Disability Service Team Leader, Ms B

Nelson Marlborough District Health Board

A Report by the

Health and Disability Commissioner

(Case 11HDC00877)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. In April 2009, Master A, aged 15 years, was accepted into the care of a community home. Master A is a young man with Down Syndrome and Autism, and he has high needs and is sometimes aggressive. Master A is the only client in the home, and he has two carers with him for 24 hours a day, seven days a week. The carers are managed by a team leader.

2. Within about three months of Master A moving into the home, concerns about the care he was receiving from the team leader, Ms B, were brought to Mr and Mrs A's attention by some of the carers in the house. In December 2009, two carers met with staff at Nelson Marlborough District Health Board (NMDHB) and raised concerns about the care provided to Master A by Ms B, in particular, concerns that she was physically and verbally abusive towards Master A.

3. Following those meetings, NMDHB staff met with Master A's carers and asked them not to swear in the house, and to work through issues "honestly and respectfully". Staff were also advised at that meeting that discussions with staff about other staff, or with family about other staff, were not appropriate and may result in disciplinary action. There is no evidence that the concerns about Ms B's behaviour were formally investigated. Mr and Mrs A were not informed by NMDHB of the carers' complaints and actions taken at that time.

4. Throughout 2010, Mr and Mrs A remained concerned about the care Master A was receiving. In August 2010, one of Master A's carers informed Mr and Mrs A of two incidents where he witnessed Ms B physically and verbally abusing Master A. Mr and Mrs A made a complaint to the Police and to the National Health Board.

5. In September 2010, following the complaint to the National Health Board, NMDHB's Sentinel Event Core Group (the Group) investigated the complaint to identify whether a full Sentinel Event investigation was required. The Group conducted a paper-based investigation into the complaints about the care provided to Master A. No staff were interviewed, and Mr and Mrs A were not involved in the investigation process. The review concluded that the complaints were not substantiated, and it was not necessary to conduct a full Sentinel Event investigation. A further review conducted between August 2011 and April 2012, which involved staff interviews, subsequently found that there was a high probability that Ms B had physically and verbally abused Master A. Ms B is no longer employed by NMDHB.

Findings

6. Considering the totality of the evidence, I find that it is more likely than not that Ms B behaved in a professionally and ethically inappropriate and inexcusable manner toward Master A. In particular, there is strong and compelling evidence that she kicked him, pulled his hair, and was regularly verbally abusive toward him. There are also accounts that Ms B was aggressive when administering Master A's medication, and that she administered medication to him over and above what was charted for him

and/or at times other than the times for which his medication was charted. Ms B's behaviour towards Master A appears to have been intentional, direct, and repetitive. To act in that way was a serious departure from the expected standard of care and showed a flagrant disregard for Master A's rights. Ms B breached Rights 1,[1] 4(1),[2] 4(2)[3] and 4(4)[4] of the Code.

7. I am concerned about NMDHB's response to the serious concerns that were brought to its attention in December 2009. In particular, I am concerned that no formal investigation was carried out, that staff were left concerned for their jobs if further concerns were raised, and that Mr and Mrs A were not informed by NMDHB of the complaint and actions taken in response to that complaint. I also consider that NMDHB's investigation in September 2010 was inadequate. In my view, it is difficult to justify a decision to conduct only a paper-based review in response to serious allegations of abuse of a vulnerable consumer.

8. In my view, NMDHB's response to the concerns raised about the care provided to Master A fell well short of the expected standard, and its failures in that regard put Master A's safety at risk. NMDHB breached Rights 4(1) and 4(4) of the Code for failing to adequately respond to concerns about Master A's care, and breached Rights 1 and 6[5] for failing to provide Master A's legal guardians with adequate information.

9. Ms B and the NMDHB have been referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

10. The Commissioner received a complaint from Mr and Mrs A about the services provided to their son, Master A, at a community home. An investigation was commenced on 30 November 2012, and the following issues were identified for investigation:

- *The appropriateness and adequacy of the care provided by Nelson Marlborough DHB to Master A between April 2009 and April 2012.*
- *The appropriateness and adequacy of the care provided by caregiver Ms B to Master A between April 2009 and April 2012.*

[1] Right 1 of the Code is the right to be treated with respect.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] 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."
[4] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."
[5] Right 6 of the Code is the right to be fully informed.

11. The parties directly involved in the investigation were:

Mr A	Complainant
Mrs A	Complainant
Master A	Consumer
Ms B	Provider, team leader
Nelson Marlborough DHB	Provider
Mr C	Provider, carer
Ms D	Provider, carer
Mr E	Provider, carer

Also mentioned in this report:

Ms F	Support worker
Dr G	Acting Chief Medical Advisor
Mr H	Business Development Manager
Ms I	Team manager
Mr J	Carer
Mr K	Manager
Ms L	Carer
Ms M	Human resources advisor
Mr N	Team manager

12. Information was also reviewed from: Ms F, the Ministry of Health, Dr G, and Mr H.

Information gathered during investigation

Summary of events

Background

13. Master A was born with Down Syndrome and has Autism. Master A has high needs and, since the age of 8 or 9 years has been unable to be left unattended. Master A often damages property, and is liable to attack members of the public without warning. Master A communicates through sign language, and expresses frustration through physical actions including violence and aggression.

14. Master A lived with his parents, Mr and Mrs A, until he was 15 years old. Because of Master A's high needs, his family investigated their options for support in caring for Master A, including additional in-home support and out-of-home placement. Following a family group conference in February 2009, Master A was approved for out-of-home placement, which the family accepted. In April 2009, Master A moved into the care of a community home operated by a disability support service (the

Disability Service).[6] Master A is the only client in the home, and he has two carers with him for 24 hours a day, seven days a week.

15. The house is staffed by support workers, who are managed by a team leader, who also provides care at the house. The team leader reports to a team manager, who then reports to a service manager. At the time of the events under investigation, the team leader was Ms B, the team manager was Ms I, and Master A's carers included Mr J, Mr C, Ms D, Ms F and Ms L.

16. This report is specifically concerned with NMDHB's management of, and response to, complaints made that Master A was the subject of verbal and physical abuse by Ms B at the house. It considers the roles and responsibilities of Ms B and NMDHB.

Complaints that Master A was being abused

Family concerns

17. Mr and Mrs A advised HDC that they met the staff responsible for caring for Master A before he moved into the house. In addition, Master A had an outing with the carers, including Ms B, before he moved in. During the outing, there was an incident involving Ms B and Master A, which left Ms B injured. Mr and Mrs A advised HDC that they were disappointed that the incident happened, because the psychologist and other carers were present at the time. Mrs A advised HDC that the incident "was quite significant at the time", and she was "surprised" that Ms B "was going to continue" caring for Master A once he moved into the house.

18. Mr and Mrs A advised HDC that, on the advice of a psychologist, they did not visit Master A during his first three weeks at the house. Mr and Mrs A stated that, when they started to visit Master A after those first three weeks, they "[i]mmediately … started to have problems with [Ms B]". Mr and Mrs A advised HDC that they would visit Master A regularly, and Ms B "became quite unusual", for example, she started commenting that the family visits were unsettling Master A. Mr A advised HDC that, at that time, he and his wife "were quite concerned at that attitude". Mr and Mrs A also recalled two incidents where their access to Master A was restricted by the Disability Service, including that staff would remain at the family's house during Master A's home visits and, at one stage, Master A's home visits were suspended without warning or explanation.[7]

19. In addition, Mr A advised HDC that within about three months, he and his wife heard "murmurings of discontent and problems at [Master A's] house". Mr and Mrs A said that concerns were brought to their attention by Master A's carers when they were visiting Master A. Mr A recalled hearing from the carers that Master A was being referred to as an animal, that excess medication was being dispensed, and that Panadol was being used as a sedative. Mr and Mrs A recalled a carer saying to them, "If CYF[8]

[6] The community home is a division of Nelson Marlborough District Health Board, but provides services on a contractual basis directly with the Ministry of Health. It provides residential support, day services and respite care for people with an intellectual disability. Mr and Mrs A advised HDC that the Disability Service was the only provider able to offer out-of-home placement in their area.
[7] The home visits were reinstated after a subsequent Family Group Conference.
[8] Child Youth and Family (a service of the Ministry of Social Development, NZ).

knew what was going on in [the] house, [Ms B] would be fired," and another carer saying "Things aren't good here." Mr A said that he was assured by staff that they would raise their concerns with management, and Mrs A said, "After this, we waited. We thought 'phew' something is going to happen."

20. Around the middle of 2009, Mr A contacted Manager Mr K and Team Manager Ms I. Mr A was advised that no complaints had been made. Mr A recalled that, although Ms I accepted that she was aware that Master A had been referred to by staff as an "animal", she attempted to justify it and said that the use of the term to describe Master A was "unfortunate" and "inconsequential". Mr and Mrs A said that they were not offered an apology.

21. Mr and Mrs A advised HDC that they recall the carers being concerned about their jobs if they raised concerns with management. Mrs A advised HDC:

> "Looking back we were naïve to trust management. We just expected that management would sort out the issues taken to them by the staff. When we did finally talk to [Mr K] sometime later, it was clear to [my husband] and I that nothing had been done … The lack of response from the management was very disappointing because it was obvious to [us] that there were problems in [the] house. We just did not know the details at that stage."

Concerns raised with management

22. On 14 December 2009, a support worker, Mr J, met with the Human Resources (HR) Advisor, Ms M, and Ms I to discuss his concerns about Ms B's behaviour at the house. The notes of the meeting record that Mr J complained that Ms B was verbally aggressive towards staff, and that he described an incident on an outing in April 2009 where Ms B allegedly assaulted Master A.[9] Mr J advised that he was not present when the alleged incident happened, but that he had been told about it by another support worker, Mr C. Mr J understood that Ms B had "laid the boot into [Master A] and [given] him 2 slaps". During the meeting, Mr J also reported that, on 14 April 2009, Ms B dragged Master A backwards, used the rumpus room for "time out", and had Master A up against the wall with both hands around his throat. Mr J also alleged that Ms B gave Master A his medications early one day, at 7.30am and again at 11am, so that Master A would not "act out" on her shift.[10]

23. On 17 December 2009, Ms M and Ms I met with Mr C to discuss the alleged abuse. The notes of the meeting record that Mr C was asked whether he had seen any violence towards Master A by staff, and that Mr C had advised that he had not witnessed any "pre-meditated aggression", but that he had "seen [Master A] be restrained, blocked with more aggression than was required". Mr C described an incident involving Ms B, and also said that Ms B and Mr J did not get on well. The notes of Mr C's description of the incident involving Ms B are as follows:

[9] This alleged incident took place during the three weeks following Master A's arrival at the house, when his parents were not visiting him (having been advised not to by a psychologist).
[10] Master A's medications should have been given at breakfast and at lunchtime.

