# Spectrum Care Trust Board

## A Report by the

## Deputy Health and Disability Commissioner

## (Case 10HDC00356)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

# Table of Contents

## Executive summary

*Background*

1. In 2010, Spectrum Care Trust Board (Spectrum Care) advised the Health and Disability Commissioner (HDC) of the drowning of Master A while in respite care. A short time later, HDC received a complaint from Ms A about the services provided by Spectrum Care to her son, Master A. Spectrum Care requested that HDC undertake an independent review.

2. Master A, 11 years old, had been receiving respite care at a facility (the facility) operated by Spectrum Care for approximately four years. Master A had autism and an intellectual impairment. He had a history of absconding from home and respite care, including three attempted escapes and two escapes from the facility in 2009.

3. Staff had been instructed to supervise Master A closely when he was outside. There had been ongoing issues with the gates to the backyard, including the gates needing to be closed firmly to ensure they closed securely. In addition, the gates had locks only on the inside, allowing entry from outside the gates.

4. One morning in early 2010, a staff member had checked that the gates were secure before the staff took all five children on an outing. On their return, the gates were not physically rechecked, although the gate through which Master A may have escaped was sighted and appeared closed.

5. Master A was allowed to move freely between the house and the backyard. He escaped from the backyard while two staff were discussing a handover and the other was reading a book to three of the children. Sadly, he was later found drowned in a nearby pond.

6. Spectrum Care undertook an internal investigation and was also investigated by the Department of Labour. The outcomes from these two investigations resulted in implementation of a number of improvements.

*Summary of findings*

7. Staff were aware that Master A was at risk of absconding. Spectrum Care took insufficient preventative action in response to Master A's previous escapes in 2009. Spectrum Care breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code), for not providing services to Master A with reasonable care.

## Investigation process

8. Although the Health and Disability Commissioner (HDC) received Ms A's complaint in early 2010, an investigation was not commenced until six months later. The commencement of the investigation was delayed until the Department of Labour had concluded its own investigation.

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

9. Information was obtained from:

| | |
|---|---|
| Ms A | Consumer's mother |
| Spectrum Care | Provider |
| Ms B | House leader |
| Ms D | Community support worker |
| Mr C | House leader |
| Coroner | |
| Child Youth and Family | |
| Department of Labour | |
| Ministry of Health | |
| A needs assessment service coordination agency | |
| New Zealand Police | |

Also mentioned in this report:

| | |
|---|---|
| Mr E | Master A's key worker |
| Mr F | Service Coordinator |
| Ms G | Community support worker |

10. Independent expert advice was obtained from a psychologist with specialist knowledge in intellectual impairment, Sharon Brandford, and is set out in **Appendix A**.

11. The scope of the investigation was:

> *Whether Spectrum Care Trust Board provided appropriate care to Master A in relation to his risk of absconding.*

12. This report is the opinion of Deputy Commissioner Tania Thomas, in accordance with the power delegated to her by the Commissioner.

## Information gathered during investigation

*Respite care*

13. The Ministry of Health funds and contracts respite services as part of a range of supports available to families of children with disabilities. The Ministry's service specifications require respite services to "enable children with disabilities to enjoy a positive, meaningful and stimulating experience that replicates the 'out of family' experiences of children who do not have disabilities". Providers are required to provide a "home-like" environment that is safe and appropriate, including ensuring "secure, physically safe internal and external environments". Providers are also required to manage "disruptive behaviour in the least restrictive way possible".[2]

[2] Ministry of Health Service Specification (National Mandatory) Out of Family Respite Care (Children). Version 1.2 September 2007.

14. Respite care providers are required to meet the Health and Disability Services (Core) Standards, including:[3]

> "The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer group.
>
> …
>
> Consumers are provided with safe and accessible external areas that meet their needs.
>
> …
>
> The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.
>
> …
>
> Consumers who require a greater degree of supervision receive the level of support necessary to protect the safety of the individual, the consumer group, service providers, and visitors to the service."

*Spectrum Care Trust Board*

15. Spectrum Care Trust Board (Spectrum Care) is an independent charitable trust that provides services for children, young people and adults with disabilities, and their families. Spectrum Care provides 24-hour support for people living in their residential homes, respite care for adults, and respite care for children, in various centres around New Zealand.

16. In response to the provisional opinion, Spectrum Care stated that its aim is to provide an environment "that enables children to express themselves according to their individual needs and preferences, and to gain a sense of stimulus and growth within a safe context that offers parents peace of mind. Finding an appropriate balance is always challenging …"

17. One of the facilities provides respite care for children and young people between five and 17 years of age. All of the service users have an intellectual impairment and/or Autism Spectrum Disorder and exhibit challenging behaviours, but they do not receive one-to-one supervision on a continuous basis. The facility has five beds and provides care 24 hours a day, seven days a week. Service users access respite care from one to 15 days per month. There were 21 children using the facility at the time of this event, and eight of these were known by staff to be at risk of absconding.

18. The backyard had a 1.8m high fence with three wooden gates. The gate at the side of the property opened into a neighbouring park. It was padlocked and unable to be opened. There were two further gates, one on each side of the front of the house. The front of the property was unfenced. The gates on the left and right sides of the house had digital keypad locks on the inside with a combination. These gates could be opened from the outside without having to be unlocked. Spectrum Care said that the gates were rarely used, mostly by the lawn

[3] New Zealand Standard 8134:2008.

mowing crew and for property maintenance and repairs. About 250 metres away there is a duck pond, which Spectrum Court advised is not visible from the side gate or the road.

19. In the backyard there is children's play equipment, including a trampoline, and a garden shed. The garden shed was used to store the barbeque, outdoor table and chairs, boxes of papers, a bike and a scooter. The shed had sliding doors, which were kept shut to secure the contents, but were not locked.

20. Spectrum Care reported that "although staff have indicated they were aware that a few balls and other items emerged from the park and that several children peeked over the fence from the park, no documentation or records can be identified that children in the neighbourhood were accessing the backyard of [the facility] to retrieve balls etc".

21. Ms B was the House Leader at the facility, and had worked for Spectrum Care for five years, including as a House Leader at another Spectrum Care house. She advised HDC that she could recall one incident when she saw a child halfway over the fence. When she asked him what he was doing he said he was retrieving a ball. She threw it over the fence for him. She advised that she did not document that incident.

22. Spectrum Care advised that, when children were in the backyard, the supervision depended on the needs of the children and staffing capacity. Staff frequently positioned themselves outside but it was also common for children to be overseen while staff remained in the house. Spectrum Care stated that "it was common practice for the gates and environment to be checked prior to enabling children to play outside".

23. The facility had last been audited in May 2007, as part of a sampling plan of Spectrum Care, and received a three-year certificate.

*The staff*

24. The staff work on a rotating roster, with two staff working in the morning and three in the afternoon and evening to manage up to five children at a time. One staff member also sleeps on the premises overnight.

25. Spectrum Care stated:

> "All staff receive specific training and coaching in managing risks and supporting individuals that are regarded as presenting high risk. The induction course includes content on health and safety and risk management … In addition, staff can attend SPELL training which provides guidelines as to how to manage individuals with Autism Spectrum Disorder.
>
> In addition, part of the role of Service Coordinators and House Leaders is to coach and guide staff to manage the needs and vulnerabilities of individuals that are at high risk. When the behaviours are of particular concern, the Behaviour Support Team is involved to provide additional advice and support to staff.
>
> Spectrum Care has also commenced the certification of all Community Support Workers. The staff that are embarking on a Level Two qualification specifically focus

> on health and safety standards, and staff embarking on a Level Three certificate complete additional standards on challenging behaviours and risk management."[4]

*Master A*

26. Master A was diagnosed with autism and an intellectual impairment. He had the cognitive functioning of a one- to two-year-old child, and a number of behavioural needs, including a tendency to abscond. Master A had a history of wandering away from his family home and respite care. He was non-verbal and he was on medication for anxiety.

27. Master A's gross and fine motor skills were severely limited. In response to the provisional opinion, his mother Ms A advised that Master A would not have been able to push a sequence of numbers on a keypad unless he had been shown repeatedly how to do so, as it took a long time to get him to do a four-piece puzzle or make a stack of blocks.

28. In 2006, Master A, who was then aged seven, started attending the facility for respite care. Master A's risk of absconding was a regular issue, and staff who had worked there for some time had experience of him attempting to leave, particularly when someone arrived at the front door.

