

Disability service referred to Director of Proceedings

21HDC00035

A disability service provider has been referred to the Director of Proceedings to investigate if further legal action should be taken. The Deputy Health and Disability Commissioner said there was public interest in holding the service to account for its failures, in a decision released today.

Rose Wall said the service, and one of its care workers, breached multiple rights of a resident under the Code of Health and Disability Services Consumers' Rights. She found several significant departures from accepted practice.

The resident - a man in his thirties at the time - and the care worker, had known each other for around 20 years. Their relationship was characterised as 'brotherly' by the care worker.

The breaches relate to multiple incidents involving the care worker, including the resident allegedly being supplied with marijuana and alcohol, physical violence, a strangulation event, sharing recordings of embarrassing acts, being injured by a piece of wood and unsafe driving.

Ms Wall said, while she was unable to make findings on some aspects of the resident's complaint, there was enough evidence to conclude the care worker acted inappropriately.

"There was a clear power imbalance and Mr B failed to maintain the professional boundaries required of him in his role as a carer," she said. She found that "by consuming alcohol with Mr A, being violent towards him, and driving in a way that made him feel unsafe, Mr B failed to provide services with reasonable care and skill."

Rose Wall was critical of the way the service managed the resident – and another care worker's – complaints, noting it was important that vulnerable consumers, especially those in residential settings, are supported appropriately to complain about the services provided to them.

"They have a right to expect that their complaints and concerns will be taken seriously and managed appropriately. Mr A raised several concerns about Mr B's behaviour with the disability service over time... Despite this, the disability service largely dismissed these concerns and failed to manage them as complaints."

Ms Wall noted the service had failed to act on, or resolve, the man's concerns about the care worker and had denied his right to efficient resolution of his complaints. No evidence was found of training or guidance on clear professional boundaries, nor were there adequate policies and procedures to manage professional boundaries and personal relationships between caregivers and residents in general, she found.

Ms Wall also found that the service did not have a structure that provided safe and appropriate services in place for Mr A for his care planning and needs assessment.

She noted there was a failure to provide services with reasonable care and skill, or comply with professional standards, which was in breach of the Code. The Ministry of Health also audited the facility and did not renew its contract with the service as a result.

The service is no longer operating. Because of this, Rose Wall recommended a trustee, or senior staff member employed at the time of the events, formally apologise to the man.

23 September 2025

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's '[Latest Decisions](#)'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website [here](#).

HDC promotes and protects the rights of people using health and disability services as set out in the [Code of Health and Disability Services Consumers' Rights](#) (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an [animated video](#) to help them understand their health and disability service rights under the Code.

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