A Needs Assessment Service Co-ordinator

A Trust

Care Group Limited

Caregiver, Mr D

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00854)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. Mr A (aged 20 years at the time of the events) had complex needs and required one-to-one care.

2. Since 2003, Mr A's mother, Mrs B, had chosen Mr A's support workers and care provider. Mrs B had a longstanding professional relationship with Mr G, who had initially cared for Mr A when he was at a disability service provider.[1] From this time, Mr G and his family members were Mr A's main support workers. Care was usually provided to Mr A in Mr G's family home.

3. In 2011, Mr A's needs assessment service coordinator, (the NASC), referred Mr A to a trust (the Trust) to provide individualised funding (IF) for Mr A. The Trust's role was to help Mrs B to understand IF, and how to organise, set up and manage Mr A's support allocations and administer payments for support services, and to help Mrs B to manage her responsibilities. The Trust was required to carry out quality monitoring at six-monthly intervals.

4. Mrs B became Mr A's IF agent. Mrs B continued to use Mr G's family as Mr A's main support workers, and privately engaged Care Group Limited (Care Group) to help manage Mr A's support package. There was no written contract between Care Group and Mrs B.

5. In 2012 (Month1[2]), Mr G went on leave. Mr G's son, Mr D, became one of Mr A's main support workers at this time. Mr D had been an independent contractor of Care Group since 29 June 2009, and was the support worker for another Care Group client (Mr H). Mr D gained his experience as a support worker for Mr A when assisting Mr G to care for Mr A for approximately one year in 2006. Prior to working with Mr A in Month1, the only training provided to Mr D by Care Group was a first aid course, which Mr D attended on 21 November 2011. There is no evidence that Mr D was offered or attended any in-service training.

6. Care Group rostered Mr D to care for Mr H on 9 Month3 from 2pm to 8pm, and also to care for Mr A from 3pm to 9pm that same day. However, Care Group told HDC that it understood that another of Mr G's family members, Mr I, would be looking after Mr A, and that Mr D would be looking after only Mr H.

7. On 9 Month3, Mr D collected Mr H at approximately 11am. Mr D left Mr H at his home to be looked after by Mr I while he collected Mr A at 3pm. Mr D proceeded to care for Mr A and Mr H at the same time that afternoon. Mr D also had his two-year-old son with him. Mr I was present, but told the Police that it was not his job to look after Mr A or Mr H, and that he would only help to keep an eye on them.

[1] This provider had provided respite care for Mr A for eight years, starting from when he was three years old.
[2] Relevant months in 2012 are referred to as Month1-Month3.

8. At approximately 6.30pm, Mr I left with friends. At approximately 7.30pm, Mr D left Mr A and Mr H unsupervised and locked in his home while he went to collect food for Mr H. A fire broke out and Mr A was unable to get out of the house and, sadly, died in the fire.

Findings

9. Mr D did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[3] by caring for three vulnerable people at one time when he knew Mr A required one-to-one care, and by leaving Mr A unsupervised and locked in his home with Mr H, despite knowing that Mr A must always be supervised.

10. Care Group Limited breached Right 4(1) of the Code by failing to:

a) adequately assess or monitor the quality of care being provided by Mr D to Mr A, and failing to provide training or supervision to Mr D in caring for clients with Mr A's needs;

b) have a formal written agreement in place with Mrs B, which resulted in uncertainty about the roles and responsibilities of those managing Mr A's support. In addition, the process for rostering Mr A's support workers created an environment where errors could occur;

c) conduct the necessary checks to ensure that Mr A would be receiving one-to-one care by a suitably qualified support worker on 9 Month3 when it realised that it had rostered Mr D to work with two clients on the same day;

d) have a care plan for Mr A; and

e) maintain appropriate written records.

11. Care Group also failed to provide services consistent with NZS 8158:2003 standards 2.7.2, 2.7.8 and 4.2.1.

12. Adverse comment is made about the Trust's quality monitoring.

13. The NASC did not breach the Code.

14. Care Group Limited and Mr D will be referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

[3] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Complaint and investigation

15. The Commissioner received complaints from Mrs B and Mr C about the care provided to Mr A (deceased). The following issues were identified for investigation:

- *The appropriateness of the care provided by Mr D to Mr A.*
- *The appropriateness of the care provided by Care Group Limited to Mr A.*
- *The appropriateness of the care provided by the Trust to Mr A in 2011 and 2012.*

16. The investigation was extended to include the following issue:

- *The appropriateness of the care provided by the NASC to Mr A.*

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

18. The parties directly involved in the investigation were:

Mrs B	Complainant and Mr A's mother
Mr C	Complainant
The NASC	Provider
The Trust	Provider
Care Group Limited	Provider
Mr D	Provider

19. Information was also received from:

A disability services provider	
Mr E	Mrs B's nephew
Mr G	Support worker
Mr I	A member of Mr G's family
Ms K	Client Care Manager
The Ministry of Health	
The New Zealand Police	

Also mentioned in this report:

Mr H	A client

20. Independent expert advice was obtained from Mr John Taylor (**Appendix A**).

Information gathered during investigation

Introduction

21. Mr A (aged 20 years at the time of the events) had complex needs and required one-to-one care. He had challenging behaviour and was non-verbal.

22. Mr C, principal of the school (where Mr A was a student), told HDC:

> "[Mr A] required constant 1:1 supervision and support throughout his schooling to ensure his safety and access to learning was assured. At times of severe behavioural episodes the ratio would sometimes increase to 3:1. He was a non-verbal student, though was able to make use of a picture exchange communication system to ask for a limited range of things he wanted … He was a young man with very complex needs. He was treasured by the staff who worked with him, and carried a lot of mana. He earned [a nickname] and had a very honourable place within our school."

23. On 9 Month3, Mr A was being cared for by his support worker, Mr D.[4] Mr D was also caring for his two-year-old son and another client, Mr H, at the same time. Mr D left Mr A and Mr H unsupervised and locked in his home while he went to collect food for Mr H. A fire broke out and Mr A was unable to get out of the house and, sadly, died in the fire.

24. At the time of Mr A's death, the following key parties were directly involved in supporting and/or administering Mr A's care:

a) A Needs Assessment and Service Co-ordinator agency (NASC).[5] This agency was Mr A's NASC from 2003, and allocated the number of carer support days per year.

b) A registered charitable trust (the Trust), and Mr A's individualised funding (IF) host provider[6] from 2011. The Trust is contracted with the Ministry of Health (the Ministry) to provide this service.

c) Mrs B, who was Mr A's mother, welfare guardian, and IF agent from 2011. Mrs B, as Mr A's IF agent, contracted with Care Group Limited (see below) to help administer Mr A's IF package. The Ministry advised that Mrs B acted as "the agent administering the support package which means she had the responsibility to oversee [Mr A's] support arrangements".

[4] Mr D is referred to in documentation and correspondence by a number of different spellings of his name. Mr D is Mr G's son, but is sometimes referred to as his nephew.
[5] NASCs are contracted by the Ministry of Health to work with disabled people to help identify their needs and outline what disability support services are available to them. They allocate Ministry-funded support services and assist with accessing other support.
[6] IF is a way of paying for home and community support services that lets a person directly manage the resources he or she has been allocated for disability supports. See further discussion below at paragraphs 37 to 41. The IF host providers are organisations contracted by the Ministry of Health to support people using IF.

d) Care Group Limited (Care Group). Care Group is a private, home-based support provider that provided services to Mr A from 2006. Care Group's website states that it is certified to the NZ Home and Community Services Standard (NZS 8158:2003)[7] and is a member of the New Zealand Home Health Association.[8]

e) Mr D, who was Mr A's support worker on 9 Month3. Mr D was an independent contractor who provided services to Care Group's clients (including Mr A).

Background

Support provided to Mr A prior to individualised funding

25. A disability services provider provided respite care[9] for Mr A from three years of age. This meant that Mr A lived some of the week at a residential facility and the rest of the time with his mother at home. The Ministry stated that the disability services provider withdrew Mr A from its respite service in 2003 because his behaviour became unmanageable.

26. The Ministry stated that from 2003, Mrs B received support in the community, and chose Mr A's support workers and care provider. Mrs B had a longstanding professional relationship with Mr G, who had initially cared for Mr A when he was at the disability services provider. From this time, Mr G and his family members were Mr A's main support workers. Care was usually provided to Mr A in Mr G's family home.

27. In 2006, Care Group received a referral from the NASC, and Mr A's care was funded with discretionary funding.[10] Care Group told HDC that its involvement in Mr A's care was "a truly unique situation", and that it became involved "because no other entity could and/or would provide the necessary services, and the Ministry of Health could not deal with [Mr A's] situation in the normal way".

28. Care Group described its role as to facilitate and coordinate Mr A's care arrangements. Care Group told HDC: "The involvement of [Mr G's family] in [Mr A's] care was inherited by Care Group as part of its acceptance of [Mr A's] referral

[7] NZS 8158:2003 was superseded by NZS 8158:2012 in April 2012. Certification to the standard is not mandatory. Care Group's certification certificate on its website expired on 15 August 2014. However, in response to my provisional opinion, Care Group provided documentation confirming that following an audit on 9 and 10 June 2014, Care Group was awarded certification from 13 October 2014 for three years (expiring on 13 October 2017).

[8] The New Zealand Home Health Association represents providers of home based support services. Its purpose is to provide a national voice that promotes and advances excellence, partnership and sustainability for the home and community sector. Although certification to the standard is voluntary, to be a full member of New Zealand Home Health Association, it is a mandatory requirement of the Association that its members are accredited to NZS 8158:2012.

[9] The provision of short-term accommodation in a facility outside the home to provide temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside the home.

[10] Discretionary funding is a form of funding used by the Ministry of Health where a contracted Ministry of Health agency is unable to provide services (usually high needs clients who have complex and unique arrangements to meet the needs of clients and families). The NASC had a discretion to contract a non-contracted agency to provide care.

from [the NASC] in 2006. [Mrs B] stipulated that [Mr G's family] were to be involved in all facilitated support for [Mr A]."

29. Care Group stated that under discretionary funding, Care Group would invoice the NASC for the hours that Mr G's family worked.[11]

30. In 2009, Care Group informed the NASC that it would continue to work with Mr G's family in order to provide services to Mr A in accordance with Mrs B's preferences.

31. The NASC told HDC:

> "[We] carried out a series of Needs Assessments and various Service Co-ordination actions during the period 2003–2012. All information on [the NASC] file indicated that from 2007 onward the carer support provided by [Mr G] was the best available for [Mr A's] needs. All issues relating to funding and service provision raised by [Mrs B] related to the occasions where [Mr A] was in her care. [Mrs B] was consistently positive about the quality of care received by [Mr A] when in the care of [Mr G] during this time."

32. In 2011, Mr A's funding package was transitioned from discretionary funding to an IF package.[12] The NASC told HDC:

> "The transition of the funding arrangement from [discretionary] to individualised funding was appropriate in the circumstances. [Mr A] was a high and complex needs client whose agent, [Mrs B], was experienced and capable of managing [Mr A's] service needs. She was also clear in her stated desire to keep [Mr A] at home while seeking flexible funding arrangement. The transition also complied with the Ministry of Health policy of providing flexible funding arrangements that enabled the clients to make decisions around the care they received."

33. From November 2011, Mr A was receiving IF from the Ministry through the Trust (as the IF host provider) with assistance from Care Group and Mrs B (as IF agent). The NASC continued to work with Mr A.

Needs assessments

34. The NASC worked with Mr A from 2003. The NASC is required to undertake needs assessments for its clients every three years as a minimum or by request when a client's needs have changed. The needs assessments are conducted to assess the level of funding and support services[13] its clients need to maximise their independence.

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[11] From 23 September 2009, Care Group received invoices from Company X. The sole director of Company X was Mr G. Company X was struck off the Companies Office Register for five months in 2012, reinstated until early 2013, and is now struck off.

[12] See below paragraphs 37–41.

[13] "Support services" is a term used to describe a range of day-to-day supports funded to assist people to live in their community. Support can include working with a person to develop or maintain his or her skills, or supporting a person with the activities he or she is unable to do. Supports include help in the home, personal assistance, information, and support to live independently. Some support is also designed to assist family/whānau, such as carer support.

35. The NASC stated that Mr A's needs assessments consistently identified him as having very high needs. The NASC carried out needs assessments in 2004, 2007, 2009, and 2012.

36. The NASC told HDC that Mrs B made various requests in 2012 for increased funding. Mrs B told HDC that she had approached the NASC for 10–15 hours extra per week in order to get Mr A to and from school safely. This resulted in a peer review of the funding arrangement. The recommendation from the peer review was to explore alternative methods of care for Mr A utilising the same funding level. Mrs B told HDC that the NASC wanted to put her son in residential care, which she did not want.

Individualised Funding

37. IF is described by the Ministry as "a way of paying for Home and Community Support Services which lets you directly manage the resources you've been allocated for disability supports".[14] The Ministry stated that IF provides the disabled person with an increased choice and control to choose how and when they use their support allocations, and who provides them with support. To be eligible for IF, the disabled person must be able to manage his or her own support services, or have someone who is able to do it on his or her behalf (a nominated agent).

38. In order to access IF, the person must be referred to an IF host provider (IF host) by his or her NASC. Each person who uses IF to manage his or her support allocations must do this through an IF host. IF hosts are contracted with the Ministry, and are required to help people understand IF, and how to organise, set up and manage their support allocations. Service Level 1 is the minimum level of service that IF hosts are expected to provide in the Ministry's Service Specification (Individualised Funding), which provides:[15]

> "**5. What the Services Offer**
>
> All People entering into Individualised Funding can expect to receive the following levels of service from their chosen Individualised Funding Host Provider.
>
> a) The provision of Individualised Funding set-up and coaching for People to manage their own requirements at each service level. This includes discussing the options and mechanisms for purchasing support services, and/or employing support workers;
>
> b) The provision of an invoicing mechanism allowing People to authorise Individualised Funding Provider/Host to make payments to service providers, pay support workers and invoice the Ministry for support hours utilised;
>
> c) Monitoring of the quality of care delivered and the hours of support provided;
>
> d) Reporting to the Ministry on the delivery of the support package on behalf of the Person;

[14] http://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/individualised-funding.
[15] June 2010 v1.5.

e) Establishment of networks for People accessing Individualised Funding to enable support, sharing of resources (such as staff, training, bureau, advice)."