> "Person followed through with … moved from passive to aggressive. Being targeted with more aggression, [Master A] kicking full force, fell over. Person crouched over the person — moment of retaliation — stance, body language — no violence or follow through. [Master A] not injured. [Ms B] did that. [Master A] deliberately targeting … [Master A] trying to bite him/head butt. Foot swiped him — didn't drop. Held onto upper body. Turned and charged [Ms B] …"

24. At the meeting on 17 December 2009, Mr C described Ms B as "not malicious", but "aggressive". Mr C referred to incidents where Ms B was "forcing meds in yoghurt down [Master A]", "Swearing at him 'you fucking aggressive bastard'", and that "[Ms B] has 40 minute showers. [Master A] then wants toilet — on floor — [Ms B] gets cross with him". Mr C raised concerns about Ms B's suitability as team leader.

25. Mr and Mrs A provided HDC with a letter dated 18 January 2010, addressed "To whom it may concern" from an unidentified support worker from Team 2.[11] The letter states:

> "During the past couple of months at [the house] I have seen and heard a couple of things involving Team Leader [name blacked out] that concern me.
>
> The first was in my first few weeks when I was comparing some of [Master A] acting out I had seen with that of my partner's kids behaviour when they don't get their own way. [Name blacked out] told me I couldn't compare [Master A] to my partner's kids as [Master A] wasn't human. I spoke to [name blacked out] about [name blacked out] comment on the next shift. He suggested I [fill out an incident form]. Knowing how he felt about [name blacked out] I ignored his suggestion at the time.
>
> On all shifts I have worked with [name blacked out] and she has given [Master A] fish and chips for lunch. I have asked why and been told by [name blacked out] it keeps him happy. Talking to other staff in the house this is what she does. My understanding is that [Master A] has certain dietary requirements and chips every lunch time isn't part of it. When [name blacked out] isn't on duty [Master A] still expects chips and telling him no has resulted in [Master A] acting out on many occasions."

Response to concerns

26. On 21 January 2010, Mr K and Ms I met with staff at the house, including Ms B, Mr J and Mr C. The notes from the meeting record that Mr K spoke to the team about conflict in the home and the need for consistency of support for Master A. In particular, the notes record that the team needed to work through issues "honestly and respectfully", that "[t]eamwork issues include trust and respect for each other — does not include talking behind people's backs", and that there was to be no swearing in the home.

[11] The name of the author of the letter has been blacked out.

27. Mr K's notes for the 21 January 2010 meeting record: "Be aware that if you make false allegations about a person then that person can take a civil action against you. Discussions with staff about other staff or with family about other staff are not appropriate and disciplinary action will be taken should this occur." Mr K's notes also record: "Note this does not mean that if you have a genuine concern that you should not raise this with your team manager appropriately using a incident form, when incidents occur stating facts as you know them not what someone has told you." Mr K's notes also record that staff were told that swearing would not be tolerated, and he noted: "It seems to me that you are spending more time worrying about what each other is doing than actually doing your job."

28. Ms B received coaching regarding her personal interactions with staff.

29. Mr and Mrs A were not informed of the above complaint and investigation; however, they subsequently found out through a support worker from Master A's house.

Family express further concerns

30. Mr and Mrs A advised HDC that, over time, they noticed changes in Master A. For example, he became more aggressive, was signing for his Dad, and was allegedly crying often, which they were not told about at the time. Mr and Mrs A advised HDC that, prior to this, Master A "would never cry", and that when they heard that he had been, they "were very surprised" and "shocked". Mr and Mrs A recalled that, when they asked Ms B about Master A's crying, she told them "it was hormones". Mr and Mrs A also stated that, in 2010, when Master A got angry, "he would pull his hair and then he would 'go off'", which was not something he did previously.

31. Mr and Mrs A recalled that Master A's carers told them that they had been told not to talk to Mr and Mrs A, because to do so would be unprofessional. Mrs A advised HDC:

> "So we respected that. This is another thing where we were totally ignorant and naïve about. We respected those wishes and all we said was 'How was [Master A] today'. But we never asked the details. We didn't ask the questions. We just expected that they would be all working these problems out. We didn't know that everyday [Ms B] was calling [Master A] an 'F … ing blah blah blah and that he had been grabbed around the throat and he had all these other things happening to him regularly."

32. Mrs A further advised HDC, "I just expected [NMDHB] to clear it up and that is what is so hard …"

33. On 29 March 2010, in an attempt to gain further information about what was happening at Master A's house, Mr and Mrs A made a request to NMDHB under the Official Information Act, for copies of the Incident Forms relating to Master A's care. The letter that Mr and Mrs A sent to Ms I requesting the information stated, "[W]e are extremely concerned about what has been happening in [the] house and are continually picking up information about aspects of [Master A's] care that is disturbing. We asked you at our last meeting that these issues would to be addressed

[sic]". The letter further stated, "carers have told us on more than one occasion that they are not to divulge any information to us about [Master A's] care."

34. Mr and Mrs A recalled that they found it difficult to access the information requested and needed to engage the assistance of a lawyer for the purpose.[12] They recalled that, when the information was provided, it did not match the information provided to them by Master A's carers regarding the nature and number of reported incidents involving Master A. Mr A advised HDC:

> "What we noticed was that they were all non important instances like '[Master A] fell over' or '[Master A] threw something' or '[Master A] had a bad toileting issue'. None of the things that we had been hearing from the staff. So we said to the staff there is nothing there and they said 'we put in heaps of forms'. In fact one of the staff members said 'I was notorious for putting in about 10 a day' … He said there must be heaps of mine there. And also [Mr C has] written a … report about the [outing] thing and that wasn't there. So we became very suspicious, as you would do, that someone had, and it had to be the team leader [Ms B] (as all the [incident] forms go past her desk), and so we felt quite sure in our own mind she was throwing out the ones she didn't want recorded."

35. On 30 April 2010, following Mr and Mrs A's request for the Incident Forms relating to Master A, Mr K wrote to Mr and Mrs A and invited them to meet with him to discuss any concerns.

36. On 7 July 2010, Mr and Mrs A met with Mr K and Ms I. Also present was a Health and Disability Advocate.[13] Mr and Mrs A advised HDC that, at the meeting, they asked whether any information about Master A's welfare had been brought to Mr K's and Ms I's attention, and they recalled that they were advised that one complaint had been made, but that it was unsubstantiated, and that any discussions relating to that complaint were confidential.

37. Mr K's notes of the 7 July 2010 meeting do not record a discussion about a complaint being made and investigated, but do record that a discussion took place "on how the service works to prevent abuse including sexual abuse of people supported by [the] DHB", and that "[t]he service makes every endeavour to ensure staff we employ are safe and have no tolerance for any form of abuse". Mr K's notes of the meeting also record:

> "[Mr K] emphasised that any specific concerns will be addressed when raised and impartial investigation made, it may not always be possible to share the specifics

[12] In response to the provisional opinion, NMDHB advised that it provided to Mr and Mrs A all the information that it legitimately could. It advised that some of Mr and Mrs A's requests did not relate specifically to Master A, for example, there had been complaints from staff in the house related to Ms B's attitude towards them as employees, and this was not information that Mr and Mrs A were entitled to. NMDHB advised, "[Master A's] records have always been made available to his mother and father."

[13] Mr and Mrs A advised HDC that they were not told about the Health and Disability Advocacy Service prior to that time.

or consequences to family but we will acknowledge and inform when things have not been done as they should have been and advise at any time of [Master A's] wellbeing."

38. The Health and Disability Advocate's notes of the meeting record:

"Met with Manager of [Disability Service] [Mr K], Team Leader [Ms I], [Mr and Mrs A] and Advocate. Lively discussion was held around the concerns of the family re their son [Master A's] care. While it was hard for them to voice specific concerns it was established that they were:

1. Lack of good male carers for [him]

2. Concerns over Team Leader ([Ms B]) and her role of managing staff and the house. It would appear that some staff have been communicating inappropriately with the family about staffing issues which of course puts the family in an uncomfortable position.

3. It was identified that effective communication was an issue.

The outcome was as follows: The provider will include family in [Master A's] ILP meetings which occur 2 monthly. The house meetings will be held every month and family will be invited to be part of this, as this is a good venue to raise issues of concerns. The Team Leader will ring the family and advise of staff changes as appropriate. The Manager will discuss with staff about effective communication and clear documentation. Although this complaint is to be closed, the family will ring Advocacy in three months to report back that these things are happening."

39. Mr and Mrs A advised HDC that, in approximately July 2010, they met with Support Works and told Master A's case manager and the Support Works manager of their concerns about Master A's safety. Mr and Mrs A recalled that it was proposed that a meeting be arranged with the DHB, but no such meeting happened at that time.

40. On 19 July 2010, Mr A wrote a note,[14] which stated:

"We had heard that there had also been complaints from staff about what had been happening in the home. One of the managers present, [Ms I] confirmed that there had been meetings with some staff with concerns but I would not be given any information about what these concerns were. I was told that these matters come under the umbrella of staff confidentiality. I strongly objected but could make no movement on the disclosure of this hugely critical information about my son.

The communication has become an, us and them scenario, which is extremely sad and has caused our family considerable heartache and pain.

I only want to know the truthful facts of my son's life and in particular all incidents or problems associated with his house that may detrimentally affect him.

[14] There is no notation as to whom the note is addressed. It is headed "From [Mr A] [Address] 19.7.10".

> My son is 16 years of age and is Autistic/Downs Syndrome. He cannot speak and is extremely vulnerable. He is greatly loved by our family and is only in a community home because of his huge needs. His attachment to our family is critical for his wellbeing therefore we need to have easy access to information about his care. He requires 2 carers 24/7. Please help us."

41. On 23 July 2010, Mr and Mrs A wrote a complaint letter, although it is not clear who the complaint letter is addressed to. The letter states: "There has been an obvious and deliberate unwillingness to allow us to have access [to] any information in relation to our son [Master A]." It further states:

> "Earlier this year we heard that [Master A's] house manager [Ms B] referred to [Master A] as an animal. We took this complaint to [Ms I] and was told that in context the statement was not so bad and that the word used was quote; 'unfortunate'. We were not happy at all with this outcome and particularly with the justification. …
>
> Soon after this in April this year we heard that staff had major concerns regarding [Master A's] treatment at his house. This includes [Master A] being sworn at. What the other concerns relate to we did not know but one carer said to us that if CYFS was involved the information uncovered would be hugely serious.
>
> …
>
> We tried vainly to express our concerns to [Mr K] but made no headway at all. Ironically we were castigated for not being specific, however that is why we were there, — to ask what management knew from staff to be a concern in relation to [Master A]. The information we had heard was that there were serious issues in relation to our son's safety and care and that staff were going to take their concerns to management. We asked [Mr K] and [Ms I] several times what these concerns were and how do they affect our son's wellbeing. We were told that only one complaint has been made about the team leader in [Master A's] house. After investigation by [Mr K] the conclusion was that the complaint did not prove to be valid or true. We raised the issue of the animal statement and were met with blank looks.
>
> We said that there had been more. We knew that. Eventually it was agreed staff had raised concerns and some had even been to [Human Resources] with complaints. We were told access to this information in relation to these discussions was covered by 'staff confidentiality' and we would not be given any information regarding the content of the staff concerns.
>
> Were any of these discussions relating to ill treatment of our son?
>
> …
>
> When we went to [Ms I] about the 'animal' incident she was already aware of it … There is no justification whatsoever for a team leader to speak in such a way to a

> very vulnerable special needs child. Why had we not been told? Why is there no apology or consequence to this behaviour?"

