A Disability Service

Caregiver, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC01655)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Relevant facts

1. This report is about the care provided to Mr A by a disability service and one of its employees, caregiver Mr B.

2. At the time of the events in question, Mr A was 18 years old and had been living in one of the disability service's long-term residential facilities, (the facility), for around one year.

3. On 18 July 2013, a verbal altercation between Mr A and Mr B occurred at the facility, culminating in Mr B (who weighed around 170kg) physically restraining Mr A (who weighed around 50–60kg). There are various accounts regarding the nature of the restraint, but it is more likely than not that Mr B "grabbed" Mr A, which resulted in both parties ending up on the floor for around 10 minutes. Whilst on the floor, Mr B held Mr A's hands and, for at least some of the restraint, positioned one hand on Mr A's chest. After the incident, Mr B and another staff member spoke with Mr A and checked his condition. Mr A appeared to be fine for the remainder of the evening (both physically and in terms of his mood/demeanour).

4. Around two and a half weeks after the incident the disability service undertook an internal investigation into what had occurred. Following that investigation, the disability service concluded that it had not been proven that a physical assault had occurred, but that the action taken by Mr B was "probably not" appropriate in terms of the two-man restraint procedure in place. The incident was also considered by the disability service's Restraint Management Committee (RMC). The matter was later referred to HDC by the District Inspector for Mental Health, pursuant to section 97(4) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Deputy Commissioner's findings

5. Mr B's decision to restrain Mr A, and the method of restraint used, were inappropriate. As a consequence, Mr B failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

6. The disability service had adequate documentation and policies in place regarding restraint, and was found to have provided Mr B with appropriate training in that regard. Accordingly, the disability service was not directly or vicariously liable for Mr B's breach of the Code. However, the disability service's policies could have been more effective in ensuring that appropriate care was provided to Mr A. In addition, aspects of the disability service's internal investigation into the incident, and consideration of the incident in the course of the disability service's RMC, were inadequate.

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

Complaint and investigation

7. The Commissioner received a complaint under section 97(4) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 regarding the services provided to Mr A by Mr B and the disability service on 18 July 2013. An investigation was commenced on 22 May 2014. The following issues were identified for investigation:

- *The appropriateness of care provided by the disability service to Mr A.*
- *The appropriateness of care provided by Mr B to Mr A.*

8. The parties directly involved in the investigation were:

Mr A	Consumer
The disability service	Provider
Mr B	Caregiver
Mr C	Caregiver
Mr D	Caregiver
Mr E	Care Coordinator/Caregiver
Ms F	Group Manager/On-Call Manager
Ms G	District Inspector for Mental Health

Also mentioned in this report:

Ms I	Care Manager

9. Independent expert advice was obtained from disability services specialist John Taylor (**Appendix A**).

10. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

Information gathered during investigation

Introduction

11. This report is about the care provided to Mr A by the disability service and one of its employees, Caregiver Mr B.[2] In particular, the report considers the appropriateness of an incident that occurred on 18 July 2013, whereby Mr A was physically restrained by Mr B.

Background information

Mr A

12. At the time of the events in question, Mr A was 18 years old and had been in the care of the disability service for around one year. Prior to that, Mr A had endured a

[2] Mr B is no longer employed by the disability service.

troubled childhood and adolescence.[3] In 2012, Mr A had faced criminal charges, but was deemed unfit to stand trial following psychiatric assessment (having been diagnosed with a mild intellectual disability). Accordingly, Mr A was placed in the care of the disability service pursuant to a Compulsory Care Order.[4]

The disability service

13. The disability service is a registered charity and provides residential and vocational support to its clients. Mr A was placed in one of the disability service's long-term residential facilities.

The incident

Undisputed facts

14. At around 7.30pm on 18 July 2013, a verbal altercation between Mr A and Mr B occurred at the facility, culminating in Mr B (who weighed around 170kg) physically restraining Mr A (who weighed around 50–60kg). The incident was witnessed by caregiver Mr C, and caregiver Mr D overheard some of what occurred from another room. Each party's account of the circumstances that led to the incident, and the incident itself, are summarised as follows.

Mr A's account of incident

15. In the course of the disability service's internal investigation (which preceded HDC's investigation), Mr A advised that, prior to the incident, he had tried to get a drink but was told by Mr B to "get out" of the kitchen. In response, Mr A said that he "mumbled to [himself] and walked down the hallway", calling Mr B a derogatory term. Mr A said that Mr B summoned him three times and asked him what he had called Mr B, and each time he responded with the derogatory term and walked away. Mr A said that Mr B then asked him whether he "want[ed] to fight" and proceeded to pick him up and throw him on the ground. Mr A said that Mr B "landed with his knee into [his] gut moving his knee around" and said it was "sore". Mr A said that Mr B then put his hands on his chest and asked him, "Are you scared of me?" Mr A said that he tried to push Mr B off and told Mr B that "he was going to get fired if he didn't stop". Mr A said Mr B responded to this by saying that he "didn't care if he got fired". Mr A said that Mr C (who was there) then told Mr B to get off him, which Mr B did by picking him up and "thr[owing] him onto the couch".

16. During Mr A's HDC interview, he described the incident as is summarised above. In addition, Mr A advised that the physical restraint commenced by Mr B grabbing him by the T-shirt, pulling him to the ground, and jumping onto him. Mr A also added that Mr B kicked him whilst he was on the ground and tried to hold him on the ground with his elbows. In terms of the duration of the restraint, Mr A said it was "a good 20 minutes or 10 minutes or something like that". Mr A said that Mr C told Mr B to "get lost" and "leave him alone" during the incident, and said that, afterwards, Mr C checked to see whether he was okay. Mr A stated that he was in "a lot of pain" around

[3] This is evidenced in numerous specialist reports.

[4] Pursuant to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. The Compulsory Care Order was varied to a Supervised Care Order in December 2013.

his ribs, and had some scratches. Mr A said that, later that evening, Mr B apologised to him and they shook hands.

Mr B's account of incident

17. Mr B's account of the incident is quite different from Mr A's. In the course of the disability service's internal investigation (and after initially denying any recollection of physically restraining Mr A), Mr B advised that, prior to the restraint, Mr A had been playing cards with another resident when their conversation became "sexual" (in relation to girls at their day programme). Mr B said he therefore asked Mr A and the other resident to stop the conversation, and directed them to watch TV rather than play cards.[5] Mr B said that, at that time, Mr A became verbally abusive as he walked past him and sat down on a one-seater chair. Mr B said that he therefore stood up in front of Mr A and said, "Where did that come from?" to which Mr A threw a pen at him, began to clench his fists, and swore. Mr B said he then "grabbed [Mr A's] hand and told him to relax and move to the bigger couch" (he said this was for safety reasons), but Mr A tried to wrestle him and so they fell to the ground. Mr B advised that, once on the floor, he held Mr A's hands and told him to relax, and that he would release Mr A once he was calm. Mr B denied using his knee to restrain Mr A (he said his knees were "on the ground"), and said that the hold was less than a minute and intended to "make sure [Mr A] was all good". Mr B said that, following the restraint, he moved Mr A to the couch. Once Mr A had calmed down, Mr B said that Mr A "had a cry, [he and Mr B] talked, shook hands and then had dinner".