29. In 2007, the House Leader, Mr C, completed a "Client Risk Management Form" for Master A. Two risks were identified. The first risk was: "Hair pulling, pinches, scratches, bites when upset, anxious & out of control". Staff were instructed, amongst other things, to "give him space to run around or play outside & on trampoline". The second risk was that Master A had no road sense and that staff were to hold his hand when near roads or out in the community. This form was evaluated in 2008 and 2009, and the risks were noted as ongoing. Spectrum Care's policy was to review this form "as needs change or at least annually".

30. Master A disliked being restricted to indoor activities and frequently played in the backyard. He would repeatedly go in and out of the house.

*Crisis plan*

31. Sometime in early 2009 (the exact date is not recorded), a community support worker wrote Master A's first Crisis Plan. The plan stated:

> "[Master A] will be watching the door (front door), he may be roaming outside & attempting to get under gaps in the fences. If [Master A] absconders [sic] he may do it when staff are preoccupied. He is quick & can get away to the main rd [sic]. [Master A] has no road safety sense and enters strangers [sic] houses, he also will go with strangers in the car.
>
> …
>
> If [Master A] absconders [sic] x 1 staff to immediately go and find him. The other staff to call Police, then call On-Call [Coordinator], then contact [Master A's] mum to let [her] know what is happening. In the past [Master A] has always headed towards [main]

[4] Spectrum Care stated that its first community support workers commenced the certification process in -mid 2009 and certification was rolled out to all its community support workers in late 2009.

> rd [sic] rather than the side rds [sic]. [Master A] also loves water & there is a duck pond meters from [the facility] that should be checked first."

32. In response to the provisional opinion, Spectrum Care advised that this practice had been amended because of the greater risk from the road, but the written crisis plan was not updated. As a result, the duck pond was not immediately checked closely when Master A was found to be missing.

33. Master A's key worker or another delegated staff member was responsible for checking that Master A's plan was up to date each month. The community support worker initialled the form for the months of January to March 2009, and Master A's key worker, Mr E, from April to June 2009. There are no initials for the months of July to October 2009.

*Risk assessment form*

34. In mid 2009, a community support worker wrote an "Individual Risk Assessment Form" for Master A.[5] On the form, under "Risk Description" was written:

> "[Master A] will take any opportunity to absconder [sic], he may do this when staff are occupied. If doors (front door) left unlocked [Master A] will absconder [sic]."

35. Under "Possible Outcomes" was written:

> "[Master A] is very quick and may get to the main [road] before staff can get him this poses the risk of him getting hit by a car. He also runs into other peoples houses, …"

36. Under "Preventions/Response" was written:

> "House to be secure (high fences), no chairs or tables left outside that [Master A] can use to get over the fence. Staff to always ensure that the front door remains locked ..."

37. Master A's risk level was given the highest rating ("catastrophic") with a moderate ("might occur at some time") likelihood of occurring. Under "Actions" was written:

> "If [Master A] is outside staff to supervise him closely. If [Master A] absconders [sic] follow the crisis plan. Keep doors, gates locked at all times. [Master A] has no road safety sense."

38. In response to the provisional opinion, Spectrum Care stated: "In terms of relative risk the area of greatest concern identified by staff was the risk of [Master A] running across a road and particularly a major road." Spectrum Care said that although the water was identified as a risk it was not reinforced by [Master A's] history and, as he had the cognitive functioning of a one- to two-year-old, his actions were likely to spontaneous in nature, rather than planned. Spectrum Care also noted that the pond could not be seen from the facility.

[5] Although the community support worker completed the form in April she initialled it for the months of January to May 2009. Spectrum Care stated that she "signed for January to March of this form incorrectly". Mr E signed the form for the months June to November 2009.

39. Spectrum Care stated that the requirement for close supervision "did not require constant observation". When asked for further clarification it stated:

> "• 'Close supervision' refers to 'looking after, overseeing, monitoring, supporting and guiding' the children's activities.
>
> • The intensity of the supervision is dependent on the needs of each child and perceptible risks associated to that individual, eg there would need to be closer oversight when out walking by the road.
>
> • Instructions and discussions about specific individual requirements are addressed in house meetings and handovers, as well as via coaching by the House Leader and the Service Coordinator.
>
> • In [Master A's] case, the Service Coordinator instructed all staff to keep a watchful eye on [Master A] between 3–4pm, or whenever visitors came to the house."

40. In response to the provisional opinion, Spectrum Care added: "Close supervision for [Master A] while he was at the house involved making sure he could be seen frequently, heard ([Master A] was often laughing loudly) and regularly monitored when he was outside." Spectrum Care said that when high levels of risk were apparent, such as when someone opened the front door, then staff would need to be particularly focussed and maintain constant observation, being ever vigilant to minimise risks.

41. In late 2009, Master A's crisis plan was typed up by Master A's key worker, Mr E, with no significant changes made. Mr E initialled the plan for the month of November, and then no further initials were added.

42. The following month, Mr E reviewed Master A's risk assessment form, but made no significant changes. Spectrum Care said:

> "The same form should have been initialled [the next month]. However, … the new House Leader was asked to review all of the Plans for every service user accessing [the facility] and this may explain why the key worker had not reviewed this particular form by the time of [Master A's] death."

43. When asked about the gaps in the recording of signatures on Master A's various plans, Spectrum Care stated that there were significant changes with documentation occurring during this time, and that the lapses in documentation was one of the primary reasons for the change in leadership towards the end of 2009. However, Master A's behaviours, activities and any risks were reviewed during each handover and discussed by staff and whānau, so any significant changes would have instigated amendments to the crisis plans.

44. In response to the provisional opinion, Spectrum Care added that "the identified expectations for documentation by staff as outlined in several parts of the report are unrealistic". Spectrum Care noted that its staff often have low literacy levels, and English as a second language, and are challenged by written communication.

*Absconding incidents in 2008*

45. In 2008, there were four incidents of Master A absconding, three from the facility and one while on an outing. Spectrum Care stated that it advised Ms A following each incident. Spectrum Care explained that it:

> "… has a manifold system to identify and manage risks and hazards. Each incident is documented and reviewed by the Service Coordinator and Team Leader. In addition, the staff review each incident during the monthly house meeting. Serious risks are drawn to the attention of management and discussed at the Regional Health and Safety meetings."

46. Mr C said that after completing an incident form he would call the service coordinator or, if after-hours, the on-call coordinator, to discuss the incident.

47. On the first occasion, Master A escaped unnoticed and was found four houses down the street by staff five minutes after he was noted to be missing. Staff could not explain how he escaped as all the doors and gates were locked. No prevention strategies were noted on the incident form.

48. On the second occasion, Master A escaped unnoticed when visitors arrived to drop off a client at the facility. Master A was found by the Police. Staff were instructed to ask visitors not to come into the house when dropping off clients, so as not to unsettle the residents.

49. On the third occasion, Master A escaped while on an outing to a park, when a caregiver was distracted by another caregiver who requested assistance. The caregiver found Master A at a nearby house. Staff were instructed to go on outings fully prepared to avoid a similar distraction.

50. On the fourth occasion, Master A is believed to have escaped out the front door when a taxi arrived to pick up a child and staff left the door unlocked for two minutes while they got the child ready to leave. Master A was found by a caregiver at the top of the road. Staff were instructed to keep the doors locked.

51. In 2009, the Family Governance Group[6] met and minuted under "Security": "There were questions of the front door having a deadlock, the doorbell has fallen off and there are issues around quick access via the gate." This was to be followed up with Spectrum Care that month.

**Absconding incidents in 2009**

52. There were three instances of Master A attempting to abscond and two escapes from the facility.

[6] The facility has a Family Governance Group made up of parents of service users and staff representatives. The Group oversees the running of the home and informs management of any issues, including health and safety issues.

*First attempt to escape*

53. On the first attempt, an electrician came to fix a sensor light in the backyard and left the right-hand side gate open.[7] Master A ran through the gate and was caught swiftly by the contractor. The gate was examined and found to be functioning properly. On the incident form it was suggested as a prevention:

> "Firstly a sign on the front door and gates to make sure they are locked upon entry and exiting. Some sort of automatic, locking device on the door/gates. Maybe?"

54. Spectrum Care later stated that as a result of this incident:

> "All contracted staff were requested to advise the house staff prior to undertaking any work on the premises and staff were asked to be vigilant when contractors are at the property. Whenever possible, arrangements are made for the contractors to arrive when no children and young people are at the house. A study of the gate determined that it was in order and functioning properly. This gate was seldom used, but staff would still undertake regular checks of this gate for any faults."