42. Mr A advised HDC:

> "I said to staff sometime in 2010 the animal thing had come up and I said yes, that was terrible that [Master A] was called that, and they said 'no that is not correct. He was called an f…ing evil animal regularly'. He was called 'inhuman'. So the staff were just strong enough to leak out the animal bit because they were so fearful of losing their jobs, because there was such a culture there that if you spoke out and criticised in any way it was like a, what's the word I am thinking of, it is like a pact where you don't leak information out."

43. In response to the provisional opinion, NMDHB advised that, at that time, no staff had raised concerns with the DHB about Master A's care and treatment in the house. As such, it is not correct to say that there were any deliberate attempts to withhold such information from Mr and Mrs A.

Family receive additional information and make complaint to external agencies

44. Mr and Mrs A advised HDC that, "in desperation", they asked Mr C to visit them at their home and tell them what he had seen. Mr C met with Mr and Mrs A on 1 August 2010, and advised Mr and Mrs A of two incidents involving alleged abuse against Master A. Mr C said that he witnessed an incident during the first week of Master A's care on an outing, when he saw Ms B attack Master A, kick and punch him, and swear at him. Mr C advised Mr and Mrs A that at the time, he assisted Master A and asked Ms B to sit in the van. Mr C advised that he completed an incident report for the event, but that it may have gone missing. Mr C also advised Mr and Mrs A that another carer had informed him that Ms B had held Master A against a wall by his throat on one occasion when Ms I was in the house. Mr C also recalled that Master A was allegedly locked in a room at that time.

45. Mr and Mrs A recall that, during the above meeting, Mr C informed them that all staff involved in Master A's care had been told by management that, if they discussed information in relation to Master A's care with Mr and Mrs A, it could result in legal action being taken against them. Mr C also informed Mr and Mrs A that they had been told that Mr and Mrs A were personal friends with management, and therefore any information from the house would get back to management and endanger the carers' employment.

46. Following the above meeting, Mr and Mrs A complained to HealthCERT[15] and the National Health Board about the care provided to Master A. Mr and Mrs A also referred the matter to the Police for investigation.

[15] HealthCERT is responsible for ensuring hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

First DHB investigation carried out

47. On 31 August 2010, the National Health Board contacted NMDHB outlining concerns raised with it about Master A's care. The complaints that had been brought to the attention of the National Health Board included: the allegation that Team Leader Ms B had kicked and punched Master A on an outing; Master A was being locked in the garage so staff could have meetings; staff who made complaints had been removed from Master A's care while Ms B remained; Ms B painted a picture of a parent sexually abusing Master A; the house where Master A lives smells of urine;[16] complaints have been made to the DHB and referred to the Family Group Conference; the Service Manager expressed confidence in Ms B after concerns were raised; repeated abuse by staff and ongoing risk to Master A; incident reports were being deleted, removed or destroyed; and that deep scratches on Master A's back and hands were caused by staff.

48. On 23 September 2010, the NMDHB Acting Chief Medical Advisor, Dr G, wrote to the National Health Board to advise that an "extensive investigation" had taken place in response to Mr and Mrs A's concerns. Dr G advised that the complaints had been referred to "the core sentinel event investigation group" given their serious nature. NMDHB advised HDC that the role of the Core Sentinel Event Investigation Group (the Group) was to investigate the issues surrounding the complaint with a view to identifying whether a full sentinel event review was required or not. Dr G, who was the Group's Chair, advised that the Group obtained and reviewed all documentation pertaining to the provision of care to Master A by the Disability Service from April 2009 to September 2010, including all reportable events. The review process, which was a paper-based review and did not include staff interviews, concluded that there was no evident basis for the specific concerns raised about the care provided to Master A. Accordingly, the complaint was not referred for a full sentinel event review. Dr G advised HDC that the Group's investigation was stymied by the lack of evidence to substantiate the allegations, and the Group was "falsely reassured" that the concerns had been investigated adequately. Dr G advised HDC that the Group was also aware at that time of the Police investigation. She stated that if the Police had found the charges to be proven at that time, the Group would have reconsidered the decision to conduct a sentinel event review.

49. In her letter to the National Health Board, Dr G noted:

> "Nowhere in either the incident reports or [Master A's] [Disability Service] daily records was there any documentation regarding the alleged incident involving staff member [Ms B] kicking and punching [Master A] while on [an outing] last year. Nor was there any other information indicative of [Master A] being ill-treated by [Ms B] or other [Disability Service] staff. In fact to the contrary, a recent report authored by [CYFS] dated 10 August 2010 concluded as follows: '… with the skills, commitment and experience of [Ms B] and her team it appears that [Master

[16] Mr and Mrs A advised HDC that they complained that the house smelled of urine, and "It was so strong and it would come up the hallway and into the lounge. It was terrible", and that it took about three months to have the issue addressed.

A's] unique needs are being very well catered for by [the Disability Service]…'."[17]

50. Dr G further advised the National Health Board:

(a) Due process had been followed by the Disability Service and NMDHB Human Resources in December 2009, when it was alleged that [Ms B] had assaulted [Master A] by kicking and punching him while on [an outing], and appropriate action was taken. The allegation "was investigated appropriately and found to be based on [hearsay] by the complainant who did not witness the alleged incident". Dr G noted that no witness came forward, and none of the staff spoken to during the investigation was able to verify that the alleged incident occurred. She also noted that staff work in pairs with Master A, "so it would be highly unlikely that behaviour of the type alleged to have occurred by [Ms B] would have gone un-noticed".

(b) There has been no evidence from the initial investigation, the Disability Service records and other documentation pertaining to Master A, including the incident reporting system, that Master A has been physically or verbally abused by Ms B or any other Disability Service staff member. There is no indication that Master A is at ongoing risk of abuse.

(c) The garage is a rumpus room, which is used by Master A for quiet or private time. The room is locked from the inside, to leave Master A in control. Staff meetings were usually held when Master A was at school, because it was not practical to have them when he was at home.

(d) Changes in staff working with Master A were unrelated to complaints.

(e) Ms B used a picture relating to urination as a means of reinforcing positive behavioural gains to improve Master A's toileting behaviour. The use of drawings is a common communication modality used by staff working with individuals with intellectual and developmental disabilities like Master A's, and it is possible that Mrs A misinterpreted the picture to be of a sexual nature.

(f) There had been an issue with the house smelling of urine secondary to Master A's incontinence and inappropriate toileting, but that has since been rectified by covering the affected floors.

(g) When the family raised concerns about Master A's management, those concerns were discussed at a meeting called by Mr K on 6 July 2010.[18] "The Family Group Conference is considered the appropriate forum to raise family concerns regarding [Master A's] safety and welfare."

(h) The Disability Service staff use the NMDHB electronic reportable event system to log incidents. Paper records are filled out then "logged" electronically, and thereby transferred to the electronic database. The original paper copies of the incident forms pertaining to Master A for the duration of his residence with [the Disability Service] have been reviewed in tandem with the electronic reportable events, and there was only one discrepancy between

[17] Mr and Mrs A expressed their concern to HDC that CYFS' statement was taken out of context, as the statement was made in the course of a review of the service that was not related to complaints concerning the alleged abuse of Master A.

[18] The meeting took place on 7 July 2010.

the two, which was where there was no corresponding paper record for a reportable event that was recorded electronically. "There is otherwise no indication that incident reports have been tampered with in any way or destroyed by staff as alleged."

(i) Master A reportedly got his finger caught in his bedroom door on 23 August 2010 when he was pulling against it, which caused his skin to tear. Master A returns from school on occasion with scratches sustained during periods of restraint, and Master A has a tendency to "punch out" at the interior of the van and in the home, and may have sustained his scratches as a consequence of that behaviour.

51. On 28 September 2010, the Ministry of Health Contract Relationship Manager, Disability Support Services, wrote to Mr and Mrs A noting that the NMDHB internal review concluded, following an "extensive investigation", that there was no basis for the specific concerns raised by them, including that incident reports had been tampered with. The Contract Relationship Manager noted that NMDHB's "review team" considered that the allegation of abuse was "investigated appropriately", and that the Police were separately investigating the allegation that Master A was assaulted.[19] She also noted in her letter: "Unless you [are] able to provide additional evidence that will support your allegations — the Ministry is unable to pursue that matter further."

Further concerns raised

52. Mr and Mrs A advised HDC that they requested a copy of Dr G's report from NMDHB by telephone and by written letter, which Mr A hand-delivered to Dr G's office. Mr A recalled that he did not receive a response or a copy of the report until he said that he would refer the matter to the Ombudsman, which was some months after the initial request was made.

53. Mr and Mrs A do not agree with Dr G's report, and have concerns about the quality of the review, including that it was paper-based and they were not informed of the investigation or involved in it. Mr and Mrs A continued to be concerned about the care Master A was receiving and believe that the report left many issues unresolved. They also expressed their concern to HDC that Ms B was not removed from the house during the Police investigation in 2010.

54. In November 2010, Mr H was appointed to the position of Business Development Manager at NMDHB. He advised HDC that he was briefed about the Police investigation into Ms B, which was then ongoing, and advised that the plan was to wait for the outcome of that investigation before determining what, if any, further action was required. When asked by HDC what action he took at the time to ensure that Master A remained safe at the house from November 2010 to January 2011, Mr H advised that no direct action was taken in relation to Ms B at that time, although staff

[19] The Police file was closed at some stage (although it is not clear when or whether it was closed in 2010 or 2011) because Master A's support staff were unwilling to make statements, and therefore the Police had insufficient evidence to progress the investigation. However, evidence was later obtained by the Police, and a conviction pursued.

were being supported by an external psychologist regarding strategies to deal with Master A's aggressive behaviour.

55. In January 2011, Mr N was appointed as the team manager at the house, and Ms B was moved to another house. Mr H advised HDC that the decision to move Ms B was made following an altercation between Ms B and Mrs A, as well as because of concerns about Master A's safety.

56. Mr and Mrs A advised HDC that Mr N had a good ability to manage Master A, and that Mr N made the house function well, which they felt relieved about. Mr and Mrs A recalled that Mr N advised them that it was "very, very common" for a complaint to be responded to "by strong counter claims" at the Disability Service.

57. Mr and Mrs A advised HDC that they tried to arrange a meeting with the Operations Manager at NMDHB, but it took some time for a meeting to be arranged.

Further meeting with NMDHB

58. Mr H advised HDC that in August 2011 he became aware that the Police had closed its investigation, and that staff had not been willing to make statements because of concerns about their future employment. At that time he made a decision to meet with staff and offer to support them to make statements.

59. On 31 August 2011, Mr and Mrs A met with Mr H and Dr G. The notes of the meeting record that Mr and Mrs A "wanted to know what had been going on with [their son]", as they had been told by staff (support workers Ms D, Mr J and Mr C) that there were concerns "at what was happening to [Master A] [by] [Ms B]". Mr and Mrs A advised that, by that stage, they had no trust or confidence in Mr K or Ms I, "as [they] believed they were covering up". In response to the provisional opinion, NMDHB advised that it was not "covering up" information. It advised that, at the August 2011 meeting, it became apparent to the NMDHB representatives that Mr and Mrs A were privy to information from staff in the house that NMDHB did not have.