18. Mr B's description of the incident during his HDC interview was largely consistent with his earlier account, summarised above. However, during the HDC interview Mr B said that, while he was restraining Mr A on the ground, he had one hand on Mr A's chest and the other on his thigh (rather than holding both of his hands). Mr B also stated that the other staff member in the room (Mr C) did not intervene during the restraint because he did not need to — the situation was under control. Mr B also said that there was "no malice, no bruising, no injury" in respect of the incident.

Mr C's account of incident

19. Like Mr B, Mr C advised the disability service's internal investigation that, prior to the incident, Mr A and another resident had been playing cards or chess in the lounge when their conversation became inappropriate. Mr C said that Mr B had asked them to stop and had advised them to watch TV, but that Mr A became verbally abusive. Mr C then described Mr B walking over to Mr A, who was on the single-seater chair, and Mr A throwing a pen at Mr B. Mr C said that Mr B then "grabbed [Mr A] to move him to the double couch to sit for one on one. [Mr A] resisted and then they kinda wrestled and both ended up on the floor". Mr C was asked whether Mr B put his knee into Mr A. Mr C responded: "He was on top of him but I don't know about the knee." Mr C later stated: "I'm not sure because [Mr B] was all over him and I was at the back." In terms of Mr C's impression of what occurred, he advised that he was "surprised" by Mr A's language/anger, but did not think that the physical restraint employed by Mr B was necessary. Mr C said: "[F]or me, I don't think it had to go there. I said 'that's enough' and [Mr B] got [Mr A] and put him on the couch to talk."

[5] That resident and one other are said to have left the room around that time.

20. During Mr C's HDC interview (and in addition to what is summarised above), he explained that restraint is a "last resort", and that the disability service's procedures, which include two-person restraint, must be followed by staff. In relation to the incident, Mr C explained that he had started approaching Mr B and Mr A at the time the incident began. In particular, Mr C stated: "[W]hen I saw the thing happen and I tried to get there so we can you know hold him both but [Mr B] was already on top of him holding him down. [Mr A was] not moving any more and just crying." Mr C also advised that Mr B had grabbed Mr A's hands/arms (rather than his T-shirt) and that Mr B held "two hands down on the floor", but reiterated that he was not sure whether Mr B had used his knee. Mr C advised that, while Mr A was restrained, he talked to him and told him to "calm down, that is enough, calm down", and told him "it was alright". Mr C said that after Mr A was calm, Mr B released him and had one-on-one time with Mr B on the couch.

21. In terms of the length of the restraint on the floor, Mr C advised HDC: "[M]aybe about 10 minutes, or something like that." Mr C said that Mr A stated that he was all right following the incident, and did not have any bruising or scratches. Mr C advised that, around 20 to 30 minutes after the incident, Mr A apologised to him and Mr B for his behaviour. Finally, Mr C advised that, whilst he had previously stated that the physical restraint was not necessary, he in fact "thought it was the right thing to do because we are not sure how dangerous [Mr A] would be at that time because I saw that he was holding a pen and I am not sure what he is going to do with the pen".

Mr D's account of incident

22. In the course of the disability service's internal investigation, Mr D advised that he was in the kitchen making dinner with another resident at the relevant time. Mr D said that "something must have happened", because he heard Mr B "interject and say 'that was enough', and that's when [Mr A] started swearing which continued". Mr D said that he "had a look" and saw that Mr B and Mr C were there, so he did not get involved. Mr D advised that the incident did not last long, and that Mr A ate dinner with the residents and staff afterwards. Mr D said that Mr A seemed "good" for the remainder of the evening and was "back to his normal self". Mr D stated that Mr A apologised to all of the staff, as "he realised what he had done". Mr D was not aware of Mr A complaining of any physical discomfort after the incident.

23. During his HDC interview, Mr D recalled that, whilst still in the kitchen, he had called out to Mr C, "[Are] you fellas alright," and Mr C replied, "[Y]es, all good." Mr D also clarified that he did not realise that Mr A was being restrained at the time the incident occurred (he couldn't see what was happening from where he was), but that he could hear Mr B and Mr C "talking [Mr A] down". Mr D said that the incident went on for "three, five minutes, maybe less" with reference to the "loud noise from [Mr A]". Mr D noted that he served dinner 10 to 15 minutes after the incident had occurred.

Actions taken following incident

Undisputed facts

24. Between 8.30pm and 8.45pm that evening, care coordinator Mr E[6] arrived at the facility with another resident. Mr B advised Mr E of the incident upon arrival.

25. At some point following the incident, Mr B filled out a restraint form dated 18 July 2013 and witnessed/signed by Mr C. The restraint form included a tick next to the box "restraint as per strategy?" and included the following summary of what had occurred:

> "*What happened?*
> '1. [Mr A] playing cards with [another resident] at dinner table.
> 2. Ask to stop card game, because inappropriate sexual behaviour.
> 3. [Mr A] not happy that [they] were told to stop, behaviour elevated, personal insults.'
>
> *What did you do?*
> '1. Supportive — talking.
> 2. Directive + set limits offered options.
> 3. Restraint — nonviolent crisis intervention.
> 4. Therapeutic rapport — negotiated with [Mr A] to prevent from happening again.'"

26. Mr E filled out the reverse of the restraint form, under the heading "Kaiwhakahaere[7] to Complete", dated 20 July 2013. That section of the restraint form included the following:

> "*What was the duration of the restraint?* '10 seconds'
> *Minimal force was used* 'Yes'
> *Was it the correct decision to restrain?* 'Yes'
> *Was policy and procedure followed in this restraint?* 'Yes'"

Mr E's recollection

27. Mr E advised the disability service's internal investigation that, during the course of that evening, Mr A had said to him that the incident "wasn't a big thing", and that it was "his fault". Mr E said that Mr A "apologised and looked happy and was joking with everyone". Nonetheless, Mr E said that he debriefed the parties and called the On-Call Manager, Ms F,[8] and the Care Manager, Ms I.[9] At that time (and despite what he indicated in the restraint form), Mr E advised of his view that the caregivers did not follow Crisis Prevention Institute (CPI)[10] procedure, and stated: "I had a problem with that because a restraint should be a last resort. I made a recommendation with [the Behaviour Co-Ordinator] to debrief CPI procedures." Mr E confirmed that further CPI training for caregivers working at the facility occurred at a later date.

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[6] Mr E advised HDC that, at the time of the events in question, he was the Care Coordinator for three of the disability service's residential facilities. Mr E advised that he was working at the facility that evening because there was a staff shortage.

[7] Kaiwhakahaere can be translated to mean "manager" or "supervisor".

[8] Mr E advised HDC that the On-Call Manager's role is to investigate the situation at the time, and facilitate a debrief with the relevant caregiver(s).

[9] Mr E advised HDC that the Care Manager's role is to look after the welfare of the clients.

[10] CPI is an international training organisation that specialises in the safe management of disruptive and assaultive behaviour.

