relation to concerns about the service provided at George Street. It appears that staff have a perception that Spectrum Care management discourage complaints about the home; this was particularly the case regarding Mr A. Concerns about incident reporting had also been identified by the Ministry of Health. In my view, fear of exposure of questionable practice that results in concerns being hidden, does not provide an environment that encourages improvement in practice and the delivery of quality care.

I acknowledge that Spectrum Care did take steps in 2005 to encourage incidents of potential abuse to be reported. However, subsequent events in 2006 suggest that these steps were not effective. I recommend that Spectrum Care seriously consider the issues relating to staff concerns that are contained in this report, and take prompt action to ensure that their staff are able to raise their concerns about the service, and to communicate more proactively with management.

Recommendations

I recommend that Ms E apologise to Mr A and Mr McEvoy for her breach of the Code.

I recommend that Spectrum Care:

- apologise to Mr A and Mr McEvoy for its breaches of the Code
- arrange training on the Code for all Spectrum Care staff during 2007 and 2008 and facilitate visits from health and disability advocates
- report back to me by Friday 28 September 2007 with the strategies it will put in place to ensure the following:
  - — staff responsible for incident investigations are trained and capable of completing timely and thorough investigations of incidents
  - — staff climate surveys are implemented annually, beginning in 2007, for the next two years and the results are reported to me annually with actions for addressing key concerns raised
  - — staff receive adequate support to manage on-the-job stress
  - — activities scheduled for residents take place regularly.
- send me copies of all audit reports relating to the George Street house, for the next two years.

Follow-up actions

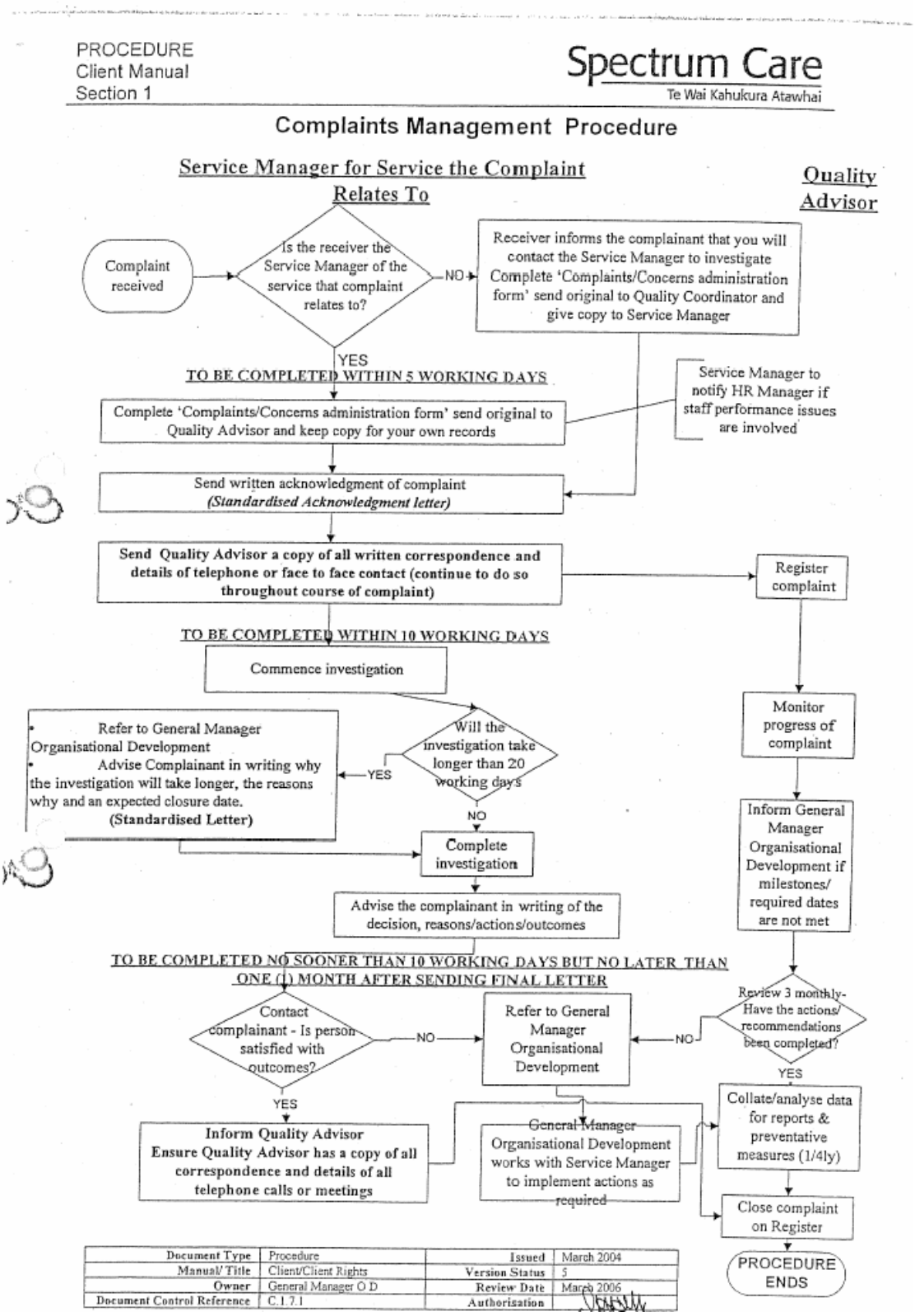
- The Director of Advocacy will be requested to assign advocates to visit Auckland Spectrum Care facilities, including George Street, at least monthly. These visits will not be at prearranged times. The advocacy service will report to me after three months and six months (or more frequently if concerns are identified) so that I can determine whether this arrangement should continue.
- A copy of this report will be sent to the Ministry of Health and Auckland District Health Board.
- A copy of this report, with details identifying the parties removed, (other than Spectrum Care) will be sent to Disabled Persons Assembly (NZ) Inc and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
- A copy of this report, with details identifying the parties removed (other than Spectrum Care) will be sent to Spectrum Care's auditor.