60. The notes of the 31 August 2011 meeting record that Mr and Mrs A agreed to Mr H's suggestion to offer staff "immunity by providing amnesty and an advocate so they can make statement to NMDHB and the Police (sic)". During the meeting it was also noted that Mr and Mrs A "had issues" with Dr G's report.

61. Also on 31 August 2011 (following the above meeting), Mr H met with Mr K, Mr N, and Master A's carers, including Mr J and Ms D. The notes from the meeting indicate that there was discussion about the concerns raised by staff, the Police investigation, and that no staff were prepared to make statements to the Police because of concerns about repercussions. Mr H advised HDC that, at the meeting, the support workers confirmed to him their fear of the consequences should they make statements. Mr H said that he reassured the carers that NMDHB policy required them to speak out and that, providing they were honest and had not themselves committed serious misconduct, there would be no consequences for their employment. It was noted that there was discussion that allegations of abuse are taken very seriously, and that it was concerning that staff felt able to discuss their concerns with Master A's family, but

not the organisation. Mr H advised the meeting attendees that "the [organisation] has clear policies [especially] around abuse", and that "part of our policy relies on disclosure to Police", and he reminded the meeting attendees of the "whistle blowing policy".

62. The notes from the 31 August 2011 meeting also record that, at that meeting, Mr J discussed his concerns regarding abuse and medication administration. The notes record that Mr J said that he spoke to Human Resources about his concerns at the time but that nothing happened and, as a result, his credibility was challenged. The notes of the meeting also record that Mr J stated: "[Ms B] told us to lock [Master A] into the rumpus room left him there." Mr J also stated that Master A was controlled with fast food. The notes of the meeting record that Ms D noted that she "got told to keep [her] mouth shut". Ms D is recorded as having stated at the meeting that Ms B was aggressive, swore at Master A and said he was "not human", was "drugging [Master A] with panadol", and that there were other incidents involving hair pulling. Ms D is also recorded to have said that she "went to [Ms I] a few times", but that she "felt that [she] got 'flogged away'".

63. Following the meeting, Mr H made an independent legal advocate available to the carers to assist them to write statements for NMDHB and the Police, and he commenced an investigation into the concerns raised about Master A's care, which included interviews with key staff. Ms B was suspended pending the outcome of Mr H's investigation.

Information gathered during Mr H's investigation

Information from Mr C

64. On 14 October 2011, Mr H spoke to Mr C and read to him the notes of his December 2009 meeting with Ms M and Ms I. Two days later, Mr C emailed Mr H to advise that the notes of the December 2009 meeting "did not quite match [his] own recollection of events". On 14 November 2011, Mr C emailed Mr H and advised as follows:

> "I emailed, spoke on the phone and met with Ms I several times regarding [Ms B's] treatment of [Master A].
>
> I was very uncomfortable with some of her actions [and] this was made clear to [Ms B], [Ms I] and to HR during the time with the company. I also answered honestly and fully the questions from the police and [Master A's] parents.
>
> I witnessed [Ms B] strike or attempt to strike [Master A] in a sustained way on at least three occasions. Once [on an outing], which you referred to on the phone, where she bent over him and attempted to punch and kick him. She landed several 'ineffectual' kicks on his thigh. I intervened and sent her to the van whilst I walked [Master A] away in order to redirect his attention. She was very angry and aggressive. This was the [incident on the outing].
>
> It was spoken about with [Ms B] and she was remorseful. I [filled out an incident form for] this incident.

I cannot recall the second incident with sufficient accuracy.

The third occasion was in the van outside his school, where [Master A] pushed her away and caught her in the throat, she retaliated with an assault which left him scratched around the neck and very upset.

Again I intervened and calmed [Master A]. Again it was debriefed and reported.

… [Ms B] was often prone to retaliation if [Master A] struck at her. Fortunately rarely with physical effect.

Suffice to say [Ms B] was frequently aggressive.

There were two further reports by me that spring to mind, one regarding the way [Ms B] administered medication, which was with extreme force, ramming the spoon into the back of [Master A's] throat and once when I was frustrated by [Ms B's] morning routine, where she would monopolise the bathroom, causing [Master A] to soil himself.

I had two meetings with [Ms I] away from [the house] and her Office.

I had a meeting with HR with [Ms I] present and when she left we continued for some time.

…

I made it clear that in my opinion [Ms B] should not be involved in the care of [Master A]. She required more training and was probably not suited at all for care of a challenging teenage boy with Autism and Down Syndrome.

…

I do not believe [Ms B] ever set out to hurt or abuse [Master A] but she was entirely the wrong person to head his care.

She responded with aggression, sometimes violence, and harsh treatment whenever she feared [Master A] was in an elevated mood.

She actually seemed to dislike him very much, using terms like '*Isn't it nice when he shows human characteristics…'*

[Ms B] was under some stress physically and emotionally during these events, and should have been removed or reassigned by her managers, but there is no question in my mind that her actions were unprofessional in the extreme and on occasion may have actually constituted abuse.

She was also keen that 'what goes on in the house, stays in the house' a term I did not agree with nor adhere to.

> Her line managers had ample warning and none of these things I communicate to you now were in any way, at any time secret."

65. On 19 October 2011, Ms I advised Mr H that, following the meeting with Mr C in December 2009, she had a clear impression that Ms B had not assaulted Master A, and that Mr C "never raised concerns with [her] about [Ms B's] behaviour towards [Master A] in separate meetings".

66. On 20 January 2012, in response to Mr C' statement, Ms M provided "contextual summary" to the December 2009 meeting with Mr C because "[the] notes could be open to interpretation". In her "contextual summary", Ms M noted that her recollection of the above incidents described by Mr C were that "what was said and in particular what [the] notes represent is that [Mr C] was summarizing in sentences about the things [Mr J] told him. In my notes … [Mr C] said he didn't believe what [Mr J] told him and indicated there was transparency with regards to issues raised in the house". Ms M further recorded in her "contextual summary" that "[t]he meeting concluded and it was our assessment that [Mr C] had not corroborated what [Mr J] had said to us", and "I am categoric in my recollection that [Mr C] did not tell us that [Ms B] abused [Master A]". She also noted: "[Ms B's] emotional state was referred to by [Mr C] … This caused concern and was followed up informally."

67. With regard to the differences in Mr C' and Ms I's and Ms M's recollections of the December 2009 meeting, Mr H stated:

> "[Mr C's] explanation for the misunderstanding at the first meeting was that he could have been misunderstood as he did not want the Team Leader to get into trouble, and may have minimised what he saw. In his view the assault was under provocation and did not seem to hurt [Master A]. He said that the Team Leader had clearly lost control and become angry. He had signed a statement outlining what he had seen to the Police. He also stated that in his view the Team Leader was not coping nor was she a suitable Team Leader to lead the care for [Master A], as she was inexperienced and inconsistent in her approach to [Master A's] care where consistency was paramount."

Information from Mr J

68. In October 2011, Mr J made the following statement, which was provided to Mr H during his investigation:

> "[Ms B's] handling of [Master A] was not appropriate and made many of my colleagues uncomfortable also the way she spoke out about him with him in the room. One common method was to pull [Master A's] hair. When she did that he stopped what he was doing and would drop to the ground.
>
> However, [Ms B's] primary method of keeping [Master A] calm was giving him paracetamol …
>
> On a number of shifts in which I worked with [Ms B], I saw her give [Master A] his medication early. He would normally receive medication at breakfast, lunch

and tea, but it was not unusual for her to give [Master A] his mid day medication at 10 or 11am. This kept him docile for most of her shift but made him very difficult at the end of the day when the other shift came on …

Giving [Master A] his medication was also an issue for [Ms B]. … I have seen [Ms B] try to give medication on a dessert spoon. Either because the spoon was too big or he was uncomfortable, [Master A] resisted and spat the medication out. In those cases, she would hold him by his neck and force the spoon into his mouth which would leave him choking afterwards …

I did witness an incident when we were both playing ball with [Master A] in the rumpus room. [Master A] showed signs of becoming quite agitated, I was momentarily distracted and I didn't see [Master A] lash out although it was clear that he had and before I had registered what had happened, [Ms B] had him momentarily around the throat restraining him. This is not a NVCI practiced hold. I quickly pushed in between them and everything calmed down.

There was another two incidents reported to me by Mr C which involved [an outing]. [Mr C] told me that [Master A] had got out of hand [on the outing]. Apparently when [Master A] made a fuss and fell to the ground, then he was kicked by [Ms B]. I don't know the exact details. Apparently on the way home, [Master A] became out of control in the van and was head butting the side of the van. Another incident happened on the way to school where [Master A] was head butting the inside of the van window [Ms B] went to the back of the van (sic). While trying to calm him down, she grabbed him by the throat (when [Master A] is in the van he has a full harness and seat belt on so that he cannot get out of the seat). I did not see the incident but I did see [Master A] afterwards with scratches on his neck that looked like nail marks. [Ms B] told us a story about a pillow trying to explain the marks on his neck.

There was another incident with the internal panels of the van [Master A] had pulled them off exposing the sharp staples when staff suggested to sort out the danger area they were told to leave it as it might stop the little shit …

On a number of occasions and this happened with many staff on duty, when [Master A] kicked off [Ms B] would lock herself in the office putting the on duty staff and [Master A] at risk. …

Some of these issues were raised with Mr K and the team manager of the time, [Ms I]. I also filled in many [incident forms] and I know that others did as well. These forms were complaints which should be recorded. My understanding is that probably as many as 20–30 forms were filled in if not more. These forms were put in a complaints file or handed to the team leader. As I understand it, the process is managed by the team manager who also codes the forms into a computer. As far as I can ascertain from my discussions with various people, many of these forms were never entered into the computer. They probably didn't go past [Ms B]."

Information from Ms D

69. On 7 October 2011, Ms D made the following statement, which was provided to Mr H during his investigation:

> "With respect to medication, [Master A] was given Panadol as required for pain relief. It also helped greatly with his behaviour. Panadol was not to be given unless it had been charted by the GP. Uncharted Panadol was always readily available in the house [for] the staff, however when [Ms B] was house manager, she used to purchase Panadol as part of the shopping and she would administer this to [Master A].
>
> She gave [Master A] the medication because it had a positive effect on his behaviour and helped keep him calm. The medication given to [Master A] that had been purchased by [Ms B] was never recorded … I observed [Ms B] giving uncharted Panadol many times. …
>
> [Master A] has charted medication at breakfast, lunch and tea. One of the effects of the medication is to make [Master A] easier to manage. It was not uncommon if [Ms B] wanted a quieter day, for her to give [Master A] his lunch time medication at 10am. This would keep him calm until she left. The people who came on at the 4pm-midnight shift, however, really suffered because by the time they started, the effects of the medication were wearing off and [Master A] became very irritable and difficult to manage. While we all knew what was going on, [Ms B] could do this without any comment because the records only show that the medication has been given, not when.
>
> … I have heard her call [Master A] inhuman on more than one occasion. She swore at him countless times and quite often called him a 'f… bastard'. She treated him like a dog and would force him to sit and wait.
>
> [Master A] clearly has feelings and it was obvious to anyone watching that [Ms B] hurt him with her taunts and swearing. He was scared of her but he followed her around all the time because she would eventually give in and would do anything for him to ensure that she had a quiet life. Giving in meant he got pies and other food that he shouldn't have. …
>
> [Master A] could be aggressive. As he gets older, he is becoming stronger and quicker and it has become more important to be able to use non violent restraint on him. [Master A] is not dangerous or looking to hurt people but he can push or if struggling, can knock a person over. When he is getting angry or excited, he needs to be treated carefully so he doesn't hurt others or himself …
>
> Once you know [Master A] then you can tell when he was about to explode. It would be at this point that [Ms B] would grab [his] hair and pull it. As soon as she pulled, he would stop doing whatever he was doing. He wouldn't move. He would stand very still. Then he would fall to the ground and curl up and the angry episode would be over. I saw [Ms B] pull his hair on numerous occasions to keep him in control.