39. The IF host provides this level of service for a fee set by the Ministry. If the person using IF would like further assistance from the IF host, for example, with the responsibility for recruiting, training and paying support workers, he or she can arrange this with the IF host for an extra fee set by the IF host.

40. The IF host must also ensure that every person accessing IF has a contingency plan in place for the delivery of services relating to IF. The contingency plan relates to situations such as when the support worker is on leave or unable to attend, and to public holidays and in the case of a natural disaster.

41. The IF host must report to the Ministry every three months (see below, paragraph 56).

The Trust

Referral from the NASC

42. The Trust was the IF host through which Mr A's carer support hours were provided.

43. The Trust told HDC that the usual process is for the NASC to assess the client and then refer him or her to an approved IF provider. On 8 December 2011, the Trust received a referral from the NASC in respect of providing IF for Mr A. The Trust stated that the NASC had assessed Mr A in accordance with standard practice and had interviewed Mrs B, and that it "did not have reason to doubt that such assessment was not carried out as [the NASC] indicated". In addition, the Trust stated that although it places reliance on the accuracy of the NASC assessments, it conducts its own assessments (a verification interview) as a "cautionary measure".

IF set-up

44. The Trust's "Individualised Funding Client Handbook" provides the following criteria (amongst other things) for those wishing to be considered for IF:

> "You will need to be able to manage a budget which will include the accounting and expenditure of the hours allocated to you.
>
> Manage all administration requirements associated with IF.
>
> Possess a clear understanding of the kind of support you need, how it is to be given and when.
>
> Be able to schedule and make alternative arrangements for your support.
>
> Be able to understand the responsibilities of being a good employer, and the required employment processes such as recruiting, hiring, and supervising staff etc.
>
> Have willingness to accept training for yourself and your support workers."

45. An IF Coach from the Trust[16] met with Mrs B on 15 December 2011. The Trust refers to this initial meeting as a "verification interview". The Trust stated that at this meeting:

a) Mrs B confirmed that she would act as Mr A's IF agent;

b) Mrs B stated that she had an arrangement with Care Group, who would be responsible for providing support workers;

c) a representative from Care Group was also present;

d) a welcome pack and other documents were reviewed at the meeting;

e) health and safety was discussed;

f) risk issues were identified; and

g) IF Service Level options were explained and Mrs B chose Level 1.[17]

46. The Trust told HDC: "Responsibilities under the IF scheme are outlined and explained at length by the [IF] Coach … When the [IF] Coach is confident that the client/agent understands the tasks involved and responsibilities, then the client/agent is asked to sign the verification form." At the verification interview, Mrs B signed a Verification Tool and Client Services Agreement. Mrs B wrote at the bottom of the Client Services Agreement: "I WISH PAYMENTS FROM [THE MINISTRY] TO BE PAID DIRECTLY TO THE ACCOUNT OF CARE GROUP WHO PROVIDE MY CONTRACTED CARE" (emphasis in original).

47. At the meeting, an Individualised Support Plan for IF for Mr A was also completed by the IF Coach and Mrs B. The Trust told HDC that this plan was prepared by the IF Coach according to the needs assessment carried out by the NASC on the understanding that the plan would be subject to changes as required by Mr A's family.

48. The Trust told HDC:

> "It was [Mrs B] who, during the first meeting with [the Trust's] Coach, made specific reference to her desire to personally manage [Mr A's] care and ensure that his needs were being met. To this end, she said she would utilise the service of Care Group, given the historical relationship between that organisation, [Mrs B] and [Mr A] … [Mrs B] made it clear to the Coach that she was fully aware of her obligations as her son's agent and that she would work with Care Group under the IF scheme as she had prearranged his care previously with that organisation."

49. The Trust's role was to help Mrs B to understand IF, how to organise, set up and manage Mr A's support allocations, administer payments for support services, and help Mrs B to manage her responsibilities, including reporting requirements, so that payments could be made to those who provided the services. The Trust provided an invoicing system to the Ministry, and coaching for Mrs B.

[16] The IF Coach provides support to people to manage their responsibilities under IF.
[17] See paragraph 38 above.

50. The Trust told HDC that, at the beginning, there was an issue with the invoices for Mr A's care not being supplied to the Trust on time. The Trust stated that the Coach visited Mrs B at home to collect the invoices and to "assist [Mrs B] with getting settled into the routine of managing the administration of the care".

51. In response to the "information gathered" section of my provisional opinion, Mrs B stated: "I can only recall having had 2–3 coaching sessions, which were in hindsight, meant to prepare me, in order to take over management of [Mr A's] IF package. I believe personally, that it wasn't enough sessions, I needed more training."

52. In response to my provisional opinion, Care Group stated that its "observations throughout its interactions with [Mrs B] were that while she was extremely well intentioned, she was not capable of satisfactorily performing the roles of an IF agent, and was not experienced in this regard".

Quality monitoring

53. The Trust's Client Services Agreement provides that the Trust will undertake quality monitoring of the services provided by it. The Trust told HDC that these checks are done with the client or agent at six-monthly intervals by telephone or, if necessary, face to face. The Trust stated:

> "The typical Quality Monitoring questions include:
>
> — Do you feel you are making progress towards your goals?;
>
> — Was the way in which your care [was] delivered flexible?; and
>
> — Overall, how satisfied are you with IF as a means to manage your disability support service?
>
> The telephone calls are opportunities for clients/agents to report back to the host on their IF plans and discuss progress, or lack thereof, in terms of care objectives. In the event that a client/agent expresses dissatisfaction or concerns about their carer or requires greater care, then they can request the host to assist directly in organising improved care services."

54. Ten months before Mr A's death, a quality monitoring telephone call was made to Mrs B. The Trust told HDC: "[Mrs B] responded that everything was going well, and that she was happy with the care arrangements and the flexibility that IF offered." The Trust told HDC that Mrs B contacted them only once to express her dissatisfaction with the NASC's assessment of Mr A's funding. A further monitoring call was made to Mrs B six months later. The Trust stated that Mrs B was happy with IF but unhappy with the NASC's services.[18] The next monitoring call was set for another six months' time.

55. The Trust had no contractual arrangement with Care Group, and told HDC that it (the Trust) was not required to carry out any on-site inspections or interview individual staff appointed by Care Group to care for Mr A. The Trust stated that Mrs B was

[18] See above paragraph 36.

responsible for the hiring and monitoring of the persons providing care to Mr A. In response to the "information gathered" section of my provisional opinion, Mrs B stated: "I had no idea that I was responsible for regular inspections of where and who was taking care of my son."

Reporting to the Ministry

56. The Ministry's information leaflet provides that the IF host will monitor and report to the Ministry on the support services delivered and the quality of those services. The Ministry's IF Service Specification states that the IF host is required to report every three months to the Ministry on the following performance measures:

a) The percentage of people receiving IF that have attained or maintained their goals.

b) The number of people receiving IF who express satisfaction with IF.

c) The number of complaints and number of people receiving IF involved, including the percentage of those complaints resolved and the action plan to address any issues.

d) Service delivery issues and emerging trends.

57. The Trust reported on the above performance measures every three months to the Ministry. There is no requirement for the Trust to report on every IF client. The Trust told HDC:

> "The 3 monthly IF Reports sent to the Ministry of Health ("MOH") indicate no incidents in respect of [Mr A's] care or any problems raised by [Mrs B]. There was one instance where she commented negatively about [the NASC] to members of [the Trust] because she wanted more hours for [Mr A's] care but was refused by [the NASC]."

58. The Ministry noted that the accountability for the appropriate utilisation of the provided support hours rested with the Trust and Mrs B.

Care Group

Assistance with administering Mr A's IF package

59. Mrs B sought assistance from Care Group to help manage Mr A's support package. In response to the "information gathered" section of my provisional opinion, Mrs B stated that she had told Care Group that she "couldn't handle the responsibility of managing [Mr A's] IF package, because the financial mathematics was difficult for [her] to comprehend. So [she] wanted Care Group to manage it for [her]." There is no written contract between Care Group and Mrs B. Care Group told HDC that it was "an oral contract on essentially the same terms as had operated for the previous 6 years" and that having no written agreement "reflected the requirements of [Mrs B]", who preferred face-to-face meetings.

60. Care Group said that it "acted as [Mrs B's] agent to perform the administrative tasks associated with the caregivers chosen by [Mrs B]". These tasks included facilitating care in accordance with Mrs B's requirements, paying the support workers who were

contracted to Care Group, and invoicing the Trust for the support worker hours provided. Care Group would invoice Mrs B $[…] plus GST per support worker hour (less the Trust's administration fee of $[…] plus GST per hour). Care Group would pay the support workers an amount agreed between the support worker and Care Group.

61. Initially, the intention was that this arrangement would be temporary until Mrs B no longer required Care Group's assistance to manage Mr A's support package. Care Group said that it became evident that Mrs B "was simply not able to perform the responsibilities of an Individualised Funding agent", and that meant that "Care Group was unable to remove itself from providing the administrative assistance to [Mrs B] as it had intended". In response to the "information gathered" section of my provisional opinion, Mrs B said she told Care Group that she could not perform the responsibilities of an IF Agent as it was too hard for her to manage.

62. In response to my provisional opinion, Care Group said that "at each point in time Care Group was expecting to only have the arrangements continue for a short time longer. The situation that Care Group found itself in was much more than it had ever anticipated."

Communication with Mrs B

63. Care Group operated a 24/7 service with an 0800 number and paging service for clients and support workers. Mrs B was also provided with the mobile number of Care Group's Client Care Manager, Ms K. Care Group advised that Ms K had a good working relationship with Mrs B, and had had close involvement with the management and coordination of Mr A's care over the previous six years. In response to my provisional opinion, Care Group told HDC that the friendship between Ms K and Mrs B "was very conducive to [Mrs B's] needs" but that it "lent itself to informality and that informality resulted in a lack of record keeping and also a laxity around the rostering and written communications". Mrs B told HDC that Ms K was "awesome" and kept her well informed.

64. Correspondence between Mrs B and Care Group was usually by text message, telephone or face to face. Mrs B told HDC that she preferred face-to-face meetings with everyone involved in Mr A's care. Mr A's client notes contain a record of the telephone conversations between Care Group and Mrs B. For the 2012 year (prior to the fire), there are seven client note entries for telephone calls with Mrs B. Care Group accepts that "it could have done better in keeping records in terms of notes about what had been discussed and agreed with [Mrs B]".

Mr A's care arrangements under IF

65. The care arrangement that was already in place[19] continued when Mr A transferred to IF in 2011. Care Group received fortnightly invoices from Company X for the care provided by Mr G's family. Mr G would sort out which family member got paid. Care Group said that throughout this period, it was only "[Mr G's] name that appeared on the roster, this being the effective description for [Company X]".

[19] See above paragraphs 25 to 30.

66. Care Group did not have a care plan for Mr A detailing (amongst other things) his toileting needs, nutrition, communication requirements and de-escalation techniques.

67. Except for Mr A's needs assessment information from the NASC, there was no document detailing what caring for Mr A should entail.

68. Care Group had an Individual Risk Profile (undated) for Mr A. In relation to his potential to cause damage to others and property, it recorded: "Ensure [Mr A] is always supervised." It does not record that Mr A had a fascination with cigarette lighters or fire.

Contingency plan

69. Care Group provided HDC with a copy of Mr A's contingency plan dated 27 July 2010. The contingency plan stated:

> "In the event that [Mr A's] usual support worker is unable to attend a shift, or resigns Care Group Limited will follow the usual back up or replacement support worker contingency plan.
>
> Provided there is time, a meet and greet will be carried out with [Mrs B] to discuss [Mr A's] and her specific needs with the new support worker. The support worker will be a male. This will likely take place in the event of resignation by primary support worker.
>
> Currently [Mr A] is supported by the same support worker [Mr G] who has worked with him for the past 9 years …
>
> The brother and son of the primary support worker [Mr G] also work with Care Group Limited with other clients and will be utilized to fill in [in] the event of annual leave or sick leave."

70. The contingency plan stated that the brother and son were familiar with Mr A's needs. It also stated that Care Group would trial new, suitably qualified support workers, if the need arose.

Mr G on leave

71. Mr G was Mr A's main support worker up until Month1, when he went overseas. In a statement to the Police, Mr G said: "In [Month1] I went [overseas] … [W]hile I was gone my wife was responsible for looking after [Mr A] in my absence. She was struggling to look after [Mr A] so she took [Mr A] back to [Mrs B]. While I was away Care Group and [Mrs B] passed the care of [Mr A] on to my son [Mr D] …" Mr G also wrote an email to Ms K on 30 Month2, in which he advised that he had told his wife and another son to contact Mr D if they could not handle Mr A while he was away.

72. Care Group told HDC that while Mr G was absent, "[Mr D] was effectively taking over this responsibility for [Company X]. Accordingly, he was having his name placed on the roster as being the person to who[m] payment was being made in the

absence of [Mr G], and [Mr D] being responsible for allocating a carer acceptable to [Mrs B], and paying that carer."

73. On 13 Month2, during Mr G's leave, a new caregiver was trialled with Mr A. In response to the "information gathered" section of my provisional opinion, Mrs B said that, in her view, the emergency caregiver was a "total disaster" and not professional. Mrs B asked Ms K if Mr D was available instead.

Mr D

74. Mr D did not have any formal disability service qualifications. Mr D told the Police that he gained his experience as a support worker for Mr A when assisting Mr G to care for Mr A for approximately one year in 2006. Mr D estimated that he had cared for Mr A for approximately one year in 2006 (ie, when Mr A was 14 years old). In contrast, Mrs B told HDC that Mr D had cared for Mr A when Mr A was nine years old.

