# Brackenridge Services Limited
# Community Support Worker, Mr D

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 20HDC00043)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report concerns the care provided by a community support worker to a young man who resides in a residential facility under a shared-care arrangement. The consumer has intellectual disabilities, is non-verbal, and has physical health problems, including epilepsy, cerebral palsy, and cortical visual impairment. He has a developmental disability and exhibits challenging behaviours from time to time.

2. In particular, the report concerns the community support worker's actions towards the young man on 5 November 2019, and highlights the importance of support staff treating consumers with respect and ensuring that challenging situations are managed appropriately irrespective of the circumstances.

### Findings

3. The Deputy Commissioner found that Brackenridge's failure to ensure that information regarding approved physical interventions was contained in the consumer's individual support plan breached Right 4(1) of the Code. The Deputy Commissioner also found that by failing to inform Oranga Tamariki in a timely manner of a complaint relating to the standard of care the young man received, Brackenridge breached Right 4(2) of the Code.

4. The Deputy Commissioner made adverse comments about the support worker's use of physical intervention to manage the young man's challenging behaviour on 5 November 2019, and the support worker's failure to complete an incident form.

### Recommendations

5. The Deputy Commissioner recommended that Brackenridge ensure that all residents' individual support plans (including the consumer's) contain clear guidelines that outline when and how staff should respond to predictable types of challenging situations and risky behaviours; ensure that all managers are aware of the physical interventions that have been approved for each resident; ensure that all members of staff have undertaken training in the management of actual or potential aggression; and undertake an audit of all complaints received over the past six months, to ensure that Oranga Tamariki is informed of any complaints within the timeframe specified in the shared agreement.

## Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms E about the services provided by Brackenridge Services Limited to Master A. The following issues were identified for investigation:

- *Whether Brackenridge Services Limited (trading as Brackenridge) provided Master A with an appropriate standard of care in November 2019.*

- *Whether Mr D provided Master A with an appropriate standard of care on 5 November 2019.*

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

8. Brackenridge was directly involved in the investigation, and further information was received from:

| | |
|---|---|
| Ms B | Chief Executive Officer (CEO) |
| Ms C | Team Leader |
| Mr D | Community support worker |
| Ms E | Community support worker |

9. Independent expert advice was obtained from a mental health and intellectual disability nurse practitioner, Bernadette Paus (Appendix A).

## Information gathered during investigation

### Introduction

10. This report discusses the care provided to Master A, aged in his late teens at the time of these events, by a community support worker, Mr D,[1] on 5 November 2019.

11. Master A lives in a residential placement[2] under a shared-care arrangement[3] whereby Oranga Tamariki|Ministry for Children (Oranga Tamariki) is Master A's guardian[4] and Brackenridge provides services to him.

12. Master A has intellectual disabilities[5] and physical health problems, including epilepsy, cerebral palsy, and cortical visual impairment. He is non-verbal[6] and expresses his wants and needs by showing and pointing, and by using body and facial expressions and an electronic tablet and pictures. Master A uses a wheelchair and has complex support needs.

[1] Mr D was also in his third year of nursing training at the time of events.
[2] Since 2016.
[3] Shared care is a care service where the Purchasing Agency places children or young people with a provider under section 362 of the Oranga Tamariki Act 1989, and custody and guardianship (where applicable) remains with the Chief Executive. Each child or young person has a designated Purchasing Agency social worker who manages the Individual Care Plan and provides social work to the child or young person and their family.
[4] Master A has no contact with his family.
[5] Agenesis of the corpus callosum, severe global developmental delay, and failure to thrive.
[6] As Master A is non-verbal, he did not provide evidence to HDC.

**Brackenridge**

13. Brakenridge is a charitable organisation that provides residential support to children, young people, and adults with intellectual disabilities and autism. It has homes across the region, including the home Master A lives in, Home 2. A further home, Home 1, is close by. The two houses are staffed by community support workers, and, because of their close proximity, they share staff members and a team leader. At the time of these events, Ms C was the team leader for both homes, and worked the majority of her shifts in Home 1.