*Second attempt to escape*

55. On the second attempt, Master A left through the front door when a parent of one of the other children arrived. Master A was caught within five metres of the front door. The incident form noted: "Staff have been directed to always lock the door but they thought a few seconds would be O.K." Under "Coordinators/Service Managers Comments" was written: "Staff have been advised to keep doors locked at all times." Spectrum Care stated:

> "Staff were advised to bolt the safety screen door once a visitor or parent was inside the house. This was to ensure that staff could better control entry and departures from the house."

56. On the following day, the lock on the left-hand side gate was noted to be loose and was serviced.

*Third attempt to escape*

57. On the third attempt, Master A again left through the front door when a parent arrived. Spectrum Care stated that staff were alert and got Master A back into the house before he left the premises. Under "Coordinators/Service Managers Comments" was written: "Sliding bolt should always be kept engaged on the screen door." Spectrum Care said:

> "The lock on the entry door was replaced with a key operated exterior and a push-button release interior lock. This would enable staff to manage access when parents were picking up and dropping children off and not be so reliant on people fastening the bolt."

*Escape*

58. Master A had been outside playing while staff were watching him from the kitchen where they were preparing dinner. Staff noticed he was gone and went outside. They found that the

[7] The right-hand side of the house looking from the road, which was also the side of the house facing away from the park next door.

left-hand side gate was open. Staff followed the crisis plan by first contacting the Police and the On-Call Coordinator. One staff member went out to look for Master A while the other remained with the other children. The Police found and returned Master A. On the incident form it was stated:

> "Police said the gate latch is not secure & the gate needs to be closed with 'force' before it will lock. The gate can appear locked if closed normally but it isn't as it needs to be pulled in hard.
>
> …
>
> Plan to check gates when starting shift as people can open the gate from the outside. Close gate hard & double check it's locked as gate doesn't always lock if not closed hard enough."

59. Under "Coordinators/Service Managers Comments" was written: "Staff have to [check] and sign in the [Communication] Book that both gates are locked." Spectrum Care stated:

> "The wooden gate swelled as a result of the rain and it needed to be forced shut before the locking devise [sic] would engage properly. The acting Service Coordinator … ensured the malfunctioning gate was fixed [the next day] by contractors. In addition, a note was placed in the house Communication Book for all the staff to check the gates are securely locked when coming on shift."[8]

60. The following day, a locksmith attended and repaired the lock on the left-hand side gate. The "Hazard Identification Assessment and Management" form was updated that day with "Referred to BST [Behaviour Support Team] doors fixed". The Service Coordinator, Mr F, put in place a plan for staff to check the gates every day for a month to assess whether they were malfunctioning. Staff recorded their daily checks in the communication book.

*Ms A's concerns*

61. Ms A said that she was concerned about the number of times Master A had been able to wander off. She said she spoke to Mr F, and told him that the facility needed better fencing.

62. In addition, Ms A said she suggested to Mr C that the facility should have "beepers" on the doors and gates, so that staff could hear the noise should they be opened. She recalls Mr C telling her that it was unnecessary and that her son would be watched one-on-one. Mr C cannot recall the details of this conversation, but does recall telling staff to be more vigilant with Master A, and that staff were trying to comply.

63. Ms A also said that Mr F provided her with a similar verbal reassurance. Mr F said that he did not contemplate a front fence until after Master A's death. However, Mr F recalls that he told staff to complete incident forms, and he ensured that the gate was functioning properly.

[8] Spectrum Care confirmed that the left-side gate was the one that was fixed.

*Further escape*

64. Master A was playing outside. One staff member was changing another child and another was serving up dinner. A staff member went to fetch Master A for dinner and discovered he was missing. The Police were contacted and Master A was found at a nearby house. On the incident form it was noted:

> "The house is secured & he has never been able to [get] over or undered [sic] fences before. We assume he has gotten out through a small gap under the fence. [Master A] needs 1:1 staffing.
>
> …
>
> [Master A] needs 1:1 staffing. Staff are constantly attending to [Master A]. As soon as they turn their backs he is … getting [into] things & now absconding and other clients are not getting equal amount of attention from staff."

65. There are no "Coordinators/Service Managers Comments" but the form is signed by the respective staff members. Spectrum Care said:

> "As a safeguard, the then Service Coordinator … developed a system for verifying the daily checking of the gates in the Communication Book. The incidents on […]/09 and […]/09 were again reviewed in the Health and Safety Meeting on […]/09. Staff were well aware of [Master A's] tendency to abscond (together with his other behavioural concerns) and continued to ensure that the gates were locked at all times. To ensure that there was no problem with the gate, staff were instructed to check the gate every day to ensure it was functioning well and continue to confirm in the house Communication Book until […]/09. Once staff deemed the gate was functioning properly, they returned to monitoring the gate regularly, as they had done before, and any problems with the gate would be addressed urgently."[9]

66. Mr C recalls telling Spectrum Care management that Master A could not have escaped through the gap under the gate to the park, which was the largest gap under a fence. Mr C also recalls that there was a discussion about requesting one-on-one funding for Master A.

67. At the next house meeting it was minuted: "[Master A] absconding — gate locked all the time now / checked."[10]

68. The following month, the "Environmental Restraint Form" stipulated:

> "All Gates x3: the gates outside should always remain shut and locked at all times to prevent the service user from absconding. The gates should be checked each day and after the lawn mowing team [has] been in."

69. Later in the year, a service coordinator reported defective digital locks on the two side gates. A locksmith repaired the lock on the right-hand side gate and replaced the lock on the left-

[9] Spectrum Care later stated that staff were requested to check both side gates.
[10] Spectrum Care later stated that the minutes should have more accurately stipulated "gates" rather than "gate".

hand side gate. The gates continued to be able to be opened from the outside without disengaging the lock.

70. In 2010, a service coordinator reported that the right-hand side gate could not be secured properly. An after-hours carpenter fixed the problem with the gate. A few days later, a service coordinator reported that the right-hand side gate lock was not working properly. A locksmith attended and reported that the lock had been fixed.

*Level of respite care*

71. In mid 2008, a needs assessment and service coordination agency (NASC) conducted a needs reassessment with Master A and his mother.[11] Since his previous reassessment in 2005, Master A had become more physically abusive when he was frustrated or angry. The 2008 assessment noted that [Master A] needed "24/7" supervision and that: "[Master A] will wander off — disappear out front door any chance he gets. Mum is constantly checking him."

72. The NASC did not provide Spectrum Care with a copy of this needs assessment, as it was not standard practice to do so. However, Master A was allocated an additional 108 days of respite care in addition to the 48 days a year he was already receiving. In early 2009, Spectrum Care put Master A on a waiting list at the facility for the additional days.

73. Master A's respite care was renewed by the NASC on in mid 2009 with the comment: "No change to current support." There were no additional comments made on the renewal form sent to Spectrum Care, including nothing noted under "current behavioural concerns". Spectrum Care said that it had no further communication with the NASC regarding Master A.

74. The NASC later explained to HDC:

> "Residential respite service providers have a staff: client ratio that they determine to meet the service quality requirements of their contracts with the Ministry of Health.
>
> To support a child with exceptional needs, a provider will manage in different ways. For instance by looking at times in service they agree with families, balance the needs of all clients, and staff rosters necessary to support clients appropriately. So for example, a child who requires closer 1:1 support may be scheduled in service when the house is not at full capacity. In very exceptional cases the provider can alert NASC that a child requires additional support beyond what they can provide using usual planning methods. We can consider this and seek consideration from the Ministry of Health to allocate additional resources. We have a Respite Coordinator who keeps an overview of respite service utilisation, capacity and any service issues. Spectrum Care has advised our Respite Coordinator that they are now using a high risk register for children posing any kind of risk."

[11] The needs assessment and service coordination service is contracted by the Ministry of Health. Its role is to "allocate support packages to meet identified needs to those under 65 with a physical, intellectual, neurological or sensory impairment".

75. Spectrum Care commented to HDC:

> "With regard to 1:1 staffing for [Master A], he already had a very high allocation of respite approved by [the NASC] (being 156 days per year). In addition to this support, he had 50 additional days of Carer Support. Even though [Master A] had very high needs, it was unlikely that further resources for 1:1 staffing would be considered by [the NASC] unless there were constant incidents and all alternative courses of action had been explored. We were already experiencing major difficulties securing supplementary funding for another child at the time, who appeared to pose a more serious risk in terms of safety. Therefore, [Master A's] needs — as demonstrated by his behaviours and environmental circumstances — were significantly below the threshold that had been established through other precedents by [the NASC], in terms of 1:1 staffing allocation."