> …
>
> On one occasion when [Master A] was curled up on the floor, I saw [Ms B] kick him. It was only once but it was a solid kick and it must have hurt. I cannot remember the date. I was the only other person to see it happen.
>
> Staff didn't report things as we were worried about losing our job.
>
> …
>
> I did try to raise issues about [Ms B] with management at various levels but felt that my complaints were not properly dealt with."

70. Mr K denied that Ms D spoke to him about these matters.

Information from Ms F

71. On 20 October 2011, Mr H met with support worker Ms F. Ms F told Mr H that Mr C had told her that he had witnessed Ms B assaulting Master A. Ms F advised Mr H that she saw Ms B pull Master A's hair, but it was in self-defence. She also said she witnessed Ms B giving Master A his medications early, and she witnessed [Ms B] calling Master A "a dick", and "a fucking animal". Ms F is also noted to have told Mr H that "staff were scared to complain because [Ms B] would reduce hours".

Information from Mr E

72. On 13 January 2012, Mr H met with support worker Mr E, who confirmed that he had seen Ms B drag Master A to his room by his hair. Mr H's notes of the meeting record that "[Mr E] was very clear that it had happened", and that he "only witnessed her doing this on one occasion".

Information from Ms L

73. On 20 October 2011, Mr H telephoned support worker Ms L. Mr H's notes of the conversation note that Ms L said that she did not work much with Ms B, but that Ms B did not have clear boundaries. Ms L advised that she did not witness anything that would be considered physical and, if she had, she would have raised it with management.

Mr H's findings

74. On 10 April 2012, Mr H completed his "Report on investigation into concerns raised about the care of [Master A] (D.O.B […])". In the report, Mr H stated:

> "All managers interviewed have made it clear that no other allegations were made to them either verbally or through incident reports of the Team Leader abusing [Master A]. They are very concerned that despite meeting with staff to discuss correct lines of communication and inviting staff to raise concerns with them, no staff raised concerns with them".

75. Mr H also stated:

"Staff interviewed provided explanation for not coming forward on the basis they did not believe management would take allegations seriously and they were fearful of the consequences of doing so on their future employment. This was based on what other staff had said and what they alleged had happened to them when they raised concerns, ie their rosters were changed to reduce their hours of work, or made unworkable for them, or they were moved to another work place. On examining the evidence, it was clear that staff were moved but for other reasons that were not related to raising allegations against the Team Leader and that rostered hours seemed to have been reduced because of health and safety issues, not because staff had made allegations. However staff were clearly of the view that because of other staff feedback, and their own experience, they were genuinely fearful of a negative impact on their future employment."

76. The report went on to note that:

- Four of the staff interviewed confirmed that they had witnessed Ms B regularly grab Master A's hair as a way of controlling/restraining him, and one staff member stated that he had witnessed Ms B grab Master A by the hair and drag him to his room;
- two of the staff interviewed confirmed that they had witnessed Ms B kick Master A;
- one staff member was able to identify that an event happened on an outing shortly after the home for Master A was opened;
- five of the staff interviewed confirmed that they witnessed Ms B verbally abuse Master A;
- three of the staff interviewed confirmed that they had witnessed medication being dispensed inappropriately to Master A (i.e., giving medication early and dispensing excessive amounts of paracetamol);[20]
- two of the staff interviewed confirmed that they had witnessed Ms B use excessive force while giving Master A his medication; and
- two of the staff interviewed confirmed that they wrote incident reports outlining their concerns regarding Ms B's behaviour towards Master A, but those incident reports cannot now be traced.[21]

77. The report also noted that general concerns were raised about staff not following Master A's dietary guidelines.

[20] Mr H's report does not identify, in relation to this incident, whether it was the team leader who was dispensing medication inappropriately, or some other person.
[21] Mr H noted that a review of the reporting system has taken place and been adjusted to ensure this cannot happen.

78. The report noted that Ms B denied the allegations, and attacked the credibility of the staff making the allegations about her and the strength of the evidence and the extent to which Mr H could take such evidence into account. Mr H rejected Ms B's submissions, and concluded that the evidence of the staff "is far more likely to be accurate than that of the Team Leader".

79. Mr H concluded that there was "a high probability" that Ms B assaulted Master A by pulling his hair and by kicking him, verbally abused Master A, and dispensed medication inappropriately and with force. He also stated that, on the basis of the evidence, "it is likely [that incident reports] were disposed of by the Team Leader". Ms B is no longer employed by NMDHB.

80. In the report, Mr H identified that concerns about Ms B abusing Master A and his rights were first raised in December 2009, and he stated: "Clearly our handling of the concerns raised by [Mr and Mrs A] on [Master A's] behalf were very poorly handled … If the concern is raised that abuse may be happening then that concern must be fully investigated."

81. Mr H made a number of recommendations in his report, including that:

- apologies be given to Master A (for the fact that he was abused while in NMDHB's care), Mr and Mrs A (for NMDHB's failure to properly investigate the concerns they raised and for the way they were treated leading up to and during the investigation), and the staff members who raised concerns regarding Master A's care (for NMDHB not properly following up on those concerns);

- an independent investigation into the circumstances surrounding the failure to undertake a full and proper investigation when concerns were raised about Master A's care be carried out;

- an independent person should be appointed to review the culture within the Disability Service; and

- NMDHB review its policies to ensure that allegations of abuse of clients result in a full investigation with, as a minimum, staff interviews.[22]

82. Mr and Mrs A confirmed that they received an apology, but said that it was from the Chief Executive, not Mr K, Ms I or Ms B, who Mr and Mrs A advised "are the people [the apology] needed to come from".

83. In February 2012, a neighbour of Master A's complained to the MP about her concerns for her safety when Master A was near the fence between their properties. The NMDHB responded directly to the neighbour to resolve those concerns.

[22] An updated document attributed to Mr H, provided to HDC, indicates that apologies had been given to Mr and Mrs A and staff who raised concerns about Master A's care, that the external investigations were in process, and that the DHB's policies had been reviewed.

Additional information obtained during HDC's investigation

Information from Mr C

84. Mr C advised HDC that he had worked as a support worker at Master A's house for just over a year. Mr C advised HDC that Ms B told him when he started working at the Disability Service that "everything that happens in the house stays in the house". Mr C also advised HDC that Ms B was "verbally aggressive and abusive".

85. In particular, Mr C advised HDC that Ms B would refer to Master A using terms such as "animal", and would say things like, "Isn't it nice when [Master A] shows human characteristics". Mr C stated that, when he confronted Ms B about her use of language, she would "shrug it off".

86. Mr C confirmed to HDC that he witnessed the incident on the outing. He advised that they were playing and Master A ran to Ms B and attempted to kick her over. Mr C recalls that Master A fell over, and Ms B "exploded" and hit, kicked and swore at Master A. Mr C recalls that he told Ms B to go to the van to cool down, and that he discussed the event with her and among the team. He advised that he completed an incident form, and Ms B was apologetic.

87. Mr C advised HDC that he witnessed a second incident involving Ms B and Master A outside Master A's school. He recalls that Master A was in the car wearing a harness. When Ms B went to undo the harness, Master A pushed Ms B away. Ms B then launched at Master A, grabbed his throat and scratched his neck. Mr C recalls that he filled out an incident form in relation to the incident, and he discussed it with Ms B. He recalls that Ms B was apologetic, but angry.

88. Mr C advised HDC that incidents would be documented on an incident form, which would then be given to Ms B, who would give it to Ms I. The forms were not numbered. Mr C said that he had no direct evidence that forms had gone missing.

89. Mr C advised HDC that he did not directly witness Master A being "over-medicated"; however, he confirmed that Ms B would put the spoon with the yoghurt and Master A's medication into Master A's mouth so far that he thought she would damage Master A's throat.

90. Mr C confirmed to HDC that he witnessed Ms B using the bathroom in the mornings for up to one hour, and advised that Master A would soil himself because he was unable to access the toilet.

91. Mr C recalls that, after his meeting with Ms I and Ms M in December 2009, Ms I left and he then had an ongoing discussion with Ms M. He said that she told him to "tell [her] everything, you can speculate, we need to know what is going on". He recalls that he told her about Ms B's treatment of Master A. Mr C believed that Ms B would then be re-located, but she was not, and his discussion with Ms M was never mentioned again.

92. Mr C stated to HDC that no one intended to hurt Master A, but it was a case of lack of training/experience with autism. He said that carers are used to low level behavioural needs with high physical needs, but Master A has high behavioural needs.

Information from Ms D

93. On 21 February 2013, Ms D spoke with an HDC Investigator about these matters. Ms D advised that she started working at the house one month after the house was established for Master A. She was initially working part-time and worked with Ms B most of the time. Ms D advised that she had a lot of concerns about how Ms B treated Master A, and she spoke of one time when she helped Ms B to restrain Master A when he was being aggressive, and said that when Master A was settled and lying on the floor, Ms B walked past and kicked him with her boots. Ms D also recalled that Ms B would pull Master A by the hair on the back of his head almost every day, and she would do this to control Master A if he acted out.

94. Ms D also considered that Ms B would medicate Master A inappropriately, giving him medication at 7am or 8am, then again at 10am to keep him quiet. She also recalled that Ms B would give Master A a lot of Panadol, including Panadol that she bought with her own money.

95. Ms D also said that Ms B would verbally abuse Master A, and would call him "animal" to his face and say he was not human. Ms D advised HDC that she spoke to Ms B about her concerns, and Ms B said, "[H]ey you've just got your payrise so keep quiet." Ms D advised HDC that she was not happy, but just prior to that two staff members who had raised concerns had been moved suddenly to another house, and she did not want to be moved so she stayed quiet. Ms D recalled that she eventually voiced her concerns to Ms I and Mr K, and they advised that they would investigate but nothing happened.[23] Ms D said that she then approached the HR Manager, Ms M, but again nothing happened. Ms D advised that she then decided to go to the Police with some other staff members, as they felt something needed to be done about Ms B's abuse of Master A.

