Disability Service

Caregiver, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 21HDC00035)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him by caregiver Mr B and a disability service. The following issues were identified for investigation:

- *Whether the disability service provided Mr A with an appropriate standard of care in 2019–2020.*
- *Whether Mr B provided Mr A with an appropriate standard of care in 2019–2020.*

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

3. The parties directly involved in the investigation were:

Mr A	Consumer
Disability service	Provider
Mr B	Provider/caregiver

4. Further information was received from:

Residential Care Manager	
Mr C	Former Manager
Mr D	Senior clinical psychologist

5. Independent advice was obtained from Dr Christine Howard-Brown, a disability specialist (Appendix A).

Information gathered during investigation

Background

6. This report concerns the care provided to Mr A (then aged in his thirties) by a disability service and its employee at the time, residential care officer Mr B. Mr A has an intellectual disability and had lived in a supported residential facility owned and operated by the disability service since he was in his mid-teens (approximately 20 years).[1]

7. The disability service told HDC that Mr A and Mr B had known each other since they were in their mid-teens, and there was camaraderie between the two men, both being of a similar age and having similar interests. Mr B told HDC that he and Mr A maintained a friendship, they were close like brothers, and they had known each other since they were kids.

[1] Mr A was referred to the disability service by Child Youth and Family (now known as Oranga Tamariki).

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Disability service

8. At the time of these events, the disability service provided community residential disability support.

9. The disability service was incorporated under the Charitable Trusts Act 1957 as a charitable trust.[2] The Trust was funded by the Ministry of Health and was contracted to provide community residential support services for people with an intellectual disability.

10. The Ministry of Health conducted an issues-based audit of the disability service in 2021 (discussed further at paragraph 85), following receipt of this complaint. The audit identified concerns about the disability service and made several requirements and three recommendations for improvements. Three of the requirements were critical. A financial audit of the disability service identified areas of concern about its financial activities and non-compliance with its contract. Subsequently, the Ministry formally notified the disability service that it would not renew its contract when it ended in 2021. The Trust is no longer in operation.[3]

Mr B's care of Mr A as described by Mr B

11. Mr B told HDC that he had been employed by the disability service for 'three years, more or less' as a residential care officer (caregiver), for 20 hours a week, from approximately 2017 to 2020, and he lived on the property.

12. Mr B explained to HDC that he had three roles at the disability service. His first role was that of a resident driver. He explained that he drove Mr A and other residents to their courses or jobs five days a week. Mr B said that he would drive Mr A to work and would pick him up at the end of his shift. Mr B's second role was that of a caregiver. Mr B said that this role involved basic care for the residents, and he did not elaborate on this point. Mr B stated that his third role was that of a yard maintenance person, and he and Mr A would complete yard maintenance tasks together, until Mr A got a job at a supermarket. The disability service did not provide Mr B's position description to HDC.

13. Mr B explained that it was 'a big thing at [the disability service] to treat residents with respect', and the disability service reminded its staff that 'it may be a job for you, but this is [the residents'] home'. Mr B stated that he was required to attend a lot of training as part of his role at the disability service, and he felt overloaded with information. He confirmed that he was aware of the Code of Health and Disability Services Consumer's Rights (the Code) but could not specifically remember receiving training on this topic.

14. Mr B denied the severity of incidents as disclosed by Mr A, and he questions Mr A's motivation for submitting this complaint. It has not been possible for HDC to maintain

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[2] A way to hold and protect assets (money, property) for charity purposes. A charitable trust is considered to be a body corporate much like a company. It is permitted to make profits on its trading activities, but these profits must be used for its charitable purposes and cannot be distributed to its trustees or related persons.

[3] However, it remains a registered charitable trust.

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contact with Mr B. It is not clear whether Mr B has continued his career as a caregiver in a residential setting.

Mr A's complaint to HDC

15. Mr A approached HDC through the Nationwide Health and Disability Advocacy Service (the Advocacy Service)[4] with the assistance of an advocate, Mr D. Mr D, a senior clinical psychologist[5] (and Mr A's treating psychologist) arranged Mr A's advocacy support and has assisted HDC with the investigation by providing further information about each of Mr A's concerns.

16. Mr D explained to HDC that during a therapy appointment on 27 October 2020, Mr A reported to him that he had been feeling unsafe in the company of a male caregiver at his residential facility, which was owned and operated by the disability service.

17. Mr D told HDC that it was not until a subsequent appointment on 10 November 2020 that Mr A provided Mr D with a detailed verbal account of past incidents of concern involving himself and the caregiver. Mr A identified the caregiver as Mr B. Mr D stated that Mr A was not able to provide exact dates of the incidents as he had longstanding memory difficulties; however, Mr A broadly estimated that they all had occurred between January 2020 and January 2021.

18. HDC was informed by the Advocacy Service that an ex-employee of the disability service, Mr C, was willing to provide evidence in support of Mr A's complaint. Mr C told HDC that during his employment at the disability service, Mr A had confided in him about concerns regarding Mr B. Mr C told HDC that he was a manager at the disability service for around 15 years and resigned in November 2020. Mr C stated that Mr A 'unloaded so much stuff' onto him, which made him very concerned about the disability service and led to his resignation from the facility. Mr C, on behalf of Mr A, formally raised concerns about Mr B with the disability service on 28 October 2020. Mr C stated that the disability service had no desire to solve the issues he brought to its attention.

19. On 28 October 2020, the disability service held a meeting with Mr C to formally discuss Mr A's concerns about Mr B. However, the disability service told HDC that it did not act on Mr C's concerns because of 'what seemed to be [Mr C's] anxiety or agitation' and difficulty having 'consistent discussion' with Mr C. The disability service told HDC that Mr C would 'change topics during the discussion, so it took several meetings before [the disability service] could ascertain the concerns he was trying to raise'. In response to the provisional opinion, the disability service told HDC that the concern raised by Mr C 'was at his request an informal meeting and he reiterated that this was NOT [the disability service's emphasis] a complaint but a concern as he was very aware of the friendship both Mr B and Mr A had and did not want to jeopardise that'. The disability service said that it took Mr C's concerns seriously, 'and acted on them with the appropriate outcome that at the time [it] believed was accepted by all parties'. The disability service said that following its meeting with Mr C,

[4] A free and independent service for consumers of health and/or disability services.

[5] Mr D was employed by a Dual Disability Service.

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it asked to discuss some of the concerns with Mr A, and around the same time it received a telephone call from Mr D about the same concerns.

20. Mr D told HDC that he spoke with Mr C on 10 and 11 November 2020 and subsequently he telephoned and emailed the disability service management on 16 November 2020 to report the concerns Mr A had raised with him. Mr D informed the disability service that given the potentially criminal nature of some of the alleged behaviour by Mr B towards Mr A, it would be best for an external investigation to take place, for example, through a police notification.[6] The disability service's response to these concerns is set out in more detail below.

Alcohol and marijuana consumption

21. Mr A alleged that he consumed alcohol and smoked marijuana with Mr B, who supplied him with these substances and would film Mr A smoking, on his phone. Mr A did not provide precise dates, but he told HDC that he estimated that the alleged events occurred between January 2020 and January 2021. Mr D added that Mr A told him that he felt pressured by Mr B to smoke marijuana with him on several occasions.

Mr C's recollection

22. Mr C told HDC that Mr A told him that he and Mr B smoked marijuana and drank alcohol together on the disability service's property, and on two occasions bags of marijuana were found at the facilities. Mr C did not provide a timeline for these allegations.

Mr B's response

23. Mr B told HDC that he was 'caught off guard' by these allegations as he consumed marijuana with Mr A once in his teens, prior to his employment at the disability service. Mr B said that on this occasion, the marijuana was supplied by a member of Mr B's family.

24. Mr B did not comment on whether he drank alcohol with Mr A.

Disability service's response

25. The disability service told HDC that when Mr A started working at a supermarket in August 2019, he told the disability service that the job was physically demanding, and he felt he deserved and enjoyed a drink. Mr A and the disability service agreed that he could drink no more than three beers on these occasions. They discussed the agreement with Mr A's GP to ensure that medication could be administered safely, taking into account the alcohol consumption. The disability service said that this agreement had been in place for several years and was an informal verbal agreement but 'one which [was] discussed between [Mr A], staff and management on a semi-regular basis'. The disability service told HDC that Mr B consumed alcohol with Mr A outside of his employment as a caregiver, during social activities such as playing pool or having a quiet pint at the local pub.

26. However, the disability service told HDC that when it asked Mr A for a timeline, he stated that it happened in approximately 2015–16, before Mr B's employment commenced. The

[6] The disability service did not provide any evidence to HDC suggesting that police were notified of the incidents alleged by Mr A.

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disability service told HDC that it first learned of the marijuana consumption from Mr D on 16 November 2020.

Allegations of violence

27. Mr A has made various allegations of violence by Mr B in his role as a caregiver at the disability service. However, the number and dates of these incidents, and what precisely occurred, is unclear.

Gym incident

28. Specifically, Mr A alleges that when he attended the gym with Mr B, Mr B used him as a 'punching bag' and filmed him in front of other people. Mr A did not provide a specific date for this incident.

29. Mr D told HDC that Mr A said that he felt pressured by Mr B to participate in boxing classes with him. Mr D said that Mr B punched Mr A several times and hurt him 'in the nose and face'. Mr A told Mr D that he 'didn't enjoy it at all'. Mr A told HDC that the disability service was advised of this incident, but it was not investigated. Mr A did not provide the date on which he advised the disability service. In response to the provisional opinion, Mr A reaffirmed that Mr B was using him as a punching bag, repeatedly hitting him and filming it.

30. Mr D also told HDC about an incident Mr A had told him about, in which Mr B put his hands on Mr A's neck. Mr A said that he was unable to get away and struggled to breathe. Mr C was also aware of this incident and said that Mr A told him that he did not report this incident to the disability service because of the fear of further violence from Mr B. This appears to be a separate allegation to the 'choke hold' allegation (referred to in paragraph 35), although, again, Mr A was unable to provide a specific date for this incident. In response to the provisional opinion, Mr A referred to an incident of violence when Mr B threw him against the wall in the garage. Mr A said that his girlfriend and another resident were present at the time. However, it is unclear whether this is the same incident referred to above, or a separate one. Mr A did not provide a specific date for this incident.

<u>Mr B's response</u>

31. Mr B confirmed to HDC that he did attend the gym with Mr A. Both men took turns holding boxing pads whilst the other punched them for practice. Mr B did not provide the date of this incident and it is not clear whether it is the same incident as alleged by Mr A. Mr B acknowledged to HDC that he could have hurt Mr A a little because of the nature of boxing combinations, but he was adamant that he was not too hard on Mr A 'because he was aware of his disability'.

<u>Disability service's response</u>

32. The disability service told HDC that it investigated an incident in 2019 that occurred at a gym when Mr B was not on shift. The incident involved Mr B '[making fun] of [Mr A] in front of [Mr B's] gym friends and had taken a video and then showed [it to Mr B's] friends'. The disability service told HDC that there were no records of this incident, but it dealt with the incident 'verbally'. Mr A was then told not to attend the gym with Mr B again.