76. Spectrum Care's General Manager Operations later told the Department of Labour that the criteria for one-on-one staffing was normally violence, and that Master A had not displayed violence.

*The incident - 2010*

77. In the morning, community support worker Mr E checked all the gates to ensure they were secure. At about 11.00am the children and staff went on an outing. The children and staff returned at about 1.45pm and entered the house through the front door. Mr E observed that there were a number of children playing in the street and the park next door. He checked the doors, but not the gates, when they returned. When Mr E left at 2pm Master A was inside playing on the couch.

78. Community support worker Ms G told the Police that she opened the sliding door to the outside because it was a hot day. Master A "would run and get grass and run back in".

79. Ms B said that she arrived at 1.45pm. She recalls parking her car on the forecourt next to the left-hand side gate and observed that it appeared to be closed. She also recalls seeing children playing in the street and park next door. She entered the house through the front door.

80. There were five children, including Master A, at the property at the time of the incident. All the service users had challenging behaviours, but none received one-on-one staffing.

81. In response to the provisional opinion, Spectrum Care advised HDC that at the time of the incident the number of children using the respite service was greater than planned, because two families had arranged to pick up their children at 6pm rather than the normal time of 3pm. Spectrum Care said that this had "a significant impact on the expected staff/child ratio" and that the four children being supported until 6pm all required support with personal cares and were "high and complex" in a number of their behaviours and needs.

82. Spectrum Care said that the policy for respite care during the weekend is that the day finishes for the children at 3pm and the new day starts at 4pm, which allows the staff to have an hour to prepare for the incoming children. Spectrum Care stated that "it had become an occasional practice for some [respite care] families to not adhere to this policy and, instead, impose on

the good will of the staff and request a late pick up. There has been no further tolerance of this behaviour since the death of [Master A]."

83. Spectrum Care stated that a staff member had called in sick that day, and a community support worker, Ms D, had agreed to cover part of that person's shift. Spectrum Care said that the house leader, Ms B, "was concerned that neither she nor [Ms D] were [sic] sufficiently familiar with the children who were coming in that afternoon at 4pm". As a result, handover began at 2.45pm.

84. Spectrum Care said: "[Ms B] was very aware that she and [Ms D] (both only having a month's experience at [the facility]) were to be left without any experienced or knowledgeable staff member and would be required to support four children until 6pm and then two until the next day, when [Ms B] would be required to organise the two who stayed overnight off to school."

85. Ms B recalls that when she arrived, Master A was on the couch in the lounge. She got the handover and then greeted all the children and staff. She read a book to two of the other children, while Master A was in the lounge. She then gathered information for the shift changes. Ms B heard Master A laughing in the bedrooms. Ms B said Master A had tipped all the beds over, which he often did to get attention. He had also put grass he had picked from the backyard in one of the bedrooms. Ms B said she suggested that he go outside and play on the trampoline. Master A ran to the playroom and Ms B walked to the lounge.

86. Spectrum Care stated that:

> "[Master A] was frequently in the backyard playing as he detested being restricted to indoor activities. However, like most children who access respite, he would go in and out of the house repeatedly. Staff stated that they would keep an eye on him, particularly when anyone was entering or leaving the house."

87. That afternoon, none of the staff physically checked the gates before Master A was allowed to play in the backyard.

88. Ms B said that she talked to Ms G about pick-up times. Master A ran past her, went outside and jumped on the trampoline. She recalls last seeing Master A around 2.30pm.[12] Ms B said she went to the kitchen area and planned what she needed to do the following morning, and then started preparing dinner. The lounge doors through which Master A was coming and going and some of the backyard are visible from the kitchen area, but the left-hand side gate, trampoline and garden shed are not visible from the kitchen.

89. Ms D was in the playroom, supervising three of the children. The other child was in the lounge watching a DVD. The playroom is directly by the left-hand side gate and faces the back of the section. Ms D recalls seeing Master A through the sliding glass doors of the playroom. She said he was picking grass in the backyard and coming and going through the lounge doors.

[12] Ms B does not recall checking her watch or a clock to establish the time.

90. In response to the provisional opinion, Spectrum Care said that allowing Master A to play outside was a behaviour management strategy, and that the dining room and lounge have ranch sliders that open to the rear of the section, "allowing for children to wander in and out while still being appropriately supervised, and typically remaining in line of sight".

91. Ms D said that she was sitting on the floor in the playroom, facing away from the window that looked out onto the left-hand side gate. She does not recall hearing any suspicious noises. When she stood up, she noticed that the sliding doors on the garden shed were open and went to investigate, as the doors were normally closed. Ms D recalls calling out to Master A and checking whether he was playing "hide and seek" in the shed.

92. Ms D closed the garden shed doors and, on her way back inside, she noticed that the left-hand side gate was wide open. She ran back into the house to check on the children. She could not find Master A, so she ran outside to look for him. She went through the gate to check whether he was at the front of the house, and then looked up and down the road. Ms D recalls seeing clumps of picked grass on the forecourt near the left-hand side gate.

93. Meanwhile, Ms B and Ms G were in the kitchen/dining area finalising handover and roster changes. Ms G was finishing her shift, and parents, including Master A's mother, were expected to arrive shortly to collect their children.

94. Around 2.45pm,[13] Ms D informed Ms B that Master A was missing. Ms G rang the On-Call Coordinator and left a message, as the Coordinator was on another call. Ms G rang the Police. In response to the provisional opinion, Ms A advised that she arrived around 2.54pm and was told that Master A had gone missing two minutes previously.

95. Ms B later told Police that Master A "may have been unaccounted for" for up to 15 minutes. However, she did not see him leave the property and can only assume that he went out through the gate that was later found to be open. Ms B told HDC that she believes that she had not seen Master A for five to ten minutes but she could not be sure of the exact time. Ms D recalls that she had not seen Master A for about 15 minutes before she noticed that the garden shed doors were open.

96. Following searches for Master A, his body was found in the pond (approximately 250m away from the facility).

*Condition of gates*

97. After the incident, Spectrum Care inspected the property. It advised that the left-hand side gate locked normally but required "extra force" to properly close and engage the lock. The other two gates were found to be secure. Spectrum Care later stated:

> "No staff or people using the respite service entered or exited via the gate prior to [Master A] leaving … [i]t is not known who the last person was that used the gate in question."

98. In her statement to the Police, Ms B said that three weeks prior to the incident she had noticed that the left-hand side gate was sticking. She stated, "I was not concerned, but made

[13] Ms D does not recall checking her watch or looking at a clock to establish the time.

a mental note that it might need attention before the winter when the gate would be wetter and might swell."

99. Spectrum Care advised that having three gates, in addition to the front door, did not place extra demands on staff, because one of the gates was already sealed prior to the incident. Spectrum Care stated: "In the event of a fire, it is important for the Fire Brigade and emergency services to have access to the building and the rear section, and this was the primary reason for not having the gates locked from both sides."

100. Spectrum Care said: "The front door was the main focus of attention as that was perceived to pose the greatest danger. This was the main source of access and [Master A] had attempted to abscond from the front door on several occasions … This did not mean that staff ignored the risk associated with the gate and a number of measures were instigated to minimise the risk."

101. Spectrum Care added that "while safety was at the forefront of consideration, it was not the backyard fencing and gates that were identified as the greatest risk for children".

102. Spectrum Care acknowledged that staff needed to ensure the premises were safe, and stated that "a staff member had physically checked the gate that day at 11am and a further visual check at 2pm indicated that the gate was secure. It was routine practice to physically check the gate daily, but not at other times during the day unless the lawn-mowing crew or a contractor was known to have visited."

103. Spectrum Care said: "This tragedy was not a result of complacency, but a profound interaction of situational and system variables that worked against best practice." Spectrum Care stated that the service it provided was affected by the resource constraints under which respite services operate, and that "the extenuating contractual and respite service model limitations were part of the system forces that were in play in the overarching service environment at the time of [Master A's] untimely and tragic death".

**Further actions**

*Spectrum Care*

104. Following the incident, Spectrum Care launched an internal investigation. It contacted the Ministry of Health, the Department of Labour, ACC, and the Health and Disability Commissioner (HDC). Spectrum Care provided financial support to Master A's family, attended his tangi and met with his family to discuss the internal investigation.