75. Care Group told HDC that it first contracted with Mr D in order to provide services to another Care Group client, Mr H. However, Care Group also said: "[Mr D] was a caregiver inherited by Care Group as part of [Mr G's family]. Accordingly, Care Group continued an existing arrangement that [Mrs B] wanted to continue, and [Mr G] and [Mrs B] acted as the referees for [Mr D]."

76. Mr D was given a copy of Care Group's "Training, Induction, and Orientation Manual" (the Manual), which he signed on 29 March 2009. This included a copy of the support worker job description, copies of Care Group's policies, and a section on self-directed learning. The policies include (amongst other things) topics on medication administration, complaints resolution, health and safety, support worker assessment, financial protection, boundaries, privacy, abuse and neglect, serious incidents, and Māori health. Care Group's Manual has since been updated (date unknown), but there is no evidence that this was provided to Mr D or that he was given copies of Care Group's new or updated policies.

77. Mr D signed an independent contractor agreement on 29 June 2009. The agreement states: "The Contractor agrees to complete every job accepted by it in a manner that is consistent with good work standards." The agreement also specifies that the contractor cannot assign its rights and obligations under the agreement without the prior written consent of Care Group, nor can the contractor "permit vicarious performance of its obligations under this Agreement".

78. The only training provided by Care Group was a first aid course, which Mr D attended on 21 November 2011. There is no evidence that Mr D was offered or attended any in-service training. In response to my provisional opinion, Mr D told HDC that he wishes that he had received more training. He said that he was only given first aid training and one day of practical training.

79. Training for specific clients was done "on the job". Care Group told HDC: "Specifically in relation to [Mr A], the circumstances around training were quite unique … [Mr D] had known [Mr A] for 14 years and was very familiar with him and

the complexities around his care … Training was on the job and with close communication between Care Group ([Ms K]) and [Mrs B] …" In addition, Mrs B told the Police: "I never mentioned anything specific [to Mr D] about [Mr A's] care as I felt I didn't need to."

80. Care Group's "Staff Assessment Policy and Procedure" states that new staff members are assessed at four months after the commencement of duties, at one year, and then at yearly intervals (or more often if the situation arises). The only record of a performance appraisal for Mr D was a partially filled out form titled, "Pay Scale/Performance Review for [Mr D]". The form appears to have been used to assess [Mr D's] support worker experience ("none personal"), disability care ("2 years adults"), child care ("some"), hoists/transfers ("some") and challenging behaviours ("very"), and the class of drivers licence ("restricted"). On the form there was space to assess training attended, flexibility, and reliability with clocking in. Mr D was not assessed on these areas. Care Group stated:

> "In [Mr D's] case, the contact between [Ms K] and [Mrs B] meant that there were very open lines of communication about everything to do with [Mr A] … [Ms K] had regular meetings with both [Mr G] and [Mrs B] in [Mr G's] home and the home of [Mrs B]. There was never any concern expressed on any person's part about the performance of [Mr D] during these meetings."

81. In Month1, Mr D became one of Mr A's main support workers while Mr G was away. Mrs B's nephew (who was also Mr A's teacher aid), Mr E, also assisted with Mr A's care during this period.

The roster

82. Care Group stated that in a "normal" arrangement with clients, rosters are sent from Care Group to support workers two weeks in advance, and it was rare for a roster to be amended. A confirmation text message is then sent to the support worker the day before each rostered shift. Support workers then log in for the shift using the client's telephone as soon as they report for their shift, and also when they are leaving at the end of the shift. Mrs B said that she has never had a "clock in system" at her address.

83. Care Group stated that the normal arrangement is different from Mr A's arrangements. In Mr A's case, it inherited a pre-existing arrangement between Mrs B and Mr G whereby care was often provided in the support worker's home.[20] In addition, Care Group said that Mrs B would change the roster directly with the support worker, and stated: "In simple terms, [Mrs B] decided who provided care, when that care was provided, and who provided it." Care Group told HDC that it was common for Mrs B to decide on her own arrangements about who cared for Mr A, and often it was informed only afterwards. Mrs B would confirm that the support worker had worked, and the number of hours claimed, by signing off the support worker's submitted time sheets. Accordingly, Care Group's roster showing which support worker was providing care to Mr A and when, was often incorrect. Care Group

[20] No health and safety assessment was conducted for the suitability of the support worker's home.

accepts that the actual name of the support worker who was providing care should ideally have been recorded on the roster when that support worker was known.

84. In response to the "information gathered" section of my provisional opinion, Mrs B said that she did not change shifts randomly unless she had a good reason to do so. She stated:

> "I believe there needed to be room for flexibility … both ways. So when shifts were changed I notified [Ms K], via txt or Cell phone directly, majority of times, or Care Groups receptionist via phone. But there were also times where caregivers didn't turn up for shifts, so I would try to make arrangements with other caregivers."

Caring for two clients at one time

85. Care Group told HDC that it facilitates support workers providing care on a one-to-one basis, and that one support worker is not rostered on to care for two clients at the same time. Care Group said that double bookings are usually evident through its client management system and, if not, then either through the roster printing and posting process or when text message confirmations are sent out.

86. Mr D told the Police that he understood that one-to-one care meant one person caring for one client, and that Mr H and Mr A "needed a one on one". Care Group stated: "While [Mr D] cared for both [Mr A] and [Mr H], this was **never** at the same time [emphasis in original]." In contrast, Mrs B told HDC that initially when Mr D started to care for Mr A he was sometimes rostered on to look after both Mr H and Mr A at the same time. She recalls seeing Mr H in the car with Mr D when he (Mr D) would come to pick up Mr A. She said that Ms K was also aware of these arrangements, but that it was meant to be only temporary. Mrs B told HDC that at some point Ms K told Mr D that he could not look after both Mr H and Mr A at the same time.

87. On 24 Month2 (two weeks before the fire), Ms K emailed Mr H's father to advise that Mr D was not available on 26 and 27 Month2. Mr H's father replied, saying: "It looks [like] [Mr D's] circumstances are changed as he is available for [26 and 27 Month2]." Ms K told HDC that following these emails, she called Mr D and advised him that he could not work with two clients (Mr H and Mr A) at the same time (26 and 27 Month2). Ms K stated that Mr D told her that another of his family members, who had previously supported Mr A and knew Mr A and Mrs B well, would be looking after Mr A and he would look after Mr H.

88. Care Group told HDC that it understood that Mr D had checked with Mrs B that she was happy with this arrangement. Care Group did not call and check the arrangements with Mrs B. In response to the "information gathered" section of my provisional opinion, Mrs B stated that she "knew nothing about the other family member from [Mr D]".

89. On 2 Month3 (one week before the fire), Mr D was rostered on to look after Mr H from 2pm to 8pm, and Mr A from 3pm to 9pm. Ms K sent a text message to Mr D on 1 Month3 stating: "I also have you booked with [Mr A] 3pm to 9pm but will call

tomorrow to confirm once I speak with [Mr G] and [Mrs B].” Subsequently, Mrs B called Care Group on 6 Month3 to advise that she had changed the roster for 2 and 3 Month3. Mr E had worked with Mr A on 2 Month3, and Mr D had worked with Mr A on 3 Month3.

90. Care Group said that Mr D was booked to work with Mr H on 9 Month3 (the day of the fire) from 2pm to 8pm, but that his name also appeared on the roster as caring for Mr A from 3pm to 9pm. Care Group said that this was the same roster as the previous two weekends. Care Group stated:

> “This rostering had occurred because [Mr G] was away [overseas] and the remainder of [Mr G’s] family were providing care for [Mr A]. During telephone discussions with [Mr D] about those arrangements during the prior weeks we informed him of Care Group’s requirements that he could not care for both clients at the same time. He confirmed his understanding of this requirement, and stated that a family member who was known and approved by [Mrs B] was caring for [Mr A].”

91. The following is a table of text messages sent between Mr D and Ms K on 8 and 9 Month3:

From	Date and Time	Message
[Ms K]	8 [Month3] 3.12pm	Tomorrows shifts — [Mr H] 2pm to 8pm. Please confirm thanks [Ms K]
[Mr D]		yes
[Ms K]	9 [Month3] 2.51pm	Wkend shifts — [Mr H] Sat 9am to 7pm and [Mr A] Sunday 9am to 9pm. Please confirm thanks [Ms K]
[Mr D]		I got [Mr A] today as well aye?
[Ms K]	9 [Month3] 2.53pm	Yes at 3pm
[Mr D]		Ok gona go there now
[Ms K]	9 [Month3] 3.02pm	I also have you booked with [Mr H] on Monday 9am to 3pm. Please confirm thanks [Ms K]
[Mr D]		Yeah
[Ms K]	9 [Month3] 3.04pm	I also have you booked with [Mr H] on Monday 9am to 3pm. Please confirm thanks [Ms K]
[Mr D]		Areu in the office?
[Ms K]	9 [Month3]	Yes

92. It is not apparent from this text message exchange that Ms K was aware that Mr D had arranged for another of his family members to care for Mr A and that he (Mr D) would care for Mr H. However, Ms K advised HDC that she understood from her correspondence with Mr D that Mr I (Mr D's ex-partner's brother) was a member of Mr G's family, and that he would be caring for Mr A, and that Mrs B was aware of this. Mrs B told HDC that she had never met Mr I, and did not know that he would be looking after Mr A.

93. Care Group said that Mr D was not responsible for managing a clash in rosters, and that it did not place any obligation on Mr D to manage the increased demands that were coming from Mr H's family and Mrs B (with whom he had direct contact).

94. Care Group told HDC that it spoke with Mrs B on 9 Month3 and arranged a meeting for 15 Month3, to "sort out [Mr A's] roster". There is no record in Mr A's client notes of this meeting being arranged, but a client note for that day recorded: "Placed a call to [Mrs B] and have confirmed the shifts for this week with her. I have created the roster based on this conversation."

Mr I

95. Mr I had been living with Mr D for six weeks from Month1/Month2 until the day of the fire.

96. Mr I did not have any prior caregiving experience, and was not paid by Mr D. Mr I told the Police that it was not his job to look after Mr A or Mr H, and that "it was [Mr D's] job to do that". He said that he would keep an eye on them and that was all.

97. Mr D told the Police that on two previous occasions he had looked after Mr H and Mr A at the same time. Mr D told the Police that he thought it was OK for both Mr A and Mr H to be under his care at the same time if Mr I was at his house to help out.

Events of 9 Month3

98. On 9 Month3, Mr I and Mr D's son (who was two years old at the time of the events) were at Mr D's home.

99. Mr D collected Mr H from his home at approximately 11am.[21] However, as noted above, Care Group's records show that Mr D held only his restricted driver's licence.[22] After shopping at the supermarket, Mr D dropped off Mr H at his (Mr D's)

[21] Mr D's shift did not start until 2pm, but he collected Mr H early at the request of Mr H's mother.

[22] The New Zealand Transport Agency website (www.nzta.govt.nz) states that a person on a restricted licence "cannot normally carry passengers, unless you have a supervisor with you. The only passengers you can carry without a supervisor are:

- your spouse, or the person you live with as if you were married or with whom you are joined in a civil union;
- children who live with you and are under the care of you or your spouse (that is, you or your spouse are their parent or guardian;
- your parent or guardian;
- relatives who live with you and who are on a social security benefit
- someone you look after as their primary caregiver."

home to be looked after by Mr I while he collected Mr A. Mr E, who had collected Mr A from school that day, told the Police that Mr D picked up Mr A at 3pm. Mr E said that there was no one else in the car with Mr D when he collected Mr A.

100. Neither Mr H's nor Mr A's family was aware that Mr D was looking after their sons at the same time.

Fire risk

101. Mr D told the Police that in the afternoon he saw Mr A playing with a cigarette lighter. Mr I took the lighter off Mr A. Mr I told the Police that he saw that Mr A was able to ignite the lighter, and that Mr D had been surprised that Mr A could do so.

102. Mrs B told HDC that it was emphasised to all caregivers that Mr A had a fascination with fire, and never to leave lighters around. Mrs B told the Police that she told Mr D a number of times not to leave a lighter lying around Mr A, and that Mr D was aware of "the dangers" as he had known Mr A for years. Mr D told HDC that he was unaware that Mr A had a fascination with fire. Mr G said that he was aware of Mr A's fascination with fire, but was unsure whether Mr D would have been aware of this. Mr E did not know of any past occasions when Mr A had been playing with a lighter or anything else to do with fire.

103. As noted above, Mr A's Individual Risk Profile does not record that Mr A had a fascination with cigarette lighters or fire, but it does record: "Ensure [Mr A] is always supervised."

Mr I leaves

104. Mr D told the Police that a group of Mr I's friends arrived at his house at either 5 or 6pm. Mr D said that as Mr I and his friends were drinking alcohol, he asked them to leave. At approximately 6.30pm, Mr I left with his friends.

Mr H and Mr A left unsupervised

105. At approximately 7.30pm, Mr D left Mr A and Mr H alone watching television so that he could collect food for Mr H from Mr H's father. Mr D took his son with him and locked the front door before he left. Mr D told the Police that he locked the house because Mr A had a tendency to run off.

106. In his Police interview, Mr D said that after collecting Mr H's food, he stopped on the way back to buy two pies and a drink for Mr A. He told the Police that he was gone for no longer than five minutes. Mr D acknowledged that he should not have left Mr A and Mr H alone in his house, and said: "[I]t was irresponsible of me to just leave them alone, but I thought, like if I can quickly go and get the stuff, come back home, feed them …"

The fire

107. While Mr D was out collecting food, a fire broke out at his home. Mr H and Mr A were unable to get out of the house, as they were locked inside. Mr H suffered burns and was taken to hospital. Sadly, Mr A died in the fire. The fire department was unable to identify what caused the fire to ignite.

Response to HDC

108. The NASC, the Trust and Care Group have cooperated with the investigation process and have provided a number of responses and documentation to HDC.

109. Mr D provided a brief response to HDC, and stated that any information HDC requires can be obtained from the Police. Mr D has not otherwise engaged in HDC's investigation. Mr D told HDC:

> "[N]ot a day has gone by that I have not thought about the tragic event and the loss of [Mr A]. I have wanted to visit and speak to [Mrs B] since what happened but I didn't know how and what I would say as nothing I say is ever going to bring [Mr A] back. Please pass on my deepest condolences to [Mrs B]. I keep praying every day that healing will come to her heart for the tragic loss."