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33. The disability service told HDC that it discussed the gym incident with Mr B at the time. Mr B accepted that a video was taken of Mr A at the gym in order to improve Mr A's technique. Mr B agreed with the disability service that showing the video to his friends was 'not the right thing to do and he had not asked [Mr A's] permission'. The disability service told HDC that Mr B was trying to motivate Mr A at the gym and this could have been misconstrued by Mr A. The disability service said that it told Mr B that the type of language used to motivate Mr A was 'not appropriate as [Mr A] had obviously taken [it] very personally and to bear in mind [Mr A's] language ability may be different to [Mr B] and that [Mr A] would no longer be going to the gym with him'.

34. The disability service told HDC that it learnt that Mr A had described Mr B using him as a 'punching bag' only on 16 November 2020 and, when the disability service questioned Mr A further on this, it learnt that this reference was regarding a boxing exercise. The disability service did not supply HDC with any incident reports or contemporaneous documentation of Mr A having raised concerns with staff.

Strangulation incident

35. Mr A's complaint to HDC states that following an evening of substance consumption together, Mr B was violent with Mr A. Mr A described Mr B putting him in a choke hold and throwing him 'up and down'. Mr A said that he advised management of this incident, but he did not receive a response. Mr D also told HDC that Mr B put Mr A in a choke hold and threw him up and down. In response to the provisional opinion, Mr A told HDC that his girlfriend was present during this incident, and that Mr B also threw him onto the bed.

Mr C's recollection

36. Mr C said: '[Mr A] has told me he has been thrown up against a wall and held in a choke hold on a bed. I add that [Mr A's girlfriend] has verified this as she witnessed it.'

Mr B's response

37. Mr B said that he has no recollection of this happening. He said that he and Mr A were close like brothers and had known each other since they were children.

Disability service's response

38. The disability service told HDC that it first learnt of the concerns about violence from Mr D on 16 November 2020, and that Mr A told them that the violence following consumption of alcohol had occurred earlier than 2020. The disability service also told HDC that when asked, Mr A told the disability service that the violence happened when Mr A and Mr B had been 'mucking around', play fighting, and Mr B had pushed Mr A against the wall and put his hands around Mr A's throat. The disability service told HDC that this scared Mr A, and he went to his room.

39. The disability service told HDC that once it learnt of this incident,[7] it spoke with Mr B and asked him to apologise, and it had 'no reason to believe that the apology did not happen'. The disability service said that Mr B told them that they had been playfighting and he had not realised that his actions had scared Mr A. The disability service said that when it asked

[7] After 16 November 2020.

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Mr B if he had put his hands around Mr A's throat, he said that he could not remember exactly what happened.

40. No incident report or documentation regarding this incident was supplied to HDC.

Wood-throwing incident

41. Mr A stated that on 16 March 2020 he was burning rubbish and wood in a field near the residence, and Mr B, on discovering the fire, threw a piece of wood, which hit him on the leg. Mr D added that Mr A informed him that he was off work for two weeks following the injury caused by Mr B. Mr B continued to work for the disability service after this incident.

Mr C's recollection

42. Mr C told HDC that it was the disability service's policy to get a trained interviewer in to obtain facts, yet this did not occur following this specific incident. Mr C said that as a result, it was 'one story [against] another' and Mr B 'suffered mild to say the least consequences' by being given a verbal warning. Mr C told HDC that Mr A was also given an official warning, and that in all his years working at the residence it was the first time he had heard of a client being given an official warning. Mr C did not explain the reason for the official warning, but an incident report provided by the disability service (discussed below) states that Mr A received the warning for throwing secateurs at Mr B. Mr C told HDC that he believed Mr A when Mr A told him that Mr B provoked him into violence.

Mr B's response

43. Mr B told HDC that Mr A had lit a fire during a total fire ban, and when he asked Mr A to put out the fire, Mr A threw secateurs towards Mr B's feet. Mr B said that he sustained a cut to his hand when he pushed away the secateurs. Mr B stated that the incident report by the disability service found that he was not in the wrong.

Disability service's response

44. The disability service provided HDC with an incident report, an investigation summary, and an ACC claim form documenting the incident that occurred on 16 March 2020. The ACC claim form stated that Mr A sustained an '[a]brasion [to his left] knee' as a result of being 'struck on the left leg with a piece of wood swung by another person'. In a letter to Mr B dated 20 March 2020, the disability service stated: 'There are specific points within the two perspectives (stories) which are the same, however other details between the two are different.' The letter concluded by advising Mr B that he had been given a verbal warning for 'the use of an object, which although not intended, resulted in physical harm to another person'.

45. The disability service told HDC that the incident occurred when Mr B was not on shift. The disability service said that its manager should have insisted that Mr B apologise to Mr A, as this would have been professional.

Recording and distributing upsetting material

46. Mr A stated that Mr B showed him a video of another resident at the disability service inserting a dildo into his mouth, which disgusted him. Mr A did not provide a specific date

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of this incident, although he estimated that it was between January 2020 and January 2021. In response to the provisional opinion, Mr A said that the video shown to him was definitely of another resident 'eating' a dildo, and he is certain that it was not chocolate (see paragraph 49).

Mr C's recollections

47. Mr C told HDC that he was told by Mr A that Mr B had showed him pornography on his phone and a video of another resident at the disability service being made to put a dildo into his mouth whilst being laughed at by Mr B and his friends.

Mr B's response

48. Mr B explained to HDC that this incident was dealt with by the disability service 'in house' and did not elaborate further.

Disability service's response

49. In its 28 October 2020 meeting notes provided to HDC, the disability service concluded that the dildo was in fact a number of melted chocolates given to a resident by a barber. The disability service said that this was a Snapchat[8] video and Mr A was advised that the perceived dildo was a couple of bars of chocolate that had stuck together, and it was not sinister or inappropriate. The disability service told HDC that when it questioned Mr A about this incident, Mr A told the disability service that the dildo could have been chocolate.

50. The disability service told HDC that it questioned Mr B about this incident. Mr B explained to the disability service that Mr A watched a Snapchat video of one of the residents who had some melted chocolate bars in a brown paper bag, which the resident had been given by a barber. Mr B said that the resident could not get the bars apart and so he was encouraged to bite into them instead. Mr B told the disability service that he did not intend to show Mr A the video, but he was 'going through videos when [Mr A] was with him'. The disability service told HDC that the video had been deleted and Mr A had been advised that the object he thought was a dildo was actually chocolate bars stuck together.

Mr B's driving

51. Mr A stated that he did not feel safe in the car with Mr B.

52. Mr B did not comment to HDC on this topic. However, in his interview with the disability service's solicitor (discussed below), it is documented by the solicitor that '[Mr B] is accepting that his driving is occasionally fast … He is conscious that he needs to drive more safely and is now mindful of his speed.'

Disability service's response

53. The records of the disability service's meeting on 28 October 2020 noted that Mr B had no driving infringement notices or speeding tickets whilst driving residents for the disability service. Mr B was said to have admitted to moving in and out of traffic when he could,

[8] Snapchat is a multimedia instant messaging phone application.

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because he did not enjoy sitting in traffic. The disability service told HDC that it advised Mr B to be patient whilst driving and not to unsettle his passengers.

Interview without a support person

54. Mr A stated that he was interviewed by the disability service's lawyer, without an advocate, about his concerns with Mr B. Mr D told HDC that Mr A disputed the written summary of the interview produced by the lawyer on 18 November 2020. Mr D told HDC that Mr A said that he told the interviewer that he did not want to have any further contact with Mr B, and that he did not understand why the summary stated that he would be satisfied with a written apology from Mr B as a resolution to the issues.

Disability service's response

55. The disability service told HDC that it had a solicitor, and that following Mr D's contact with the disability service on 16 November 2020 it arranged for a statement to be taken from both Mr B and Mr A on 18 November.

56. The disability service told HDC that it stood by its decision to allow the solicitor to interview both Mr B and Mr A. The disability service stated that it attempted to contact the Advocacy Service to obtain representation for Mr A. It left a message for an advocate to call back but did not receive a response. However, the disability service later accepted that it had used an incorrect number for the Advocacy Service. The disability service said that it told Mr A that an advocate could not be reached at that time, that time was of the utmost importance, and that the solicitor would give Mr A the opportunity to air his concerns.

57. The disability service said that the solicitor was not asked for recommendations. Furthermore, the disability service told HDC that after the interview, when a manager asked Mr A how it went, Mr A replied with 'really well, I liked [the solicitor], he made it easy'.

Solicitor's report

58. The solicitor wrote in his report of 18 November 2020 that his brief was to investigate an allegation that Mr B assaulted Mr A. The report does not detail which allegation he was asked to investigate, and his report mentions several different incidents.

59. The report stated that the solicitor first interviewed Mr A, and then Mr B. Other than a brief explanation of the nature of the alleged assault from the disability service's management, the solicitor wrote that he sought no further detail before the meetings to ensure that he had no preconceptions. Furthermore, the report stated that the solicitor noted that both Mr B and Mr A were, in his view, 'at ease and happy to talk openly with [him] about any issues [he] raised'. The solicitor wrote: 'They both presented open, willing and honest when discussing all matters with me and I saw no signs of deception.'

60. The solicitor's report outlined broadly the same issues Mr A raised with HDC. However, additional information not discussed above was recorded by the solicitor as follows:

> '[Mr A] reports of an incident in a garage where [Mr B] shoved him forcefully on his chest and [Mr A] nearly fell backwards. [Mr A] says there were 2 witnesses but [the

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solicitor] did not believe it necessary nor helpful to inquire as to who were the witnesses. [Mr A] says that he could have fallen and suffered a significant head injury.'

61. In relation to this incident, Mr A said that the two men had been drinking and were intoxicated when this incident occurred.

62. The solicitor's report discussed Mr B's response to Mr A's concerns by stating:

> '[Mr B] was fully aware of the incidents [Mr A] reported to [the solicitor] and spoke openly about them … [Mr B] suggested that the incidents [Mr A] reported to [the solicitor] are only now an issue and have arisen because of an alleged complaint made against [Mr A] by another of [the] residents about 2 months ago. [Mr B] believes that [Mr A's] above untrue and/or exaggerated complaints are a means for [Mr A] to deflect attention away from his alleged misconduct.'

63. The report stated that Mr A suggested to the solicitor that as a means of resolution, he wanted to give Mr B a second chance. The report noted:

> '[Mr A] would be happy to have this matter resolved by way of a written apology to him from [Mr B] … If [Mr B] denies the allegations and refuses an apology, [Mr A] thinks [Mr B] should get a written warning from [the disability service] or have his employment terminated.'

64. The solicitor wrote that his brief did not include recommendations, and he believed the disability service's management had 'sufficient information to form their own view as to the reasonable and appropriate steps to take having particular regard to [Mr A's] suggestion'.