14. Ms C told HDC that three challenging young men resided at Home 2, and the young men would fight and argue with each other and could become aggressive towards staff and each other. She stated that Home 1 staff would often "tag out" to give Home 2 staff a break, as it can be very hard going, and often she would be called into Home 2 to support staff.

15. Brackenridge provides monthly updates and incident reports to Oranga Tamariki, and holds monthly meetings regarding Master A's care. A social worker visits Master A every eight weeks. Master A's day-to-day care is managed and overseen by the service manager for Brackenridge's young persons service.

**Mr D**

16. Mr D[7] had worked with Master A previously in another home in 2016. Mr D told HDC that he found working with Master A difficult because of his challenging behaviour, and he informed Brackenridge's management of this.

17. Brackenridge told HDC that when there is a breakdown in a relationship between a person it supports and the staff who are working with the person, it will try to work with the staff to see whether the relationship can be restored. Brackenridge noted that this is not always possible, and that in these cases, it will work with the staff member to try to find a more appropriate place for them to work.

18. Ms C told HDC that Mr D had told her that he found working with Master A challenging, so he was never scheduled to work as Master A's key worker, but he would take over if a female member of staff was seen to be hurt, and would remove Master A to a safe place by lifting him under his arms and helping Master A to walk.

**Staff levels on 5 November 2019**

19. On 5 November 2019, Mr D[8] and Ms E[9] worked the 10am to 2pm shift in Home 2. Ms E completed her orientation shift with Brackenridge on 12 October 2019, and 5 November 2019 was the first time she had worked with Master A. Brackenridge rostered Mr D to work in Home 2 on 5 November 2019, because no one else was available to work, and it was Ms E's first shift in Home 2 and it was considered that it would be helpful for her to work with someone who had worked with Master A previously.

[7] Mr D had been employed by Brackenridge in a full-time capacity as a community support worker since 2017.
[8] Shift leader on 5 November 2019.
[9] Community support worker.

20. On 5 November 2019 there were two residents (including Master A) present during the incidents outlined below. Ms E and Mr D's role was to engage with Master A and one other resident (who were not attending school[10]) and to prepare meals for all residents when the third resident returned home from school. Brackenridge told HDC that the other resident present during the day was also a high and complex needs client.

21. Ms C provided a handover to Mr D and Ms E before the start of their shift. Ms C told HDC that she gave Ms E the client's book, the information book, and the home information book to read to assist with her daily activities, as it was her first shift in Brackenridge.

**Incidents on 5 November 2019**

*Climbing of fence*

22. Ms E told HDC that at around 10.30am, Master A was outside attempting to climb a fence. It is documented in Master A's clinical records that Master A was unsettled in the morning and was trying to climb the fence "for him to go out". Ms E stated that she asked Mr D to help her to bring Master A inside,[11] and he told her to leave him because he would just go outside again, and he was unable to actually climb the fence. Ms E told HDC that Mr D told her to "just pull him down, no one will see you". Mr D denies that he said this, and, in his interview with Brackenridge,[12] stated that Master A always wanted to be outside, and that he had never seen Master A climb fences and he was not capable of doing so, and he had seen Master A crawl under a fence but not climb one. Mr D said that he knew Master A's needs and behaviours well. In response to the provisional opinion, Mr D stated that it was unlikely that he would have told Ms E to pull Master A down from a fence if he had observed him to be on the ground.

23. Ms E escalated the issue to Ms C when Master A climbed onto the fence, and Ms C (who was working in Home 1) went to Home 2. Ms C told HDC that when she arrived, Master A had climbed over onto the other side of the fence. Ms C said that at this time, Mr D was speaking to Master A in a gentle tone, and Master A was aggressive and shuffling on his buttocks towards the road. She stated that Mr D picked up Master A under his arms and supported him back to Home 2.

*Voice raising*

24. In her interview with Brackenridge, Ms E stated that she and Mr D had prepared food for Master A's lunch,[13] but he was repeatedly pointing to the kitchen and tapping on the table. Ms E said that Master A went into the kitchen and was by the pantry, and they then realised that he was trying to use the food processor, and Mr D yelled at him to get out and go to the dining area.

[10] Master A's transport to school was unavailable on this day.
[11] Ms E stated that Master A was on the ground when she asked this.
[12] In December 2019.
[13] Ms E stated that the food had not been processed, and they had not been informed about this in the handover. It is documented in Master A's clinical record that he ate beans, bread, and yoghurt for his lunch.