105. The internal investigation found that the gate had been physically checked at 11am by Mr E, and then visually checked by Ms B at 2pm. Spectrum Care concluded that a member of the public may have entered the property via the gate and not closed it properly. Spectrum Care commented that:

> "[t]he back area was considered secure by staff and their major concern for [Master A] was preventing his departure from the front door, which was the area of departure he had previously targeted. [Master A] had not run away for a considerable period. He had free access to the backyard over the proceeding month and no problems had been experienced. Staff therefore perceived the back area as safe for [Master A] and allowed

him to go in and out of the house to play on the trampoline with regular, but not constant, monitoring (which was consistent with his risk assessment).

…

It was noted that a number of children were playing in the vicinity of the gate and they may have accessed the property. This had occurred several times in the past as children had sought to retrieve balls etc.

Although less likely, another possibility is that [Master A] entered the numbers on the combination lock and exited. The combination numbers were "1234" and [Master A] may have, by chance, pushed the correct numbers and then turned the knob to exit through the gate."

106. Spectrum Care stated that all the staff on duty at the time of the incident indicated that they were aware that Master A was an absconding risk. Spectrum Care noted that once staff were aware that Master A was missing they followed his risk management plan, including starting a search and contacting the on-call coordinator and the Police.

107. As a result of its internal investigation, Spectrum Care made the following changes:

- The park and left-hand side gates have been sealed.
- The gate on the right-hand side has been replaced with a steel and plywood gate with locks on either side. It is self-closing and has a buzzer to alert staff when it is opened.
- The garden shed doors have been padlocked.
- Wooden gates have been replaced with self-closing metal gates at other properties where there is a risk of children and/or young people absconding.
- A steel fence and gates have been installed across the front.
- The fence along the park-side and rear of the property has been heightened.
- A new "Review of Property Form" was developed to review the suitability of the fences, gates, doors and windows, and implemented at each of Spectrum Care's houses.
- A new "Emergency Plan Form" was developed to ensure all staff (permanent and casual) are aware of any major risks that may apply to the care and support of each individual, including specific roles for staff in the case of an emergency.
- The "Hazard Identification Assessment and Management" documentation and the identification of service users that require intensive support are agenda items for the Family Governance Group meetings.
- Spectrum Care and the NASC have developed a liaison agreement on how they can work collaboratively.
- Handovers are now undertaken at the dining table (to ensure maximum visibility) and are as pertinent and succinct as possible.
- Handover guidelines have been amended to highlight the need for staff to be aware of each individual's needs and safety.

108. Spectrum Care stated that "[e]ssentially, Spectrum Care has now moved outside the current respite service specifications by providing a relatively secure environment, closer to the security of care expectations for children supported under the IDCCR[14] legislation".

*Standards and Monitoring Service for Respite Care Audit*

109. In mid 2010, the facility was audited by the Standards and Monitoring Service (SAMS) as part of a broader audit of Spectrum Care's respite services in the region. SAMS is an independent, not-for-profit organisation governed by people with a disability and family/whānau. The audit noted that Spectrum Care had recently reviewed individual assessments to identify children at high risk. Six children had been identified as requiring a higher level of support during their stay, and referrals were made to the NASC. All children at risk of absconding were identified, and this issue was noted on their files.

110. While waiting for a response from the NASC, staff at the facility were reviewing combinations of children staying together, activity options, and the strengthening of environmental restraints. Staff were also identifying which individual child they would each be supporting during their shifts.

111. The audit required Spectrum Care to follow up with the NASC on higher levels of support and obtaining resource consent to increase the height of the backyard fence.

*Department of Labour investigation*

112. Spectrum Care sent a Serious Harm report to the Department of Labour. The Department of Labour investigated Master A's death and identified the following practicable steps that Spectrum Care could have undertaken:

"
- To have an effective supervision and monitoring procedure for the service users during staff handover.
- Staff handovers from one shift to another to occur in a location that maximised supervision of the service users.
- To have had an effective system to identify and implement appropriate security arrangements relevant to the service users and setting.
- Ensure the facility is secure at all times, especially when returning to the house when it has been unoccupied for several hours.
- To have had an effective system to identify and manage hazards at this facility.
- The need for a climb free front fence and gate.
- Have only one gate to rear of property and one at the front of the property.
- Install [a] child proof locking system on the gates to prevent the gates being opened from the outside and the inside of the property.
- Warning devices on the gates so that when the gate [was] opened an alarm was activated.
- Replace gates with metal self closing gates.
- Erect climb proof fencing around the property.
- Consider the use of personal alarms for clients.

[14] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

- Consider one on one care for high risk clients."

113. The Department of Labour concluded that there was "insufficient evidence to proceed with any charges under the Health and Safety in Employment Act 1992" as it was unable to show whether the action or inaction of a particular employee led to Master A's death.

**Responses to provisional opinion**

114. Responses were received from Ms A and Spectrum Care. These have been incorporated into the opinion as the Deputy Commissioner considers appropriate and relevant.

## Opinion: Breach — Spectrum Care Trust Board

115. Master A was an 11-year-old child who had been diagnosed with an intellectual impairment and autism. Master A had a number of behavioural needs, including a tendency to abscond. Master A had a history of wandering away and, in many cases, he attempted to leave through the front door, when someone was arriving or leaving. He was described as being extremely quick. Master A escaped and, sadly, shortly afterwards was found to have drowned in a nearby pond.

116. Master A had attended the facility for respite care since 2006. The facility is a Spectrum Care-owned respite care house for children and young people with an intellectual impairment and/or autism spectrum disorder. The staff at the house are employed on a rotating roster and usually two staff are employed in the morning and three in the afternoon and evening to manage up to five residents. One staff member sleeps on the premises overnight. Spectrum Care is contracted to provide a home-like atmosphere, rather than a locked down facility.

117. The main issue in this case is whether the care provided to Master A was adequate in light of his high needs, which were required to be balanced with the requirement to maintain a home-like atmosphere, and whether Spectrum Care's actions, taking into account the resource constraints that Spectrum Care has advised are faced by providers of respite care, were reasonable in the circumstances.

118. In response to my provisional opinion, Spectrum Care submitted that providers may alter the eligibility of future referrals to limit the participation of children who have a major risk of absconding in response the findings in this opinion. Spectrum Care commented that "the sad irony of this is that the families and children most desperate for support may now have limited access to these very supports". In my view, a provider who accepts the responsibility for a child with known risk factors, such as a tendency to abscond, has always been required to take reasonable steps to minimise the risk. My findings in this case do not alter that general proposition.

119. Spectrum Care stated: "The context of inclusion and achieving valued lives challenge staff to take calculated risks that shift responsibility and decision-making, as much as possible, back to the person with a disability." I note that Master A had a mental age of a one- to two-year-old child and that his management plan allowed him to wander in and out of the house at

will. In my view, Spectrum Care had a duty to ensure that Master A was able to be adequately monitored in these particular circumstances.

120. The circumstances were that handover was taking place, additional children who were being collected late required supervision, and the staff were inexperienced. In my view, it was unwise to allow Master A to play outside at that time. I do not consider that the notions of individual decision-making and calculated risk are relevant in this case.

*Previous escapes*

121. In 2008 there were four incidents of Master A absconding while in respite care, three of the four from the facility. There were no further absconding incidents recorded for the next six months.

122. In early 2009, a crisis plan was developed, which identified that Master A was at risk of absconding. The specific risk of Master A leaving the premises was clearly identified. Master A's individual risk assessment was developed in late 2009 and a hard copy was kept in his file. The plan stipulated:

> "If [Master A] is outside, staff are to supervise him closely. If [Master A] absconds then the crisis plan was to be followed."

123. The crisis plan stipulated:

> "[Master A] will be watching the door (front door), he may be roaming outside & attempting to get under gaps in the fences. If [he] absconders [sic] he may do it when staff are preoccupied. He is quick & can get away to the main rd [sic]. [Master A] has no road safety sense and enters strangers [sic] houses, he also will go with strangers in the car.
>
> …
>
> If [Master A] absconders [sic] x 1 staff to immediately go and find him. The other staff to call Police, then call On-Call [Coordinator], then contact [Master A's] mum to let [her] know what is happening. In the past [Master A] has always headed towards [main] rd [sic] rather than the side rds [sic]. Master A also loves water & there is a duck pond meters from [the facility] that should be checked first."

124. In response to my provisional opinion, Spectrum Care advised that the practice that had developed was first to search the road rather than the pond area, because that was seen to be a greater risk. However, the crisis plan was not updated. In my view, it was important to ensure there was a current written crisis plan for Master A, and that all staff were familiar with it. The necessity for this is demonstrated by the circumstances, in that two of the staff members who were on duty at the time Master A absconded each had only one month's experience at the facility.