Termination of Mr B's employment with the disability service

65. The disability service told HDC that following receipt of the solicitor's report, on 22 November 2020 Mr B was stood down from his employment until 'a solution was reached'.

66. On 7 December 2020, the disability service wrote to Mr B with an official warning for the allegations made against him by Mr A. The allegations included: 'Holding [Mr A] aggressively against the wall; Holding [Mr A] aggressively on the bed; unsafe driving in a [disability service] vehicle.' The disability service also informed Mr B that it was aware of other allegations made against him, that the manager was unable to investigate those allegations 'due to the incidents occurring before [the manager's] employment' at the disability service, and that if Mr B wished to continue his employment with the disability service, the following criteria must be met:

'• Attend a defensive driving course. [The disability service] will book and pay for this to occur. Should there be any further complaints about your driving, stricter actions will be taken which may result in a reduction of hours.

• Attendance to ALL compulsory training. This includes, but is not limited to, First Aid training, Autism training, Behaviour Support training, Medication training, CPI (nonviolent crisis intervention) training.

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- Attendance to an anger management course. [The disability service] will book and pay for this to occur.
- The written warning period will be disregarded after a 12-month period but will remain on your file. During this 12-month period, your conduct will be observed. Any re-occurrence will lead to termination.'[9]

67. The disability service told HDC that it sent a text to Mr B on 20 December 2020 requesting a response to the official warning letter.

68. The disability service said that on 21 December 2020 it received a response from Mr B stating that he had been 'off the grid' and that he would read over everything that day.

69. The disability service told HDC that it did not receive any further correspondence from Mr B, and on 6 January 2021 it sent Mr B a letter terminating his employment as a residential care officer (caregiver) with the disability service.

Relevant documents provided by the disability service

Mr A's Daily Life Goals at the disability service

70. The disability service told HDC that Mr A's care plan included a document titled 'Daily Life Goals', which documented Mr A's goal progress on a fortnightly basis.

71. A copy of Daily Life Goals provided by the disability service showed that Mr A's goal from 4 March 2019 to 23 June 2019 was to 'Save his money' and 'Get himself a job'. The document contained all the resident's goals on the same page and a short progress note alongside the goal to demonstrate steps a resident was taking to achieve a goal. The disability service told HDC that there were months where Mr A's achievement was 'the same'.

72. Similarly, a copy of Mr A's Daily Life Goals for the period of 20 January 2020 to 20 December 2020 had the same goal of 'Save my money'.

Mr A's needs assessment

73. The disability service provided Mr A's needs assessment that was completed on 7 October 2020. The document stated that the needs assessment was completed to ensure that Mr A's support still matched his needs.

Staff Training Register

74. The disability service provided its 2019–2020 training register. It included 15 training sessions offered to its staff throughout 2019 and 2020. Of those, eight were attended by Mr B. Training topics attended by Mr B included 'Privacy & Confidentiality, Civil Defence'; 'Behaviour Management Strategies, Mission Statement, Cultural awareness, Aim & Objectives'; 'ASK: Identifying Emotions'; 'Health & Safety Policy'; 'Code of Conduct & Confidentiality Policy'; 'Infection Control Policy', and 'Enabling Good Lives training & team

[9] The disability service told HDC that Mr B was asked to make contact by 13 December 2020 regarding these requirements if he wanted to return under these stipulations.

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building'. The disability service told HDC that further training did not occur because of the COVID-19 lockdown, which disrupted its training schedule.

Mr B's appraisal document dated 8 November 2019

75. The appraisal document contained 17 topics and requirements that required an achievement rating. The topics included:

- Daily Routines;
- Assisting in planning effective support for the individuals through consultation and partnership;
- Promotion of self-esteem of the clients;
- Enhancing by words and actions the image of persons with a Psychiatric/Intellectual Disability;
- Support people with Psychiatric/Intellectual Disability to gain skills and confidence to self-advocacy;
- Help client with the complaints procedure, Assist client to contact an advocate, Respect the client's right to choose, Be conscious of the fact that the home is the client's not yours;
- Ensure that people with a Psychiatric/Intellectual Disability are provided with quality and appropriate information on which to base their choices;
- Each person with a Psychiatric/Intellectual Disability will be assisted to make informed choices about their lifestyle;
- Allocate your time so that you can spend time with the clients;
- Take time to listen;
- Suggest other organisations that could assist.

76. Mr B had 10 partially achieved and six minimally achieved ratings. The document did not suggest any further training or improvements.

Policies and procedures

77. The disability service provided its Code of Conduct workbook (Appendix B).

Further information

Statement provided by Mr C, former employee of the disability service

78. Much of the information supplied by Mr C has been incorporated above. In addition, Mr C told HDC that Mr A's girlfriend had obviously been affected by what had been going on between Mr A and Mr B. Mr C stated that although in his view Mr B's actions towards Mr A were inappropriate, Mr B was a young man who was not equipped to work in the disability field and should never have been employed there.

79. Mr C advised HDC that the disability service was negligent in allowing Mr A, a vulnerable person, to go out and drink alcohol. Mr C informed HDC of an incident in which Mr A went out drinking with an unknown friend, leading to a criminal incident at the facility. Mr C told HDC that the disability service did not follow its own policies and guidance regarding incidents at its facilities.

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Further information from the disability service

80. The disability service told HDC that it did not have a formal complaints register prior to an audit carried out by the Ministry of Health|Manatū Hauora. The issue-based audit commenced after the events alleged by Mr A and focused on the safety and wellbeing of individuals residing at the disability service. It also looked at the support provided to Mr A following his complaint to HDC. The disability service said that following the audit, any complaints instigated by residents were recorded on a complaint form that the residents either wrote themselves or had support to write. The form was then 'filed in the relevant folder'. However, in response to the provisional opinion, the disability service told HDC:

> 'We have always had a register and have complied with Ministry requirements. the disability service had been service audited over many years and our complaints policy and register met the requirements.'

81. The disability service told HDC that given the historical nature of Mr A's concerns, initially it managed these concerns to the best of its ability. The disability service maintained that it investigated the incidents it knew about, and it kept Mr A informed of the outcomes. The disability service said that it did not intend to diminish the importance of these concerns to Mr A.

82. The disability service told HDC that it appears that there was a camaraderie between Mr A and Mr B based on age-appropriate behaviour, similar points of interest, and a general 'joking familiarity'. The disability service said that this was likely because Mr B knew most of the residents from his youth. The disability service told HDC that at different times, Mr A would seek out Mr B when Mr B was not rostered on. The disability service explained that Mr B was advised to reduce the amount of time he and Mr A spent together outside of employment hours, to reduce the blurring of lines between friend and carer.

83. The disability service told HDC that for four weeks from 25 September to 25 October 2020, following a criminal incident involving Mr A at its residence that required Mr A to relocate for a short period of time, Mr A asked to move in with Mr B, who was living offsite at the time.[10] The disability service told HDC:

> '[Mr B] was the first to put up his hand to support [Mr A] during this time. [Mr B] made sure [Mr A] joined him in doing the grocery shopping and choosing what they would eat, he made sure to remind [Mr A] to wash his work clothes, to pack lunch/dinner to take to work, and to leave on time to get to work. [Mr B] and [Mr A] both agreed there were difficulties sometimes, as would be expected when two people are (effectively) sharing a flat but it was also noted the number of times [Mr A] and [Mr B] were together on social occasions — when stopping in at the residential facilities to pick up or drop off items — and how happy [Mr A] appeared.'

[10] Mr B previously lived on site during his employment at the disability service.

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Further information from Mr B

84. Mr B told HDC that it was always challenging to balance his relationship with Mr A, by which he meant taking off the 'brotherly hat' and putting on the carer hat. Mr B said that Mr A always saw him as a brother and that meant that he 'didn't really respect [Mr B's] authority at work'. Mr B stated that because he lived at the residence he worked at, there was no chance for him to 'take off hats'. He said that because of Mr A's complaint, he was now more aware of the importance of professional boundaries.

Ministry of Health audit of the disability service

85. On 8 January 2021, HDC wrote to the Ministry of Health (MOH) to inform it of concerns raised by Mr A about the disability service.[11]

86. MOH advised HDC that in response to being notified of Mr A's complaint, it initiated an issues-based audit, which was completed in 2021. The audit substantiated concerns about the protection and safety of vulnerable people, and concerns about healthy relationships, informed consent, and sexuality.

87. MOH provided HDC with several reports, the findings of which are outlined below.

Critical Requirements Report

- The manager of the service commenced employment on 11 June 2018. There was limited information in her personal file (for example, position description not dated or signed, no training evident, no personal development plan, no evidence of performance appraisals, no evidence of Curriculum Vitae, no person specification identifying skill sets for the position, no documented induction). 'The Manager has not had the support and does not have the knowledge and skills to undertake investigations of the serious nature that have been documented. Governance has not provided the Manager with the tools or support she needs to learn how to manage a residential service.'

Audit report for the disability service

- The audit report stated that concerns regarding the protection and safety of vulnerable people were substantiated, and that three incident reports were sighted, which included the firewood throwing incident on 16 March 2020; the alleged assault of another resident by Mr A; and a report of another resident entering a neighbour's backyard on 19 December 2020.
- The concern regarding the attitude of staff and management to incidents was partially substantiated. The audit stated: 'Staff are good at reporting incidents, however the Manager does not appear to have the knowledge and/or skills to complete the process of incident investigation.' It also found that usually incidents were discussed in person (rather than being documented), which did not allow for skilled investigation or identification of trends.
- Concerns regarding healthy relationships, informed consent, and sexuality were substantiated, with a 'critical' rating, as there was no policy for informed consent/sexual

[11] Pursuant to section 39(2) of the Health and Disability Commissioner Act 1994.

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consent in place in the Policies and Procedures Manual. There was also no evidence of education and/or training for people in the service or the staff supporting the people in the service.

- Concerns regarding reporting systems, processes, and policies were also partially substantiated. The MOH noted that the Policies and Procedures Manuals were dated February 2018 and were due for review in 2022. It was evident that some policies required updating, due to regulatory changes. 'The Operations Management Report to [the] Board includes breaches of the Privacy Act, is verbose and includes information that should stay with the Manager, unless it has a bearing on governance operations. Practice and paperwork do not align. [A document for residents] introduced in 2018 is still not fully implemented.'
- Concerns regarding staff training and support were also substantiated, in that it was 'not evident'.
- The audit also found that there was no complaints register, no evidence of complaint resolution, and no evidence of which improvements had occurred based on the analysis of the complaint received from HDC.

88. MOH stated that the audit identified serious concerns about the disability service, and it made several requirements and three recommendations for improvements that were necessary for the disability service to continue its business. MOH stated that three of these requirements were critical. MOH explained that consequent to the audit report, the disability service assured MOH that it had addressed the critical requirements. However, MOH considered that the disability service had failed to demonstrate sufficient understanding of the seriousness of the concerns. Subsequently, MOH decided not to renew the contract it held with the disability service. The disability service is no longer in operation.