Changes made

The NASC

110. The NASC stated: "At this stage based on the current philosophy and intent of IF, we have not identified any immediate changes we would make to our current processes. However, as IF continues to evolve and expand we will continue with this review process and give feedback to the Ministry of Health where appropriate."

The Trust

111. The Trust told HDC that it has used this incident to implement further improvements to its service, which include the following:

a) It now insists on greater detail of the disabilities and risks of each patient/client to be supplied by the NASC on each referral.

b) It now has a clinically trained person taking on the role of the IF Coach.

c) It has implemented annual on-site visits to each IF client.

Care Group

112. In Month3, in response to these events, Care Group contacted a quality and risk management service, to arrange an audit, which was conducted on 11 and 12 Month3.[23]

113. In response to my provisional opinion, Care Group provided a copy of the audit conducted on 9 and 10 June 2014. The audit identified a number of low, moderate and high risk corrective actions. The moderate risk corrective actions concerned quality and risk management, essential and emergency systems, service planning, and its review of service planning. The high risk corrective actions concerned orientation, induction, on-going development and competency of staff, supervision of staff and medicine management. On 20 October 2014, the quality and risk management service wrote to Care Group and stated: "While a number of areas for improvement were

[23] The audit identified a number of low risk corrective actions and one moderate risk corrective action involving medication.

identified at audit you have made significant improvements so that we have been able to recommend certification …"

114. In addition, Care Group has made the following changes to its service:

a) Support workers will be moved from independent contractors to employees to allow more control over the service being provided to clients.

b) Employee agreements now specifically mandate that support workers are to provide one-to-one support in the client's home.

c) The Induction and Training Manual has been amended to include a more comprehensive explanation of support worker and client responsibilities.

d) Verbal confirmation of shifts and appointments is no longer accepted. All support workers are now required to text back to confirm shifts. If this is not possible, the co-ordinator will enter notes from a telephone call into the electronic notes.

e) All communication with both clients and support workers must be entered into the client management system, as well as comprehensive notes for all meetings added to the client and/or support worker files.

f) It has employed a new Client Care Manager, who is a registered nurse and experienced in the sector.

Response to the provisional opinion

115. A response to the "information gathered" section of my provisional report was received from Mrs B. Responses to the provisional opinion were received from Care Group, the Trust and Mr D. Where appropriate, the responses have been incorporated in the "Information gathered" section above or in the section that follows.

Mrs B

116. In response to the "information gathered" section of my provisional opinion, Mrs B stated:

> "[W]ith all the taxing that went on in [Mr A's] package … I couldn't manage his I.F myself, which encompassed everyone that had anything to do with it. I definitely needed more support from the system. But sadly [Mr A] didn't qualify for the extra hours needed to keep him safe, out in the community, nor did he qualify for professional in house care on a respite basis. He was too old and the only other option was Residential Care, which I had refused, because I chose de-institutionalisation over institutionalisation, as his Mother, which had been encouraged by the Government's system over time."

The NASC

117. In response to my provisional opinion, the NASC stated that it did not wish to comment.

Mr D

118. In response to my provisional opinion, Mr D told HDC that this day still haunts him and that there isn't a single day that goes by where he doesn't think about what

happened. He said that what he did was not on purpose and that if he had been given all the information he needed about caring for Mr A, and if he knew Mr A was a fire risk, he never would have left Mr A alone. He said that he was trying to help Mrs B out, and that "on the day [he] thought it was a good choice".

119. Mr D stated: "It is not that I am not sorry. I want to approach and talk to [Mrs B] but I am too afraid as to how she will react. There are no words that I can say to make anything better." He told HDC that every night before he goes to bed he prays that Mrs B will be OK.

Care Group

120. In response to my provisional opinion, Care Group stated:

> "Care Group Limited accepts the factual findings (related to Care Group) in your provisional opinion. Care Group also accepts that in this instance it breached the Code of Rights in relation to the care provided to [Mr A]. Care Group and the individuals associated with Care Group have always regretted that it had any involvement in the events leading up to the death of [Mr A], which has been severely felt by the organisation."

The Trust

121. In response to my provisional opinion, the Trust stated that it "continues to treat this matter with the severity it deserves".

Relevant standards

122. The New Zealand Home and Community Support Sector Standard NZS 8158:2003 sets out what people receiving support in a home or community setting can expect from the services they receive, and the minimum requirements to be attained by organisations. NZS 8158:2003 was superseded by NZS 8158:2012, which was published on 19 April 2012. NZS 8158:2012 has four sections that state the intended outcomes and describe the systems, policies and procedures and actions required to support achievement of good outcomes, compliance and consistent quality expectations. NZS 8158:2003 and NZS 8158:2012 are voluntary sector standards. Care Group advises on its website that it is a "fully accredited" New Zealand owned and operated home health organisation certified to the industry standard NZ 8158.

123. Care Group's website further notes that "currently certification to this standard is not mandatory however, with an increasing number of people choosing to stay in their own homes for longer, certification is one way to ensure you are receiving comprehensive, quality, person centered care by professionals".

124. For relevant extracts from NZS 8158:2003 see **Appendix B**, and for NZS 8158:2012 see **Appendix C**.

Opinion: Mr D — Breach

Introduction

125. Mr D did not have any formal disability service qualifications. He had been contracted as a support worker by Care Group since 2009 and gained his experience as a support worker for Mr A in approximately 2006, while assisting his father (Mr G) to care for Mr A. As stated below, Mr D was poorly trained, monitored and supervised by Care Group. Despite these factors, I am of the view that Mr D is also responsible for failing to provide services to Mr A of an appropriate standard.

Services of an appropriate standard — Breach

126. In Month1, Mr D became one of Mr A's main support workers while Mr G was overseas. Mr A was funded for one-to-one care, and Mr D was aware that Mr A needed one-to-one care.

127. Care Group told HDC:

> "During telephone discussions with [Mr D] about those arrangements during the prior weeks we informed him of Care Group's requirements that he could not care for both [Mr A and Mr H] at the same time. He confirmed his understanding of this requirement, and stated that a family member who was known and approved by [Mrs B] and was caring for [Mr A]."

128. Mr D told the Police that on two previous occasions (prior to the fire) he had looked after Mr H and Mr A at the same time. Mr D stated that he thought it was OK for both Mr A and Mr H to be under his care at the same time if Mr I was at his house to help out.

129. On 9 Month3, Mr D collected Mr H at approximately 11am. Mr D left Mr H at his home to be looked after by Mr I while he collected Mr A at 3pm. Mr D proceeded to care for Mr A and Mr H at the same time that afternoon. Mr D also had with him his two-year-old son, which meant, essentially, that Mr D was caring for three vulnerable people at one time. Mr I was present, but told the Police that it was not his job to look after Mr A or Mr H, and that he would help only to keep an eye on them.

130. Mr D told the Police that at approximately 6.30pm Mr I left with his friends. At approximately 7.30pm, Mr D left Mr A and Mr H alone watching television so that he could collect food for Mr H. Mr D took his son with him and locked the front door before he left. Mr D told the Police that he locked the house because Mr A had a tendency to run off. Mr D did this knowing that Mr A should always be supervised.

131. While Mr D was out collecting food, a fire broke out at his home. Mr H and Mr A were unable to get out of the house as they were locked inside. Mr H suffered burns and was taken to hospital. Mr A died in the fire. Mr D acknowledged that he should not have left Mr A and Mr H alone in his house, and that this was irresponsible.

132. I acknowledge the lack of training, monitoring, and supervision provided by Care Group to Mr D. However, I do not think that this mitigates his decision to look after

Mr A, Mr H and his two-year-old son at one time, and to leave Mr A unsupervised. I agree with my expert advisor, Mr John Taylor, who stated: "None of these mitigating circumstances reduce the fact that his care of [Mr A] was significantly below what should be expected."

133. Mr Taylor stated: "In my opinion it is very clear that [Mr D] failed, severely, to provide adequate care to [Mr A] on 9 [Month3]." I agree, and consider that Mr D's actions on 9 Month3 were seriously suboptimal.

134. By caring for three vulnerable people at one time when he knew Mr A required one-on-one care, and by leaving Mr A unsupervised and locked in his home with Mr H despite knowing that Mr A must always be supervised, Mr D did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Care Group Limited — Breach

Introduction

135. Care Group, as a provider of disability support services, is responsible for providing services to its clients in accordance with the Code. In addition, as Care Group advertises that it "is certified to the New Zealand Home and Community Support Sector Standard 8158 [NZS 8158:2003 superseded in April 2012 by NZS 8158:2012]", I consider that Care Group should provide services consistent with that standard.

136. In my view, Care Group had a responsibility to ensure that Mr A received appropriate and safe services from suitably skilled and experienced support workers. I consider that there are several areas where the care provided to Mr A by Care Group fell well short of the accepted standard. I have set out those areas below.

Quality of care and role

Informal arrangement

137. Care Group said that it "acted as [Mrs B's] agent to perform the administrative tasks associated with the caregivers chosen by [Mrs B]". These tasks included facilitating care in accordance with Mrs B's requirements, paying the contracted support workers, and invoicing the Trust for the support worker hours provided.

138. Although ultimately Mrs B chose the support workers who would care for Mr A, Care Group took responsibility for contracting with and rostering those support workers.

139. There was no written contract between Care Group and Mrs B (as Mr A's agent). Care Group told HDC that its agreement with Mrs B was "an oral contract on essentially the same terms as had operated for the previous 6 years", and that having no written agreement "reflected the requirements of [Mrs B]", who preferred face-to-face meetings. Mr Taylor stated:

> "This may have been acceptable if the term of engagement had only been very short term but once more than 6 months had elapsed this should have been required. It is not sufficient to say that an organisation ignores good practice at the request of a consumer/ service user. It is their professional responsibility to convey to that person why they need to operate in certain ways and to find a position that satisfies each party. There may well have been other ways to record the agreement if writing it down was truly objectionable to [Mrs B]. For example, an audio or video recording of an agreement works for some people."

140. In addition, NZS 8158:2003 stated that each service provider shall ensure each service user has a written agreement that explains the service they are to receive.[24]

141. Care Group commented a number of times to HDC that Mr A's situation was unique and did not reflect its normal arrangement with clients. Care Group stated that it was common for Mrs B to decide on her own arrangements about who cared for Mr A, and that often it was informed only afterwards. Mrs B would confirm that the support worker had worked and the number of hours they claimed by signing off their submitted time sheets. Accordingly, Care Group's roster showing which support worker was providing care to Mr A and when, was often incorrect. Care Group accepts that the actual name of the support worker who was providing care should ideally have been recorded on the roster when that support worker was known.

142. Mr Taylor stated that the informal nature of the agreement between Mrs B (for Mr A) and Care Group "was not appropriate given the fact that it was for funded services supporting a vulnerable young man". I accept Mr Taylor's advice. In particular, I consider that the process for rostering Mr A's support workers, and the very loose nature of this arrangement, created an environment where errors, including double bookings, could (and did) occur.

143. Mr Taylor opined:

> "I acknowledge they were genuinely attempting to help out in this situation; one that was complicated by a number of the contracting features […]. Not-withstanding this, it remains their responsibility to operate to a certain standard and to refuse to operate if the structure of support could pose a significant danger to those being supported."

144. In my view, where the care arrangements for a particular client fall outside of an organisation's usual practice, it is paramount that the arrangements be carefully documented so that each party is aware of their role and responsibilities. Care Group was responsible for ensuring that this occurred, and it failed to do so.

145. In addition, I do not accept that as part of the informal arrangement, Care Group held an administrative role only. Although ultimately Mrs B chose the support workers who would care for Mr A, Care Group provided the contracted support workers, and with that comes certain responsibilities (as discussed below).

[24] Standard 4.2.1.

146. In my view, by failing to have a written agreement with Mrs B, Care Group did not provide services of an appropriate standard to Mr A, or services consistent with NZS 8158:2003 standard 4.2.1.

Training and supervision

147. Mr D was contracted to supply support worker services to Care Group from 29 June 2009. Except for being provided with a copy of Care Group's "Training, Induction, and Orientation Manual", the only training provided by Care Group was a first aid course, which Mr D attended on 21 November 2011. In response to my provisional opinion, Mr D told HDC that he wishes that he had received more training.

148. NZS 8158:2003 provided:[25]

> "The service provider implements a system to identify, plan, facilitate and record training and education for all staff, ensuring they continue to provide safe and effective services to service users.
>
> NOTE — This may be achieved by, but is not limited to ensuring new staff:
>
> …
>
> (b) Have their training needs identified and planned for;
> (c) Receive regular performance reviews."

149. In addition, NZS 8158:2003 stated that the service provider must ensure that all support workers are supervised.[26]

150. In Month1, Mr D became one of Mr A's main support workers while Mr A's usual support worker, Mr G, was overseas. Care Group told HDC that Mr D had known Mr A for 14 years, and that his training was on the job and with close communication between Care Group and Mrs B. However, Mrs B told the Police that she did not mention anything specific to Mr D about Mr A's care, except that he was a fire risk, as she felt she did not need to.

151. The care provided to Mr A by Mr D between Month1 and Month3 took place in Mr D's home. Care Group was aware of this arrangement. There was no health and safety assessment done to check the suitability of Mr D's home. In addition, there is no evidence that Care Group actively supervised or monitored the care provided by Mr D to Mr A at any time. Care Group did not meet with Mr D on a regular basis, and its main form of communication with him was by text message or by telephone. It also appears that Mr D was not required to log in at the beginning and end of each shift by telephone.

152. Mr Taylor stated:

> "[…] [T]hey had accepted to work with [Mr A] and so should have adapted their business model to support him adequately. They did not do this in various ways,

[25] Standard 2.7.2.
[26] Standard 2.7.8.

> one of them being in relation to supervision and training of direct support people. In my view this is a significant lack of proper process and left [Mr A] vulnerable to poor or inadequate support."

153. I agree, and I consider that it was Care Group's responsibility to ensure that its support workers had the required experience and skills, and received appropriate and relevant training.