Information from Ms F

96. On 21 February 2013, Ms F spoke with an HDC Investigator about these matters. Ms F advised that she worked at the house for about one and a half years, and she worked with Ms B "quite often". Ms F advised that she did not think Ms B was inappropriate in her care of Master A. She said there was a time that she thinks Ms B's reaction was a bit aggressive in that Ms B grabbed Master A around the neck, but she said it was a human response to being attacked by Master A and Ms B did not intend to hurt him. Ms F recalled that Master A is very violent, and that Master A would target Ms B. Ms F said that Ms B may have pulled Master A's hair when they were dragging Master A to his bedroom when he was out of control, but it would have been inadvertent when trying to get Master A to his room as fast as possible. Ms F also recalled a couple of times when Ms B had been hurt by Master A and would say something along the lines

[23] Ms D advised Mr H that, when she raised her concerns about Ms B's behaviour with Mr K, "[Mr K] shrugged this off and I never heard back on the outcome". It is unclear when exactly she raised her concerns with Mr K.

of "you little bugger", and said that Ms B would try to "buy" a good day with Master A by buying him extra food. Ms F considered that Ms B was out of her depth, and may have overreacted to Master A's behaviour at times. Ms F advised that Ms B was in a difficult situation because she had no management experience and no experience with challenging behaviour, and yet she was the team leader of the house with Master A, who was very challenging and violent. Ms F felt that Ms B was not supported by management.

Information from Mr E

97. On 21 February 2013, Mr E spoke with an HDC Investigator about these matters. Mr E advised that he started working at the Disability Service in October 2010, and worked almost every day with Ms B for two to three months. Mr E said that he was concerned about "everything" when he started working at the house. He said that Master A was being fed junk food to keep him happy, he wasn't getting exercise, and there were issues with the set-up of the house. Mr E recalled an incident when Master A asked Ms B to re-tie the elastic band on his hand. When Ms B refused to do so, Master A got angry and he grabbed Ms B's shirt around the neck. Mr E recalled that he pulled Master A off Ms B and restrained Master A face down. He recalled that Ms B then got up and grabbed two handfuls of Master A's hair and pulled him a couple of steps to the hallway. Mr E advised that this hurt Master A, and he helped to pick up Master A and take him to his bedroom. Mr E also recalled that Ms B would call Master A a "fucking dick", and other names that he did not feel comfortable repeating. Mr E said he discussed his concerns with support worker Ms D. Mr E stated that he understood that people who had raised concerns previously had been moved to different houses. Because Mr E considered it better for Master A if he remained at the house as Master A's caregiver, he did not say anything to NMDHB management.

Ms B's response

98. On 21 December 2012, Ms B advised HDC that she denies any ill treatment of Master A, and she asserted that "at all times [she] provided good appropriate care for [Master A]".

Subsequent events

NMDHB policy review

99. On 6 August 2012, NMDHB advised HDC that its policy on abuse has been adjusted to set a minimum standard of investigation if abuse is suspected. It also advised that the Disability Service is working with the main union and its delegates to explore ways to make it easier for staff to disclose concerns and ensure that those concerns are taken seriously.

Independent investigation

100. In December 2012, a report was provided to the Chief Executive Officer of the NMDHB on the Review of the Service Arrangements Relating to Master A (the Review), which was an external review commissioned by the NMDHB. The report included an examination of why concerns initially raised by staff were not investigated.

101. The Review concluded that the original allegations of abuse were not dealt with professionally or thoroughly and that, at the beginning of the informal investigations, there was little understanding of what "abuse" is. The report concluded that there was a serious lack of trust on all sides, and the Business Development Manager was misled by the Service Manager, in that the Service Manager stated that there were no problems with staff raising their concerns with management when clearly there were staff concerns. The Review recommended service-wide comprehensive training on abuse and neglect, extensive training on team dynamics and staff management for the Service Manager and the team managers, and a review of the skills of team managers and service managers, especially in the area of respectful interactions with staff. The reviewers also made several recommendations specific to Master A's service, including improved communication, professional supervision for staff, external expertise input, feedback to staff, and planned staff/family interactions.[24]

Independent review of culture at the Disability Service

102. In December 2012, another report was provided to the Chief Executive Officer of the NMDHB on the Review of Disability Support Services (the Review), which was an external review commissioned by the NMDHB to examine the overall culture of the Disability Service. The Review was also tasked with examining existing arrangements for managing complaints and incidents, and determining whether there were any systemic limitations that could preclude or overlook the proper investigation of individual incidents.

103. The reviewers interviewed 82 people representing service users, the DHB, the Disability Service, the needs assessment service, a support service for the families of those with intellectual disabilities, family interests and external behaviour support services, and reviewed policies, procedures, staff files and other relevant documentation.

104. The Review identified a number of factors that suggest that staff and management relationships at the Disability Service are problematic in a number of areas and that, while there are systems to manage risks, these are not universally applied, including the following:

(a) There is considerable variability of interpretation of what constitutes abuse and neglect and the requisite threshold, and how it is reported and followed through.
(b) Relationships between the Disability Service and other relevant stakeholders is variable.
(c) The manner in which the Incident and Accident system is being applied limits the ability to effectively manage high risk incidents.
(d) There is a concern that complaints are not being managed in a manner that gives staff confidence that they will be appropriately handled to improve performance or reduce risk.

[24] Mr and Mrs A stated that they have concerns about the Review, including that they were not spoken to during the course of the review, and that there was a lack of transparency in the appointment of the reviewer, who had a previous relationship with NMDHB and who they consider was biased.

(e) The Disability Service has a significantly high number of reportable health and safety incidents. While some of those are attributable to the nature of the service, there is limited evidence of management working with health and safety advisors for staff to have the tools and skills to manage those inherent risks.
(f) There seems to be a reliance on scheduled team meetings and policies and procedures to equate to staff being informed and having the requisite knowledge of how to apply expectations and policy requirements. As a consequence, there is variable adherence to, and knowledge of, policies and procedures that directly impacts on service delivery.
(g) There is a low level of trust amongst colleagues and across the Disability Service.

105. In particular, the following are examples of concerns noted in the Review:

- 15 of 29 support workers did not feel supported by their team leader or made no comment on the matter, and there was a similar perception about the team managers;

- 26 of 29 support workers did not consider the service manager to be supportive;

- while the majority of support workers were aware of the complaints procedure (including the Protected Disclosures Act), one support worker stated that, although she was aware of the complaints procedure, "… people are too scared to speak out … they could be seen as trouble-makers";

- only 10 of 29 support workers said they felt comfortable going to their team leader or team manager to discuss concerns about an issue in their house, and most of the support workers were not confident that management would deal fairly and promptly with any issues they felt uncomfortable with;

- families expressed concern that support workers were remaining silent when they knew something was wrong out of a fear of losing their jobs; and families reported a lack of confidence in the team managers.

106. The Review made a number of recommendations, including recommendations in the following areas: developing a change management plan; increasing staff knowledge of the abuse and neglect policy, the parameters of abuse, requirements under the 2012 amendment to the Crimes Act to report abuse, and the provisions of the Protected Disclosures Act 2000; the investigation of alleged abuse; the Incident and Accident system; health and safety; workforce introduction, training, development and performance management; and complaints.

Concluding comments from Mrs A

107. Mrs A advised HDC:

> "… I would like to see parents being more empowered I think, not disempowered. We were just so trusting and so naïve. We had no idea about the mentality that I believe that has allowed this to happen and that it got this far."

108. She further advised:

> "We trusted this service to act professionally but that trust was broken when at management level there was no desire to know the truth about events happening in [Master A's] house through the team leader. Transparency is paramount because [Master A] has no way of telling anybody what has happened to him."

NMDHB response to the provisional opinion

109. NMDHB's response to the provisional opinion has been incorporated into the information above, where relevant. In addition, NMDHB stated:

> "The events that have taken place within this case are inexcusable, and we are totally committed to ensuring that there is no chance of events even remotely similar. We recognise that the staff working within this service are presented with very challenging situations, and we will do everything we can to ensure that we provide the training and the tools for staff to manage the situations they find themselves in, and to escalate any concerns if they should rise promptly."

110. NMDHB further advised that it has taken steps to strengthen its systems and processes. It noted that it complies with the required process in relation to sentinel event reviews and, when an incident meets the threshold, a full investigation is completed. It also advised that any incident in which there are allegations of abuse against patients/clients is now automatically recognised as an event that requires a sentinel event review.

111. NMDHB also advised that it has been unable to substantiate what happened to the incident reports that the organisation could not find. It stated that the family's concerns were taken seriously and acted upon where that information existed and where they had a right to such information. It stated: "The interpretation that could be drawn from the Provisional Opinion is that NMDHB was obstructive in this regard. We contend that this was not the case, and note that we have put a system in place to ensure that all incident forms are lodged, and if not it is immediately apparent that they have gone missing."

Opinion: Breach — Ms B

112. I accept that Master A was a difficult and aggressive client. However, for any health or disability services provider to abuse a vulnerable consumer — either verbally, physically or both — when that provider has been entrusted with the consumer's care, is fundamentally wrong — professionally, ethically, and legally. There can be no excuse for such behaviour. As noted in two previous HDC Opinions, "It is … plainly unprofessional to physically assault a patient. This is so fundamental that it requires little further comment".[25]

113. In this case, five support workers who cared for Master A at the house with Ms B have raised concerns about the appropriateness of Ms B's behaviour towards Master A. Those concerns include verbal and physical abuse, over-medicating, and forceful medication administration.

114. Ms B denies any such behaviour towards Master A.

115. In a criminal investigation, the standard of proof is beyond reasonable doubt. However, the standard of proof in a Commissioner investigation under the Health and Disability Commissioner Act 1994 (the HDC Act) is the balance of probabilities, which is the standard that applies in civil litigation. In *Miller v Minister of Pensions*,[26] Lord Denning summarised the standard of proof in a civil case in the following words:

> "It must carry a reasonable standard of probability, not so high as is required in a criminal case. If the evidence is such that the tribunal can say: 'we think it more probable than not', the burden is discharged, but if the probabilities are equal it is not."

116. This means that, when considering a case, I need to be satisfied that, on the balance of the evidence, it is more likely than not that the act or omission that is alleged to have breached the Code occurred.

117. With regard to the allegation that Ms B physically abused Master A, the following evidence has been made available to me:

(a) Mr C has given evidence that Ms B was "frequently aggressive". He stated that he "witnessed [Ms B] strike or attempt to strike [Master A] in a sustained way on at least three occasions". In his evidence, Mr C described one event "… [on an outing] … [Ms B] bent over [Master A] and attempted to punch and kick him. She landed several 'ineffectual' kicks on his thigh", and a further event "… in the van outside his school, where [Master A] pushed [Ms B] away and caught her in the throat, she retaliated with an assault which left him scratched around the neck and very upset". Mr C stated: "[T]here is no

[25] Opinion 05HDC13588 and Opinion 07HDC20395, both available at www.hdc.org.nz.
[26] [1947] 2 All ER 372.

question in my mind that her actions were unprofessional in the extreme and on occasion may have actually constituted abuse".

(b) Mr J has given evidence that, on one occasion when he and Ms B were playing ball with Master A, Master A became agitated and must have lashed out and, "before he registered what had happened, [Ms B] had [Master A] momentarily around the throat restraining him". Mr J explained that the technique Ms B used to restrain Master A around his throat was not an approved and practised restraint technique.