Responses to provisional report

89. Mr A was given the opportunity to comment on the 'information gathered' section of the provisional report. Where relevant, his comments have been incorporated into this report.

90. Mr B was given the opportunity to comment on relevant sections of the provisional report. However, despite several attempts to contact him via phone, email, and contact tracing, HDC was unable to contact him, and he has not provided his comments on the provisional report.

91. The disability service was given the opportunity to comment on the provisional report. Where relevant, its comments have been incorporated into this report. In addition, the disability service said that it was happy to provide an apology to Mr A.

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Opinion: Mr B — breach

92. Mr A raised several concerns about the standard of care provided to him by caregiver Mr B. In particular, Mr A complained that Mr B pressured him into consuming alcohol and marijuana, was violent towards him, and demonstrated other inappropriate behaviour towards him, including showing him an inappropriate video recording on his phone.

93. I find the concerns raised by Mr A with HDC about Mr B's behaviour towards him to be very serious. However, it is difficult to verify either version of events. I am unable to make a finding on all incidents, as described by Mr A, because of the at times conflicting information provided by each party. Any ability to make findings of fact is also hampered by the disability service's lack of independent investigation and contemporaneous documentation of these concerns, which is discussed below in my opinion on the disability service.

Alcohol and marijuana consumption

94. It is not disputed that Mr B and Mr A consumed alcohol together during Mr B's employment at the disability service. Mr B told HDC that he drank beer with Mr A during social occasions. The disability service did not have any documented policies or guidelines relating to the consumption of alcohol, and Mr B is clear that he did not consume alcohol with Mr A while he was on shift. Mr A has not advised whether the incidents of drinking occurred while Mr B was on shift. I do not consider it appropriate that Mr B drank alcohol with Mr A while he was employed as a carer (irrespective of whether this occurred while Mr B was on shift). There is an inherent power imbalance between a caregiver and a resident. Because of this, clear professional boundaries must be maintained, and it is my view that by drinking alcohol with Mr A, Mr B did not maintain professional boundaries.

95. I am unable to make a finding on Mr A's and Mr B's consumption of marijuana, as virtually no evidence is available except Mr A's allegation. However, if true, I would also be extremely critical of this.

Recording and distributing upsetting material

96. Considering the allegation of Mr B showing Mr A inappropriate material on his phone, I am unable to make a finding on whether the video was of a resident eating chocolate or of a pornographic nature. Regardless of the content of the video, it is generally unwise for providers to show consumers content from their personal devices, especially when the content involves humour at another consumer's expense.

Mr B's driving

97. Mr A complained that he did not feel safe in a car with Mr B. Mr B said that part of his role at the disability service was to drive the residents to their appointments but offered no further comment. However, the notes of his interview with the disability service's solicitor document: '[Mr B] is accepting that his driving is occasionally fast … He is conscious that he needs to drive more safely and is now mindful of his speed.'

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98. The disability service advised that when this was brought to its attention on 28 October 2020, it noted that Mr B had no driving violations but, when questioned, Mr B admitted to moving in and out of traffic because he did not enjoy sitting in traffic.

99. Taking into account Mr A's allegation and Mr B's admission to the solicitor that occasionally his driving was fast, I consider it likely that at times Mr B may have been driving unsafely with Mr A in the car.

Allegations of violence

100. Mr A referred to various incidents, sometimes following consumption of alcohol, including attempted strangulation, Mr B using Mr A as a 'punching bag' at the gym, and Mr B throwing a piece of firewood at Mr A.

101. Mr C, a former employee of the disability service, supported Mr A's accounts of violence, but said that he had not witnessed them personally. Mr D, Mr A's treating clinical psychologist, did not witness the alleged incidents but was particularly concerned about Mr A's reports of violence and suggested that the disability service involve the police.

Gym incident

102. Regarding the gym incident, Mr A was unable to provide a specific date on which this occurred but said that Mr B used him as a 'punching bag'. Mr D also told HDC that Mr A had told him about this incident. Mr A said that he informed the disability service of the incident, but it was not investigated. On the other hand, Mr B said that Mr A did join him at the gym and that both men took turns holding the pads while the other punched for practice. He said that it is possible that he did hurt Mr A, as that is the nature of boxing combinations. The disability service said that it investigated an incident in 2019 that occurred at a gym when Mr B was not 'on shift' and involved Mr B making fun of Mr A and videoing him to show his friends. The disability service said that there is no record of this incident, but it was dealt with verbally and Mr B was told not to attend the gym with Mr A in the future. It is unclear whether this is the same incident as Mr A reports above.

103. Clearly there are conflicting accounts about the incident at the gym. Unfortunately, it is difficult to reconcile these accounts because there is no contemporaneous evidence. However, Mr B accepted that he attended the gym with Mr A and that it is possible that he hurt him during their training session (although it is unclear when this occurred). It is also clear that the disability service was advised in 2019 of an incident at the gym where Mr B made fun of Mr A and shared a video of Mr A with his (Mr B's) friends. I have also taken into account Mr C's comments that he supported Mr A's accounts of violence despite not witnessing them, and the information provided to Mr D by Mr A. Accordingly, I consider it more likely than not that Mr B acted inappropriately at the gym with Mr A on at least one occasion, and that he likely hurt Mr A while they were training. I cannot say whether this was intentional, but in any event, I find it to be inappropriate behaviour from a carer in Mr B's position.

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Strangulation incident

104. Mr A alleged that after a night of substance use with Mr B, Mr B put him in a choke hold and thew him on the bed. Mr A said that he reported it to the disability service, but he did not receive a response. Mr C recalls Mr A telling him that he was thrown against a wall and held in a choke hold on a bed. Conversely, Mr B told HDC that he had no recollection of this occurring. It is of note, however, that the disability service told HDC that once it learned of the incident from Mr D after 16 November 2020, it spoke with Mr B and told him to apologise. The disability service said that Mr B explained that they had been play fighting and he had not realised that his actions had scared Mr A. The disability service said that when it asked Mr B whether he had put his hands around Mr A's throat, he said that he could not remember exactly what happened.

105. There is no contemporaneous documentation or incident report from this event.

106. Having considered all the information available to me, including Mr A's allegation, Mr C's recollection (noting that he was not present during this incident), and Mr B's contradictory statement that he has no recollection of this event despite the disability service affirming that it spoke to Mr B and he admitted to 'playfighting' with Mr A, I find it more likely than not that some inappropriate physical contact occurred between Mr A and Mr B. Again, owing to a lack of evidence I am unable to ascertain the exact nature of this contact and the extent of force used, but I consider that again it demonstrates a blurring of professional boundaries between Mr B and Mr A. In my view, this was inappropriate behaviour by Mr B and resulted in Mr A feeling unsafe. I also consider that it will always be inappropriate for a carer in a similar position to Mr B to playfight with the person to whom they are providing care. In short, aggression shown by Mr B toward Mr A is unacceptable in any circumstance.

Wood-throwing incident

107. Mr A complained that on 16 March 2020 he was burning rubbish and wood in a field near the disability service and, when Mr B discovered the fire, he threw a piece of wood at him, hitting and injuring his leg. Mr D reported that Mr A required two weeks off work for his injury. It is also alleged that Mr A threw a pair of secateurs at Mr B. Mr C recalled this incident and added that Mr A had been given an 'official warning'. Mr C said that he believed Mr A's account of Mr B provoking Mr A into throwing the secateurs. Conversely, Mr B said that throwing the wood at Mr A was a response to Mr A throwing the secateurs (which he pushed away, suffering a cut to his hand). Mr B told HDC that the incident report completed by the disability service found that he was not in the wrong.

108. The disability service provided HDC with an incident report, an investigation summary, and an ACC claim form detailing the injury to Mr A's leg. In a letter to Mr B dated 20 March 2020, the disability service stated: 'There are specific points within the two perspectives (stories) which are the same, however other details between the two are different.' The letter concluded by advising Mr B that he had been given a verbal warning for 'the use of an object, which although not intended, resulted in physical harm to another person'. The disability service told HDC that this incident occurred while Mr B was not on shift.

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109. There is evidence to support Mr A's allegation of violence by Mr B on 16 March 2020. While Mr A and Mr B's accounts of what exactly occurred that day differ, it is undisputed that at some stage, Mr B threw a piece of wood at Mr A, injuring his leg. In my view, again it is irrelevant whether this incident occurred while Mr B was on shift, and I find it unacceptable that Mr B threw a piece of wood at Mr A on 16 March 2020.

Conclusion

110. I have carefully considered the accounts from each party and have made some findings of fact in relation to the allegations made by Mr A. Although there are some aspects of Mr A's complaint that I have been unable to make findings on, I consider that there is sufficient information to conclude that on occasion Mr B acted inappropriately with Mr A, and in particular that they consumed alcohol together, and that Mr B behaved violently towards Mr A on more than one occasion. In my view, there was a clear power imbalance, and Mr B failed to maintain the professional boundaries that were required of him in his role as Mr A's carer.

111. I acknowledge that there were circumstances that may have influenced the blurring of professional boundaries between the two men, including that they had a personal friendship spanning several years prior to Mr B's employment at the disability service and that they were of similar age and had similar interests. I have also considered the fact that the disability service did not have policies or procedures to help guide Mr B in his role as a carer to Mr A, particularly in relation to maintaining professional boundaries (discussed below in my decision on the disability service). Notwithstanding these factors, in my view, by consuming alcohol with Mr A, being violent towards Mr A, and by driving in a way that made Mr A feel unsafe, Mr B failed to 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).[12]

Opinion: Disability service — breach

112. This report highlights problems that can occur when personal and professional boundaries become blurred, and the group provider does not have adequate processes and policies in place to manage the situation. The situation is further compounded when senior management staff are not equipped with the skills and expertise to respond to incidents appropriately.

113. I am very critical of the disability service's operation as a residential facility providing services to vulnerable residents. I discuss this in detail below.

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

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Complaint management

Response to complaints raised by Mr A

114. Mr A told HDC that he did not raise many of his concerns about Mr B with the disability service prior to Mr C's and Mr D's involvement because of the disability service's failure to investigate complaints raised in the past properly.

115. The disability service told HDC that prior to MOH's audit, the disability service did not have a complaints register, and it managed all complaints from its residents informally. The disability service said that despite this, it managed Mr A's complaints to the best of its ability, and the concerns that were known to it about Mr B's behaviour were investigated, and Mr A was kept informed. In response to the provisional opinion, however, the disability service said that it has always had a complaints register (and did at the time) and that it has always complied with Ministry of Health requirements, including being service audited over many years. I note that the information provided by the disability service is conflicting, but I have not seen any evidence to suggest that the disability service had an adequate complaints register in place at the time of the events.

116. My advisor, Dr Christine Howard-Brown, considered that it was of 'significant concern' that the disability service did not have a complaints register or formal complaints process in place at the time of the events. Dr Howard-Brown advised that this represents a significant departure from accepted practice. I accept Dr Howard-Brown's advice and note that the MOH audit also identified the lack of a robust complaints process at the disability service.