154. Care Group's "Staff Assessment Policy and Procedure" states that new staff members' performance is assessed at four months after the commencement of duties, at one year, and then yearly thereafter.

155. The only record of a performance appraisal for Mr D was a partially filled out form titled "Pay Scale/Performance Review for [Mr D]", which is undated. The form was used to assess Mr D's support worker experience ("none personal"), disability care ("2 years adults"), child care ("some"), hoists/transfers ("some") and challenging behaviours ("very"), and his class of drivers licence ("restricted"). On the form there was space to assess training attended, flexibility, and reliability clocking in, but these areas were left blank.

156. In relation to Mr D's performance assessments, Care Group stated:

> "In [Mr D's] case, the contact between [Ms K] and [Mrs B] meant that there were very open lines of communication about everything to do with [Mr A] … [Ms K] had regular meetings with both [Mr G] and [Mrs B] in [Mr G's] home and the home of [Mrs B]. There was never any concern expressed on any person's part about the performance of [Mr D] during these meetings."

157. I do not accept that Care Group discussed Mr D's performance with Mr G or Mrs B. Mr G was on leave during the period that Mr D provided care to Mr A. In addition, Care Group made no written record of the discussions. Mrs B told HDC that she did not discuss Mr D's performance with Care Group or Mr G.

158. I am also concerned that, despite Care Group records stating that Mr D held a restricted drivers licence, Care Group was aware that Mr D was transporting both Mr H and Mr A in his car. This was in breach of the restriction on his licence.

159. In my view, it is vital that Care Group conduct regular performance assessments of its support workers to ensure that they are performing well and in accordance with Care Group's culture and systems. Performance assessments are an important tool that enable an organisation to provide feedback, and to identify strengths and weaknesses, training needs, and any areas for improvement in the disability service that is being provided. Care Group also had responsibility to ensure that its support workers had the required experience and skills, and received appropriate and relevant training. Mr D was a contractor for Care Group for almost three and a half years, and was responsible for the care of very vulnerable clients. In my view, Care Group did not provide Mr D with the necessary training for caring for Mr A, who had complex needs, and Care Group did not assess Mr D's performance regularly and, therefore, was unaware of how he was performing. I consider the failure to provide adequate

training and to conduct regular performance assessments in an area where vulnerable clients are being provided with services, to be very poor practice, and that this had a significant impact on the quality of care provided to Mr A. In addition, Care Group did not provide services consistent with NZS 8158:2003 standards 2.7.2 and 2.7.8.

Failure to ensure one-to-one care

160. Care Group had a duty to ensure that it was providing appropriate and safe services to Mr A, and that included the services provided by Mr D. It was Care Group's responsibility to manage a clash in a support worker's roster. Care Group did not take reasonable steps to ensure that alternative and appropriate care arrangements had been made for Mr A on 9 Month3 when it was apparent that it had rostered Mr D to work with two clients on the same day.

161. The only record of the correspondence between Care Group's Client Care Manager, Ms K, and Mr D are the text messages sent between them on 8 and 9 Month3. The text messages confirm that Ms K was aware that Mr D was on the roster to care for Mr H on 9 Month3 from 2pm to 8pm, and also on the roster to care for Mr A from 3pm to 9pm. Mr D sent a text message to Ms K at 2.15pm on 9 Month3 saying, "I got [Mr A] today as well aye," and Ms K replied, "Yes at 3pm." At 2.53pm, Mr D replied, "Ok gona go there now."

162. Ms K said that she understood from her communication with Mr D on 8 and 9 Month3 that Mr I (Mr D's ex-partner's brother) would be caring for Mr A, and that Mrs B was aware of this. Mrs B told HDC that she was not aware that Mr I would be looking after Mr A. Irrespective of whether this was Ms K's understanding or not, alarm bells should have rung when Mr D told her that he was going to collect Mr A. Ms K was aware that Mr D was rostered to look after Mr H that afternoon. In my view, by 2.53pm on 9 Month3, Ms K was aware that Mr D was going to collect Mr A from his home knowing that Mr D also had Mr H in his care at the same time. In my view, at this point, Ms K should have questioned Mr D as to why he was collecting Mr A when she understood that he was caring for Mr H, and that Mr I would be caring for Mr A.

163. I consider that Care Group did not take adequate steps to ensure that alternative and appropriate care arrangements were in place for Mr A. In the circumstances, it was inappropriate for Care Group to rely on Mr D's assurance that Mr I was part of Mr G's family, would be caring for Mr A, and was an appropriate caregiver. I am very concerned by the lack of action taken by Care Group. I consider that, at the very least, Care Group should have contacted Mrs B to confirm that she was aware that Mr I would be caring for Mr A, and should have made enquiries as to whether Mr I was suitably qualified to care for Mr A.

164. I acknowledge that Care Group thought that Mr I would be caring for Mr A. However, in my view, not only did Care Group fail to ensure that this was the case, it also failed to conduct the necessary checks to ensure that Mr A would be receiving one-to-one care by a suitably qualified support worker. Although I consider that it was poor judgement by Mr D to care for two clients at the same time, in my view ultimately it was Care Group's responsibility to ensure that this did not occur.

Care planning

165. Care Group did not have a care plan for Mr A detailing (amongst other things) his toileting needs, nutrition, communication requirements, and de-escalation techniques. Except for Mr A's Individual Risk Profile, and needs assessment information from the NASC, there was no document detailing what caring for Mr A should entail. Care plans are an essential tool for ensuring that each client's care requirements are communicated to all staff involved in that client's care. In Mr A's case, there were a number of different support workers who provided care for Mr A. In my view, it was essential that Mr A's support workers had an up-to-date care plan that they were able to reference when providing care to him. In my view, by failing to have an appropriate care plan for Mr A, Care Group's care planning fell well short of the accepted standard.

Record-keeping

166. I am critical of Care Group's standard of documentation. In Mr A's file, there were no client notes recorded in the eight months up to 9 Month3. In particular, there are no client notes recorded during the period that Mr G went on leave. Key decisions about Mr A's care arrangements should have been carefully recorded in his client notes. Care Group has acknowledged that its record-keeping could have been better. As the agreement between Mrs B and Care Group was verbal, I consider that Care Group should have been particularly vigilant with its record-keeping.

Conclusion

167. I do not accept that as part of the informal arrangement, Care Group held an administrative role only in providing care to Mr A. Although ultimately Mrs B chose the support workers who would care for Mr A, Care Group contracted with and rostered those support workers.

168. I note Mr Taylor's acknowledgement that Care Group was genuinely attempting to help out in this situation — a situation that was complicated by a number of the contracting features. Not-withstanding this, as noted by Mr Taylor, it remained Care Group's responsibility to operate to a certain standard and to refuse to operate if the structure of support could pose a significant danger to those being supported.

169. In my view, Care Group did not adequately assess or monitor the quality of care being provided by Mr D to Mr A. Despite Mr D being a contractor for Care Group for almost three and a half years, and being responsible for the care of very vulnerable clients, Care Group did not provide training or supervision to Mr D in caring for clients with Mr A's needs. In addition, Care Group did not provide services consistent with NZS 8158:2003 standards 2.7.2 and 2.7.8, which stipulated that it must ensure all support workers receive regular performance reviews and are supervised. I consider that these failures left Mr A vulnerable to poor or inadequate support.

170. Care Group did not comply with NZS 8158:2003 standard 4.2.1, as it did not have a formal written agreement in place with Mrs B, which created uncertainty about the roles and responsibilities of those managing Mr A's support. In addition, the process for rostering Mr A's support workers created an environment where errors could occur.

171. I am concerned at Care Group's failure to conduct the necessary checks to ensure that Mr A would be receiving one-to-one care by a suitably qualified support worker on 9 Month3 when it realised that it had rostered Mr D to work with two clients on the same day. I also consider that Care Group's care planning and record-keeping were suboptimal.

172. Accordingly, for the reasons stated above, Care Group Limited failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: The Trust — Adverse comment

173. In December 2011, when Mr A's support package was moved from discretionary funding to IF, the Trust became Mr A's IF host through which his carer support hours were provided. Mrs B was Mr A's IF agent.

174. In order to be considered for IF, the client, or his or her IF agent, must be able to manage all the administration requirements associated with IF, including managing a budget and care arrangements, and that their responsibilities as an employer are met.

175. Service Level 1 is the minimum level of service that IF hosts are expected to provide. Under Service Level 1, the Trust's role was to help Mrs B to understand IF, and how to organise, set up and manage Mr A's support allocations, administer payments for support services, and help Mrs B to manage her responsibilities, including reporting requirements, so that payments could be made to those who provided the services. The Trust is also required to do quality monitoring and report to the Ministry every three months on specific performance measures.

176. A Trust Coach met with Mrs B on 15 December 2011 to discuss the responsibilities under IF. The Trust told HDC that Mrs B made it clear to the IF Coach that she was fully aware of her obligations as Mr A's agent. Mrs B opted for Service Level 1 but privately engaged Care Group to assist with employing support workers. A representative from Care Group was present at this meeting. The Trust told HDC:

> "It was [Mrs B] who, during the first meeting with [the Trust's] Coach, made specific reference to her desire to personally manage [Mr A's] care and ensure that his needs were being met. To this end, she said she would utilise the service of Care Group, given the historical relationship between that organisation, [Mrs B] and [Mr A] …"

177. At the meeting, an Individualised Support Plan for IF was also completed by the IF Coach and Mrs B for Mr A. The Trust told HDC that this plan was prepared by the IF Coach according to the needs assessment carried out by the NASC on the understanding that the plan would be subject to changes as required by Mr A's family.

178. Mr Taylor stated:

> "I think that [the Trust], with good justification in this situation, identified their role as being 'based around the initial set up of the IF scheme with the client, management of the allocation, budgeting of the hours, invoicing to the [Ministry] and paying the client/agent so they can pay their support workers' (p3, [Letter from the Trust's lawyer] 9 Dec 2013, Doc 17). I think this view is strongly supported by the usual business an IF Host managing HCSS [Home and Community Support Services] supports would involve itself in. Coupled with this, for [Mr A's] care [the Trust] was clearly brought in as a fund-holder to an already established support arrangement."

179. The Trust reported every three months to the Ministry on the following performance measures (as required by the Ministry's Service Specification):

a) percentage of people receiving IF who have attained or maintained their goals;

b) number of people receiving IF who express satisfaction with IF;

c) number of complaints and number of people receiving IF involved including the percentage of those complaints resolved and action plan to address any issues; and

d) report on service delivery issues and emerging trends.

180. There is no requirement for the Trust to report to the Ministry on every IF client. However, the Trust's Client Services Agreement provides that the Trust will undertake quality monitoring on the services provided by it. The Trust told HDC that these checks are done with the client or agent at six-monthly intervals by telephone or, if necessary, face to face. The Trust stated:

> "The telephone calls are opportunities for clients/agents to report back to the host on their IF plans and discuss progress, or lack thereof, in terms of care objectives. In the event that a client/agent expresses dissatisfaction or concerns about their carer or requires greater care, then they can request the host to assist directly in organising improved care services."

181. Quality monitoring telephone calls were made to Mrs B in January and June 2012, with a further call set for 15 December 2012. Other than these telephone calls, the Trust told HDC that Mrs B contacted them only once in March 2012 to express her dissatisfaction with the NASC. Mr Taylor stated:

> "[The Trust] undertook 6 monthly checks and [Mrs B] reported no relevant issues. Therefore, given the nature of IF in general and this arrangement in particular, it was reasonable for [the Trust] to assume she was operating comfortably within the role."

182. Mr Taylor also advised:

> "The level of monitoring was within the contractual guidelines and the usual expectations for this type of service. It probably wasn't sufficient in this case but it wasn't the frequency that was the only inadequate element. The nature of [Mr A's] care required frequent supervision of the staff and on-site visits. It is clear that this

did not occur and it is also clear to me that this was well beyond the brief of [the Trust]."

183. However, Mr Taylor commented that in his view the Trust had a too "hands off" approach. He considered that "[The Trust] had a clear duty to ensure that what they were facilitating was both robust and fit-for-purpose. This may not be a contractual requirement but it is demanded by professional standards." I agree with Mr Taylor and consider that in these circumstances six-monthly quality monitoring telephone calls were insufficient, and it would have been appropriate for the Trust to have undertaken more vigorous quality monitoring checks.

184. Since this incident, the Trust has implemented annual on-site visits to each IF client. I consider that the changes implemented by the Trust are appropriate, but I also note my further recommendations below.

Opinion: The NASC — No breach

185. The NASC allocated the number of Mr A's carer support days per year. The NASC was required to undertake needs assessments for Mr A every three years, as a minimum, or by request when his needs changed. The NASC stated that Mr A's needs assessments consistently identified him as having very high needs. The NASC carried out needs assessments in 2004, 2007, 2009, and 2012. The NASC stated that when Mr A transitioned to IF in 2011, it was not necessary to carry out a needs assessment as a result of the change in the funding arrangement.

186. The NASC told HDC that in 2012 Mrs B made a number of requests for increased funding. This resulted in a peer review of the funding arrangement by the NASC. The recommendation from the peer review was to explore alternative methods of care for Mr A utilising the same funding level.

187. On 8 December 2011, the NASC referred Mr A to the Trust for IF. My expert advisor, Mr John Taylor, stated:

> "The NASC then has three main options for funding these services. These are: allocating funding to a [Ministry] contracted service provider, indirectly funding the individual via an Individual Funding Host Agency, or funding a service provider, including a non-[Ministry] contracted provider, through Discretionary Funding."

188. Mr Taylor noted that there are many people, including Mr A, who do not easily fit within one of those options, and the NASC will try to fit the person into one of those options as best they can.

189. Mr Taylor stated: "[The NASC] did do the job required of them by the [Ministry], to an adequate level and within the [Ministry] framework." I accept Mr Taylor's advice.

In my view, the NASC provided Mr A with an appropriate standard of care and did not breach the Code.

Recommendations

190. I recommend that Mr D provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of this report, for forwarding to Mr A's family.