25. Mr D told HDC that Master A was in the kitchen trying to operate the food processor, and that he offered Master A his favourite food, which he declined, and then gave him choices of other food, which he also declined. Mr D said that he asked Master A to leave, for his own safety around electrical equipment. Mr D told HDC that "[Master A] was not following directions from [him]", and that Master A was kicking him when he was "directing him". In his interview with Brackenridge, Mr D acknowledged that he raised his voice to get Master A to listen to instructions, as he would ignore any requests Mr D made.

26. Mr D told HDC that when Master A is elevated he is unable to respond to a normal voice, and staff may need to raise their voice to get his attention. Mr D said that he was trying to calm Master A down by raising his voice.

27. In response to the provisional opinion, Mr D stated that perhaps as a consequence of Ms E being unfamiliar with Master A and his behaviour, she interpreted his (Mr D's) raised voice as yelling.

*Dragging Master A*

28. Ms E told HDC that Master A did not leave when Mr D asked him to, and was on the floor, and Mr D grabbed his ankles and dragged him to the dining area. She said that Master A kept returning to the kitchen, and Mr D dragged him out five times. Ms E stated that she saw Mr D grab Master A, and Master A tried to kick him, and Mr D grabbed him by the arms, crossed them over Master A's chest, and put his weight on top of him. She stated that five times she witnessed Mr D "pulling [Master A's] feet and dragging on the floor and … putting his full weight onto [his] body".

29. In his interview with Brackenridge, Mr D said that he could not really remember the events as it was a long time ago,[14] but that he definitely would not have dragged or pushed his weight onto Master A, but possibly he may have held Master A's ankles to stop him kicking him and other people. In contrast, he told HDC that he picked up Master A and dragged him on the floor (because he was heavy) as Master A was at risk of hitting the kitchen island and bench with his legs. In this statement, Mr D did not clarify whether he picked up Master A by his arms, or his ankles. In response to the provisional opinion, Mr D stated that his usual practice was to lift up Master A under his shoulders from behind, and it would not have been possible for him to put his weight on Master A's chest from that position. Mr D also stated that it is difficult to see how he could have been both applying his weight to Master A's chest and dragging him by the ankles at the same time.

30. In both his interview with Brackenridge and his statement to HDC, Mr D denied pushing down on Master A's chest. He stated that at the time of events, he was a third-year nursing student and was aware that the chest has vital organs and that putting pressure on the chest would drastically compromise Master A's bodily function.

[14] In response to the provisional opinion, Mr D stated that he went on leave after 5 November 2019 for family reasons, and because he had a lot of pressure in his life at the time of Brackenridge's investigation, it took him some time to recall the events.

31. Ms E said that she realised that Master A had been trying to tell them that he required his food to be puréed. She stated that she felt bad that she had not been provided with this information in the handover.

32. Mr D stated that as the behaviour from Master A was common, he "did not think of it as an incident that needed reporting". He said that if he had communicated with Ms E effectively whilst trying to manage Master A's behaviour, she may not have perceived his actions as abuse.

33. Neither Mr D nor Ms E completed an incident report for the events of 5 November 2019.

34. In response to the provisional opinion, Brackenridge stated that it perceives any action taken by Mr D on 5 November 2019 would have been in line with Brackenridge's behaviour support policy where Mr D had reasonable concerns about risk of harm to Master A whilst attempting to use the food processor. Brackenridge further stated that when supporting people with challenging behaviours, activities that others may describe as incidents can be a regular occurrence and part of the daily events for the clients and staff involved, and therefore Brackenridge works with staff to determine the threshold at which behaviours and activities necessitate a formal incident being recorded.

**Subsequent events**

*Concerns reported*

35. On 7 November 2019, Ms E telephoned Ms C and expressed her concerns about the events outlined above. Ms C emailed the duty managers, outlined the complaint, and stated that Ms E felt that she "was witnessing child abuse" by Mr D. Ms C's email stated that Ms E had witnessed Mr D dragging Master A out of the kitchen by his feet, gripping Master A's hands and dragging him, and that Mr D "refused him in doing things". Ms C also outlined that Ms E had explained that whilst outside, Master A had wanted to go out and began to climb the fence, and Mr D told her to "just pull him off".