117. The disability service was not able to provide HDC with any records of investigations or comment on when Mr A first complained about Mr B. However, the disability service disclosed that some of the concerns raised by Mr A to HDC about Mr B were known to it prior to Mr D's email on 16 November 2020. For example, the disability service told HDC that in 2019 it received a verbal complaint from Mr A about Mr B's behaviour towards him at a gym. The disability service said that Mr A complained that Mr B '[made fun] of [Mr A] in front of [Mr B's] gym friends' and that Mr B recorded a video of him and showed it to Mr B's friends.

118. The disability service told HDC that it discussed this complaint with Mr B at the time and dealt with it by advising Mr A not to go to the gym with Mr B again. The disability service was satisfied with Mr B's explanation that he was taking a video of Mr A to help Mr A improve his technique.

119. My advisor, Dr Howard-Brown, said that her peers would likely find the disability service's disclosure — that as a conclusion to Mr A's verbal complaint it advised Mr A to stop going to the gym with Mr B — to be a moderate departure from accepted practice. Dr Howard-Brown noted that this incident should have been investigated better.

120. I accept Dr Howard-Brown's advice and I am very critical of the disability service's premature response to Mr A's complaint. I also note that the disability service continued to dismiss Mr A's complaints in a similar manner, removing his ability to complain even when a member of its own staff, Mr C, attempted to advocate on Mr A's behalf.

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121. The first documented complaint about Mr B's inappropriate behaviour towards Mr A came from Mr C. Mr C told HDC that Mr A confided in him about Mr B's treatment of him, and on 28 October 2020 Mr C requested a meeting with the disability service's managers to raise his concerns formally.

122. However, the disability service told HDC that it did not act on the concerns raised by Mr C on behalf of Mr A because of 'what seemed to be anxiety or agitation' and difficulty with having consistent discussion with Mr C.

123. Dr Howard-Brown advised:

> '[My] [p]eers would consider that actions taken and inactions at the time this complaint was raised [by Mr C on behalf of Mr A] would be a significant departure from accepted practice, particularly as risks were not being managed … Peers would consider these allegations to be serious and the management of the complaint investigation including the absence of onward actions to be sub-standard.'

124. Dr Howard-Brown stated that her peers would treat any notification of a complaint as an official complaint and would provide acknowledgement letters. Dr Howard-Brown said that the information provided indicated that the disability service did not manage Mr A's concerns adequately, and her peers would consider this to be a significant departure from accepted practice and required standards. I accept Dr Howard-Brown's advice.

125. It is not clear when Mr A first raised concerns about Mr B. However, taking into account Mr A's complaint, Mr C's statement, the fact that the disability service confirmed that it did not have a complaints register and that it treated all complaints from residents 'informally' (meaning that any complaints it did receive were unlikely to be documented/recorded), and the fact that the disability service confirmed that it was aware of the incident at the gym in 2019, I find it more likely than not that periodically Mr A had raised concerns about Mr B with the disability service verbally, from at least 2019, but these concerns were not treated as complaints.

126. I also note the inconsistencies in the information that the disability service provided to HDC regarding its knowledge of Mr A's concerns. The disability service advised that prior to 2020 (when Mr C raised concerns), it knew about only the gym incident (2019) and the wood-throwing incident (documented in an incident report). The disability service also told HDC that given the historical nature of Mr A's concerns, the initial management of these concerns was to the best of its ability, and it investigated the incidents it knew about (as above) and kept Mr A informed of the outcome. However, I have been unable to find any evidence of adequate investigation/management of Mr A's concerns. Accordingly, I consider that Mr A was denied the right to complain in a form that was appropriate to him, which in his case was via discussions with managers, with appropriate advocacy support. I consider that in the absence of any formal complaints process, this was the most suitable way for Mr A to complain to the disability service at that time.

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127. Dr Howard-Brown stated:

> 'If dissatisfaction or concerns expressed by [Mr A] were treated as complaints and managed consistent with a good complaints policy, then any misunderstandings and resulting escalation may have been avoided.'

Investigation of wood-throwing incident

128. Mr A told HDC that Mr B threw a piece of wood at his leg, which caused an injury that resulted in him being off work for two weeks. Mr A said that the disability service did not listen to his side of the story and focused only on the alleged assault by Mr A on Mr B during the same incident. Mr A was not satisfied with the outcome of the disability service's conclusion and specifically was not satisfied that Mr B continued to work at the disability service.

129. The disability service provided HDC with a record documenting this incident containing statements from Mr B and another employee who witnessed it. The disability service also provided HDC with an ACC claim form recording the injury to Mr A. The disability service does not dispute that Mr B caused an injury to Mr A, and that Mr B received a verbal warning for causing the injury. The disability service said that it would have been professional for Mr B to have apologised to Mr A for having caused him an injury, and the disability service accepted that it was not right that this did not occur.

130. Mr B told HDC that he threw a piece of wood at Mr A, which resulted in a personal injury claim with ACC and time off work for Mr A. However, Mr B said that the disability service found that he was not at fault for this incident. Mr B told HDC that he threw a piece of wood at Mr A in self-defence after Mr A threw secateurs at him.

131. The wood-throwing incident is the only concern raised by Mr A about Mr B that was documented by the disability service prior to the 28 October 2020 meeting with Mr C.

132. The disability service's Code of Conduct document classes '[a]ny form of physical contact with clients that has not been authorised or set out in a behaviour strategy (inappropriate touching, hitting, smacking, holding hands, kissing)' as 'unacceptable behaviour' that will result in disciplinary action against the staff member concerned, and that may include dismissal. The Code of Conduct states that action may be in the form of oral or written warnings in less serious instances.

133. Dr Howard-Brown advised that her peers would view the verbal warning as one of the options arising as an outcome from the investigation into this incident. Furthermore, Dr Howard-Brown noted that Mr B offering Mr A an apology would be the usual practice in these circumstances. Dr Howard-Brown said that not offering a resident an apology was a moderate departure from accepted practice.

134. I accept Dr Howard-Brown's advice. In my view, investigation into this incident and the subsequent conclusion was suboptimal and lacked detailed assessment. Apart from Mr B's statement, no further information about this allegation against Mr A was documented. I am concerned about the adequacy of the investigation given the injury to Mr A.

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Conclusion

135. It is important that vulnerable consumers, specifically those in a residential facility, are supported appropriately to complain about the services provided to them. They have a right to expect that complaints will be managed appropriately, and that their concerns will be taken seriously. I am critical of the disability service for not having a complaints procedure that reflected the rights set out in Right 10[13] of the Code. Mr A raised several concerns about Mr B's behaviour with the disability service in 2019, and Mr C complained on behalf of Mr A on 28 November 2020. Despite this, the disability service largely dismissed these concerns and failed to manage them as complaints, as required under Right 10(1) of the Code. In addition, the disability service failed to carry out an adequate investigation into the incident where Mr B injured Mr A's leg by throwing wood at him. I am particularly critical that following the meeting on 28 October 2020, the disability service failed to act on or resolve Mr A's concerns about Mr B and denied Mr A his right to efficient resolution of his complaint.

136. Accordingly, I find the disability service in breach of the following Code Rights:

- Right 10(6) for failing to have a formal complaints process.
- Right 10(1) for not managing Mr A's verbal concerns about Mr B in 2019 as complaints.
- Right 10(3) for failing to facilitate the fair, simple, speedy, and efficient resolution of the incident where Mr B injured Mr A with a piece of wood and of Mr A's complaint in October 2020.

Policies and procedures at the disability service — breach

137. The disability service had a responsibility for ensuring that its staff, including Mr B, provided Mr A with services of an appropriate standard and that the services were provided with reasonable care and skill. Commonly this is ensured through a provider's policies and procedures, and through training provided to its staff.

Training at the disability service

138. The disability service provided HDC with its training register outlining 15 training sessions delivered to its staff during 2019–2020 and noting that eight sessions were attended by Mr B. The training covered a range of topics, including privacy, health and safety, code of conduct, and behaviour strategies.

139. The disability service did not offer its staff training on the Code of Health and Disability Services Consumers' Rights (the Code) in 2019–2020, and specific training on the Code was not delivered to its staff until 2021. The disability service told HDC that despite the lack of formal training, it had regular discussions about the Code with its staff. Mr B told HDC that he was aware of the Code but did not recall receiving specific training on this topic.

140. Dr Howard-Brown advised that her peers would consider that most but not all core training requirements were listed on the disability service's training register. Dr Howard-Brown said:

[13] Right 10 of the Code provides that every consumer has the right to complain.

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'For example, missing is the Code of Rights, Restraint Minimisation and Safety Practice, Abuse and Neglect. Reference to Infection Control related to the policy and not the practicalities such as hand hygiene for example. Most of these topics are required to be provided on an annual basis. Peers would consider the register to be an acceptable summary but only on the basis that other more detailed information would be held. The absence of some core topics would be a moderate departure from accepted practice.'

141. Dr Howard-Brown noted that the training register contained insufficient information to review the adequacy of the training delivered to its staff. She also noted that due to lack of detail it was not possible to review the standard of the content, duration, and how skills were learnt, or competence was assessed. Furthermore, Dr Howard-Brown advised that the training register did not mention the identity, competency, and skill of the trainer, as well as a comment on whether they were external or internal to the disability service.

142. Dr Howard-Brown advised that in a performance appraisal completed for Mr B on 8 November 2019, Mr B's performance was rated as minimal and partially achieved across a range of topics. However, no training was recommended to support improvements in Mr B's skills. Dr Howard-Brown advised that her peers would consider it usual that training needs would be identified and implemented following performance appraisals and as recommendations arising from complaints. Dr Howard-Brown advised that her peers would view this as a moderate to significant departure from accepted practice.

143. In my view, there is no evidence that Mr B undertook any relevant training prior to his employment, and the standard of training he received to perform his role as a caregiver at the disability service was very poor. I accept Dr Howard-Brown's advice on the quality of training, as well as the development and support provided to Mr B. I am very concerned about the standard of training that was available at the disability service as well as the support structure available for its staff. I find that it was not appropriate for Mr B to work with individuals with disabilities in a residential facility without appropriate training.

144. I also note that there is no evidence to suggest that Mr B received training or guidance in relation to maintaining professional boundaries. It is essential that employers of unqualified, unregistered caregivers provide adequate training to staff, including information about maintenance of professional boundaries. This is particularly important when the staff member and a resident are already known to each other prior to the staff member's employment, as was the case here.

Policies and procedures at the disability service

145. The disability service provided HDC with several policies and procedures, including the 49-page handbook and its Code of Conduct document.

146. Dr Howard-Smith noted that none of the disability service's policies and procedures contained a section on conflicts of interest. She advised that if a section on this topic had been included, it may have assisted the disability service in determining how the relationship between Mr A and Mr B could have been managed better.