191. I recommend that Care Group Limited:

a) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Ensure that it has written agreements in place for all clients.

c) Ensure that its staff orientation and training programme includes core disability focused training, such as managing challenging behaviour, human rights, advocacy, communication, risk minimisation, the Code of Rights, record-keeping, and common diagnosed and presenting symptoms, and report back to HDC that such training has been incorporated into its staff orientation and training programme, within two months of this report.

d) Develop a policy for when services are provided in a support worker's home, including close monitoring of the support worker by unscheduled telephone contact, personal visits to the home, and a health and safety assessment of the physical environment, and provide HDC with a copy of that policy within two months of this report.

e) Implement robust procedures to monitor employee and contractor performance and compliance with policies and procedures, and report back to HDC on these procedures within two months of this report.

192. I recommend that the Trust:

a) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Further review its quality monitoring processes and report back to HDC on any changes following its review, within two months of this report.

193. In light of the findings in this report, I recommend that the Ministry of Health consider reviewing the management, monitoring, and reporting requirements for any clients receiving IF, and report back to HDC whether a review has been conducted and, if so, the outcome of the review and any changes made, within six months of this report.

Follow-up actions

194.
- Mr D and Care Group Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Coroner, the New Zealand Police, and the Ministry of Health.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Care Group Limited, will be sent to the CEO of the relevant District Health Board, and it will be advised of Mr D's name.

- A copy of this report with details identifying the parties removed, except Care Group Limited and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

195. The Director of Proceedings did not institute proceedings against Care Group Limited. The matter was resolved by way of a negotiated settlement.

196. The Director of Proceedings filed proceedings by consent against Mr D in the Human Rights Review Tribunal. The Tribunal issued a declaration that Mr D breached Right 4(1) of the Code by failing to provide services with reasonable care and skill.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from Mr John Taylor:

"**HDC Independent Advisor's Report on: [Mr A] 13/00854**

I have been asked by the Health and Disability Commissioner to provide an opinion on case number C13HDC00854 that relates to the care provided to [Mr A]. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

I have the following qualifications and experience to fulfil this request.

Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc in Science and Ethics; LTh.

Experience: 27 years of working within the disability sector including the following roles: direct support worker, agency management (over 10 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MOH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up four disability support agencies, two provider umbrella groups and two disability related businesses.

I have been asked to comment on the following:

1. Are there sufficient checks in place to ensure that the funding provided by MOH is being used appropriately?
2. [Section redacted not relevant to the decision]
3. Was individualised funding appropriate for [Mr A]?
4. Did [the Trust] provide adequate support/guidance/mentoring for [Mrs B] as an IF agent? Was the responsibility placed on her as IF agent appropriate (employing, rostering, invoicing etc)? Was there sufficient monitoring of her role as an agent?
5. If the sole responsibility does lie with the IF agent to raise concerns about the quality of care being provided, is this appropriate?
6. Was the quality monitoring carried out by [the Trust] every six months sufficient?
7. Were the respite arrangements between [Mrs B], [Mr G's] family and Care Group appropriate? In particular, the rostering and invoicing arrangements.
8. The adequacy of the training, supervision and monitoring by Care Group Ltd of [Mr D].
9. The appropriateness of the care provided by [Mr D] on 9 [Month3]. In particular, his decision to care for two clients that each required 1:1 care.

10. Any other comment you wish to make about the appropriateness of the care provided to [Mr A].

I have based my comments on the information listed below. When I quote from a document I will provide its name or the number it has been given on this list.

Guidelines	1. Guidelines for Independent Advisors
Complaint	2. Complaint
MOH	3. Health Report 20130860 4. […] document dated 29 [Month3] 5. Email from [MOH] dated 17 October 2013 containing timeline 6. MOH Service Specification (Individualised Funding) June 2010 7. MOH 'Your Guide to Individualised Funding' 2012 7a. MOH Service Specification (Home and Community Support Services) July 2007
[The NASC]	8. Response to notification dated 22 April 2014 (including enclosures) a) MOH Service specification NASC b) [Mr A's] support needs assessments [2004–2012] c) Client notes d) Individualised Support Plan for Individualised Funding — [Mr A] e) Support Package Allocation Tool f) Support Needs Assessment Service Co-ordination, Policy, Procedure and Information Reporting Guidelines 9. Response dated 1 August 2013 10. Support Package Allocation Tool 11. Correspondence regarding [Mrs B's] request to increase [Mr A's] package (notations on documents by [the NASC])

[The Trust]	12.	Response dated 13 March 2014
	13.	[The Trust's] Individualised Funding Information Pack (Handbooks and Information)
	14.	[The Trust's] Individualised Funding Information Pack (Employment & Human Resources)
	15.	[The Trust's] Individualised Funding Information Pack (Payroll Forms for Payroll)
	16.	[The Trust's] Individualised Funding Information Pack (Finance Forms Invoicing)
	17.	Response dated 9 December 2013 (including enclosures)
	18.	Client Services Agreement (signed by [Mrs B])
	19.	Response dated 22 November 2013
Care Group Limited	20.	Response dated 14 March 2014
	21.	Response dated 2 December 2013 (including enclosures)
	22.	Response dated 16 October 2013
	23.	Response dated 29 August 2013 (including report)
	24.	Care Group Limited Report into events around the death of [Mr A] dated 19 November 2013
	25.	Example invoice
	26.	Accident Report dated 11 November 2013
	27.	Email and text communications between Care Group Limited and [Mrs B], Care Group Limited and [Mr D], Care Group Limited and [Mr G]
	28.	Client Roster 1 [Month2] to 11 [Month3]
	29.	Client Notes Report
	30.	Individual Risk Profile
	31.	Risk Management/Contingency Plan
	32.	Client Referral Form

Other	Documents from [Mr D] 33. [Mr D's] response dated 2 December 2013 34. Documents from [Mr C] ([Mr A's] School) 35. Supporting Information provided by ([Mr A's] School 36. Incident Report forms from ([Mr A's] School [2012] Documents from [Mrs B] 37. Letter to [Mrs B] from [the NASC] dated 9 June 2009 38. Individualised funding example provided to [Mrs B] 39. Minutes of meeting dated [2012] Police File 40. Statements provided to the police a) Interview with [Mr D] b) [Mrs B] c) [Mr E] d) [Mr G] e) [The NASC] f) [Director] Care Group Limited g) [Ms K], Client Care Manager, Care Group Limited h) [Mr C], ([Mr A's school] i) [Mr I] [Mr D's] employment information provided by Care Group Ltd 41. Training and Induction Manual 42. Application form 43. CV 44. Support worker job description 45. Independent contractor agreement 46. Performance Review dated 4 August 2009 47. Training record

Background

[Mr A] (aged 20 years) had [complex needs] and challenging behaviour. At school he required 1:1 staffing and sometimes 2:1 staffing depending on the activity.

At the time of his death, he was receiving individualised funding (IF) from the Ministry of Health through [the Trust] (IF host provider) and Care Group Limited (facilitator). [The NASC] was [Mr A's] needs assessor/ service coordinator (NASC).

[Mr A's] package consisted of […] hours of Home and Community Support per year. His total support package was $[…].

The incident

On the night of 9 [Month3], a relief support worker, albeit one who knew [Mr A] well, was supporting [Mr A] — [Mr D], who at this time was also caring for another consumer. Both young men being supported were allocated 1:1 funding by [the NASC].

[Mr D] locked both young men in his flat while he went to collect some food for their dinner. During his absence, [Mr D's] flat caught fire and [Mr A] was killed. The other young man sustained superficial burns.

Comment

Because there are four notified parties, I have structured my comments in such a way as all the above questions are answered but done so in relation to each of the notified parties. In this way I hope to cover off all of the relevant areas for comment in a way that is easy to identify how each party acted in relation to this complaint. I associated the questions with the party I deem has the most relevance to that question but there will be some that relate to several parties.

Introductory Comments

In considering the appropriateness of the care offered to [Mr A] by these four parties, I will firstly focus on the environment in which they operate. I do this because I think the system within which they operated is relevant to the decisions made. I think that poor system design greatly increased the likelihood of this situation occurring. That is, the disability support system as it was configured at the time, and as it is still configured, does not have the necessary processes in place to routinely provide adequate support to people who present with issues similar to those of [Mr A].

Over time the Ministry of Health's Disability Support Services (MOH[27]) has created a limited 'menu' of clearly defined service specifications for those supports they will fund. Principally these are: Residential Care (usually meaning a group home), Supported Living (usually meaning support to live in your own home), Home and Community Support Services (usually meaning household management and personal cares), and Respite and Carer Support. They also provide the NASCs (essentially their funding agent) some 'flexible funding' to plug any service gaps; but this appears to be used less and less at MOH direction.

[27] The Disability Support Services (DSS) division of the Ministry of Health is the funder for most disability support services in New Zealand (approx $1.1 billion). The other key support service funders are Ministry of Social Development for adult day activity support and the Ministry of Education for school support. The DSS is usually referred to in the disability sector as: 'The Ministry of Health (MOH)', and I will continue that tradition throughout.

The Ministry of Health's Disability Support Services is the sole funding agency for support services that provide to people in [Mr A's] situation. As such, the way the MOH structures its funding lines and allowable service lines has a critical bearing on the choices other agencies and people within the sector make and, indeed, can make.

The issue being confronted here is that the environment shapes people's thinking to a very large extent; so much so that many people working within it do not look beyond the imposed framework to consider the person in a different light. In [Mr A's] situation there is clear evidence that the limited menu of services were not meeting his need but those concerned could not, or did not, look outside the menu. As examples, I refer to:

1. MOH […] document dated 29 [Month3] (4). […]
2. [The NASC's file note] — [2012] (Doc 8c). [Mrs B] asked for more DSS support. The comment made was: '[Mr A] has had two recent requests for increases recently declined through reconsiderations with a break down of how [t]he hours are utilised. This breakdown of need versus Supports showed that [Mr A] had the appropriate support service in place.'

The above two quotes indicate how people within the system unwittingly translate concepts such as 'it isn't working' or 'I need more help' into the limited service menu on offer and do not appear to be able to see beyond these.

In the first instance the MOH employee looked to solve the support impasse by offering a different menu option. This was offered even though it was known to be unacceptable to [Mr A's] mother and welfare guardian — [Mrs B]. In the second quote, even though the supports were clearly not working for [Mrs B], [the NASC] employee could assert that [Mrs B] and [Mr A] were getting 'the appropriate support service'.

[The NASC]

[The NASC] is a Needs Assessment and Service Coordination (NASC) agency. As such it is at the front end of managing this service system. NASCs essentially act as the MOH's agents in prescribing service options to people based on a MOH designated needs assessment process. In other words, NASCs are contractually highly constrained in how they operate and the decisions they can make. This is particularly so of the service coordination function; the part where they fund supports.

In theory the service coordinator can suggest all manner of community based options but, if the NASC is to fund these options, then it must be through a MOH approved service line. The NASC then has three main options for funding these services. These are: allocating funding to a MOH contracted service provider, indirectly funding the individual via an Individual Funding Host Agency, or funding a service provider, including a non-MOH contracted provider, through Discretionary Funding. The NASC can also reimburse the person directly for

Carer Support in the situation where there is a private respite option operating. (In the past Direct Funding to the disabled person happened more frequently prior to IF Host Agencies being set up.)

There are many people who do not easily fit within the above menu of service and funding options, and it appears to me that [Mr A] was one of them. When this occurs, NASCs tend to try and fit the person into one of the available options as best they can. It appears this is what [the NASC] did.

Question 1: Are there sufficient checks in place to ensure that the funding provided by MOH is being used appropriately?

The answer to this question turns on the understanding of 'appropriately.' If the question means: are there sufficient checks and balances to ensure the money was spent as designed by the Ministry of Health in this situation, then the answer, in my opinion, is yes. The funding allocated to [Mr A] and [Mrs B] was paid for as an hourly rate for HCSS support and as a daily amount for Carer Support. In both instances the money paid can be, and was, easily tracked. If a support person did an hour's work, or a night of respite was purchased, then this was accounted for via timesheets and claim forms and then paid for.

If on the other hand 'appropriately' means effectively for [Mr A] and [Mrs B], then the answer is probably not. As the above discussion indicates, the system is not well equipped to provide for the likes of [Mr A] so his needs, his support requirements, have been shaped to fit the system. [Mrs B] was clearly indicating that she was not getting what she required. There is evidence that [Mr A] was not getting what the Needs Assessment stated he required. The 2004 Needs Assessment said: *'1. Needs ongoing respite and carer support to enable [Mr A] to remain in the family unit. 2. Needs on-going professional support to enable [Mr A] to develop his skills towards independence for his future.'* (p4 [The lawyer's] response, doc 8).

The support package offered to [Mr A] and [Mrs B] was focused very much on respite for [Mrs B] and not on skill development for [Mr A]. They were fitted into a HCSS funding stream where people were paid to 'look after' [Mr A] for [Mrs B], not to teach [Mr A] for independence.

In terms of this complaint, I think [the NASC], and the other agencies involved, accounted for the money, as they were required to do so within the support system as it operates. In other words, they counted out-puts in relation to in-puts. There appears to have been little measurement of actual outcomes for [Mr A] and [Mrs B]; nor was there a contractual expectation for this.

Question 2: [Section redacted not relevant to the decision]

Question 3: Was individualised funding appropriate for [Mr A]?

[Mr A's] support package was moved from Discretionary Funding (DF) to Individualised Funding (IF) in 2011. In the MOH's [document dated 29Month3]

(Doc 4) they say: 'The family chose to move to Individualised Funding,' and that '[Mr A] and his whanau chose Individualised Funding (IF) as the preferred purchasing mechanism.'

In this instance it is hard to understand what the choice was. There wasn't a respite provider who could accommodate [Mr A] (Doc 4). The MOH wanted to move from DF to IF (Doc's 5, 23). There wasn't a contracted HCSS service that had adequately met their needs so far (Doc's 8, 21).