(c) Ms D has given evidence that she saw Ms B pull Master A's hair "on numerous occasions to keep him in control", and that Ms B would pull Master A's hair almost every day. Ms D has also given evidence that she witnessed Ms B kick Master A on one occasion "when [Master A] was curled up on the floor".

(d) Ms F has given evidence that she witnessed Ms B pull Master A's hair. Ms F also advised HDC that Ms B grabbed Master A around the neck.

(e) Mr E has given evidence that he witnessed Ms B drag Master A to his room by his hair, and that on one occasion when Master A became angry and grabbed Ms B's shirt, he restrained Master A and then Ms B "got up and grabbed two handfuls of [Master A's] hair and pulled him a couple of steps to the hallway".

118. With regard to the allegation that Ms B verbally abused Master A, the following evidence has been made available to me:

(a) Mr C has given evidence that Ms B would refer to Master A using terms such as "animal", and that Ms B would swear at Master A calling him a "fucking aggressive bastard".

(b) Ms D has given evidence that she heard Ms B call Master A "inhuman" on more than one occasion, that Ms B would call Master A "animal", and that she swore at him "countless times and quite often called him a 'f… bastard'".

(c) Ms F has given evidence that she witnessed Ms B call Master A "a dick" and "a fucking animal".

(d) Mr E has given evidence that Ms B would call Master A a "fucking dick" and other names.

119. With regard to the allegation that Ms B used extreme force in administering Master A's medication, the following evidence has been made available to me:

(a) Mr C has given evidence that Ms B would administer Master A's medication with "extreme force, ramming the spoon into the back of [Master A's] throat", and that Ms B would put the spoon with the yoghurt and Master A's medication into Master A's mouth so far that he thought she would damage Master A's throat.

(b) Mr J has given evidence that he saw Ms B "… try to give medication on a dessert spoon. Either because the spoon was too big or he was uncomfortable, [Master A] resisted and spat the medication out. In those cases, [Ms B] would hold [Master A] by his neck and force the spoon into his mouth which would leave him choking afterwards."

120. With regard to the allegation that Ms B over-medicated Master A and/or gave him medication at times other than when medication had been charted for him, the following evidence has been made available to me:

(a) Ms D has given evidence that Ms B would purchase Panadol and administer it to Master A because it had a positive effect on his behaviour, and that she observed Ms B give uncharted Panadol to Master A "many times". Ms D stated: "It was not uncommon if [Ms B] wanted a quieter day, for her to give [Master A] his lunch time medication at 10am … While we all knew what was going on, [Ms B] could do this without any comment because the records only show that the medication has been given, not when." Ms D stated that the medication Ms B gave to Master A that she purchased was not recorded.

(b) Ms F has given evidence that she witnessed Ms B give Master A his medications early.

(c) Mr J has given evidence that Ms B's "primary method of keeping [Master A] calm was giving him paracetamol". He stated: "On a number of shifts in which I worked with [Ms B], I saw her give [Master A] his medication early. He would normally receive medication at breakfast, lunch and tea, but it was not unusual for her to give [Master A] his mid day medication at 10 or 11am. This kept him docile for most of her shift …"

121. Ms B has denied the allegations, but has not provided any evidence to support her account that the alleged events did not take place.

122. The consistency in the accounts of the five carers who worked with Ms B, and who have come forward with concerns about her behaviour, is telling and persuasive. Considering the totality of the evidence, I am satisfied, on the balance of probabilities, that it is more likely than not that Ms B behaved in a professionally and ethically inappropriate and inexcusable manner toward Master A. There is strong and compelling evidence that Ms B pulled Master A's hair, kicked Master A, and was regularly verbally abusive toward him. I am also satisfied that Ms B was aggressive when administering medication to Master A, and that she administered medication to him over and above what was charted for him and/or at times other than the times for which his medication was charted. In my view, the burden of proof in this case has been met.

123. I am of the view that Ms B's inappropriate and inexcusable behaviour towards Master A appears to have been intentional, direct, and repetitive. To act in that way was a serious departure from the expected standard of care, and showed a flagrant disregard for Master A's rights. In my opinion, Ms B failed to treat Master A with respect, and

breached Right 1 of the Code. By physically and verbally abusing Master A, Ms B failed to provide services to Master A in accordance with professional and ethical standards, and breached Right 4(2) of the Code. By administering medication to Master A in a forceful way, and at times other than when medication was charted to him, Ms B breached Rights 4(1) and 4(4) of the Code.

124. There are many other elements of Ms B's alleged behaviour as the team leader at Master A's house that concern me. For example: the allegations that Ms B would use the bathroom for over an hour in the mornings, making it unavailable for Master A, who would, as a result, often soil himself; that Ms B would lock herself in the Office and not assist the other staff caring for Master A; that Ms B excluded Master A's parents and legal guardians from his care; and that Ms B fostered a culture of secrecy by telling staff, "Everything that happens in the house stays in the house."

125. My vision for the health and disability sector in New Zealand is a consumer-centered system. The Code of Health and Disability Services Consumers' Rights 1996 is designed to achieve that end. Engagement, transparency, and a culture that supports appropriate service delivery and that empowers consumers, families and staff to speak up are features required to achieve such a system. Much of what has been reported to me about how Ms B managed Master A's house and cared for Master A in that house goes against that. This is far from what we are entitled to expect from disability services in New Zealand.

Opinion — Breach: Nelson Marlborough DHB

126. DHBs have clear responsibilities to provide safe, quality services. In particular:

(a) The New Zealand Public Health and Disability Act 2000 provides that DHBs are responsible for planning, funding and providing health care services for their resident population, and have a duty to monitor the delivery and performance of services by it, and by persons engaged by it to provide services.[27]

(b) DHBs must comply with relevant service standards issued under the Health and Disability Services (Safety) Act 2001. The Health and Disability Sector Standards set out basic responsibilities, including: the responsibility to ensure that consumers receive timely, appropriate and safe services from suitably qualified/skilled and experienced providers (Standard 2.7); and the responsibility to ensure that consumers receive safe and reasonable services in a manner that is respectful of their rights and minimises harm, including that consumers are not subjected to abuse and/or neglect as a result of service delivery (Standard 1.1).

[27] Section 23(1)(i) of the New Zealand Public Health and Disability Act 2000.

(c) DHBs are health care providers under the HDC Act and so are subject to the duties in the Code.

127. The organisational duty of care of a DHB under the HDC Act and Code has been considered in several HDC reports.[28]

128. As noted in one of those reports, the *Tauranga Hospitals Inquiry*, when concerns about a health or disability service provider's competence (and/or conduct) are raised, the employer must respond to those concerns in a decisive and timely manner. Patient safety must be the paramount consideration. As noted in the employment context by Judge Finnigan in *Air New Zealand Ltd v Samu*, "[W]here safety is genuinely involved in the operations of an employer it is not just another ingredient in the mix, another factor to be taken into account. Safety issues have a status of their own."[29] As stated in the *Tauranga Hospitals Inquiry*:

> "What is true for the safety of air travel (with which parallels are often drawn by quality experts in the medical profession) is equally true of patient safety in hospitals. Hospitals must have in place a clear mechanism for dealing decisively with concerns about an employee's competence. Although employees are entitled to be treated fairly, hospitals cannot allow patient safety to be jeopardized …"[30]

129. In addition, the contractual agreement between the Ministry of Health and residential service providers (the DSD Residential Agreement, October 2005) requires residential service providers contracted with the Ministry of Health to have a complaints procedure that ensures that all complaints are handled at the level appropriate to the complexity or gravity of the complaint, and that the person handling the complaint is impartial and acts fairly.[31] The DSD Residential Agreement also requires residential service providers contracted with the Ministry of Health to "safeguard service users, staff and visitors from abuse" and, to that end, "have policies and procedures on preventing, detecting and removing abuse and/or neglect", which "include definitions of abuse and neglect and will clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring, and corrective action". The DSD Agreement further provides that service providers "will ensure that relevant employees are able to participate in family, inter-agency or court proceedings to address specific cases of abuse and neglect". Furthermore, the Ministry of Health Service Specification for Community Residential Support Services, Intellectual Disability (DSS1031 July 2008), part of the DSD Residential Agreement, sets out service provider requirements for risk management and complaints resolution, amongst other things.

130. In December 2009, NMDHB was formally put on notice of serious concerns about the appropriateness of Ms B's conduct. In particular, Ms M and Ms I were advised by Mr

[28] See, for example: Opinion 10HDC00703, *Tauranga Hospitals Inquiry* (Opinion 04HDC07920, 2005), the *Whanganui District Health Board Report* (Opinion 07HDC03504, 2008), and the *North Shore Inquiry* (Opinion 07HDC21742).
[29] [1994] 1 ERNZ 93, 95.
[30] See the *Tauranga Hospitals Inquiry* (Opinion 04HDC07920, 2005), available at www.hdc.org.nz.
[31] See section B6.6 of the DSD Residential Agreement.

J that Ms B was verbally aggressive, that she administered medications early, and that she had physically abused Master A during an incident on an outing. Ms M and Ms I were then advised by Mr C that he had seen Master A "restrained, blocked with more aggression than required", that Ms B was "aggressive", that Ms B "forced [medications] in yoghurt down [Master A]", and that Ms B swore at Master A and called him a "fucking aggressive bastard".

131. The evidence suggests that very little action was taken in response to those allegations.

132. Although Mr C allegedly did not corroborate the complaint that Ms B physically assaulted Master A on an outing (as had been reported by Mr J), he did raise other serious concerns about Ms B's behaviour. I am concerned about NMDHB's response to those concerns. In particular, I am concerned that no formal investigation was carried out. I consider that the meetings with Mr J and Mr C put NMDHB on notice of serious concerns about Ms B's conduct, which required active follow-up to ensure Master A's safety. No such steps were taken. There is no evidence that other staff members were interviewed, that Ms B was spoken to, or that any other steps were taken to respond to the concerns that had been raised. Indeed, the documentation provided to HDC suggests that the only action that was taken was a meeting with staff at Master A's house, during which staff were told not to swear in the house, and were spoken to about trusting and respecting each other and "not … talking behind people's backs". Mr K's notes of the meeting also indicate that staff were warned about making false allegations, and that disciplinary action would be taken if staff talked to the "family about other staff".

133. The above meeting was clearly insufficient in terms of addressing the serious concerns that had been raised by Mr J and Mr C and, rather, shows a complete disregard for what those employees reported. The Protected Disclosures Act 2000 was passed to facilitate the disclosure and investigation of serious wrongdoing[32] in or by an organisation, and to protect people who make disclosure of information about serious wrongdoing.[33] All public sector organisations, including DHBs, are required to have internal procedures for dealing with information about serious wrongdoing and information about the existence of the internal procedures, and adequate information on how to use the procedures, must be published widely in the organisation.[34] The allegations made by Mr J and Mr C were allegations of serious wrongdoing by Ms B, yet there is no indication that Mr J or Mr C were given the opportunity to use the Protected Disclosure Act, or that there was any consideration of

[32] The Protected Disclosures Act 2000 defines serious wrongdoing in section 3 as including "any serious wrongdoing of any of the following types: an unlawful, corrupt, or irregular use of funds or resources of a public sector organisation; or an act, omission, or course of conduct that constitutes a serious risk to public health or public safety or the environment; or an act, omission, or course of conduct that constitutes a serious risk to the maintenance of law, including the prevention, investigation, and detection of offences and the right to a fair trial; or an act, omission, or course of conduct that constitutes an offence; or an act, omission, or course of conduct by a public official that is oppressive, improperly discriminatory, or grossly negligent, or that constitutes gross mismanagement.