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147. As noted, Mr A and Mr B were known to each other prior to Mr B's employment at the disability service. Mr B socialised with Mr A, partaking in social activities such as gym and boxing, and consuming alcohol together. Mr B said that it was very hard for him to separate his friendship with Mr A from his job, and due to their friendship, Mr A did not respect his authority as a caregiver.

148. I agree with Dr Howard-Brown that the lack of robust and clear policies played a significant part in the poor standard of services the disability service provided to Mr A. Mr A was a vulnerable individual, and, considering that he raised concerns about Mr B to the disability service on several occasions, the disability service should have been aware that he was at risk of further harm. The disability service should have had in place adequate policies and procedures to guide its staff in situations such as this.

149. As a result of its inadequate policies and procedures, the disability service did not act proactively or appropriately to manage the relationship between the two men and failed to ensure that Mr A was receiving safe and appropriate care from Mr B. By failing to have in place appropriate policies and procedures, the disability service also failed to support Mr B in separating his roles as a friend and a carer to Mr A.

150. Dr Howard-Brown advised that professional boundaries were blurred in this case and that peers would consider this to be unacceptable. She concluded that the blurring of professional boundaries was likely a major contributing factor to the complaints raised by Mr A.

151. I accept Dr Howard-Brown's advice. I find that the disability service did not have adequate policies and procedures to manage professional boundaries and personal relationships between caregivers and residents.

152. I have also considered the issue of Mr B drinking alcohol with Mr A and have found that this was inappropriate. However, I am also concerned that despite the disability service advising that it monitored Mr A's alcohol use and had received advice from his GP, there were no documented policies or guidelines regarding alcohol use. This is particularly concerning given Mr B and Mr A's relationship as friends and as the disability service was aware that they were drinking alcohol together on occasion. In my view, it is unacceptable that the disability service did not have policies in place to guide decision-making on alcohol use, and to guide staff (such as Mr B) in such situations.

Conclusion

153. Right 4(1) of the Code stipulates that every consumer has the right to have services provided with reasonable care and skill. I find that the disability service breached Right 4(1) for the following reasons:

- Staff training at the disability service was inadequate.
- Mr B was not provided with sufficient training and professional development support.
- Processes and procedures did not adequately cover situations that would equip its staff to deal with challenging situations.

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- The disability service did not have adequate documentation or policies/procedures around alcohol use, particularly in relation to staff and residents using alcohol together.

Mr A's care plans and support documents — breach

154. Although Mr A did not complain about his care plan, I have considered its adequacy. Mr A was a resident at the facility for over 20 years. However, the disability service provided HDC with minimal documentation demonstrating how it was supporting Mr A and his needs over this time and in line with the principles of the 'Enabling Good Lives' approach. Dr Howard-Brown advised that the title on the progress records had been deleted and replaced with 'daily life goals'. She said that each form has a date range (some for more than week-long periods) and five resident names with space for a goal and progress notes. Under the progress note heading, there are also various brief entries, some with dates 'but all with no indication of the author or their designation'. Dr Howard-Brown advised that this documentation does not meet accepted practice.

155. Dr Howard-Brown also noted that a timeline for reviewing the goals was not documented, and the overall standard of Mr A's documentation did not meet accepted practice consistently. Dr Howard-Brown stated that her peers would likely consider this to be a moderate departure from accepted practice.

156. Dr Howard-Brown noted the following:

> 'Each resident should have their own running progress record, which is dated and signed with the designation of the author. In my experience, most residential disability services would document more frequently than the examples provided for review. If the service is required to conform to the Health and Disability Services Standards, then the standard of records would not meet these Standards. There were also no records provided for review which indicates a risk assessment and plan is in place …'

157. I accept Dr Howard-Brown's advice and am critical that Mr A's care planning documentation was brief, underdeveloped, and repeatedly contained the same goals with no real progress recorded for years. Mr A was a vulnerable consumer and a long-term resident of the disability service, who required a care plan that evolved over time to reflect his changing needs.

158. I find that the disability service did not have in place a structure that provided safe and appropriate services for Mr A with regard to its care planning and needs assessment. Accordingly, I find that the disability service failed to provide services to Mr A that complied with the Health and Disability Services Standards, and therefore breached Right 4(2)[14] of the Code.

Support person during interview on 18 November 2020 — adverse comment

159. Following Mr D's email to the disability service on 16 November 2020, the disability service asked its solicitor to interview both Mr B and Mr A to gather further information about Mr

[14] Right 4(2) of the Code states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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A's concerns. The solicitor documented that Mr B accepted some of the allegations and concerns made by Mr A; however, Mr B stated that Mr A was exaggerating some aspects of the stated events. The solicitor noted that Mr A would accept an apology from Mr B as a means of concluding his complaint. However, Mr A, in his complaint to HDC, denied that he told the solicitor that he would accept an apology from Mr B and was concerned that he was not offered an independent advocate to support or represent him.

160. Dr Howard-Brown advised that if a provider requests that a resident take part in an investigation in respect of a complaint, it would be usual that the resident could choose whether to participate and would be offered a support person.

161. The disability service told HDC that it attempted to contact the Advocacy Service, but it had the incorrect number, and to speed up the process it decided to go ahead with the interviews anyway.

162. Dr Howard-Brown said that proceeding with the interview without a support person in this instance was a mild departure from accepted practice, particularly as Mr D stated in his email that this was discussed and Mr A was prepared to participate in such a meeting. In addition, Dr Howard-Brown said that the solicitor also noted in his report that Mr A appeared at ease and consented to participate in the process.

163. I accept Dr Howard-Brown's advice. However, I am concerned that the disability service did not make more effort to find a support person for Mr A. I am also concerned that it could not obtain the correct telephone number for the Advocacy Service for Mr A's benefit, and that as a provider of disability services to vulnerable people it did not have the correct number for this service in the first place. The number is readily available on the Advocacy Service's website, and it is not clear why the disability service could not, for example, email the service after discovering that the telephone number was incorrect.

Recommendations

164. Following the cessation of the disability service's contract with the Ministry of Health|Manatū Hauora, the disability service ceased operation as a residential facility. Having carefully considered the repercussions of Manatū Hauora's audit, and the fact that the disability service is no longer operating, with limited communication channels available for Mr B, I make the following recommendations.

165. I recommend that the trustees of the disability service or an individual of similar seniority from the disability service at the time of these events provide Mr A with a written apology for the departures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

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166. I recommend that Mr B provide Mr A with a written apology for the departures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

167. The disability service 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. In taking this action I have considered the multiple significant departures identified by my independent advisor, and that the disability service failed to ensure that Mr B was supported to carry out his role appropriately. In my opinion, the disability service had a responsibility for ensuring that there was a clear demarcation between the professional relationship Mr B had toward Mr A as an employed support worker and the personal relationship the two individuals had shared over an extended period. This lack of clarity and the blurring of roles was a significant contributing factor in the inappropriate behaviour Mr B demonstrated toward Mr A on several occasions. It is worthwhile noting, however, that any aggression shown by Mr B toward Mr A in any circumstance is unacceptable.

168. I have also considered that Mr A, as a vulnerable consumer, was reliant on the disability service to provide him with safe and supportive care, and to respond appropriately to protect him when incidents of concern occurred. In my view, there is public interest in holding the disability service to account for these failures.

169. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Ministry of Disabled People|Whaikaha and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Deputy Commissioner

The following independent advice was obtained from Dr Christine Howard-Brown on 19 September 2021:

'**Complaint: 21HDC00035/the disability service**

I agreed to provide an opinion to the Commissioner on case number 21HDC00035. I have read and followed the Commissioner's Guidelines for Independent Advisors, and am not aware of any conflicts of interest in relation to this case.

My qualifications are a Bachelor of Nursing (Massey University); Master in Business Administration (merit) (Victoria University of Wellington) and Doctor of Philosophy in Medicine (University of Otago). I have extensive experience working in the health and disability sector in a variety of roles including executive and senior leadership, quality audit, service design and service improvement.

I received instructions from the Commissioner to review documents and provide an opinion on whether the care provided to [Mr A] by [the disability service] was reasonable in the circumstances, and why. In particular, there were five areas where the Commissioner sought advice.

1. The appropriateness of [the disability service's] management of [Mr A's] concerns, and in particular:

    a) In response to [Mr A] reporting to the manager that [Mr B] had become violent with [Mr A] one evening after they consumed alcohol together ([Mr A] said [Mr B] put him in a chokehold and threw him up against the wall and onto the bed). In particular, please comment on the adequacy of the investigation undertaken by [the disability service] in response to these concerns.
    b) The incident in which [Mr B] threw wood at [Mr A], after [Mr A] had started a fire in one of the paddocks neighbouring the home.
    c) In response to [Mr A] reporting his concerns to the manager about the way in which [Mr B] had treated him at the gym (please note that [Mr A] told HDC that [Mr B] "treated him like a punching bag" and filmed this behaviour, whereas [the disability service] told HDC that [Mr A] reported to the manager that [Mr B] had "been mean" to him at the gym).
    d) Any other incidents that you consider warrant comment.
    e) The adequacy of training provided by [the disability service], and in particular in relation to treating consumers with respect and consumer rights under the Code.
    f) The overall standard of [the disability service's] documentation.
    g) The adequacy of [the disability service's] policies and procedures, including in relation to complaint and staff conduct.
    h) Any other matters in this case that you consider warrant comment.

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The Commissioner provided the following information for review:

Correspondence

1. Letter of complaint from the Nationwide Advocacy Service on behalf of [Mr A] dated 21 December 2020
2. HDC investigation record from a phone meeting with [Mr B] dated 1 March 2021
3. Email from [Mr D] (clinical psychologist) to [the disability service] dated 16 November 2021
4. Response letter from [the disability service] to HDC dated 21 April 2021
5. Response letter from [the disability service] to HDC dated 30 July 2021

Staff training related

6. [Disability service] Training Register 2019–2020
7. [Disability service] staff meeting records (x6) variously dated between 7 February 2019–14 November 2019

Consumer related records

8. [Mr A], "[A document for residents]" plan dated 4 March 2021
9. [Mr A], progress records/daily life goals variously dated between 4 March 2019–20 December 2020
10. [NASC] authorisation for [Mr A] dated 17 June 2020
11. [NASC] assessment of [Mr A] dated 7 October 2020
12. Incident record in relation to [Mr A] dated 16 March 2020
13. ACC injury claim form in relation to [Mr A] dated 16 March 2020

[Disability service] investigation related

14. [Disability service's] meeting record and findings to an incident (16 March 2020) dated 20 March 2020
15. Investigation report (allegations against [Mr B]) written by [the solicitor] dated 18 November 2020
16. Letter (written warning) from [the disability service] to [Mr B] dated 7 December 2020

Staff member

17. Individual employment agreement [Mr B] dated 1 August 2019 (excludes position description, but names position as residential care officer)
18. Support worker assessment for [Mr B] dated 8 November 2019

Policies and procedures

19. [Disability service] policies and procedures
    a. Rights and choices — decision making/informed consent
    b. HDC Code of Rights
    c. Handbook — a comprehensive reference for all employees
    d. Code of conduct
    e. Induction

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f. Complaints
g. Job Description — Senior House Leader
h. Job Description — Residential Manager

To support the opinions I have expressed, I have relied on the following:

Employment New Zealand Disciplinary Process, available at: Disciplinary process » Employment New Zealand

Workplace Policy Builder, available at: Workplace Policy Builder (business.govt.nz)

Health and Disability Services Standards, available at: https://www.standards.govt.nz/sponsored-standards/health-care-services-standards/?utm_source=MoH&utm_medium=weblink&utm_campaign=HealthStandards

Enabling good lives approach, available at: Key Characteristics - Enabling Good Lives

The Code of Health and Disability Services Consumers' Rights, available at: Code of Health and Disability Services Consumers' Rights - Health and Disability Commissioner (hdc.org.nz)

Contracts and service specifications, Disability Support Services, available at: Contracts and service specifications | Ministry of Health NZ (Note that the provider will have its own copies of the relevant specifications).