So, despite a view held that [Mrs B] 'choose' IF, I think that she chose to retain control of [Mr A's] support arrangements and IF was the only option available for her to do this. In making this 'choice' [Mrs B] was also no doubt aware that the package would now cost money to host whereas under DF it was free. (At […]% this was an annual cost of $[…], or a loss of […] hours per week of funded support.) I also note that on a couple of occasions where people asked her if she wanted more support from the Host agency, she refused vociferously. I suspect she was upset at the extra cost incurred for these services.

IF was, and is, typically used as a way for a person to access HCSS services in a more flexible way than through a service provider. Typically this flexibility comes about as a result of the individual employing their own staff and therefore having much more say about when and where support occurs.

The HCSS service is also intended to be a flexible service and is often used when no other service on the 'menu' fits. However, it is still funded as, and configured as a predominantly in-home support service based around personal care and home management. To quote from DSS HCSS Service Specification current at the time:

> 'The Services may include Personal Support, for example assistance with showering and dressing, and sleepover/night support; and Household Support, for example helping to prepare meals or home cleaning.
>
> In discussion and agreement between the Person and the Service Provider, Services may also support the Person to access community activities through natural networks such as family/whanau, friends, marae, neighbours and others.'

HCSS is not designed to fund a situation where the individual requires 'on-going professional support to enable [them] to develop … skills towards independence for [their] future' as was the case with [Mr A]. This is because the pricing structure for HCSS is based on the completion of household tasks and providing personal care. [Section redacted not relevant to decision].

In my opinion then, Individualised Funding was not appropriate for [Mr A's] support. Having said that though, I would also acknowledge that under the system current at the time, there was no other option available for [Mrs B] to 'choose' or for [the NASC] to select.

As a final note I would add that some of the work the MOH has been doing on its New Model for disability support and the Enabling Good Lives work should go some way towards rectifying this situation. In particular I refer to Local Area Coordination/Navigation (which will help with client focused planning), and Enhanced Individualised Funding (EIF) with the new Purchasing Guidelines (which will allow the money to be spent in a way that works for the individual and not by pre-determined service specifications).

The appropriateness of the care provided by [the NASC] to [Mr A].

[The NASC] is a contracted NASC and as such works within the framework set out for it by the MOH. Its fundamental role is to facilitate the assessment of needs for people eligible for DSS funding, to allocate a quantum of service type and assist the person select the appropriate service provider. They are required to report to the MOH on service delivery (Doc 8a, 5.12) and its acceptability (Doc 8a, 8.2.3) and any safety concerns (Doc 8a, 8.2.4).

However, under IF this tends to relate to the IF Host agencies service delivery. In these circumstances it is expected the individual consumer directly judges the quality of support and takes personal responsibility for it.

In the case of [Mr A], because [Mrs B] contracted a non-MOH contracted agency to supply the support, who in turn used an Independent contractor model, it was further complicated. It meant that there was a growing distance between the funder and the real supplier with duty of care diminished at each step. This is a risk [the NASC] probably should have noted. There is no record I can find that they did.

In my opinion [the NASC] showed evidence of trying to find a match for the support [Mrs B] was requesting but were unable to appropriately because of the systemic failings that existed. They did do the job required of them by the MOH, to an adequate level and within the MOH framework. They may have attempted to answer the really important question: 'Is this support fit for purpose; that is does it work for [Mr A]?' but because they remained within the prescribed system, I think the result was a poor fit for [Mr A].

[The Trust]

[The Trust] was contracted as the IF Host agency in December 2011 when the support package for [Mr A] was moved from Discretionary Funding to Individualised Funding. I think it is clear from the evidence presented that their expected role was to host the package so that the support arrangements that were already in place for [Mr A] could be maintained.

Under a typical Level 1 hosting arrangement [the Trust] would have been expected to assist the person, or agent as in [Mr A's] situation, to understand all the intricacies of employing staff, managing the budgeted hours and providing invoices and accountability forms to ensure the money is paid correctly. There is evidence that this information was presented to [Mrs B]. The significant

difference is that it was not intended that she take on the role of employer. This job was to fall to Care Group Ltd who contracted [Mr G's] family as [Mr A's] carers and who attended the meetings between [Mrs B] and [the Trust].

I have already discussed IF in some detail above so won't repeat that here. What I will say though is that as an IF Host, [the Trust] would have been subject to the same limitations of expectation as others in the sector were. That is, it seems reasonable to assume that they too expected people within an IF environment to be able to assess for themselves the adequacy of support and whether the individualised support plan (ISP) was fit for purpose. Their systems appear to have been built around this understanding.

Question 4: Did the Trust provide adequate support/guidance/mentoring for [Mrs B] as an IF agent? Was the responsibility placed on her as IF agent appropriate (employing, rostering, invoicing etc)? Was there sufficient monitoring of her role as an agent?

I think the answer to this is yes. [The Trust] and [the NASC] worked with [Mrs B] to clarify the agent role. They clearly provided additional assistance with invoicing arrangements. [Mrs B] was not doing the employing and rostering functions as these were carried out by Care Group Ltd.

They undertook 6 monthly checks and [Mrs B] reported no relevant issues. Therefore, given the nature of IF in general and this arrangement in particular, it was reasonable for [the Trust] to assume she was operating comfortably within the role.

Question 5: If the sole responsibility does lie with the IF agent to raise concerns about the quality of care being provided, is this appropriate?

I think that in most circumstances this is appropriate. I do not think it was appropriate in [Mr A's] situation because, as I have said already, IF and HCSS were a poor fit for the nature of support that he and his mother required. [Mr A] was not able to, or at least there is no evidence that he was asked, about the appropriateness of his care. [Mrs B] was often not present where the care occurred. She no doubt was left judging the care by whether it appeared safe for [Mr A] and she had a break. So the basic premise of the person receiving the care is best placed to judge that care was compromised. It was further compromised by the poor fit of service type with need.

Question 6: Was the quality monitoring carried out by [the Trust] every six months sufficient?

The level of monitoring was within the contractual guidelines and the usual expectations for this type of service. It probably wasn't sufficient in this case but it wasn't the frequency that was the only inadequate element. The nature of [Mr A's] care required frequent supervision of the staff and on-site visits. It is clear that this did not occur and it is also clear to me that this was well beyond the brief of [the Trust].

The appropriateness of the care provided by [the Trust] to [Mr A] in 2011 and 2012?

I think that [the Trust], with good justification in this situation, identified their role as being 'based around the initial set up of the IF scheme with the client, management of the allocation, budgeting of the hours, invoicing to the MOH and paying the client/agent so they can pay their support workers' (p3, [Letter from the Trust's lawyer] 9 Dec 2013, Doc 17). I think this view is strongly supported by the usual business an IF Host managing HCSS supports would involve itself in. Coupled with this, for [Mr A's] care [the Trust] was clearly brought in as a fund-holder to an already established support arrangement.

I do however think they took too much of a hands off attitude regardless of how justified it may appear. They had a clear duty to ensure that what they were facilitating was both robust and fit-for-purpose. This may not be a contractual requirement but it is demanded by professional standard. They should have been clear about their ability to do the work they charged for in a safe manner beyond acting as a functionary.

I note that they have a sense of this themselves with the changes they have made to their business process. I think that their failure in this regard was not the critical failure that led to [Mr A] losing his life. I am not even sure it would have made a significant difference given that the agent — [Mrs B] — so clearly told them everything was OK. I believe their peers would consider this departure from best practice a minor failure.

Care Group Ltd (CGL)

There is a degree of inconsistency of information relating to the part CGL played in this tragedy. One area was the names used for some of the people involved. I propose therefore to list the main people affected by this with the variations of their names that appear in the material so it is clear whom I am referring to at any time. (I have put the names I will use in bold; including a formal title.)

[Mr D]. ([Mr D] is usually referred to as [Mr G's] son but sometimes as his nephew.)

[Mr G]

[Ms K]

[Mr I]

Care Group Ltd is a small home care provider that is not contracted to the MOH but that has been accredited to the appropriate standard for HCSS agencies. It has on a number of occasions supported people who were funded by [the NASC] — The NASC; usually funded under the Discretionary Funding arrangement. According to CGL these people have tended to be 'high needs clients who are difficult to provide on-going care for, often meaning complex and unique arrangements' (p2, Doc 24).

CGL has also pointed out a number of times that the arrangements for [Mr A] were 'unique' due to the complexity of his needs, because they 'inherited' [the family] to support him and because '[Mrs B] decided who provided care, when that care was provided, and who provided it' (p1, Doc 20). They considered that they only 'acted as [Mrs B's] agent to perform the administrative tasks associated with the caregivers chosen by [Mrs B]' (p1, Doc 21). Based on this analysis CGL distinguish the support provided to [Mr A] as not being 'normal' (p1, Doc 20).

These two positions of working with a number of complex people and [Mr A's] support being completely unusual are difficult to reconcile.

In the material CGL provided they also make three other significant claims in mitigation of their responsibility. The first is that [Mr D] was 'a caregiver inherited by Care Group as part of [Mr G's] family at [Mrs B's] request' (p2, Doc 21). Other material contradicts this claim. [Mr D] was employed by CGL for 2 to 3 years prior to the incident to work with [Mr H]. Further, according to [Mr D's] police interview, he had not had anything to do with [Mr A] for 6 or 7 years prior to being asked to support [Mr A] when [Mr G] went [overseas] a few weeks prior to the incident.

The second claim was that '[Mr D] was not employed by Care Group' (p2, Doc 21). Care Group Ltd's practice appears to have been to contract for services with a funding agent and then contract people as independent contractors to do the support.

The third claim was that CGL never rostered a single support worker to look after two people at the same time and that, specifically, they did not roster [Mr D] to look after two clients (Doc 23). They report that [Mr D] was rostered to work with [Mr H] and that he had informed CGL that [another of family Mr G's members] was caring for [Mr A] (Doc 23). The transcripts of the text messages between [Ms K] and [Mr D] and the actual roster do appear to give a contradictory picture to this.

The police interview suggests that [Mr D] was rostered for both [Mr A] and [Mr H] on the afternoon and evening of 9 [Month3] and had been on at least two previous occasions — 26 [Month2] and 27 [Month2] (Doc 39b, second interview, p78).

The text transcripts show [Mr D] was rostered with both [Mr H] and [Mr A] and don't mention [Mr I] working with [Mr A], nor a warning not to work with 2 people. (The bold added by me to highlight the relevant comments.)

Text messages:

1. [Ms K] (8 [Month3] 3:12pm): **Tomorrows shifts — [Mr H] 2pm to 8pm**. Please confirm thanks [Ms K]
    a. [Mr D]: yes
2. [Ms K] (9 [Month3] 2:51pm): Wkend shifts - [Mr H] Sat 9am to 7pm and [Mr A] Sunday 9am to 9pm. Please confirm thanks [Ms K]

   a. [Mr D]: **I got [Mr A] today as well aye?**
3. [Ms K] (9 [Month3] 2:53pm) **Yes at 3pm**
   a. [Mr D]: Ok gona go there now
4. [Ms K] (9 [Month3] 3:02pm): I also have your booked with [Mr H] on Monday 9am to 3pm. Please confirm thanks [Ms K]
   a. [Mr D]: Yeah
5. [Ms K] (9 [Month3] 3:04pm): I also have your booked with [Mr H] on Monday 9am to 3pm. Please confirm thanks [Ms K]
   a. [Mr D]: Areu in the office?

I also note from the documentation that [Mr G] was back in New Zealand before 9 [Month3]. It appears [Ms K] knew this as of 29 [Month2] so could have had [Mr G] pick up the work with [Mr A] once she realised there was a roster clash. This failing is not explained.

Question 7: Were the respite arrangements between [Mrs B], [Mr G's] family and Care Group appropriate? In particular, the rostering and invoicing arrangements.

The above discussion leads well into question 7. CGL did not have a written agreement in place with [Mrs B] as [Mr A's] agent. This meant there was no clarity about their role, or the role for [Mr G's] family, or [Mrs B]. This led to a very informal arrangement between these three parties, which was not appropriate given the fact that it was for funded services supporting a vulnerable young man.

This situation could have 'just happened' over the six years CGL were involved with the support of [Mr A] through using [Mr G's] family. However CGL have commented on the uniqueness of this situation and this should have led them to be even more motivated than normal to have an agreed understanding of each party's responsibilities.

The second inadequacy of this arrangement was to contract with support people as independent contractors and with [Company X]. By doing this CGL severely limited their ability to control the quality of care or to influence how and when and by whom it was carried out. (This arrangement was also probably outside the accepted IRD operating principles.) In normal circumstances this is a critical aspect to providing quality care so I see this as another significant departure from acceptable practice. I do note though that CGL have now changed this practice and directly employ staff.

I did not note any inadequacy with the invoicing but the rostering of support appears to have suffered from the lack of control mentioned above. Because CGL had largely left the rostering to [Mr G], that is [Mr G] was always rostered on and then he assigned a family member as required, they did not appear to have an adequate plan in place when [Mr G] was no longer available. CGL agreed to engage [Mr E] ([Mrs B's] nephew) and [Mr D] to cover while [Mr G] was [overseas]. However CGL does not appear to have made any adjustments to [Mr

D's] work schedule with [Mr H], rather they just added [Mr A] into the mix. This made it [Mr D's] responsibility to manage the clash. This is very poor practice.

Question 8: The adequacy of the training, supervision and monitoring by Care Group Ltd of [Mr D].

[Mr D] was engaged as an independent contractor. These independent contractors were interviewed, referee and police checks performed and provided with an orientation manual. At least in the case of [Mr H], [Mr D] had a period of time when he was 'trained' by a more experienced support person in the individual's specific needs. Other training, at least of [Mr D], appears to have been limited to a single First Aid course over the nearly 3 years he was contracted by CGL.

The 'Training, Induction and Orientation Manual' that was supplied to [Mr D] is wide-ranging but it is inadequate as a primary training tool. The manual is information dense, written in small print and over 130 pages in length. Most of the information included is about CGL, providing home management and personal care type support and staff expectations. There is nothing about supporting someone with [Mr A's] needs, so its direct relevance to the work [Mr D] was doing as an independent contractor supporting [Mr H] or [Mr A] is low.