125. In 2009 Master A attempted to abscond five times, and on two of these occasions he managed to escape. Staff completed incident forms and usually contacted Ms A after each incident. Preventative measures were identified and followed up after each incident.

126. Master A had absconded from the backyard twice in one month, in mid 2009. On the second occasion, it was not ascertained how he got out. Despite this, Spectrum Care said in response to my provisional opinion: "The front door was the main focus of attention as that was perceived to pose the greatest danger. This was the main source of access and [Master A] had attempted to abscond from the front door on several occasions." I accept that the front door was a risk but, in my view, Spectrum Care was on notice that [Master A] could and would wander from the backyard, if he had the opportunity to do so. I consider that the focus on the front door was unfortunate and, although [Master A] had not absconded for eight months, the risk remained.

127. It is not known how Master A escaped in 2010. However, at the time he was noticed to be missing, the side gate was found to be wide open. I conclude that it is more likely than not that Master A escaped through the gate.

128. It was observed that the gate appeared to be closed at 1.45pm; however, the gate was not physically checked at that time. The most likely explanation for the gate being found open appears to be that some person opened the gate from the outside, either while the residents and staff were at the park or in the period between the return from the park and Master A's escape. A less likely possibility is that Master A pushed the correct combination on the lock, which was "1,2,3,4". In response to my provisional opinion, Ms A advised that Master A would not have been able to push a sequence of numbers on a keypad, unless he had been shown repeatedly how to do so.

*The gates*

129. As advised by my expert advisor, psychologist Sharon Brandford, extra demand was placed on supervision by staff, because there were three possible perimeter exit points, the two side gates[15] and the front door. She advised that it would have been a relatively easy task to cut off use of at least one, to ease the task for staff in supervisory roles.

130. Ms Brandford further advised that it was unusual to have external perimeter gates that could be accessed from the outside. She considered that inattention to the knowledge that the gates could be unlatched from the outside, together with failing to factor into the risk management that the pond and stream were in close proximity, meant that a foreseeable hazard was not managed sufficiently.

131. In response to my provisional opinion, Spectrum Care advised that the pond was at least 200 metres away and, as Master A had the cognitive functioning of a one- to two-year-old, his actions were likely to spontaneous in nature, rather than planned. I accept that Master A would not have had the cognitive capacity to consciously plan to exit the property in order to access the pond. However, it was recognised that he was at risk in a number of ways when outside the property, such as the risk posed by the road. In my view, the foreseeable hazard was that Master A would take any available opportunity to leave the property.

132. Spectrum Care said: "The front door was the main focus of attention as that was perceived to pose the greatest danger. This was the main source of access and [Master A] had attempted to abscond from the front door on several occasions … This did not mean that staff ignored

[15] The third gate was unable to be opened.

the risk associated with the gate and a number of measures were instigated to minimise the risk."

133. Spectrum Care acknowledge that staff needed to ensure the premises were safe, and state that "a staff member had physically checked the gate that day at 11am and a further visual check at 2pm indicated that the gate was secure. It was routine practice to physically check the gate daily, but not at other times during the day unless the lawn-mowing crew or a contractor was known to have visited."

134. The policy that the gates were to be checked each day and after the lawn-mowing team had been on the property was introduced in mid 2009. I note Ms Brandford's comment that although staff were required to check gates and doors daily, this does not appear to have been recorded in a communications diary on a regular basis, which would restrict a manager's ability to verify that the procedure was being adhered to.

135. In response to my provisional opinion, Spectrum Care advised that it was not reasonable to suggest Spectrum Care had taken "insufficient preventative action" as, before the incident occurred, it had not been identified that the locks were not fit for the purpose, and the gates were rarely accessed. However, I note that there had been a number of issues with the gates, such as the wood having swelled, the requirement of considerable force to be closed securely, and problems with the locks in late 2009 and early 2010.

136. In addition, Spectrum Care stated that there are no standards or guidelines on fencing or gates, and risks from the gates were not identified by contractors or during Ministry of Health audits. In my view, these are not the relevant factors. Spectrum Care was on notice that Master A had previously absconded from the backyard, and Spectrum Care knew that the side gates could be opened from the outside at any time.

137. Spectrum Care further stated: "In the event of a fire, it is important for the Fire Brigade and emergency services to have access to the building and the rear section, and this was the primary reason for not having the gates locked from both sides." I do not accept that this is a valid reason for having gates that were not secure from the outside. The fire service has ladders and other equipment (such as axes) and could have accessed the backyard through the wooden fence via the park in an emergency.

138. In my view, it was foreseeable that the gates could be opened from the outside at any time, not only during the period of time the residents and staff were absent from the house, or overnight. Although Master A had not absconded for eight months, the set-up of the gates was an ongoing risk.

139. I consider that, by having gates that could be opened from the outside, Spectrum Care failed to address a factor that contributed to the environment being insufficiently secure. I do not consider that it was sufficient to check the gates daily or even on each occasion the children went outside, as a gate could be opened and left insecure at any time, including during the time the children were playing outside. The gates were not in line of sight of staff inside the house. Given Master A's speed, he could have absconded within a very short period of opportunity.

*Supervision*

140. Spectrum Care said that the requirement for "close supervision" of Master A did not necessitate constant observation. Spectrum Care stated that close supervision refers to "looking after, overseeing, monitoring, supporting and guiding" the children's activities and, although staff frequently positioned themselves outside, it was also common for children to be overseen when playing outside by staff who remained in the house. They advised that it was common practice for the gates and environment to be checked prior to enabling the children to play outside.

141. In response to my provisional opinion, Spectrum Care added: "Close supervision for [Master A] while he was at the house involved making sure he could be seen frequently, heard ([Master A] was often laughing loudly) and regularly monitored when he was outside." Spectrum Care said that when high levels of risk are apparent, such as when someone opened the front door, then staff would need to be particularly focussed and maintain constant observation, being ever vigilant to minimise risks.

142. Ms Brandford noted that the measures put in place had prevented Master A from absconding for the previous eight months and, in her view, other providers might also have reached the conclusion that his needs could be met within current resources.

143. Ms Brandford advised that the staffing levels were marginally appropriate for Master A, but it would have been desirable to have had higher staffing. However, the circumstances that arose impacted on the level of supervision provided. In response to my provisional opinion, Spectrum Care said: "[Ms B] was very aware that she and [Ms D] (both only having a month's experience at [the facility]) were to be left without any experienced or knowledgeable staff member and would be required to support four children until 6pm and then two until the next day, when [Ms B] would be required to organise the two who stayed overnight off to school." In these circumstances, I consider that, on that day, the staff would have been stretched.

144. At the time of his escape, Master A was wandering in and out of the house, while a staff member was reading to three other residents and another resident was watching a DVD. Ms B and Ms G were in the kitchen/lounge area discussing the handover. Ms Brandford advised that "supervision at handover time needs to be tightly managed, as it is a foreseeable daily routine which can divert staff attention from direct observation".

145. In response to my provisional opinion, Spectrum Care said that the policy for respite care during the weekend is that the day finishes for the children at 3pm and the new day starts at 4pm, which allows the staff to have an hour to prepare for the incoming children. However, on the day of this event, handover took place at 2.45pm when all the children were present, because the house leader, Ms B, was concerned that neither she nor Ms D was sufficiently familiar with the children who were coming in that afternoon at 4pm.

146. Spectrum Care further advised that the number of children using the respite service was greater than planned, because two families had arranged to pick up their children at 6pm rather than the normal time of 3pm. Spectrum Care said that this had "a significant impact on the expected staff/child ratio" and that the four children being supported until 6pm all

required support with personal cares and were "high and complex" in a number of their behaviours and needs.

147. In my view, it was unwise of Spectrum Care to allow a practice of late pick-ups of children, especially in the circumstances they have stated. Ms B required a detailed handover, which should have occurred without the distraction of needing to ensure the children were adequately supervised.

148. Ms Brandford commented that "in hindsight" Master A was not appropriately supervised while playing outside that day. However, Ms Brandford observed that "descriptions of his speed, agility and long history of absconding mean that any provider would be constantly challenged to ensure his supervision never lapsed".

149. In response to my provisional opinion, Spectrum Care said that allowing Master A to play outside was a "behaviour management strategy" and that the dining room and lounge have ranch sliders that open to the rear of the section "allowing for children to wander in and out while still being appropriately supervised, and typically remaining in line of sight". I accept that this was a planned strategy to manage Master A. However, it is clear that Ms D did not have a line of sight to the left-hand gate, and the other two staff members, who were in the kitchen, had a restricted view of the backyard.