28. During Mr E's HDC interview, he reiterated what is set out above, including his view that Mr B did not follow CPI procedure during the restraint. He advised of his understanding that Mr B had been lying on top of Mr A with his elbow in Mr A's stomach without the support of another staff member (Mr E said that "you cannot go in by yourself" to restrain someone, "you always seek the support of your other staff for safety, both for the client and for yourself"). Overall, Mr E expressed his view that "it wasn't an incident that required restraint" anyway. In terms of Mr E's telephone call to Ms I, he said that she enquired how Mr A was, and that he responded by saying that Mr A "seemed fine", and there was "no bruising or marking". Mr E said that Ms I was going to follow up with Mr A the next day. Mr E did not provide details of his conversation with the "On-Call" (Ms F), and could not remember whether she attended the facility that evening. Finally, Mr E clarified that he recorded the restraint as lasting for 10 seconds on the restraint form on the basis of what Mr B had told him.

Mr C's recollection

29. Mr C advised during the disability service's internal investigation that, after the incident, "straight away everything went back to normal". Mr C told HDC that the restraint form was filled out that evening and the On-Call Manager contacted, who attended the facility that evening and was debriefed on what had occurred. Mr C told HDC that the On-Call Manager said: "[Staff] have done everything properly" (in relation to the process followed after the incident), and advised that Ms I would oversee an investigation into the incident. Mr C said that they had attempted to contact Ms I that evening, but had not been successful.

Mr B's recollection

30. Mr B advised the disability service's internal investigation that, after the incident occurred, he and Mr C had a debrief with Mr E and that, as a result of the On-Call Manager being contacted, "retraining" on restraint occurred. During Mr B's HDC interview, he also said that he filled out an "incident form" (presumably the restraint form), but noted that it was a further two weeks before any action was taken by the disability service.

Ms F's recollection

31. Ms F advised HDC that she was contacted the evening of the incident by Mr B, who told her that he had "performed a restraint" on Mr A. Ms F advised HDC that she could not "deal with [the incident] at the time", as she was involved in assisting another client, and so arranged for Mr E to follow up with Mr A on the reported restraint. The relevant entry in the "On Call Report" document set out the following:

"Date	Time	Whare	Kaimahi	Incident	Outcome
18/07/13	22.10pm	[The facility]	[Mr E] Kaitaataki	[Mr A]— Verbal abusive towards another mokopuna.	— Restraint as per strategy — I/A filed — NIDCA on call notified"

Internal investigation

32. The District Inspector for Mental Health, Ms G, stated in her complaint to HDC (detailed below from paragraph 36) that Ms I received an anonymous complaint on 6

August 2013. However, during Mr B's and Mr E's interviews with the disability service on 8 and 15 August 2013, they both advised that Mr A had laid a complaint about the incident. Contrary to these recollections, the internal investigation documentation[11] indicates that Ms I was not advised of the incident until 6 August 2013, and therefore the disability service's internal investigation was not commenced until around two and a half weeks after the incident occurred. Ms I no longer works at the disability service, and HDC was unable to make contact with her during the investigation to clarify when she became aware of the incident. On the "Complaint/Concern form" dated 6 August 2013, it is set out that Ms I received a complaint of "Physical Abuse during a restraint", and on the "Summary of Complaint" form it states: "An investigation was conducted … in relation to physical assault on mokopuna ([Mr A]) by [Mr B]."

33. On 30 August 2013, once the relevant parties had been interviewed, the internal investigation concluded that "the allegation of physical assault ha[d] not been proven". That decision was based on the rationale that had the incident occurred as Mr A had described, "it would be reasonable to assume that [Mr A] would have sustained some kind of serious injury or injuries to his body". The decision set out that, to the contrary, Mr A "did not require medical attention, nor did he complain about being hurt or sore, and as established during the investigation [Mr A] was apologetic for his actions". However, the decision also stated that, upon reflection, the action taken by Mr B was "probably not" appropriate "in terms of 'one man restraint'". The document noted that staff at the facility had undergone further CPI training on 25 July 2013. Mr B (who had been suspended for the duration of the internal investigation) was able to return to work after 30 August 2013.

34. Mr B advised HDC that, following the internal investigation, he was told to use two-man restraint in future. However, Mr B also advised of his view that this had not been necessary regarding the incident with Mr A, given his size compared to Mr A's, and the fact that he had "had it under control".

Restraint Management Committee

35. On 29 August 2013 (just before the internal investigation ended), the disability service's Restraint Management Committee (RMC) met and reviewed the restraint of Mr A. The RMC meets monthly and reviews all restraints and/or incidents of challenging behaviour and identifies trends for appropriate actioning. The RMC Report from that meeting included the following:

"Mokopuna	Recommendations
[Mr A] (IDCCR)	Inappropriate sexual behaviour during card game. Became agitated & confrontational when asked to stop. — Ensure [Mr A] understand the rules Do's & Don'ts of the card games — Maintain CPI Verbal de-escalation techniques when [Mr A]

[11] For example, the "Complaint/Concern Form" and the "summary of complaint" document.

	becomes verbally challenging"

District Inspector for Mental Health

36. On 6 August 2013, Ms I contacted Ms G (the allocated District Inspector for Mental Health that day). Ms G telephoned Mr A that day and asked if he consented to her discussing the matter with Ms I, which he did. Ms G stated: "It was apparent from the disclosure that there had been a physical restraint involving a staff member [Mr B] placing himself over the body of [Mr A]."

37. Ms G met with Mr A and Ms I on 11 September 2013. Ms G said that Mr A told her that he and another mokopuna were being cheeky while playing cards, and that he called Mr B a derogatory term. Mr A told Ms G that Mr B got up from the sofa and threw him onto the ground, and said that he was not scared to lose his job over this. Mr A said that Mr B had his knee into his (Mr A's) gut and they were on the ground for a while. He said that other staff were telling Mr B to get off him but did not physically intervene, and that Mr B eventually got off him and left him sitting on the couch.

38. In December 2013, Ms G referred the matter to HDC pursuant to section 97(4)[12] of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act), for the following reasons:

- Concerns (both procedural and substantive) regarding the disability service's internal investigation process.
- Concerns that the restraint did not comply with Mr A's Care Plan.

39. Ms G's referral letter also noted her view that Mr B had "reacted inappropriately and subjected [Mr A] to a restraint" contrary to section 61(3)(a),[13] (b)[14] and (c)[15] of the IDCCR Act.

Relevant documents and policies

Restraint Approval Form

40. Mr A's Restraint Approval Form, in place at the relevant time, set out the following:

"*Describe when the restraint will be used:*

[12] Section 97(4) of the IDCCR Act states: "The responsible district inspector must notify the Health and Disability Commissioner under the Health and Disability Commissioner Act 1994 of every complaint that concerns a breach of a right under the Code of Rights."

[13] Section 61(3)(a) of the IDCCR Act states that "a person exercising the power of restraint may not use a greater degree of force, and may not restrain the care recipient for longer, than is required to achieve the purpose for which the care recipient is restrained".

[14] Section 61(3)(b) of the IDCCR Act states that "a person exercising the power of restraint must comply with guidelines issued under section 148 that are relevant to the restraint of the care recipient".

[15] Section 61(3)(c) of the IDCCR Act states that "in an emergency, a care recipient may be restrained by a person who, under a delegation given by the care recipient's care manager, has immediate responsibility for the care recipient, but that person must immediately bring the case to the attention of the care manager".