Background

[Mr A] lives with an intellectual disability. During the time he lived in a supported residential facility owned and operated by [the disability service], he alleged that a support worker [Mr B] acted inappropriately. In particular, [Mr A] alleges that he consumed alcohol and marijuana with [Mr B] (substances that [Mr B] supplied), that [Mr B] physically assaulted him on several occasions, and that [Mr B] behaved inappropriately in other various ways.

[Mr A] also complained that the incidents were not appropriately managed by [the disability service]. In particular, [Mr A] complained that:

a. When [Mr A] was interviewed by [the disability service's] solicitor he did not understand at the time, that he was being interviewed by [the disability service's] solicitor and did not have his own representation (he was not assigned an advocate or asked whether he wished to bring a support person).
b. [The disability service] did not manage adequately [Mr A's] allegations concerning [Mr B].
c. After [Mr A] raised his concerns, [the disability service] gave him the warning that he may be evicted.

Advice

There are several factors specific to this case that I have considered in providing advice.

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— the timeline for concerns raised by [Mr A] with some being of an historic nature and some only coming to light within the investigation completed at the end of 2020 by [the disability service]
— that the two men were known to each other prior to [Mr B's] employment at [the disability service] and it was difficult to determine whether some events related to a time prior to [Mr B's] employment
— the two men continued to socialise together outside of [Mr B's] hours of employment
— there was also a period of time where the two men lived together whilst [Mr B] was employed (which appears to be related to an event when [Mr A] had to temporarily find alternative accommodation based on a separate … matter).

1. The appropriateness of [the disability service's] management of [Mr A's] concerns

Investigation of alcohol consumption by the pair resulting in violence
There was no incident report related to this event. There was no complaint beyond that made via the Nationwide Advocacy Service to HDC (dated 23 December 2020) by [Mr A]. However, records provided for review included a meeting record dated 28 October 2020 with follow-on dates noted as 29 October, 3 November and 5 November 2020. The record reads as one record where it cannot be determined what content was gathered on what date. Although not explicit, it appears that the author and investigator was … the chairperson of [the disability service]. The record also indicates that [Mr A] was interviewed as part of this complaint.

The meeting record clearly outlines a number of serious allegations which appear to have been raised by another staff member that relate to [Mr B]. This includes reference to supporting [Mr A] to buy and consume alcohol with him; and also drinking with residents. The record does not include any reference to violence associated with alcohol consumption. In respect of alcohol consumption by the pair, it was accepted by [the disability service] that this occurred prior to [Mr B's] employment with [the disability service]. There was an explanation provided by [Mr B] as to the additional purchase of alcohol and "empties" at the property which [the disability service] accepted. The record identified some of the other allegations made were substantiated or partially substantiated.

Peers would consider that actions taken and inactions at the time this complaint was raised, would be a significant departure from accepted practice, particularly as risks were not being managed beyond advising [Mr B] to change his behaviour. Peers would consider these allegations to be serious and the management of the complaint investigation including the absence of onward actions to be sub-standard.

There was also an email sent by [Mr A's] psychologist to [the disability service] on 16 November 2020 bringing to the attention of [the disability service] that [Mr A] had made some serious allegations of physical abuse by [Mr B] requesting [the disability service] take action including notifying the Police and getting assistance from an external interviewer. There is an investigation report dated 18 November 2020 completed by a solicitor engaged by [the disability service] and a resulting formal written warning

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provided to [Mr B] on 7 December 2020 which relates to a number of allegations including that [Mr B] assaulted [Mr A] on more than one occasion and that they had been drunk together including in July 2019. The solicitor's report does not form a conclusion but rather outlines the facts as presented by the two men interviewed separately. This includes that [Mr B] accepted one allegation (related to driving too fast) and that others were not accepted or partially accepted on the proviso by [Mr B] that they had been over stated by [Mr A]. There is no supporting documentation to this investigation provided for review other than a formal written warning.

The resulting formal written warning and its requirements of the employee do not entirely align with the investigation report and usual processes for a disciplinary investigation do not appear to have been followed. Areas that peers would consider do not meet accepted practice are the absence of an incident report(s), complaint information, no terms of reference for the investigation and not following the steps for a fair disciplinary process as per Employment New Zealand. Given the serious nature of the allegations, this would be considered a significant departure from accepted practice. It is recommended that the employer follow Employment New Zealand processes for disciplinary processes.

In addition, if requesting that a resident be part of an investigation in respect of a complaint, it would be usual that the resident have a choice as to whether to participate and be offered a support person. Although attempts were made by management to facilitate this, it did not eventuate and the resident complained about this subsequent to the meeting with the solicitor. This is a mild departure from accepted practice (particularly as [Mr A's] psychologist stated in email correspondence that this was discussed and he was prepared to participate in such a meeting), given the solicitor states in his report that the resident appeared to be at ease and consented to participating in the process.

<u>Investigation of wood being thrown causing an injury in respect of a bonfire</u>
There is an incident form completed for this event dated 16 March 2020 and completed by the staff member on duty at the time. The completed form provides adequate information and was reported to the manager on the same date. [Mr A] was taken for medical assessment by the staff member on duty. The incident form includes the portion completed by the manager that includes reference to an investigation being commenced 17 March 2020. This incident was complicated by [Mr B] being at the property but was not working at the time and taking the action he chose to.

An investigation summary report dated 20 March 2020 includes a summary of information gathered and a conclusion reached by the manager to issue a verbal warning to [Mr B]. The investigation confirmed that [Mr B] had caused an injury to [Mr A]. The Code of Conduct includes any form of physical contact with residents as being unacceptable behaviour and that this can result in a verbal or written warning. The stated self-defence actions taken would not meet an accepted standard of practice. Peers would view the verbal warning as one of the options arising as an outcome from the investigation. Peers would likely, however, also look towards what additional

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training might be needed (e.g. refresher or new training) as this would give the employer confidence that [Mr B] would appropriately handle any similar situations in the future. It would also be usual that the resident, [Mr A], would be given an apology for the incident. This was not a recommendation or requirement arising from the investigation. This would be seen as a moderate departure from accepted practice. Recommendations for improvement relate to improved documentation of the investigation completed, issuing a genuine apology to the resident and considering actions that can be taken that help prevent a future occurrence rather than a verbal warning as being the resulting outcome.

Investigation of an incident of harm (physical and or emotional) and filming that occurred at the gym (including sharing filmed material)
There is documentation in responses to HDC by [the disability service] that indicates the manager was partially aware of this event and, as a result, changed processes that meant [Mr B] would not be attending the gym with [Mr A]. This is consistent with the meeting record dated 28 October 2020. Harm occurring in respect of alcohol use and attendance at the gym was also included within the solicitor investigation report dated 18 November 2020. This clearly states that [Mr A] reported he felt like [Mr B's] punching bag when they were training together.

Peers would likely find this as being a moderate departure from accepted practice not to investigate more fully. However, it is not clear as to whether the timeline for this event was before or after the complaint meeting record dated 28 October 2020.

Other comment
I note that [the disability service] stated complaint acknowledgement letters or complaint responses were not provided for HDC review because there were no complaints raised by [Mr A] in 2019–2020. It appears that allegations were made by another staff member (October 2020), and then by [Mr A's] psychologist on his behalf 16 November 2020 and then separately by [Mr A] in December 2020 via the Nationwide Advocacy Service.

The meeting record dated 28 October 2020 clearly references [Mr A] being interviewed at this time where he was in effect making a complaint to [the disability service]. He again complained through his psychologist in November 2020. Complaints were not managed using a full complaints process. Peers would treat any notification of a complaint as a complaint and provide acknowledgement letters and follow the Code of Rights process. It was noted by [the disability service] complaints by staff were managed informally and that a complaints register had only recently been put in place. Peers would find these factors to be a significant departure from accepted practice.

In summary, information provided indicates the appropriateness of [the disability service's] management of concerns related to [Mr A] were not adequately managed. Peers would consider this represents a significant departure from accepted practice and required standards.

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2. The adequacy of training provided by [the disability service], and in particular in relation to treating consumers with respect and consumer rights under the Code.

A training register (comprising the date, type of training and attendees) was provided for review. It included 15 training sessions offered throughout 2019 and 2020. Of those, eight were attended by [Mr B]. The type of training offered covered a range of topics including privacy, health and safety, code of conduct, behaviour strategies. There was no Code of Rights training offered until 2021. [The disability service] made comment that there had not been Code of Rights training, but discussions are regularly held. There is insufficient information available for review to determine the adequacy of training. For example, the content, duration and how skills learnt or competence is assessed. There is no reference to the trainer and their competence to provide training so it is unclear whether trainers are internal or external to [the disability service]. Peers would consider that most but not all core training requirements are listed. For example, missing is the Code of Rights, Restraint Minimisation and Safety Practice, Abuse and Neglect. Reference to Infection Control related to the policy and not the practicalities such as hand hygiene for example. Most of these topics are required to be provided on an annual basis. Peers would consider the register to be an acceptable summary but only on the basis that other more detailed information would be held. The absence of some core topics would be a moderate departure from accepted practice.

It was noted that in the 28 October meeting record, there were concerns raised as to the training that [Mr B] had received, as raised by another staff member. This record indicates that there had been inadequate training. In a performance appraisal completed of [Mr B] dated 8 November 2019, performance was rated minimal and partially achieved across a range of topics, yet there was no training recommended to support improvements. Peers would consider it usual that training needs would be identified and implemented following performance appraisals and as recommendations arising from complaints. Peers would see this as a moderate to significant departure from accepted practice.

Also provided for review were six records of staff meetings. The duration of these meetings were not always recorded but where this was recorded, the meetings were between 1–1.5 hours. The agenda set for each varied but had a concentration on various policies and procedures. Discussion points on a variety of general staff meeting matters were documented. Peers would consider these records to be typical of staff meetings and a useful way to continue to raise awareness and knowledge of policies and procedures.