[33] See section 5 of the Protected Disclosures Act 2000.

[34] See section 11 of the Protected Disclosures Act 2000.

its application in relation to their complaints. There is no evidence that staff were informed of the internal procedures for dealing with information about serious wrongdoing, and how to use those procedures, as required by that Act.

134. Given the response to the concerns that were raised with NMDHB management in December 2009, it is no wonder that staff were then reluctant to raise further concerns. Staff were left feeling worried about their jobs, and were told that they were "… spending more time worrying about what each other is doing than actually doing [their] job". The poor response to the concerns raised in December 2009 led to Master A being unnecessarily exposed to harm from Ms B's inappropriate conduct for an inexcusable period of time, and the NMDHB must accept responsibility for that.

135. I am also concerned that Mr and Mrs A were not informed by NMDHB of the above complaint in 2009 and the actions taken in response to that complaint. Mr and Mrs A, as Master A's legal guardians at the time, should have been given that information.[35] As noted in the HDC Guidance on Open Disclosure Policies,[36] consumers (and their legal guardians) have a right to know what has happened to them because: ethically and legally it is the right thing to do; it affirms consumer rights; and it fosters open and honest professional relationships. In addition, Right 6 of the Code provides that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive". Such information includes an explanation of the consumer's condition (Right 6(1)(a)). Furthermore, Right 1 of the Code provides that consumers (and their legal guardians) have the right to be treated with respect, and "[r]espect requires a truthful and sensitive discussion about any harm or incident affecting the consumer".[37]

136. Mr and Mrs A were not informed about what was happening with their son and, as his legal guardians, they should have been. Master A is a vulnerable consumer and his parents are his guardians[38] and advocates. Not to involve Mr and Mrs A in that process was contrary to the principles of transparency and engagement. It also showed a lack of respect for Master A and his legal guardians. It was NMDHB's responsibility to ensure that open disclosure was practised by its staff, and it failed to do so when concerns were raised in December 2009 about the care Master A was receiving.[39]

137. I am also concerned that carers appear to have identified their concerns to Mr and Mrs A, but not to their employers. Mr and Mrs A were given concerning information about

[35] Clause 4 of the Code defines "consumer" as "a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer". Mr and Mrs A were Master A's legal guardians, and therefore entitled to consent on his behalf and, therefore, entitled to information about Master A's care and treatment under Right 6 of the Code.
[36] Available at www.hdc.org.nz.
[37] See: HDC Guidance on Open Disclosure Policies, available at www.hdc.org.nz
[38] At the time of these events, Mr and Mrs A were Master A's legal guardians. Mr and Mrs A are currently Welfare Guardians for Master A.
[39] As noted in the HDC Guidance on Open Disclosure Policies, provider organisations have a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management.

the care provided to, and the safety of, their son. However, they were left unsupported and experienced difficulty in obtaining any information or response to those concerns from NMDHB. While I accept that staff did not raise their concerns directly with NMDHB management, there is evidence that throughout 2010, Mr and Mrs A attempted to obtain information about the concerns that had been raised with them about the care of their son, with little success. For example, they made an Official Information Act request for information in March 2010 and, in the letter requesting information, sent to Ms I, they noted that they were "continually picking up information about aspects of [Master A's] care that is disturbing", and they met with Mr K and Ms I in July 2010. Mr and Mrs A were told that the use of the term "animal" to describe Master A was "unfortunate" and "inconsequential". They were told that they were not entitled to information about complaints that had been made because that information was confidential.

138. When Mr and Mrs A raised concerns with the National Health Board, the matter was referred to NMDHB's Core Sentinel Event Investigation Group, and an investigation was carried out for the purpose of determining whether a full sentinel event review was required. I share Mr and Mrs A's concerns about the quality of that investigation. This was the second time concerns had been formally raised with NMDHB about the care provided to Master A. Yet again, Mr and Mrs A were not involved in the investigation, the investigation was paper-based, and no staff were interviewed (including Ms B). In my view, given the nature and seriousness of the allegations made, a paper-based review was wholly inadequate. It is difficult to justify a decision to conduct only a paper-based review in response to serious allegations of abuse of a vulnerable consumer. As is evidenced by Mr H's review a year later in 2011, evidence supporting Mr and Mrs A's concerns would have been available from staff if they had been interviewed in the course of the Group's investigation, and had been supported to raise their concerns.

139. The duty to resolve complaints is particularly important when providing services to vulnerable consumers who may be unable or unwilling to complain themselves. While I commend NMDHB on the quality of Mr H's investigation in 2011 and 2012, including the important safety step of suspending Ms B pending the outcome of the investigation, I am concerned that NMDHB's delay in taking active steps to respond and address the serious concerns about the care being provided to Master A in the years prior to Mr H's investigation put Master A's safety at significant risk, and affected the quality of care he received.

140. In my view, NMDHB's response to the concerns about the care provided to Master A fell well short of the expected standard. In December 2009, the NMDHB was on notice of concerns about the appropriateness of the care being provided to Master A, and concerns about his safety, but it failed to respond to those concerns appropriately. It also failed to respond adequately when ongoing concerns were brought to its attention in 2010.

141. I find that NMDHB breached Rights 4(1) and 4(4) of the Code for failing to adequately respond to concerns about the care being provided to Master A, to ensure that he received services with reasonable care and skill, and that potential harm to him

was minimised. I also find that NMDHB breached Rights 1 and 6 of the Code for failing to provide Master A's legal guardians, Mr and Mrs A, with adequate information about Master A's care and treatment, including information about the concerns that had been raised and NMDHB's response to those concerns.

Opinion — Adverse Comment: Ministry of Health

142. The Disability Service is a division of NMDHB, but provides services on a contractual basis directly with the Ministry of Health.

143. In August 2010, Mr and Mrs A complained to the National Health Board at the Ministry of Health about the care provided to Master A by the Disability Service. On 31 August 2010, the National Health Board contacted NMDHB about the concerns, and requested a response.

144. In response, NMDHB's Core Sentinel Event Investigation Group carried out an investigation with a view to identifying whether a full sentinel event review was required or not. NMDHB reported the investigation findings to the National Health Board on 23 September 2010. In particular, it advised the National Health Board that an "extensive investigation" had taken place, that all documentation had been obtained and reviewed, and that there was no information "indicative of [Master A] being ill-treated by [Ms B] or other [Disability Service] staff". NMDHB's report to the National Health Board does not refer to any interviews having been carried out, or state that the review was anything other than paper-based. As noted above, I am critical of the quality of NMDHB's September 2010 investigation.

145. On 28 September 2010, the National Health Board wrote to Mr and Mrs A and advised them of NMDHB's investigation. The National Health Board further advised Mr and Mrs A, "Unless you [are] able to provide additional evidence that will support your allegations — the Ministry is unable to pursue that matter further."

146. It was not wholly unreasonable for the National Health Board to rely on the response provided to it by NMDHB. However, Mr and Mrs A raised very serious concerns about the care being provided to Master A. It appears that the National Health Board formed a view on the adequacy of NMDHB's response to those concerns with very little information. In my view, as the contract holder and funder of the Disability Service, the National Health Board should have actively enquired into the matter to assure itself of the adequacy and appropriateness of NMDHB's investigation, which should have included interviews with staff.

147. In response to the provisional opinion, the Acting Director-General of Health acknowledged that the National Health Board should have managed its process more effectively, and advised that it has since implemented changes with respect to its performance and quality management processes to ensure it avoids similar cases in the future. In particular, he noted that the National Health Board should have initiated

an issues based audit/evaluation that would have allowed for interviews with Master A, Mr and Mrs A and staff of the Disability Service.

148. The Ministry of Health has commissioned an external review of the National Services Purchasing — Disability Support Services, which is expected to be completed by 30 September 2013. The review includes, as an objective, an assessment of whether "the current processes involved in the evaluation, monitoring and complaints management by National Services Purchasing support provider improvement and the safety and well-being of people with disabilities".

Protection of the public

149. As noted above, Ms B's actions were a serious departure from the expected standard of care, and showed a flagrant disregard for Master A's rights.

150. Because of my concerns about Ms B's actions, I intend to refer her to the Director of Proceedings, to consider whether proceedings should be taken.

151. At the conclusion of proceedings taken by the Director of Proceedings, if any, and consistent with the HDC Naming Policy (see: www.hdc.org.nz), I will also name Ms B.

Recommendations

1. I recommend that Ms B apologise to Mr and Mrs A and Master A for her breaches of the Code. A written apology should be sent to this Office by **19 July 2013** for forwarding to Mr and Mrs A.

2. I recommend that NMDHB:

   - apologise to Mr and Mrs A and Master A for its breaches of the Code. A written apology should be sent to this Office by **19 July 2013** for forwarding to Mr and Mrs A;
   - review its policies and procedures for investigating and responding to complaints, protected disclosures, and other concerns it receives about care and treatment provided to consumers under its care, and provide evidence to HDC that such reviews have taken place by **19 July 2013**;
   - provide staff education on the internal procedure for protected disclosure complaints and provide evidence to HDC that such education has taken place, and will continue to take place, by **19 July 2013**;

- provide evidence that the recommendations, as set out in Mr H's investigation report, the Report, and the Review, have been implemented, by **30 October 2013**; and
- provide evidence that staff have received appropriate training in providing care to consumers with challenging behaviour, including safe restraining practices, and that a policy is in place to ensure that such training is ongoing, by **19 July 2013**.

3. I recommend that the Ministry of Health review and amend its contract and/or service specifications as they relate to contracted and/or funded intellectual disability residential support services, to ensure that allegations of abuse of consumers result in a full and independent investigation with, as a minimum, staff interviews.

Follow-up actions

- Ms B and NMDHB will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the NMDHB and the Ministry of Health (National Health Board), will be sent to the Ministry of Health and DHB Shared Services, and they will be advised of Ms B's name.

- A copy of this report, with details identifying the parties removed, except the NMDHB and the Ministry of Health (National Health Board), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes. At the conclusion of proceedings taken by the Director of Proceedings, if any, Ms B will be named in the copy of this report on the Health and Disability Commissioner website.

Addendum

The Director of Proceedings decided not to issue a proceeding against Ms B because a criminal prosecution against Ms B had already taken place. The Director took proceedings against NMDHB to the Human Rights Review Tribunal which were resolved by negotiated agreement. NMDHB accepted that it had breached Rights 4(1) and 4(4) of the Code for failing to adequately respond to concerns about Master A's care, and breached Right 6 for failing to supply Master A's parents with adequate information.