- When [Mr A] places himself at risk of harm
- When [Mr A] places others at risk of harm

Length of time to be used:
- 5 minutes"

Care Plan

41. Mr A's Care Plan, in place at the relevant time, set out the following:

"***Seclusion and restraint requirements***
De-escalation techniques
- Immediately become SUPPORTIVE at first signs of anxiety or agitation (C.P.I Crisis Development Model level — 1).
- SET LIMITS ensuring all limits are Simple, Reasonable, Enforceable (C.P.I Crisis Development Model level — 2).
- Application of EMPATHETIC LISTENING techniques taking into account Precipitating Factors.
- As an absolute last resort — NON VIOLENT PHYSICAL CRISIS INTERVENTION level — 3.
- In all instances THERAPEUTIC RAPPORT to be foundation for relationship building (C.P.I COPING model level — 4).

Threshold
- Behaviour which endangers the health and wellness of the Care Recipient.
- Behaviour which endangers the health and wellness of others.
- Indicators/Triggers that will compromise safety for Care Recipient.
- Indicators/Triggers that will compromise safety for others.

Technique
- Crisis Prevention Institute methodology.
- Where applicable, Police intervention.

Reporting methods
- As per section 61(3) of the Intellectual Disability Compulsory Care & Rehabilitation Act 2003.
- In accordance with National Standards of Restraint Minimisation.
- Service Policy and procedure.

Staff responsibilities
- Adhere to Care Plan.
- Report to Designated Care Manager in all instances.
- Complete all required documentation …"

Managing Challenging Behaviour Policy

42. The disability service's Managing Challenging Behaviour Policy, in place at the relevant time, set out the following:

"*Policy*

…

A restraint may only be used to prevent a person doing harm to themselves or others, and only following continued attempts to positively manage the behaviour.

Procedure

1) the [facility's] kaimahi are obligated to familiarise themselves with mokopuna/tangata whaiora … lifestyle and well-being plans.

…

4) Kaimahi are not permitted to use physical violence towards mokiouka/tangata whaiora at any time, including as a response to behavioural challenge.

…

7) Instances of challenging behaviour are recorded on Incident/Accident forms and in mokopuna/tangata whaiora [lifestyle and well-being plans].

…

9) The Restraint Management committee (RMC) meets monthly. It reviews all restraints and/or incidents of challenging behaviour and identifies trends for appropriate actioning.

10) The Restraint Management committee ensures the maintenance of restraint minimisation standards.

11) [Non-violent Crisis Prevention Intervention] training is provided to whare-based kaimahi on orientation. This includes:

- verbal and non-verbal communication skills
- triggers and early indicators of challenging behaviour
- early intervention action
- personal safety management.

12) Refresher training must be undertaken at a 2-yearly minimum."[16]

Managing Challenging Behaviour, Aggression and Violence (extract from the facility's Manual)

43. The disability service's Managing Challenging Behaviour, Aggression and Violence chapter in the facility's Manual, in place at the relevant time, set out the following:

"*Techniques to use when the behaviour becomes disruptive*

- Sit with mokopuna

…

- Maintain a 1:1 until mokopuna has calmed

…

- When mokopuna becomes verbally threatening to themselves or others, maintain a 1:1 or 2:1 presence and redirect them to a safe area.

…

[16] The disability service provided documentation showing that Mr B attended CPI training in November 2010, December 2011 and November 2013.

In some situations, physical restraint may be required but this should be managed according to the agreed behaviour management plan in [the disability service's lifestyle and well-being plans], and by kaimahi trained and equipped to deal with the situation."

CPI Participant Workbook — nonviolent crisis intervention

44. The CPI Participant Workbook — nonviolent crisis intervention (the CPI Workbook), used by the disability service at the relevant time, set out the following:

"*CPI Team Control Position*[SM]

The CPI Team Control Position[SM] is used to manage individuals who have become dangerous to themselves or others. Two staff members hold the individual as the auxiliary team member(s) continually assess the safety of all involved and assist, if needed. During the intervention, staff members who are holding the individual should:

- Face the same direction as the acting-out person while adjusting, as necessary, to maintain close body contact with the individual.
- Keep their inside legs in front of the individual. (Fig. A)
- Bring the individual's arms across their bodies, securing them to their hip areas. (Fig. B)
- Place the hands closest to the individual's shoulders in a C-shape position to direct the shoulders forward. (Fig. C)

…

Nonviolent Physical Crisis Intervention[SM]

Nonviolent Physical Crisis Intervention[SM] should be used only as a last resort. At this point, all verbal means of managing the situation may have been exhausted. If the person is no longer responding to reason and he presents a danger to himself, staff, or other people in the area, you should consider physically controlling the person's behaviour until he can regain control on his own.

You want to avoid physical intervention for several reasons. First, there are regulatory and legal implications in using physical restraints. Also, physical intervention can be dangerous to both the individual and staff. But equally important, you don't want to use a hands-on approach until it is absolutely necessary because you run the risk of escalating a situation that might have been defused through verbal means."

Reporting Abuse Policy

45. The disability service's Reporting Abuse Policy, in place at the relevant time, set out the following:

> "*Policy*
> Mokopuna/tangata whaiora will be protected against all forms of abuse including neglect, and any situation of abuse that arises will be managed promptly, professionally and with respect.
>
> *General principles*
> …
> 4. Alleged abuse is reported immediately i.e. kaimahi must report to their Line Manager if they observe mokopuna/tangata whaiora abuse or hear someone allege that mokopuna/tangata whaiora has, or may have:
>
> - sustained injury at the hands of another person
>
> ...
>
> - been victimised in any way
> - had someone shout at or verbally abusing them
>
> *Procedure*
> 1. Kaimahi must in the first instance, report any occurrences of abuse and/or neglect to their Line Manager/On Call Manager as appropriate.
> …
> 3. The alleged offender may be suspended while the matter is being investigated in accordance with complaints policy."

Restraint Minimisation Manual

46. The disability service's Restraint Minimisation Manual, in place at the relevant time, set out the following:

> "*Function of the Restraint Minimisation Committee*
> 1. To ensure that all the restraints imposed meet the principles of the Managing Challenging Behaviour in the Adopted Policy of The Disability service and are compliant with the Restraint Minimisation Standard NZ 8134:2008 … "

Response to provisional report

47. Having reviewed the information gathered section of the provisional report, Mr A advised HDC that he had "no other comments to add".

48. The disability service advised HDC that it had "no further comment to make" in response to the provisional report, and stated that it "respect[s] the findings, decisions and recommendations of the Commission[er]".

49. Mr E also had no comment to make on the provisional findings as they related to him.

50. Mr B advised HDC that Mr A's account of the incident, as set out in the provisional report, "did not happen". Beyond that, Mr B advised that he did not feel further comment on the provisional report was necessary, having already provided his account of what occurred to the disability service and HDC.

Relevant standards

Health and Disability services (Restraint Minimisation and Safe Practice) Standards[17]

51. Standards New Zealand has produced standards for the Health and Disability sector.[18] The foreword to the Restraint Standard states:

> "The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.
>
> Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

The relevant Standards are:

Restraint minimisation

Standard 1 Services demonstrate that the use of restraint is actively minimised.

Safe restraint practice

Standard 2.1 Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint and ongoing education on restraint use and this process is made known to service providers and others.

[17] NZS 8134.2:2008.

[18] Standards New Zealand explains standards on its website as follows: "Standards are agreed specifications for products, processes, services, or performance. New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input. New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."