Non-referral to Director of Proceedings

In a case where a disabled consumer is neglected and has received such poor care, clearly I need to consider whether it is in the public interest to refer the provider to the Director of Proceedings. Providing services to Mr A requires a high level of skill, and is no easy matter. In my view it is more productive to provide Spectrum Care with an opportunity to demonstrate leadership in an area that is likely to be an issue for other providers in similar situations. Therefore I will not be referring Spectrum Care to the Director of Proceedings.

Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Appendix 1



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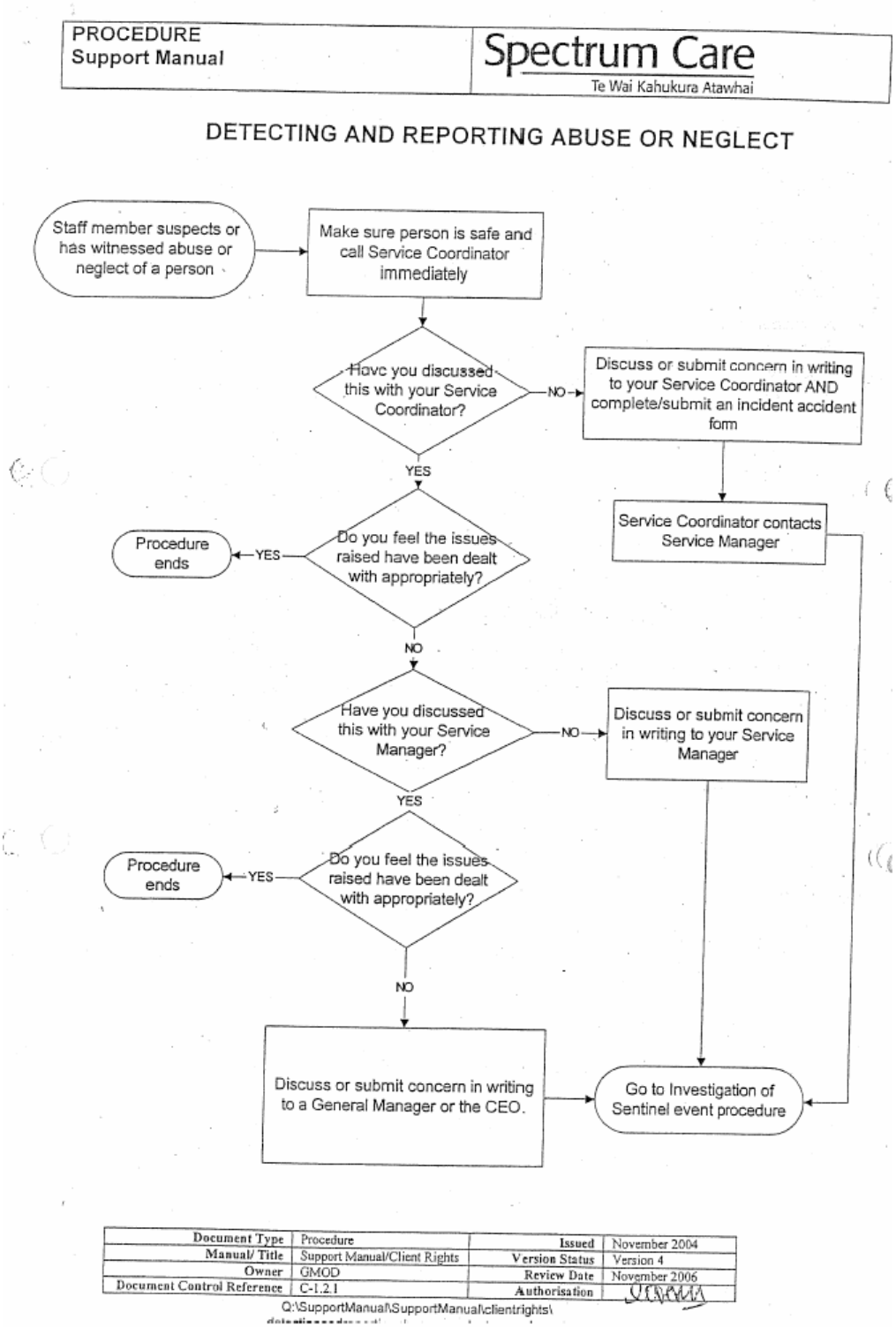
Appendix 2



Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

POLICY
Care & Support Manual

Spectrum Care
Te Wai Kahukura Atawhai

DETECTING AND REPORTING ABUSE OR NEGLECT

Legislation:

- **Code of Health & Disability Services Consumers' Rights 1996 (The Code)**
- **Contractual Agreements with the Ministry of Health and Child Youth and Family**
- **CYF Standards**
- **CYP&F Act**
- **Health and Disability Sector Standards**
- **Human Rights Act**
- **NZ Bill of Rights Act**

Related Policies:

- Advocacy
- Code of Conduct
- Code of Ethics
- Code of Rights
- Customer Feedback
- Discipline and Performance Problems
- Employee Assistance Programme
- Incident Accident
- Personal Account Management
- Sentinel Events Investigation
- Staff Complaints
- Whistle Blowing and Protected Disclosure

Purpose:

- To protect people from abuse and/ or neglect and to provide clear guidelines for staff where any possibility of abuse or neglect may be suspected.
- To ensure staff understand their responsibilities and know what to do if they suspect or identify abuse or neglect of any person in our care.

Definitions:

Abuse can be defined as including any of the following:

- **Physical abuse:** where there is the infliction of pain, injury or force by another person in the absence of a pre-approved restraint protocol.
- **Psychological/ Emotional abuse**- where there is abuse that causes mental or emotional anguish, stress, and/or fear. Such abuse includes verbal abuse, insults, negative comments of any kind, shouting, seclusion or restraint in the absence of a Behaviour Management Plan.
- **Sexual abuse**- Sexually abusive and exploitive behaviours involving threats, sexual innuendo, force or the inability to consent. It includes any unwanted or non consensual sexual contact/behaviour e.g. touching, indecent exposure, exposure to pornography, or being exposed to any level of sexual relationship with a staff member
- **Material/financial abuse**- illegal or improper exploitation and/ or use of funds or other resources (Refer to Personal Account Management Policy).

Document Type	Policy	Issued	August 2005
Title/Manual	Care& Support/ People's Rights	Version Status	Version 5
Owner	Q&RM	Review Date	August 2006
Document Control Reference	C-1.2.2	Authorisation	

Q:\Man.Manuals\Care & Support Manual\People'sRights\Current\DetectingReportingAbuseNeglect V5.doc Page 1 of 3

Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

POLICY
Care & Support Manual

Spectrum Care
Te Wai Kahukura Atawhai

Neglect is defined as –

- An act or condition that occurs as a result of a staff member failing to meet the physical or emotional needs of a person. Examples of neglect can include a person being deprived of treatment, care, food, comforts, and or any right he/she is entitled to receive in accordance with Spectrum Care's policies.
- **Active neglect**, which is conscious and intentional deprivation by a staff member of a person's basic necessities, resulting in harmful physical, psychological, material and/or social effects.
- **Passive neglect**, which is refusal or failure by a staff member because of inadequate knowledge or understanding or disputing the value of the prescribed services, to provide basis necessities for a person, resulting in harmful physical, psychological, material and/or social effects.

