Profoundly disabled teenage boy left alone in bath (16HDC00085, 29 June 2016)

Disability service provider ~ Community support worker ~ Respite ~ Policies and procedures ~ Risk management ~ Culture ~ Standard of care ~ Right 4(1)

A teenage boy, aged 15 years at the time of these events, had cerebral palsy, epilepsy, profound intellectual disability, and spastic quadriplegia. He was fully dependent for all cares. A disability service provider provided respite care for the boy at a house where up to six young people at a time received respite care.

One night, two community support workers (CSW) were on an overnight shift together, caring for six high-needs young people. Their shift began at 2.30pm. Their evening duties included signing in the service users for that evening and any medications they brought, making and serving afternoon tea and dinner, administering medications, bathing service users, and assisting them to bed.

The house had two bathrooms, each with a bath. There were instructions for bathing service users, which included, "Never leave the children unsupervised whilst they are in the bathroom area", "full supervision" and "always be present when a person is bathing". However, a practice had developed at the house whereby community support workers would leave children/young people, including this boy, alone in the bath for short periods of time. The boy's personal support information included statements that he must be "supervised at all times" and "cannot be left alone". The boy was not funded for 1:1 care.

One CSW assisted the boy into the bath using the hoist at around 8.20pm or 8.30pm. She assisted with the other service users, including running a bath in another bathroom for another child. She checked on the boy every few minutes. Once the second bath was run, she assisted the other CSW to bring the other child inside and help him into the bath. Both CSWs then left the bathrooms to do other tasks.

At around 9pm the second CSW checked on the boy and discovered that the boy's head was submerged in the water and he was not breathing. The CSWs removed the boy from the bath. One commenced CPR and the other telephoned 111. An ambulance was despatched at 9.02pm and arrived at the house at 9.14pm. CPR was continued until the paramedics took over. The boy was taken to hospital, where he died at 11.58pm.

The boy was vulnerable with high needs, and he relied on the service to provide him with services of an appropriate standard. It was held that the disability service provider failed to ensure that adequate policies and procedures were in place, and complied with, in order to support the boy effectively and prevent him being left unsupervised in the bath. Accordingly, the disability service provider failed to provide services to the boy with reasonable care and skill and breached Right 4(1).

There was a lack of clarity in policies and procedures regarding bathing, and the first CSW did not receive adequate training in caring for the boy. However, she was aware that previously the boy had had a seizure while in the bath, and it was held that it was evident that it was an unsafe practice to leave the boy unattended in the bath. By

leaving him unattended, the CSW did not provide services to the boy with reasonable care and skill and breached Right 4(1).

The second CSW was aware that the boy was left unsupervised. Despite the lack of clarity in policies and procedures, it was evident that it was an unsafe practice to leave the boy unattended in the bath. Accordingly, by allowing the boy to remain unsupervised, the second CSW failed to provide services to the boy with reasonable care and skill and breached Right 4(1).

The disability service provider has made substantial changes since this event. The Deputy Commissioner made the following additional recommendations:

a) Commission an independent review of:

    1. the changes made since this event;
    2. the personal plans and risk management plans for each client at the house to ensure that each contains clear instructions specific to that person; and
    3. the manner in which important information is conveyed to staff to ensure that this accommodates the English reading skills of staff;

    and report to HDC on the findings and any resulting action.

b) With the assistance of an independent reviewer, develop a methodology for allocating staffing levels commensurate to the needs of service users. Provide this information to HDC.

c) With the assistance of an independent reviewer, develop policies and provide training to ensure that community support workers are aware of their ability to access on-call staff at any time. Provide HDC with evidence of the completed policies and training.

The disability service and the CSWs were each asked to provide a written apology to the boy's family.