Standard 2.2	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.
Standard 2.3	Services use restraint safely.
Standard 2.4	Services evaluate all episodes of restraint.
Standard 2.5	Services demonstrate the monitoring and quality review of their use of restraint.

Opinion: Factual findings

52. As is clear from this report, there are varying accounts of the incident that occurred between Mr A and Mr B on 18 July 2013. Those accounts, and my findings in respect of them, are summarised below.

The incident

Events prior to the incident

53. Mr A advised that, prior to the incident, he had tried to get a drink from the kitchen but was told by Mr B to "get out". Mr A said he then walked down the hallway and used a derogatory term to describe Mr B (which he says he repeated). However, Mr B and Mr C both advised that, prior to the incident, Mr A and another resident were in the lounge playing cards, which Mr B asked them to stop as they were having an inappropriate conversation. Mr B and Mr C advised that this caused Mr A to become verbally abusive towards Mr B, and said that Mr A threw a pen at Mr B. Mr B also said that, prior to the incident, Mr A had clenched fists.

54. On the basis of the accounts provided by both Mr B and Mr C, I am of the view that it is more likely than not that Mr A was playing cards with another resident in the lounge prior to the incident and, having been told to stop, became agitated and verbally abusive towards Mr B, and threw a pen at him.

The incident

55. Mr A said that Mr B picked him up, grabbed him by his T-shirt and threw him/pulled him to the ground. Mr A said that Mr B then put his knee into his stomach and moved it around, jumped on him, put his hand on his chest, kicked him, and tried to hold him on the ground by his elbows. Mr A said the restraint ended by Mr B throwing him onto the couch.

56. Mr B said that he grabbed Mr A's hand "and told him to relax and move to the bigger couch", but Mr A tried to wrestle him and so they fell to the ground. Once on the ground, Mr B said he held Mr A's hands, but later said he had one hand on his chest and the other on his thigh. Mr B said he did not use his knees, and moved Mr A to the two-seater once he was calm.

57. Mr C also advised that Mr B grabbed Mr A to move him to the couch, and that Mr A resisted and wrestled, so the pair fell to the ground. Also similar to Mr B's account, Mr C said that Mr B grabbed Mr A's hands/arms and held his hands on the floor. Mr C was unsure whether Mr B used his knee to restrain Mr A. Mr C said that he could not see because Mr B was "on top" of Mr A and "all over him". Mr C said that Mr B released Mr A after he told him to calm down.

58. All parties involved, or present at the time, refer to Mr B "grabbing" Mr A, and all refer to Mr B and Mr A ending up on the floor; I am therefore satisfied that this occurred. I also accept that Mr B held Mr A's hands whilst he and Mr A were on the floor (as stated by Mr C and as initially stated by Mr B), but I am not convinced that this was the only method of restraint used; as Mr B later stated, and as referred to by Mr A, I consider it likely that one of Mr B's hands was positioned on Mr A's chest for at least some of the incident. I am unable to make a finding on the other aspects of Mr A's allegations regarding the physical restraint, due to the lack of supporting evidence.

What was said during the incident

59. Mr A said that Mr B asked him whether he "want[ed] to fight", asked him, "Are you scared of me?" and said he didn't care if he got fired (in response to Mr A saying that was what would occur). Mr A also said that Mr C told Mr B to get off him and leave him alone.

60. Mr B said that, during the restraint, he told Mr A to relax and he would release him after he was calm, and said that Mr A cried after he had calmed down. Mr C described Mr B talking Mr A down during the restraint, and said that Mr A was crying when he was being restrained by Mr B. Mr D said that he could hear Mr B and Mr C talking down Mr A during the incident.

61. In all of the circumstances, I acknowledge that there may have been a verbal altercation between Mr A and Mr B during the restraint; however, what exactly was said cannot now be determined, based on the information provided. I accept that Mr B and Mr C attempted to talk Mr A down in the course of the restraint, and Mr C encouraged Mr B to release Mr A.

Duration of the incident

62. Mr A said that he was restrained for 10 to 20 minutes; Mr B said less than a minute; Mr C said about 10 minutes; Mr D said the incident lasted "three, five minutes, maybe less" (based only on what he could hear); Mr E recorded "10 seconds" on the restraint form (based on what Mr B had told him).

63. Both Mr A and Mr C (who were part of the incident/a witness to it) approximated that the restraint lasted for 10 minutes (or more, according to Mr A). Accordingly, I consider it more likely than not that the restraint lasted for around 10 minutes.

Directly after the incident

64. Mr A said that, after the incident, Mr B apologised to him and they shook hands, and Mr C checked to see whether he was okay. Mr B said that he spoke to Mr A after the incident and they shook hands. Mr C also said that Mr B and Mr A spoke after the

incident. Mr C, Mr D and Mr E also said that Mr A apologised to them after the incident (they also advised that Mr A apologised to Mr B).

65. In terms of Mr A's physical condition, he said that he was in "a lot of pain" and had scratches. However, Mr B, Mr C, Mr D and Mr E all advised that Mr A was not physically injured and/or said he was fine after the incident. Mr C, Mr E and Mr D also commented that Mr A seemed fine/normal/happy for the remainder of the evening.

66. It is clear that, directly after the incident, Mr B and Mr C spoke with Mr A and checked his condition. With reference to the accounts from all staff members involved, I also accept that Mr A apologised following the incident, and appeared to be fine for the remainder of the evening (both physically and in terms of his mood/demeanour).

After the incident

Who was contacted that evening

67. Mr E advised that he telephoned Care Manager Ms I the evening the incident had occurred, and said that she advised that she would follow up with Mr A the next day. Mr C said that contact with Ms I had been attempted that evening, but was unsuccessful.

68. Mr E, Mr C and Mr B all advised that the On-Call Manager, Ms F, was contacted following the incident (Mr E said that he called her). Mr E advised that he could not remember whether Ms F attended the facility that evening. Mr C advised that the On-Call Manager did attend the facility that evening, debriefed what had occurred, expressed satisfaction with the process staff had followed following the incident, and advised that Ms I would oversee an investigation into the incident. Ms F confirmed that she was contacted the evening of the incident, but indicated that she did not attend the facility then, as she was assisting another resident.

69. Given my inability to hear from Ms I as to whether she was contacted the evening of the incident, I am unable to make a finding in this regard. Regarding Ms F, I am satisfied that she was contacted, most probably by Mr E, but I do not think it likely that she attended the facility that evening, given her own recollection.

Debrief that evening

70. In terms of the debrief that occurred following the incident, Mr E advised that he debriefed the parties. Similarly, Mr B advised that he and Mr C had debriefed with Mr E. As set out above, Mr C said that Ms F debriefed what had occurred; however, Ms F indicated that she did not attend the facility that evening, and also said that she asked Mr E to follow up on the incident with Mr A (presumably "debrief" him). Having considered all of the accounts, I am of the view that it is more likely than not that Mr E debriefed the parties following the incident.

Opinion: Mr B

Care provided on 18 July 2013 — Breach

71. In my view, Mr B responded to Mr A's agitation in a manner that was unnecessary and inappropriate. I accept the advice from disability services expert Mr John Taylor that both the decision to restrain Mr A, and the method of restraint, represented departures from accepted standards of care.