When [Mr D] was asked to support [Mr A] the assumption was made by CGL that, because he was part of [Mr G's] family, he would know what to do. No additional training or coaching was recorded as having happened or being offered.

It appears that [Mr D] had very little face-to-face contact with management from CGL. The main form of communication with support workers appears to have been by phone and text. Rostering was sent out to people and then they received a text the day before to remind them.

In my opinion this is well below expectation when working with a person like [Mr A]. This is another situation where CGL was structured to do a different job than what they found they were performing with [Mr A]. Their business is structured in a way that is probably adequate for performing home management and personal care type tasks. […] [T]hey had accepted to work with [Mr A] and so should have adapted their business model to support him adequately. They did not do this in various ways, one of them being in relation to supervision and training of direct support people. In my view this is a significant lack of proper process and left [Mr A] vulnerable to poor or inadequate support.

In my opinion this means that [Mr D] had very little training in, or supervision of, the work that he was doing. This is a meaningful departure from the expected standard for working with people such as [Mr A]. This lack of training and supervision could have contributed to the very poor decision [Mr D] made [when] he left [Mr H] and [Mr A] unsupervised and in a locked flat.

The appropriateness of the care provided by Care Group Limited to [Mr A].

Care Group Ltd is an organisation working within the home care industry and appears to usually offer household management and personal care support. They

claim to have some experience of working with people with challenging support needs and to have had six years of experience with [Mr A] and to know his particular needs well. However, in reading this material I think their systems were poorly adapted to supporting people with the challenges presented by [Mr A].

In my opinion their care of [Mr A] fell short of the required standard by a significant margin. They did not have a service agreement that would have provided a clear designation of responsibilities for them, [Mrs B] and the contracted support staff. […] Their departure from appropriate standards of care are most evident in relation to [Mr D]. Care Group Ltd provided very poor training and supervision and, at best, ambiguous rostering. These three elements could well have had a direct influence on [the incident].

[Mr D]

[Mr D] appeared to have known [Mr A] in the past through the work his father ([Mr G]) did supporting [Mr A]. From what the records show [Mr D] had had very little or nothing to do with [Mr A] directly for some 6 or 7 years prior to [the incident].

[Mr D] was contracted by Care Group Ltd as a care-giver/support worker for one young man — [Mr H] — for between two and three years prior to the incident. From the information provided it appears he fulfilled this role entirely adequately.

As mentioned in the previous section, [Mr D] received very little training or supervision in his role and appears to have negotiated how the support arrangement was conducted directly with [Mr H's] parents. There is no evidence of what skills he brought to the work.

On 9 [Month3] [Mr D] was rostered to work with both [Mr H] and [Mr A]. It appears this came about because he was asked to 'fill in' when [Mr A's] main support person — [Mr G] — was [overseas].

I can find no evidence of any particular training offered to [Mr D] to ensure he could adequately support [Mr A]. Both CGL and [Mrs B] considered [Mr D] knew [Mr A] well enough to offer support because of his history with [Mr A].

While [Mr D] was rostered to work with [Mr H] and [Mr A] on 9 [Month3], he also had his young son in his care. This meant he had the care of three vulnerable people with only his ex-brother-in-law ([Mr I]) to assist him.

This all sets the scene for what appears to be a series of unfortunate incidents and poor decision making that compounded each other and ended in the death of [Mr A]. I have listed the main ones below:

1. [Mr D] rostered with two young men at the same time.
2. [Mr D] agreed to continue the support with the help of [Mr I].

3. When [Mr D] picked up [Mr H], [Mr H's] parents had not managed to complete [Mr H's] evening meal preparation, which required [Mr D] to pick it up later.
4. Friends of [Mr I's] turned up and they began to drink alcohol and subsequently left a couple of hours prior to [Mr A's] support concluding.
5. [Mr D] decided to continue to support the two men on his own knowing this was not acceptable to CGL.
6. [Mr D] continued with his plan to pick up [Mr H's] food instead of ringing someone for help.
7. He decided to leave [Mr H] and [Mr A] unsupervised and locked the doors so [Mr A] would not leave the house.

Any one of the above elements and decisions could have resulted in no significant incident occurring, but in combination they increased the likelihood enormously.

The appropriateness of the care provided by [Mr D] to [Mr A] on 9 [Month3]. In particular his decision to care for two clients that each required 1:1 care.

In my opinion it is very clear that [Mr D] failed, severely, to provide adequate care to [Mr A] on [this day]. He made some very poor decisions about risk and he knowingly went against the directions of Care Group Ltd by choosing to continue to support both young men when his housemate — [Mr I] — left. There is no question in my mind that these poor decisions influenced the events that led to the death of [Mr A].

There are mitigating circumstances though. [Mr D] was poorly trained and poorly supervised. He was rostered inappropriately and it was left to him to resolve the situation. [Section not relevant to decision.] On two other occasions he had had the same two young men in his care with the same arrangements and nothing of this nature had occurred so he probably assumed this time would be OK as well.

None of these mitigating circumstances reduce the fact that his care of [Mr A] was significantly below what should be expected. They do however provide a context in which [Mr D's] failure can be seen, in part, within the process failure of Care Group Ltd.

Final comments

It seems to me that [Mr A] was badly let down by the entire system and in particular by Care Group Ltd and [Mr D]. The disability support system was inflexible through overly detailed contract specifications, […] and there are multiple layers of responsible parties. All of this means that [Mrs B's] requests for support were interpreted into what the system had arranged to purchase, whether or not this was fit for purpose in her and [Mr A's] situation."

Further expert advice provided by Mr Taylor on 9 February 2015

"In June 2014 I was asked to write an opinion relating to the care provided to [Mr A] (C13HDC00854) by the Health and Disability Commissioner. This report was

completed on 31 July 2014. In response to that written report three of the notified parties responded. This paper is my further comment to those responses.

1. [The NASC]
[The NASC] responded via [their solicitor] to say that they saw no need to respond except to acknowledge that they do work within a constrained environment as I had mentioned in my original report.

2. [The Trust]
Likewise, [the Trust] responded via [their solicitor]. They made no objection to my report and they reiterated that they had made a number of service improvements post [Mr A's] death.

3. Care Group Ltd (CGL)
CGL responded via [their solicitor] twice; initially on 19 September 2014 and then again on 14 November 2014. In my report of July 2014, I was critical of some of the operation of CGL as it related to the care of [Mr A]. In particular I commented on:

a. The lack of a written agreement for the services they were to provide
b. Using third party contracting to engage staff
c. Their training programme
d. Supervision and monitoring of 'staff' performance
e. Their reliance on that third party to manage day-to-day rostering clashes
f. Operating outside of their area of expertise

Firstly, CGL, through [their lawyer], reiterate that they saw themselves as a temporary agent who was responding to the 'requirement of [Mrs B]' and who were 'simply helping a person out with administration roles for what was thought to be a short period.' They state that this temporary status and following [Mrs B's] direction exculpated them from, variously, adapting their business model, having a written plan, ensuring they had all the necessary documentation and providing the necessary oversight to and selection of staff/contractors. The letter refers to a number of specific examples relating to this and in each case I would comment again that they indicate poor practice, probably resulting from CGL operating outside of their usual area of endeavour.

As an example CGL comment that they did not have a written agreement for service because [Mrs B] did not want one. This may have been acceptable if the term of engagement had only been very short term but once more than 6 months had elapsed this should have been required. It is not sufficient to say that an organisation ignores good practice at the request of a consumer/service user. It is their professional responsibility to convey to that person why they need to operate in certain ways and to find a position that satisfies each party. There may well have been other ways to record the agreement if writing it down was truly objectionable to [Mrs B]. For example, an audio or video recording of an agreement works for some people.

Secondly CGL did not see themselves as responsible for the people who directly supported [Mr A]. In particular they did not think they had a role in the engagement of those people or the rostering and payment of those people. This was, in their opinion, entirely the prerogative of [Mrs B]. As such, they claim their rostering referred to [Mr D] only as he represented [Company X].

However, I again state that their intention to support [Mrs B] to manage all these processes was not the reality. From the reports and other documents that were supplied to me it is clear they did engage people — specifically [Mr D] — on a job description and with employee style expectations even though they used an independent contractor's agreement as the vehicle. They did charge $[…] per hour for this work — significantly more than it would cost if the expectation was just to process the paperwork. And they clearly did do the rostering even if it was entirely at the direction of [Mrs B]. None of this may have been their intention but over a long period of time it was the reality so does not excuse them from taking greater care than they did.

Finally, CGL reiterates their claim that [Mr A's] situation was 'unique.' It may well have been in their experience but is not within the broader sector. What this indicates is that CGL was operating outside of their usual area of expertise and therefore should have taken even greater care to get it right.

I acknowledge they were genuinely attempting to help out in this situation; one that was complicated by a number of the contracting features […]. Not-withstanding this, it remains their responsibility to operate to a certain standard and to refuse to operate if the structure of support could pose a significant danger to those being supported."

Appendix B — NZS 8158:2003

NZS 8158:2003 includes (amongst other things) the following:

"…

2 Organizational Management

2.1 Governance

Outcome ***The service provider has effective and efficient governance.***

2.1.2 The governing body shall ensure effective systems are developed for the regular monitoring and evaluation of the service.

NOTE — This may include but is not limited to monitoring and evaluation of:

(a) The operational framework and direction;
(b) Strategic/operational outcomes;
(c) Resourcing levels;
(d) Quality and risk management systems;
(e) Financial management delegations;
(f) Cultural appropriateness, input and competencies.

…

2.2 Service Management

Outcome ***The service is managed in an efficient and effective manner that ensures the provision of timely, appropriate and safe services to service users.***

…

2.7 Human Resource Management

Outcome ***Human resource management processes are conducted in accordance with good employment practice and comply with relevant legislation.***

…

2.7.4 The service provider implements a system to identify, plan, facilitate and record training and education for all staff, ensuring they continue to provide safe and effective services to service users.

NOTE — This may be achieved by, but is not limited to ensuring new staff:

(a) Receive an orientation to the service;
(b) Have their training needs identified and planned for;

(c) Receive regular performance reviews.

2.7.5 The service provider shall have a system in place to determine and monitor the competency of its support workers. This shall include but is not limited to ensuring:

(a) Support worker competency is determined by an individual(s) with the appropriate skills and knowledge;
(b) Support worker competency is assessed against the service provider's policies and procedures;
(c) Specialist advice, training, information and supervision are provided for support workers by individuals who are trained/qualified and competent to undertake this role.

…

2.7.7 Support workers shall only assist service users requiring personal care and support when:

(a) The level of assistance/intervention is clearly defined in the individual service plan;
(b) They have been assessed as competent in providing the level and type of care and/or support;
(c) They clearly recognize and understand their individual 'scope of practice';
(d) They receive a level of supervision in line with the requirements 2.7.9;
(e) They know how to seek assistance or advice from their nominated supervisor when the limit of their competency, knowledge or experience is reached.

2.7.8 The service provider shall ensure all support workers are supervised.

NOTE — Supervision is defined as the day-to-day management of the support worker. The level and type of on-going supervision may be determined by, but is not limited to the following:

(a) The level of competency of the support worker;
(b) The specific limitations of the support worker (i.e. support worker returning to work after injury);
(c) The level and type of support required by the service user;
(d) The complexity of support required by the service user;

…

2.8 Support Worker Availability

Outcome ***Service user receive timely, appropriate and safe service.***

2.8.1 The service provider has a clearly documented rationale for determining support worker availability and skill mixes in order to provide a safe service for service users.

NOTE — This may be achieved by, but is not limited to:

(a) Determining sufficient support worker levels in consultation with a health professional where the service meets a particular clinical need, particularly when the service manager has no clinical background;
(b) Implementing systems that match support worker resources to service user needs.

2.8.2 The service provider has a system for the appropriate allocation of suitably qualified/skilled and/or experienced support workers to meet the needs of service users in a competent, safe and timely manner.

…

4.2 Individual Service Agreements

Outcome ***Each service user has a written agreement with the provider for the provision of service.***

NOTE — The written agreement may form part of the individual plan.

4.2.1 The service provider shall ensure each service user has a written agreement that explains the service they are to receive.

…"

Appendix C — NZS 8158:2012

NZS 8158:2012 includes (amongst other things) the following:

"…

2 ORGANISATIONAL MANAGEMENT

Outcome 2 Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

2.1 GOVERNANCE

Standard 2.1 Consumers receive services that are planned, coordinated, and appropriated to their needs.

…

2.2 SERVICE MANAGEMENT

Standard 2.2 Consumers receive timely, appropriate, and safe services through efficient and effective service management.

…

G 3.2.2 This may include, but is not limited to, having:
(a) An organisational staff training plan;
(b) Individual training plans for all staff;
(c) Educational and training records.

…

G 3.2.3 This may include, but is not limited to, having:
(a) A competency framework;
(b) A competency checklist;
(c) Ongoing competency assessment.

…

3.2 ORIENTATION, INDUCTION, ONGOING DEVELOPMENT, AND COMPETENCY

Standard 3.2 Consumers receive services from service providers who are trained and assessed as competent to provide services.

Criteria The criteria required to achieve this outcome shall include ensuring:

3.2.1 An induction process is completed by all service providers, prior to commencement of duties, and a record of the induction programme and attendance is maintained.

3.2.2 A developed, implemented, and recorded training plan relevant to the service provider's scope of practice is maintained.
3.2.3 There is a system to determine and develop the competencies of the organisation's service providers to meet the needs of consumers. This shall be achieved by, but is not limited to:
a) The service provider's competency is assessed against the organisation's policies and procedures;
(b) Competency gaps between consumer's needs and services provider's competency are identified;
(c) Specialist advice, training, information, and oversight are provided by individuals who are trained/qualified and competent to undertake this role.

…

4 SERVICE DELIVERY

Outcome 4 Consumers receive services that contribute to their agreed outcomes, and that support their independence, safety, and well-being.

4.1 SERVICE AGREEMENT

Standard 4.1 The consumer, organisation, and service provider have a full understanding of and agree to the services to be provided.

Criteria The criteria required to achieve this outcome shall include ensuring:

4.1.1 Each consumer shall have a written service agreement with the organisation providing the services …"