Care of young man in a residential disability service
15HDC01145, 11 April 2018

Disability support service ~ Residential home ~ Disability ~ Indecent assault ~ Burns ~ Risk management ~ Right 4(1)

A young man with intellectual, physical, and developmental impairments and who was dependent on others for his care entered a residential disability support service facility (Support Service facility). The man's transition plan from school to the Support Service facility recorded: "[He] is extremely vulnerable to any harm — physical, emotional, occupational."

The man was assessed by a Needs Assessment and Service Coordination agency as requiring a very high level of support. The Support Service said that a safety plan/risk management plan (RMP) was put in place for significant risks to the man. The document contains three columns, recording "current" risks, risk triggers, and a management plan (prevention, intervention, crisis). The document was not updated during the two years of the man's residence at the facility, although the Support Service said that a safety plan was formulated and updated, and advised that a safety plan is equivalent to a risk management plan. The RMP and safety plan do not refer to risks from other service users, and include only the risks of the man becoming physically aggressive and self-harming.

The man lived with another resident who also had an intellectual disability. This resident had a history of serious aggressive behaviour and sexually inappropriate behaviour. Incidents involving the resident exposing his genitals in front of the man, and incidents whereby the resident had physically assaulted the man were recorded in incident reporting forms, but were not followed up at the time. Following a further physical assault on the man by the resident, the man went home for several weeks before being relocated to another facility operated by the same Support Service.

The man later became acutely unwell and was transferred to hospital by ambulance. He underwent a laparotomy, and a plastic surgical glove was located in his bowel. The plastic glove had caused an infection, and required a temporary loop colostomy. An independent review could not determine who inserted the glove, or when or where it was inserted, but reached the conclusion that the glove was most likely inserted by a third party as a result of a sexual assault.

The man then suffered burns as a result of spilling a staff member's hot drink, which had been left within his reach. Following this incident the man was removed from the Support Service facility by his mother, and he now lives at home with her.

Findings

The Support Service failed to ensure that sufficient trained staff were on duty at all times, placed the man with another resident who exhibited inappropriate behaviour towards him, did not update the man's risk management plan and failed to identify risks sufficiently and to put in place prevention strategies. In addition, the Support

Service did not have in place policies and training to reinforce to staff that hot liquids should never be left in a manner that could put service users at risk. Further, staff did not manage incident reporting adequately. Noting the above, it was found that the Support Service failed to provide services with reasonable care and skill, and breached Right 4(1).

Criticism was made in relation to a support worker's failure to recognise that it was unwise to leave a hot drink in a place where an intellectually impaired, blind client might be able to access it.

Recommendations
It was recommended that the Support Service complete the following actions:

a) Commission an independent review of:

   i. the effectiveness of changes made to the service in light of the events highlighted in the investigation report;
   ii. the personal plans and risk management plans for each client to ensure that each has been reviewed and updated appropriately and contains clear information specific to that person. If the review identifies deficiencies, the review should extend to a random audit of clients; and
   iii. ongoing training needs of support workers, including in the area of first aid

   and report back to HDC on the actions taken in response to this review.

b) Conduct an audit, over a three-month period, of compliance with incident reporting procedures and timelines.
c) Report on progress with the introduction of the electronic delivery system and evaluate the effectiveness of the system.

It was also recommended that the Support Service provide the man and his family with a written apology for the failings identified in the report.