Behaviour did not warrant restraint

72. Although I accept that Mr A may have exhibited challenging behaviour prior to the incident occurring, I do not consider that behaviour to have warranted restraint. For the avoidance of doubt, even if Mr B's intention had been to restrain Mr A only insofar as was required in order to move him to the couch (as he says), I still do not consider that action to have been necessary in the circumstances. It is my view that restraint should be used only as a last resort.

73. The above view is supported by the fact that Mr B was required[19] to adhere to/act in accordance with the following documentation and policies in place at the disability service:

- Mr A's Restraint Approval Form, which stated that restraint was to be used only when Mr A "place[d] himself at risk of harm" or "place[d] others at risk of harm".

- The "restraint requirements" in Mr A's Care Plan, which set out various de-escalation techniques, and that restraint should be used only as "an absolute last resort". In terms of the threshold for when restraint might be appropriate, the Care Plan went on to specify circumstances where Mr A endangered/ compromised the health, wellness and safety of himself or others.

- The CPI Workbook (on which Mr B had received training — see footnote 16), which also stated that restraint "should only be used as a last resort". That Workbook went on to suggest that this would be when "the person [was] no longer responding to reason" (ie, verbal means of managing the situation had been exhausted) *and* the person "present[ed] as a danger to himself, staff, or other people in the area".

- The disability service's Managing Challenging Behaviour Policy, which stated that restraint was to be used only "to prevent a person doing harm to themselves or others" *and* "only following continued attempts to positively manage the behaviour".

74. The above documentation made it clear that restraint was appropriate only if non-physical attempts to de-escalate Mr A had been unsuccessful, and Mr A presented as a risk to himself or others. In my view, neither of those circumstances existed in this case.

[19] Mr B's individual employment agreement with the disability service included the requirement that he "conduct himself in a manner befitting an employee of the disability service and comply with the disability service's 'Policies and Procedures'".

75. For completeness, I note that the disability service's Managing Challenging Behaviour, Aggression and Violence chapter in the facility's Manual stated that "when mokopuna becomes verbally threatening to themselves or others, maintain a 1:1 or 2:1 presence and redirect them to a safe area". While I accept that Mr B may have thought it appropriate to redirect Mr A to the couch in light of that policy (the couch being a "safe area"), I do not consider such redirection required restraint in the circumstances. Overall, I share the following view, expressed by my expert advisor, Mr John Taylor:

> "It appears that, in responding to [Mr A] as he did, [Mr B] escalated a situation that may have been diffused by a different strategy. In my opinion [Mr B] did not meet the expected standard of practice in this area and this departure would be considered a mild to moderate departure by his peers."

Method of restraint inappropriate

76. Mr A's Care Plan and the disability service's Managing Challenging Behaviour Policy both referred to the CPI methodology and/or training in specifying appropriate restraint technique. The CPI Workbook (on which, as already set out, Mr B had received training) clearly set out the elements of CPI methodology regarding restraint which, amongst other things, included two staff members holding the individual in a prescribed manner (see the diagrams included earlier in this report).

77. Having found it likely that Mr B grabbed Mr A and held him on the floor for around 10 minutes, it is clear that he did not adhere to the CPI technique in any respect in restraining Mr A. Mr Taylor provided the following comment in this regard which, again, I agree with:

> "It is my opinion that the 'restraint' was both unnecessary and performed contrary to [the disability service's] policy and to good practice. The training [Mr B] received, [Mr A's] care plan and the policy documents make it clear that a restraint is a last resort and should be performed by two staff people. This would be viewed as a significant departure from accepted practice."

78. While I have found that restraint was not necessary in the circumstances, given Mr B did decide to restrain Mr A, it would have been appropriate for him to have followed the CPI methodology and disability service policy. In my view, when restraint is required, it should be carried out in a controlled and methodical manner; this intervention was not.

Conclusion

79. In my view, both Mr B's decision to restrain Mr A, and the method of restraint used, were inappropriate. As a consequence, Mr B failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

Actions taken following incident — No Breach

80. Irrespective of what is set out above, I am satisfied that the steps Mr B took following the event, in terms of procedure, were adequate. Mr B advised Mr E of what had occurred, and Mr E contacted On-Call Manager Ms F (and possibly Care Manager Ms

I). With reference to the disability service's Reporting Abuse Policy, Mr Taylor advised that process was "in accordance with [the disability service's] procedural expectations", which I agree with.

Opinion: The disability service

General comment

81. The disability service had overall responsibility for ensuring that Mr A received an appropriate standard of care. It needed to have adequate systems, policies and procedures in place regarding restraint, and then ensure compliance with those policies, so that the care delivered to Mr A was appropriate.

82. In addition to the overall responsibility referred to above, employers such as the disability service can be found vicariously liable for an employee's breach of the Code.[20] However, it is a defence for an employer to prove that it took such steps as were reasonably practicable to prevent the act or omission of an employee who breached the Code.[21]

83. In my view, Mr B's failures to provide services to Mr A with reasonable care and skill on 18 July 2013 were matters of individual error. Having had adequate documentation and policies in place, and having provided Mr B with training on appropriate restraint techniques, the disability service was entitled to rely on Mr B to provide appropriate care in the circumstances. Accordingly, I do not find the disability service directly or vicariously liable for Mr B's breach of the Code.

84. Despite what is set out above, I am of the view that some of the disability service's policies relevant to this investigation could have been more effective in ensuring that appropriate care was provided to Mr A. In addition, I am critical of the disability service's internal investigation into the incident, and its consideration of the incident during the RMC on 29 August 2013. My comments in respect of each of those issues are set out as follows.

Documentation and policies — Adverse comment

Policies

85. In Mr Taylor's advice, he noted that, over the last few decades, there has been a shift within the disability sector regarding management of challenging behaviours for those with intellectual disabilities. Mr Taylor identified that shift as moving away from "behaviour management" and towards "positive behaviour support" (the latter model now considered to be best practice). Mr Taylor explained that behaviour management "tends to assume that the challenging behaviour is an attribute of the individual and often leads towards restriction and physical intervention", whereas positive behaviour support "tends to assume the challenging behaviour is the person's best attempt at

[20] Section 72(2) of the Health and Disability Commissioner Act 1994 (the Act).
[21] Section 72(5) of the Act.

letting others know there is a mismatch between what they need and what they are getting and focuses on building trusting relationships …".

86. In terms of the documentation and policies in place at the disability service, Mr Taylor advised: "In general I found most of what was presented to be adequate … " However, in light of what is set out above, Mr Taylor went on to comment as follows:

> "What I didn't find was very much evidence that indicated that [the disability service] was operating within a positive behaviour support framework. There were statements about increasing the life outcomes for 'mokopuna' which do align with a positive behaviour approach … However … I only found one reference to behaviour being communicative in function, or any other positive behavioural approach, within the policies and processes relating to challenging behaviour."

87. The "one reference" referred to above was the Managing Challenging Behaviour, Aggression and Violence chapter in the facility's Manual. Mr Taylor advised that that document "… provided a good list of preventative strategies to reduce the likelihood of 'disruptive behaviours'". However, Mr Taylor also noted that some of those preventative strategies were "quite intrusive" (for example, "sit with mokopuna" and "maintain a 1:1 until mokopuna has calmed") — in this regard he stated:

> "While at first glance this may appear caring, it offers a process that would be inflammatory in many situations where, for example, the function of the behaviour was to let people know the individual needed space — something quite common in group situations. Having this as the only process is an indication of the [disability service] exerting a level of control over the person; which is antithetical to a positive behavioural approach."