150. In my view, in light of the staff available, it would not have been practically possible to have constantly observed Master A while he wandered in and out of the house, while still providing the required care to the other four residents. As stated by Spectrum Care, the intensity of the supervision is dependent on the needs of each child and perceptible risks associated with that individual. Although Master A had not escaped for eight months, his tendency to do so was a known and serious risk. In my view, it was unwise to allow Master A to play outside at a time when handover was taking place and the available supervision was limited.

*Resources*

151. In response to my provisional opinion, Spectrum Care stated that their actions were reasonable, in light of the resource constraints under which respite services operate. In my view, the factors that led to this tragic event were not resource issues. Rather, they were failures to recognise the risks and ensure that adequate systems were in place, and complied with, in order to minimise the risks.

152. Spectrum Care also submitted: "This tragedy was not a result of complacency, but a profound interaction of situational and system variables that worked against best practice." I agree that best practice was not followed and, additionally, in my view, some of the variables could have been, and were, anticipated. The risk posed by the gates, the possibility of staff illnesses, the likelihood that Master A would take advantage of any opportunity to abscond, and the problems caused by allowing parents to collect their children at a later time were all recognised variables and should have been appropriately managed.

*Conclusion*

153. In my view, there was not just one issue leading to a problem with Master A's safety but a series of inadequate or incomplete strategies. In light of Master A's known propensity to

abscond, the layering together of a number of factors resulted in an accumulation of defects which point to a pattern of suboptimal provision of services to Master A.

154. These factors were: that the gates were able to be opened from the outside; the level of supervision during the handover process; the failure to ensure that Master A's crisis plan was updated; the failure to reliably record that the gates and doors had been checked; and the focus on Master A's absconding through the front door.

155. Ms Brandford generally viewed Spectrum Care's failures as mild departures from expected standards. She considered that failing to factor into the risk management that the pond and stream were in close proximity was a moderate departure from expected standards. However, I accept that the pond was at least 200 metres away and out of sight, so Master A would have been unlikely to have absconded with the intention of accessing the pond.

156. In my view, when all the factors are layered together, they have a cumulative effect, which resulted in Spectrum Care failing to provide services to Master A with reasonable care. Accordingly, I find that Spectrum Care breached Right 4(1) of the Code.

157. However, I acknowledge that Spectrum Care has made many improvements since the incident, has undergone two external quality audits, was proactive in reporting the incident to a number of agencies, and has made attempts to support the family through this difficult time.

## Recommendations

*Spectrum Care Trust Board*

158. I recommend that Spectrum Care Trust Board:

- review the progress made in updating its security and procedures at the facility and report back by **30 August 2012** on steps taken to address the issues highlighted by this report and the Department of Labour's investigation. As part of the review consideration should be given to:
  - external peer review of site hazards and risk assessment plans; and
  - audits of key health and safety requirements and adherence to individual risk assessment plans.

## Follow-up actions

- A copy of this report will be sent to the Coroner, the New Zealand Police, and the Department of Labour.

- A copy of this report with details identifying the parties removed, except the Spectrum Care Trust Board and the expert who advised on this case, will be sent to the relevant district health board, the Ministry of Health, and the NASC and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: Independent expert advice

The following expert advice was obtained from psychologist Sharon Brandford:

> "I have been asked to provide an opinion to the Commissioner on the circumstances regarding [Master A] — Case Number 10/00356. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a registered psychologist within the Clinical scope of practice, and have been registered since 1983. *(Reg. No. 90-00363).* I have spent all of the years since applying my knowledge and practice within the field of intellectual disability. The majority of my career over the past 28 years has been spent in advisory and management roles in community-based disability services within non-government organisations. I have been employed within that period with IHC, and its subsidiary companies responsible for service delivery (IDEA and Timata Hou). I was employed by Standards and Monitoring Services for five years which involved me entirely in the evaluation of community-based disability services across NZ. While the majority of these services were designed for adults with disability, service options for families and children were included. My special interest portfolio at the time was out of home placements for children (inclusive of respite options), so I have an understanding of the principles on which the current service is based. I have presented original research on family support options at an international conference on respite. I am a member of NZ Psychological Society, and also a Council member of Australasian Society for Intellectual Disability (ASID): Research to Practice.
>
> At the time of writing, I am employed by IDEA as its National Manager of Specialist Services, which includes the contracted provision of specialist behaviour support, and family-based interventions and parent education related to Autism Spectrum Disorder (ASD). I have indicated that I am familiar with Spectrum Care as a provider, and have been on several working groups alongside [the General Manager Operations]. I have no professional relationship with him or Spectrum however, such that I believe there would be any conflict of interest.
>
> My instructions in the provision of this report were as follows:
>
> To provide independent expert advice about whether Spectrum Care Trust Board provided appropriate care to [Master A] in relation to his risk of absconding.
>
> 1. Were the services provided to [Master A] appropriate to his risk of absconding?
> 2. What standards apply in this case?
> 3. Were those standards complied with?
>
> If not covered above, please provide comment on the following:
>
> 1. Was [Master A's] level of supervision appropriate?
> 2. Was the security at [the facility] appropriate for [Master A]?

- Were sufficient steps taken to minimise harm and ensure external areas were safe?
- Were the ongoing issues with the gates appropriately identified and dealt with?

3. Should Spectrum Care Trust Board have requested a further needs assessment for [Master A] following his absconding incidents in 2009?
4. Are the changes made by Spectrum Care Trust Board following [Master A's] death sufficient to prevent a similar situation occurring at [the facility]?
5. What if any, further changes could be made?

**Supporting Information**

- Letter of complaint to the Commissioner from [Ms A], dated […] 2010, marked with an 'A'. (Pages 1 to 3)
- Notes of a phone conversation with [Ms A] on […] 2010, marked with a 'B'. (Page 4)
- Email from Spectrum Care Trust Board on […] 2010, marked with a 'C'. (Pages 5 to 17)
- Email from Spectrum Care Trust Board on […] 2010, marked with a 'D'. (Pages 18 to 46)
- Letter from Spectrum Care Trust Board dated […] 2010, marked with an 'E'. (Pages 47 to 56)
- Letter from Spectrum Care Trust Board dated […] 2010, marked with an 'F'. (Pages 57 to 110)
- Email from Spectrum Care Trust Board on […] 2010, marked with a 'G'. (Pages 111 to 132)
- Letter from Spectrum Care Trust Board dated […] 2010, marked with an 'H'. (Pages 133 to 266)
- Email from Spectrum Care Trust Board on […] 2010, marked with an 'I'. (Pages 267 to 270)
- Information received from the Coroner on […] 2010, marked with a 'J'. (Pages 271 to 314)
- Letter from [the NASC] dated […] 2010, marked with a 'K'. (Pages 315 to 327)
- Letter from the Ministry of Health dated […]2010, marked with an 'L'. (Pages 328 to 348)
- Information received from the Department of Labour dated […] 2010, marked with an 'M'. (Pages 349 to 754)

**Were the services provided to [Master A] appropriate to his risk of absconding?**

The key service mechanisms for managing his risk of absconding are:
1. Staff
2. Property and environmental
3. Policies and procedures

1. I am of the view that staffing levels were marginally appropriate to his needs in the context of the other demands within [the facility]. It would have been desirable to have had higher staffing.

Commentary:
With careful planning and timing of children using the respite facility, the staffing levels could generally be managed. Service delivery of the standard expected by [the NASC] and funders would be stretched if unforeseen events took staff attention from everyday tasks. This was illustrated in incident reports [on two occasions in early 2009]. [Master A's] needs were significant and placed constant demands on staff responsible also for other children. The challenges to the staff team to ensure safe and appropriate care within these constraints is constant.

I did not identify any approach to [the NASC] for funding for additional staffing beyond the ratio accepted for usual provision consequent on several absconding events in 2009. Related correspondence suggested that the provider had some difficulty in communication with [the NASC], and had a belief that applications for additional funding were met with resistance. Spectrum reports they did not have a copy of the 2008 needs assessment in which his absconding risk was very clearly indicated. This would have been an opportunity to raise the question of additional funding for closer staff supervision. Such could also have occurred after the 2 incidents in [mid] 2009. It appears that internal changes were made such that [Master A] did not abscond again. It would be reasonable for Spectrum therefore to have assumed it had the risks under control.