3. The overall standard of [the disability service's] documentation.

There are several examples in information supplied for review as to the standard of documentation. Those meeting an accepted standard include staff meeting minutes, the single incident form provided for review.

Those that peers would likely determine do not meet an accepted standard of practice include the absence of or missing incident forms associated with events; the absence of

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or missing investigation reports for serious events; the absence of or missing terms of reference for investigations; the absence of or missing acknowledgements and results of investigations or reviews into complaints made (consistent with the Code of Rights). The standard of documentation for supporting [Mr A] would be considered to be brief and not to an acceptable standard. The [document for residents] plan was dated March 2021. It did not include any prior information as to achievement of goals, there was some incomplete information, goals did not always have timeframes and the plan for each goal was brief and under developed, especially when matched to the … needs assessment which identifies a range of abilities that would enable [Mr A] to have more developed plans to match his goals. A timeframe for reviewing the goals was not documented. The title on the progress records has been deleted and replaced with daily life goals. Each form has a date range (some for more than week long periods) and five resident names with space for a goal and progress notes. Under the progress note heading, there are various brief entries, some with dates but all with no indication of the author or their designation. Documenting this way doesn't meet accepted practice. Each resident should have their own running progress record, which is dated and signed with the designation of the author. In my experience, most residential disability services would document more frequently than the examples provided for review. If the service is required to conform to the Health and Disability Services Standards, then the standard of records would not meet these Standards. There were also no records provided for review which indicates a risk assessment and plan is in place unless the service is relying on the [NASC] documentation to serve this purpose.

Based on the information provided for review, the overall standard of documentation does not consistently meet accepted practice. Peers would likely consider this to be a moderate departure from accepted practice and would recommend following the Health and Disability Services Standards (even if there is no requirement to be certified against the Standards); and the characteristics of the Enabling Good Lives approach. It could also be useful for [the disability service] to form a collegial relationship with larger intellectual disability services and connect in with the Enabling Good Lives work programme if it has not already done this. This would likely assist [the disability service] in strengthening its services and standards of documentation.

4. The adequacy of [the disability service's] policies and procedures, including in relation to complaint and staff conduct.

A variety of policies and procedures were provided for review. Most were contained in the handbook developed for employees. In general, these policies and procedures would be considered to be brief, with some missing standard information. For example, there are no references, some cross references do not match, staff leave doesn't include reference to sick leave. I note that the job description for the senior house leader is not documented to the same standard as the residential manager job description (which provides a better typical example). I also note that the individual employment agreement template is not up-to-date with all current legislative requirements. It is not clear from information provided as to whether there are further policies available to employees that are required to support legislative requirements.

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Peers would likely consider these policies and procedures to be a mild–moderate departure from accepted practice that could be easily improved (and to be compliant) by using the Workplace Policy Builder available through business.govt.nz.

The complaint and staff conduct policies were reviewed in detail as requested by the HDC. The complaints policy and procedure policy statement includes complying with the Ministry of Health contract terms, quality specification and the Health and Disability Services Standards. The procedure incorrectly references the Code of Rights and does not follow the expectations of the Code of Rights. The Health and Disability Services Standards includes a requirement to have an up-to-date complaints register which is not referenced in the procedure. The code of conduct policy doesn't split unacceptable behaviour into misconduct and serious misconduct. The disciplinary policy mentions a distinction between misconduct and serious misconduct with reference to the individual employment agreement, but the individual employment agreement doesn't include this distinction. Code of conduct usually also includes reference to privacy and conflicts of interest which are not explicit in the policy reviewed. Peers would consider these policies are a moderate departure from accepted practice and would result in a partial attainment in an external audit should they be audited. They could be easily amended to be compliant and in doing so provide more guidance to the service. If for example, policies and procedures addressed conflict of interest, it may have been helpful in determining how the relationship between [Mr A] and [Mr B] could have been better managed as conflict of interest and standards of conduct appear to have been a major factor in this complaint. If dissatisfaction or concerns expressed by [Mr A] were treated as complaints and managed consistent with a good complaints policy, then any misunderstandings and resulting escalation may have been avoided.

5. Any other matters in this case that you consider warrant comment.

Professional boundaries were blurred in this case. Peers would consider this as being unacceptable. It is likely a major contributing factor to the complaints as raised.

The [NASC] authorisation indicates that [Mr A] is being funded under a Ministry of Health residential service. Therefore, the standard expected for an individual support plan is set out in the service specification as is minimum staffing requirements. The staff mix and qualifications of [Mr B] are not known from the information provided for review. I would encourage [the disability service] to review the tier one, two and three specifications which will provide direction to the service.

Nāku noa, nā

Christine Howard-Brown

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Addendum 25 November 2021

Following receipt of my advice by [the disability service], further information was provided by [the disability service] which was provided for review. Further comment is made below in relation to that information.

Confirmation by [the disability service] that the manager was made aware of an incident relating to [Mr A] and [Mr B] consuming alcohol together some time after it occurred but at [Mr A's] request did not formally manage this as a complaint as he considered himself partially responsible. This resulted in the manager giving [Mr B] a verbal warning. [The disability service] considered the action of the manager to be appropriate so as not to disempower [Mr A's] management of the incident. However, peers would consider this a significant departure from accepted practice, particularly if [Mr B] was an employee at the time. Certainly an incident report would usually be written for such an event irrespective of whether [Mr B] was an employee or not. The incident report could then have included information as to [Mr A's] preferences in how the complaint was managed and actions taken to prevent a reoccurrence of such an event. It would have also documented any verbal warning. If at the time the incident was reported, [Mr B] was an employee, if a verbal warning was given, this would be documented in human resources records.

[The disability service] stated attempts were made to find a support person for [Mr A] to accompany him to the interview with the solicitor and that the manager offered to be present. Ultimately, [the disability service] stated [Mr A] was comfortable without a support person.

In relation to the bonfire incident [the disability service] stated it would have been professional for [Mr B] to apologise and regrets that [the disability service] did not facilitate this. The absence of onward training for [Mr B] was disrupted due to COVID-19 level 4 lockdown. Most health and disability services, have taken the opportunity to use on-line learning due to pandemic restrictions. This option does not appear to have been considered by [the disability service].

[The disability service] stated it was satisfied with its complaints management process and recent changes had been made in respect of legislative changes that have occurred between 2018 and 2021. Irrespective, if following the Code of Rights and Health and Disability Services Standards, the management of complaints by [the disability service] would be considered a departure from accepted practice by peers.

Further comment about training topics were made and a statement by [the disability service] that it would have been beneficial for [Mr B] to receive additional training.

[The disability service] noted an independent audit of the service had occurred in 2021. As part of the audit findings, policies and procedures were required to be updated and that this requirement had subsequently been met. [The disability service] noted it had received positive comments about the alignment of the [document for residents] plan with Enabling Good Lives.

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Having considered the additional information provided, it has not given cause for me to change my advice.

Nāku noa, nā

Christine Howard-Brown'

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Appendix B: Code of Conduct as provided by the disability service to HDC

CODE OF CONDUCT

PURPOSE:
As an employee of [the disability service] a certain standard is expected of you.

The purpose of this Code is to assist you to know and understand the standards of behaviour expected of you and your employer.

COVERAGE:
This Code applies to all [disability service] employees: permanent full-time and permanent part-time, temporary, casual and staff on contract.

EXPECTATIONS:
[Disability service's] expectations of its staff

The [disability service] expects you to:

Work within the law with honesty and integrity;

Respect the rights of clients and colleagues;

Comply with the policies of [the disability service] and behave in a manner that does not have the potential to embarrass or bring [the disability service] into disrepute;

Provide a quality service at all times to … the clients, the public and your colleagues;

Comply with all lawful and reasonable instructions

STAFF EXPECTATIONS OF THE EMPLOYER
All employers have an obligation to behave in a fair and reasonable manner towards their staff. As a good employer [the disability service] is committed to ensuring that the following staff expectations are met:

Unbiased and open to selection and appointment procedures;

Effective processes for the delivery of information;

Fair rate of remuneration for skill, responsibilities and performance;

Good and safe working conditions;

Adequate training and tools to do your job; including an up-to date job description that provides clear statements of your duties and responsibilities;

Freedom from being harassed or discriminated against in the workplace;

Appropriate disciplinary and dispute procedures;

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The opportunity to seek assistance against unfair or unreasonable treatment by the employer.

UNACCEPTABLE BEHAVIOUR
Behaviour considered unacceptable by [the disability service] includes:

Ignoring or refusing to carry out lawful and reasonable instructions from your manager;

Presenting yourself in an unfit state to work;

Being under the influence of alcohol, illegal drugs or solvents during working hours which interferes with your performance;

Theft, misuse, abuse or unauthorised use of [disability service] funds, resources or property (including telephones, facsimile machines, photocopiers, computers and vehicles) for non [disability service] related activities.

Any form of physical contact with clients that has not been authorised or set out in a behaviour strategy. (inappropriate touching, hitting, smacking, holding hands, kissing)

Inappropriate, obscene or threatening language to clients or colleagues;

Discuss information concerning clients outside the work place

Possession of/resident/employee/[disability service] property without proper authorisation.

Falsification of time sheets, vehicle running sheets or submitting false claims for expenses.

Making unauthorised statements to the media

Failure to notify Manager of inability to commence work at rostered times; habitual late arrival, unsatisfactory explanation of absences; leaving work without authority; or being absent for three consecutive days without notification to The Manager.

Any other acts detrimental to the quality or efficiency of [the disability service] or the safety of clients, staff or visitors.

BREACHES OF THE CODE OF CONDUCT
This Code of Conduct describes the standards of behaviour expected of staff.

Behaviour or actions that are in breach of the Code or are considered unacceptable by [the disability service] will result in disciplinary action against the staff member concerned; such disciplinary action may include dismissal.

Action may be in the form of oral or written warnings in less serious instances, but in some circumstances this may extend to dismissal.

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Appendix C: Ministry of Health | Manatū Hauora, Health and Disability Services Standards NZS 8134.1:2008

An extract from Assessment section

Standard 3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner

The criteria required to achieve this outcome shall include the organisation ensuring:

3.4.1 Service providers seek appropriate information and access a range of resources to enable effective assessment.

3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

3.4.3 Assessments are conducted in a safe and appropriate setting as agreed with the consumer.

3.4.4 Assessment and intervention outcomes are communicated to the consumer, referrers, and relevant service providers.

3.4.5 Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

An extract from Service Delivery/Interventions section

Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessment needs and desired outcomes.

The criteria required to achieve this outcome shall include the organisation ensuring:

3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

3.6.2 Appropriate links are developed and maintained with other services and organisations working with consumers and their families.

3.6.3 The consumer receives the least restrictive and intrusive treatment and/or support possible

3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.

3.6.5 The consumer receives services which:

(a) Promote mental health and well-being;

(b) Limit as far as possible the onset of mental illness or mental health issues;

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(c) Provide information about mental illness and mental health issues, including prevention of these;

(d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

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