88. Overall, however (and as already indicated), Mr Taylor advised that the relevant policies and procedures in place at the time were adequate, which I accept. For completeness, he further stated:

> "It is my opinion that the policies and procedures in place at [the disability service], and that were presented to me, were within the acceptable range if one assumes a framework of behavioural management. However, in terms of best practice — that is operationalising a positive behavioural support approach, my opinion is that their policies and procedures were below standard and therefore less effective than they might otherwise have been."

Documentation accuracy

89. I also note that Mr E signed the back of the restraint form, which stated that policy and procedure was followed in this restraint, and it is recorded in the On Call Report that the restraint was carried out "as per strategy" when, in fact, it had not been. I accept that Mr E and the person who filled out the On Call Report may have simply been recording what they were advised at the time; however, in my view, they should have made further enquiries to ensure that the information they had been provided was correct.

Internal investigation — Adverse comment

90. While some aspects of the disability service's internal investigation were thorough and procedurally sound, I am not satisfied that the investigation occurred in a timely manner, nor am I satisfied that the restraint incident was considered appropriately.

91. In terms of the timeliness of the internal investigation, it is unclear why two and a half weeks elapsed before that process commenced. In my view, that delay demonstrated a lack of communication and/or awareness regarding the incident amongst relevant staff at the disability service and, in light of the nature of the incident, had the potential to place Mr A and other residents at risk. Further, the lack of clarity as to why the delay occurred/how the matter came to Ms I's attention (who initiated the commencement of the investigation) was not addressed adequately in the investigation documentation, which I think is poor.

92. Once the disability service's internal investigation did commence, it appeared to focus solely on whether physical abuse had occurred; when that threshold was not satisfied, there was no consideration as to whether the restraint was warranted in the first place, nor was there meaningful consideration regarding the appropriateness of the method of restraint used (and, consequently, there was no follow-up in respect of those issues). In this regard, Mr Taylor advised as follows:

> "… there was no immediate investigation into the appropriateness of the 'restraint' or the manner of the 'restraint' in and of itself. When the investigation did commence, its scope was set by the allegation of abuse … Given the evidence available the investigation reached the almost inevitable conclusion that this was not probable.
>
> However, the investigation did not ask the really important questions such as: was the restraint required ... Instead [the disability service] appeared to assume the restraint was required albeit improperly administered …
>
> This inadequacy in considering the important issues about the 'restraint' are a substantive failure of process and, in my opinion would generally be seen with moderate to severe disapproval by others in the sector."

93. I agree with Mr Taylor's comments, and consider these omissions resulted in considerable gaps in the disability service's investigation findings. I do not consider that it was appropriate for the disability service to confine its investigation to whether there was physical abuse. The disability service should have examined whether restraint was appropriate in the circumstances, and how it was carried out.

Restraint Management Committee — Adverse comment

94. The disability service's Restraint Minimisation Manual stated that the function of the RMC was to "ensure that all the restraints imposed me[t] the principles of the Managing Challenging Behaviour … Policy … and [were] compliant with the Restraint Minimisation Standard NZ 8134:2008". With reference to the RMC Report from the RMC meeting that occurred on 29 August 2013, it does not appear that that function was fulfilled; the incident appears to have been considered only insofar as it related to Mr A's behaviour and the fact that staff should "Maintain CPI Verbal de-

escalation techniques when [Mr A] becomes verbally challenging". Accordingly, I am of the view that the RMC did not consider the restraint appropriately in accordance with its own established process, and consider that to have been inadequate.

Recommendations

95. I recommend that Mr B provide a written apology to Mr A for his breach of the Code. That apology should be sent to HDC, for forwarding to Mr A, within **one month** of the date of this report.

96. I recommend that the disability service undertake the following:

- Obtain an independent review of its policies, procedures and documentation relating to restraint, and report back to HDC regarding the outcome of that review, within **three months** of the date of this report.
- Undertake staff training on the use of restraint in the context of "positive behaviour support", and provide HDC with evidence of that training having occurred, within **three months** of the date of this report.
- Ensure that staff are aware of their obligations in considering incidents of restraint (both in terms of the internal investigation process and the RMC process), and provide evidence that this has occurred, within **three months** of the date of this report.

Follow-up actions

97.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be provided to the District Health Board, and it will be advised of Mr B's name.

Appendix A — Expert advice

On 20 April 2015, the following expert advice was obtained from John Taylor:

"I have been asked by the Deputy Health and Disability Commissioner to provide an opinion on case number 13/01655 that related to the care provided to [Mr A] by [the disability service] in 2013. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

I have the following qualifications and experience to fulfil this request.

Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh.

Experience: 28 years of working within the disability sector including the following roles: direct support worker, agency management (over 10 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses.

I have been asked to provide advice to the Deputy Health and Disability Commissioner regarding the care provided to [Mr A] by [the disability service] in 2013. In particular I have been asked to comment on the following:

1. The adequacy of the relevant policies and procedures in place at [the disability service] at the time of the events in question.
2. The appropriateness of [Mr B's] decision to restrain [Mr A].
3. The appropriateness of the method used by [Mr B] to restrain [Mr A].
4. The adequacy of the action taken by [Mr B] and [the disability service] following the restraint.

I have based my opinion on the information listed below. When I quote from a document I will provide its name and the number it has been given on the following list.

1	Guidelines for Independent Advisors
2	Summary of facts gathered (by HDC)
3	[The disability service's] confidential investigation documents including: a. Complaint/Concern Form b. Mokopuna Behaviour Restraint Form c. Letter to [Mr A]: 'Outcome of Complaint Lodged 6th August 2013'
4	[Mr A's] Restraint Approval Form

5	[Mr A's] Individual Care and Rehabilitation Plan
6	Relevant policies from [the disability service's] Policy Manual d. Reporting abuse e. Duty of Care f. Managing Challenging Behaviour g. Kaimahi Supervision ('On Track Chat') h. Induction i. Managing Challenging Behaviour, Aggression and Violence (extract from [the facility's manual])
7	[The disability service's] Restraint Minimisation Manual
8	[Mr B's] Participation Certificates for CPI training on non-violent crisis intervention
9	The CPI Participant Workbook on Nonviolent Crisis Intervention
10	*From Behavior Management to Positive Behavioral Supports: Post-World War 11 to Present:* Kappel, Bruce; Dufresne, Derrick; Mayer, Mike (March 2012)

Some initial comments

In the area of working with people with learning disability (intellectual disability) who present behaviours that challenge there has been a seminal change over the past few decades. This change is from focusing on Behaviour Management to understanding behaviour as communication and the associated development of Positive Behaviour Support. The change has led to different service responses to those whose behaviour challenges. Behaviour Management tends to assume that the challenging behaviour is an attribute of the individual and often leads towards restriction and physical intervention. Positive Behaviour Support tends to assume the challenging behaviour is the person's best attempt at letting others know there is a mismatch between what they need and what they are getting and focuses on building trusting relationships, the person's life opportunities and on altering their environment. (Doc 10)

In the New Zealand context, as in other jurisdictions, this has not been a sequential change in that one has replaced the other. Instead, both philosophies operate in competition with different government policies, different organisational policies and different people operating under one or the other. Best practice however, both internationally and within NZ, is clearly aligned with using positive behavioural supports.