Policy Statement:

- Spectrum Care is committed to the prevention and early detection of abuse and/or neglect. We will not tolerate any behaviour from staff that causes or results in abuse or neglect to any person we support. Our policy is one of 'zero-tolerance' to all forms of abuse and neglect.
- Spectrum Care recognises that many of the people we provide services to will exhibit challenging behaviours from time to time. The Behaviour Support Team staff are available to provide specialist advice for all staff regarding the management of persons exhibiting challenging behaviours. The use of approved restraint under a Behaviour Management Strategy is not considered to be abuse or neglect.
- All people working for Spectrum Care must ensure they represent and adequately protect the rights and interests of the people we support.
- The rights and interests of all people for whom we provide services are Spectrum Care's first and paramount consideration. Our initial obligation will be to ensure the immediate safety of all person(s) involved in an allegation of abuse and/ or neglect. In accordance with ensuring the safety of the people, any staff member suspected or alleged to have abused someone will be suspended on full pay pending the results of the Police investigation, the investigation by Spectrum Care and any investigation by external funding agencies such as Child Youth and Family, Ministry of Health and ACC (Ref Discipline and Performance Problems Policy).
- It is the responsibility of all staff working for Spectrum Care to report any suspected or known case of abuse or neglect immediately to their manager and complete an Incident/ Accident form (Refer Incident/Accident Policy). This is our preferred approach. However abuse may also be reported anonymously on 0800 688-568 or 0800 – OUTLOUD (Refer to Whistle Blowing and Protected Disclosure policy).
- In the case of reporting abuse or neglect of a child, Spectrum Care will report the abuse under section 15 of the CYP&F Act. Special protections exist under section 16 or the CYP&F Act 1989 for those persons reporting the abuse and/ or neglect of a child. The Service Manager of CYF holds the position of 'Director' and has special obligations as part of their job description. The General Manager of Community Services or the Team Leader of CYR deputise in the absence of the Service Manager Child and Family Services. Child

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Names (except George Street home, Spectrum Care Trust, and Mr Allan McEvoy) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

POLICY
Care & Support Manual

Spectrum Care
Te Wai Kahukura Atawhai

Youth and Family will conduct a full investigation in accordance with their Child Abuse Reporting Protocol (Ref: CYFS Provider Guide, 2002, pages 49-54) and Spectrum Care will work with and take advice from CYF to ensure the safety of the child is paramount.

- If suspected or known abuse or neglect of a person is not reported, staff members involved or suspected to be involved will face disciplinary action. (Refer Code of Conduct policy).
- Staff reporting such cases will be protected and not disadvantaged (Refer to Whistle Blowing and Protected Disclosure policy).
- All incidents of suspected abuse will be reported as Sentinel Events to the Contracted Agency e.g. Child Youth and Family, the Ministry of Health or ACC.
- Spectrum Care will immediately inform the person's Next of Kin or Guardian (if appropriate).
- The Human Resource Manager will report abuse to the police. (Ref Reporting Incidents to Police policy) and the Police will, if they decide, investigate the suspected or alleged abuse to determine if a crime has been committed.
- Spectrum Care will also investigate the suspected or alleged abuse to determine if a breach of the Code of Rights or the Code of Conduct has occurred (Refer to Sentinel Events Investigation Policy).
- Spectrum Care will provide feedback to the person(s) reporting the abuse if their identity is known. If the matter is not investigated to the reporting person's satisfaction, they must also report their dissatisfaction to their manager (Refer Staff Complaints Policy).
- Spectrum Care acknowledges that all staff involved in providing ongoing support may be subject to work related stress because of an investigation. Spectrum Care commits to support staff through the Employment Assistance Programme. (Refer to Employment Assistance Programme policy).

Related Procedures:

- Detecting and Reporting Abuse or Neglect

Related Forms:

- Incident/Accident
- Sentinel Event

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