I note, as did Spectrum's CEO in actions after the tragedy, that supervision at handover time needed to be tightly managed, as it is a foreseeable daily routine which can divert staff attention from direct observation of the children. Each provider with similar rostered staffing structures must problem-solve shift handovers within their own context. Strain is potentially exacerbated when managers tend to use this opportunity to 'catch up' with staff at this same time of day, creating a conflict for staff as to where their attention should go. I do not know whether such a dynamic actually existed at [the facility].

2. I believe the property arrangements were broadly appropriate to the management of his risks. I believe some property features were not adequately accounted for.

Commentary:
I believe the provider had good regard for its obligation under its service specification to provide a home-like environment primarily. As noted by senior manager [General Manager Operations] to Department of Labour, this service was not purchased as a lock-down facility. Good regard was made for the balancing of the need for security with that of providing a pleasant 'home away from home' environment.

The environmental factors not appropriately managed were as follows:

a) Having three possible perimeter exit points placed extra demand on the supervision by staff. It would have been a relatively easy task to have cut off use of at least one, easing the task for staff in supervisory roles.

b) It is unusual for there to have been partial security of external perimeter gate such that it could still be accessed from the outside. Inasmuch as the facility supports highly vulnerable children, attention to this small security feature could have reasonably added to their protection from the public. Inattention to this has opened the question that the gate may have been opened by unknown members of the public, permitting [Master A's] escape.

3. I believe that policy and procedures were appropriate to [Master A's] needs but their adherence to these was not up to their own standard.

   a) The Risk assessment omitted drawing the link between a known water hazard and [Master A's] attraction to it.

   b) It is difficult to know if staff adhered to daily checks on the perimeter security, and to record this.

Commentary:
It is appropriate that there be an Individual risk assessment for each child, and this has been confirmed for [Master A]. However, the hazard identification was not sufficiently robust in one matter. It was well known that he had an interest in water, (referred to in his crisis plan p000143) yet the implications of the pond and stream in proximity do not appear to have been factored in to the Risk Management, by cutting off any possible access to the pond. I believe this omission, along with the inattention to the knowledge the gate could be unlatched from the outside, meant that a foreseeable hazard was not managed sufficiently.

I also note that the knowledge that he had previously absconded through exits other than the front door appears to have got lost in managers' and staff minds, such that their risk mitigation strategies ended up focussing on preventing his exit from the front onto the road. Dilution of detail is more likely when there has been high staff turnover. It is possible this may have contributed to a reduction in the quality of facts informing the Risk Assessment and management plan.

In recognition of his extreme flight risk, staff were required to check gates and doors daily. It appears this was done on the day of [Master A's] death. It does not appear to have been recorded on any regular basis in a Communication diary. Therefore a manager would have no way to verify adherence to the procedural requirement. Vigilance of the level [Master A] required for the previous eight months appears to have been maintained (no incidents of absconding reported).

There was some reference in family correspondence to loose supervision practice by staff when they had cigarette breaks. The policy material provided does not appear to address this risk. There is no indication from testimony provided that any staff were having smoking breaks at the time of [Master A's] disappearance.

**What standards apply in this case?**

1. HDSS Core Standards NZS 8134.1.4 Safe and Appropriate Environment

   *Std 4.2.4 the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.*

2. Service Specification for Respite home provision (Tier 1 and 2) — specifically Settings (5.2: p 3 Tier 2), and Safety and Efficiency (8.4: p4 Tier 2)

   *'…will ensure secure, physically safe internal and external environments that meet the people's particular mobility and safety requirements.' (detailed in Tier 1 p5, applicable to Tier 2)*

   *'Children will be cared for in an environment that is safe for them, their primary carers/family/whanau and other people using facilities on the site.' (8.4: p4 Tier 2)*

3. HDSS Standards re Restraint Minimisation and Safe Practice NZS 8134.2:2008

4. Standards described in internal organisational policy

I make an observation that material provided by the Ministry of Health after the tragedy should not be applied as a standard applicable to this circumstance. The Security Matrix is a planning and Standards document relevant to the risk management of people with high and complex needs with forensic issues, subject to court-mandated conditions under the IDCCR Act. It has only broad guidance value to the circumstance here.

**Were these standards complied with?**

Standards 1–2 It is my opinion that the standards 1 and 2 above were complied with, inasmuch as these standards are general, leaving it to a provider to make specific adjustments according to location, occupancy and staffing.

Standard 3 Environmental restraints such as locked gates and doors were recorded. Some providers use this standard to enable closer scrutiny of practices required to ensure safety, such as secure perimeter management. I am not able to comment on its relevance for this incident, as the mechanism by which restraints are approved, reviewed and monitored is not provided.

Standard 4 I do not believe that the service complied with internal Spectrum standards as related to Documentation and to Risk Assessment.

Hazard register documentation for [the facility] identified [Master A's] absconding behaviour as a dynamic hazard, but makes no mention of the permanent hazard of the nearby ponds. In relation to his absconding, the action recommended was a referral to Behaviour Support Team, but I saw no progress on that action or decision to revise it. Facility plans would have had opportunity then for external scrutiny.

**Was [Master A's] level of supervision appropriate?**
Clearly in hindsight, he was not appropriately supervised while playing outside that day. However I would observe that descriptions of his speed, agility and long history of absconding mean that any provider would be constantly challenged to ensure his supervision never lapsed.

**Was security appropriate?**
See above comment regarding inaction on multiple exit points from the property and external access through gate by the public.

Past issues with the gates' functionality were appropriately addressed.

**Should Spectrum Care Trust Board have requested a further needs assessment for [Master A] following his absconding incidents in 2009?**
As indicated above, it would have been reasonable to have done so. However, in that there had been measures put in place which had stopped absconding for the previous eight months, other providers might also have reached the conclusion that his needs could be met within current resources.

**Are the changes made by Spectrum Care Trust Board following [Master A's] death sufficient to prevent a similar situation occurring at [the facility]?**
There can be no guarantee that future incidents such as this will not recur. I have therefore considered whether Spectrum Care Trust Board took reasonable and prudent measures to minimise the risk of recurrence.

In the main the actions made were in accordance with those any other provider could reasonably have endorsed. There was very effective response to property audit and actions arising consequent to this event.

I also note that new handover guidelines were introduced. These mechanisms provide a clearer articulation of expectations. Their impact will be limited by managerial scrutiny, as detailed below.

**What if any, further changes could be made?**
Provision of respite services presents complex and constantly changing challenges. If one overlays the changes of users to the facility with a circumstance of staff turnover, then a reliance on documented procedural guidelines also requires an increase in management oversight and monitoring to ensure compliance.

Strategies focused on increasing compliance with existing policies and guidelines include the following:

- Manager undertaking internal audits of key health and safety requirements, or adherence to individual risk assessment plans.

- External peer review of procedures such as site hazards, or risk assessment plans might also introduce 'fresh eyes' to situations staff and managers are immersed in daily, and mitigate against the 'dilution of information'.

I trust the above is of assistance to the Office of the Health and Disability Commissioner in progressing this investigation."

On 11 May 2011, further advice was obtained from Ms Brandford regarding the severity of her concerns in relation to the following (Ms Brandford's comments are italicised):

"1. You expressed concern that Spectrum Care did not raise the question of additional funding in order to more closely supervise [Master A] after the two incidents of absconding [in mid] 2009. You stated 'it appears that internal changes were made such that [Master A] did not abscond again. It would be reasonable for Spectrum therefore to have assumed it had the risks under control'. Could you please indicate how seriously you view the failure to ask for additional funding (is it mild, moderate or severe)? *Mild, given their stated prior history with poor response to funding applications. They reasonably believed that they had the risk under satisfactory control.*

2. You expressed concern about there being three possible perimeter exit points and stated 'it is unusual for there to have been partial security of external perimeter gates such that it could still be accessed from the outside'. Could you please indicate the severity of your concern (is it mild, moderate or severe)? *Mild.*

3. You expressed concern about the hazard identification, in particular, that it was known that [Master A] had an interest in water and this was not factored into the risk management. Are you implying that it was inappropriate for [Master A] to be in this respite facility? *No, what was inappropriate was their non-inclusion of this variable in their risk assessment and response.* If so, what is your level of disapproval (is it mild, moderate or severe)? *Moderate.*

4. You observed that the focus was on [Master A's] absconding through the front door rather than through the other gates. Please indicate your level of disapproval of this focus (is it mild, moderate or severe)? *Mild.*

5. You expressed concern that the checks of gates and doors were not recorded on any regular basis in the communications diary. Please indicate your level of disapproval of this (is it mild, moderate or severe)? *Mild.*"