Because best practice is the use of positive behavioural supports, this is typically the way policies are framed. However, the procedures tend to be more instructive as to whether positive behaviour supports are actually being used and/or are in fact driving the thinking behind any interventions.

1. The adequacy of the relevant policies and procedures in place at [the disability service] at the time of the events in question.

The context of support for [Mr A] is within a government mandated care facility established under the Intellectually Disabled (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act). This Act establishes a scheme which authorises the provision of compulsory care and rehabilitation to individuals with an intellectual disability 'that have been either found unfit to stand trial on, or convicted of, an imprisonable offence.' (ID (CC&R) Act)

This means that many of the people living in these care facilities have not been able to operate successfully within the wider community and have been required to live in more secure situations. Whether this is an attribute of the individual or a failure of competency of other support situations is not clear, however the result is a higher level of containment for the person. In turn, this requirement to provide secure accommodation frequently leads organisations to conclude that their major business is behaviour management.

[The disability service's] policies and training information relevant to this incident will be written to match the context. As such, the information listed within documents 4, 5, 6, 7 and 9 above need to be seen is this light. In general I found most of what was presented to be adequate for the purpose, in that they covered the areas that need to be covered and many, such as the 'Individual Care and Rehabilitation Plan' were well detailed documents. Other documents, such as the 'Restraint Minimisation Manual,' contain large amounts of information that does not appear to be directly related to the topic of the manual. What I didn't find was very much evidence that indicated that [the disability service] was operating within a positive behaviour support framework. There were statements about increasing the life outcomes for 'mokopuna' which do align with a positive behaviour approach. For example, Goal 2 of the 'Restraint Minimisation Manual' (doc 7) says: 'Provide a range of choices that enhance mana and improve lifestyle options.' (p8) However, because this is within the context of 'restraint' it could be easily subsumed into that framework. I only found one reference to behaviour being communicative in function, or any other positive behavioural approach, within the policies and processes relating to challenging behaviour. That was in the 'Managing Challenging Behaviour, Aggression and Violence' extract from [the facility's] Manual (doc 6f).

This document provided a good list of preventative strategies to reduce the likelihood of 'disruptive behaviours.' However the techniques it suggested to follow should they become 'disruptive' were quite intrusive: 'Sit with mokopuna; ... Maintain 1:1 until mokopuna has calmed' etc. While at first glance this may appear caring, it offers a process that would be inflammatory in many situations where, for example, the function of the behaviour was to let people know the individual needed space — something quite common in group situations. Having this as the only process is an indication of the organisation exerting a level of control over the person; which is antithetical to a positive behavioural approach.

All the other documents that related to responses to behaviours that challenge appear to assume the need for management of the person up to and including restraint. In addition the only training presented was the CPI course. This is a very well regarded course and does teach some of the best non-violent intervention strategies in the sector. However, if this is the only training staff receive in respect of behavioural support then it tends to reinforce the idea that behaviours are attributes of the individual that need managing and ignores the main thrust of positive behaviour support.

It is my opinion that the policies and procedures in place at [the disability service], and that were presented to me, were within the acceptable range if one assumes a framework of behavioural management — which is common when working in the ID(CC&R) Act framework. However, in terms of best practice — that is operationalising a positive behavioural support approach, my opinion is that their policies and procedures were below standard and therefore less effective than they might otherwise have been. I further think that because of this, the policy and procedural framework would have created an environment where incidents, such as the one that is the focus of this complaint, would be more likely to occur. It would also have influenced the subsequent management and investigation of the incident.

2. The appropriateness of [Mr B's] decision to restrain [Mr A]

There are differing accounts as to what was occurring at the time [Mr B] decided to restrain [Mr A] but the three eye witness accounts all agree that the altercation began from a derogatory comment [Mr A] made to [Mr B] and [Mr B's] subsequent reaction. The issue here is the requirement for support staff to be able to de-personalise such comments and not react to them, despite how difficult this can be. This is a primary preventative strategy within a positive behavioural approach. It appears to me that in responding to [Mr A] as he did, [Mr B] escalated a situation that may have been diffused by a different strategy.

In my opinion [Mr B] did not meet the expected standard of practice in this area and this departure would be considered a mild to moderate departure by his peers.

3. The appropriateness of the method used by [Mr B] to restrain [Mr A].

If the account of [Mr A] is the correct account then it is my opinion that this incident may have been an assault rather than a restraint.

If the accounts of [Mr B] and [Mr C] are more accurate then it is arguable that [Mr B] was attempting to follow [the disability service's] de-escalation procedure and sit with [Mr A]. (I have already given my opinion as to the efficacy of this.) In these two accounts it appears that in the process of doing this [Mr A] and [Mr B] fell to the floor where [Mr B] 'restrained' [Mr A] until the latter calmed down.

It is my opinion that the 'restraint' was both unnecessary and performed contrary to [the disability service's] policy and to good practice. The training [Mr B] received, [Mr A's] care plan and the policy documents make it clear that a

restraint is a last resort and should be performed by two staff people. This would be viewed as a significant departure from accepted practice.

4. The adequacy of the action taken by [Mr B] and [the disability service] following the restraint.

Following the incident it appears [Mr B] notified his superior — [Mr E] — and filled in the appropriate form as would have been required of him. He also appears to have re-established a more friendly relationship with [Mr A]; albeit with [Mr A] accepting responsibility for the incident. In my opinion this is in accordance with [the disability service's] procedural expectations, even though it misses the point of the necessity for the incident to have occurred in the first place. As an aside, the content of the Mokopuna Behaviour Restraint Form (doc 3b), is procedurally problematic. This form was filled out by [Mr B], apparently without reference to the opinions of [Mr A]. It is likely this is the standard practice for [the disability service], as with many other organisations, but it is less than best practice.

From the documents I have been provided, it is unclear exactly what prompted the follow up action from [the disability service]. It appears that the follow up, which began 19 days after the incident, was based on an allegation of abuse. What is not clear to me is whether [Mr A] made the allegation and then the investigation began, or whether the investigation prompted the allegation.

It appears that, despite reservations held, and made known, by [Mr E] there was no immediate investigation into the appropriateness of the 'restraint' or the manner of the 'restraint' in and of itself. When the investigation did commence, its scope was set by the allegation of abuse. In other words, it was limited to deciding whether or not [Mr A's] account of the nature of the alleged abuse/assault was accurate or probable. Given the evidence available the investigation reached the almost inevitable conclusion that this was not probable.

However, the investigation did not ask the really important questions such as: was the restraint required? Did [Mr B] act appropriately prior to the incident? What other training or processes may be required to reduce the likelihood of a repeat situation? Instead [the disability service] appeared to assume the restraint was required albeit improperly administered: 'On reflection was "appropriate" action taken during this incident, probably not in terms of a "one man restraint".' (Doc 3c). In similar vein, when [the disability service] acknowledge the need for further training in the letter it is for more CPI training, presumably to eliminate the 'one man hold.'

This inadequacy in considering the important issues about the 'restraint' are a substantive failure of process and, in my opinion would generally be seen with moderate to severe disapproval by others in the sector."