36. Ms C's email also stated:

> "I [told Ms E] that it was important to talk to management as this is abuse and needs to be taken further. As this is very serious and need[s] to be dealt with … I will follow it up in the morning …"

*Investigation*

37. In response to Ms E's complaint, Brackenridge undertook an employment investigation and met with Ms E, Mr D, and Ms C to discuss the events of 5 November 2019. The investigation concluded that Mr D's conduct did not warrant disciplinary action, and the record of the investigation stated the following:

- Mr D had raised his voice, and speaking loudly and firmly is a recommended practice in Home 2.

- Mr D had worked with Master A before and was aware that Master A was unable to climb very high and there was little risk of harm to leaving Master A on the wall.
- Mr D needed to learn new ways of keeping himself and others safe without physically restraining, and Brackenridge restrains residents only as a last resort.
- Mr D would not work with Master A again, and will attend Management of Actual or Potential Aggression (MAPA)[15] training, and will have coaching from a practice leader or service manager.

38. Brackenridge told HDC that it considered that Ms E's inexperience with Master A contributed to how she perceived the level of support he had, and, considering a range of factors, it accepted Mr D's account of events. Brackenridge told HDC that it considered that Mr D was a motivated employee with a strong service focus, and that his positive record with Brackenridge was taken into account when it considered the next steps.

*Notification of social worker*

39. Brackenridge told HDC that the Service Manager met with the Oranga Tamariki social worker on 30 January 2020 for a regular check-in to review four tamariki (including Master A). Master A's social worker was made aware of Ms E's complaint at the beginning of February 2020 in Brackenridge's monthly report to Oranga Tamariki. Brackenridge told HDC that its usual practice is to report such an incident immediately, and the failure to do so is at odds with its Child Protection policy. The Child Protection policy states that Oranga Tamariki is the agency responsible for investigating and responding to suspected abuse, and that Oranga Tamariki is to be notified immediately for advice on managing a situation. The agreement between Brackenridge and Oranga Tamariki, as Master A's legal guardian, for such incidents was to inform the Oranga Tamariki social worker immediately (within one hour).

40. Brackenridge told HDC that Oranga Tamariki was not informed immediately because the managers wanted to speak to Mr D before doing so, but he went overseas,[16] and Master A's social worker and Brackenridge's Service Manager and General Managers were all on annual leave. Brackenridge acknowledged that it could have contacted Master A's social worker earlier by email.

41. Shared Care Service specifications state that when there is an allegation of assault against a child or young person, Brackenridge is to, within one hour, contact Oranga Tamariki's call centre, the Executive Manager, the Manager High Needs, and the Contract Manager, and complete an incident report form and email it to the purchasing agency's Executive Manager, the child or young person's social worker, and the Contract Manager within 24 hours of the event having occurred.

[15] A behaviour management system that teaches skills for assessing, managing, and responding to risk behaviour. The focus is on verbal de-escalation, prevention, and early intervention.
[16] Brackenridge told HDC that Mr D's last shift before his annual leave was on 6 November 2019.

### Master A's support plans

42. Master A's behavioural support service plan,[17] dated 3 March 2019 (seven months old at the time)[18] records that his challenging behaviour includes hurting staff, kicking, hitting, scratching, head banging, grabbing clothing, throwing objects, damaging property and his wheelchair (tipping himself out),[19] and targeting and attacking his housemates. The support plan also notes that when travelling, Master A attempts to remove his harness, opens the car doors, grabs the driver or other people in the vehicle, and throws himself onto the floor of the vehicle.

43. Master A's Individual Support Plan (ISP), dated February 2019, records that he has a high level of upper body strength and requires watching because he is able to climb over the fence. The ISP notes that Master A will put himself at risk if he cannot get his own way or does not have his needs met, and that caregivers should walk away and not engage in the behaviour, and provide the necessary support as required to keep him and others safe.

44. Master A's behaviour support service plan, dated 12 December 2019 (after the events of this case), records that caregivers are to move Master A away from other residents, especially ones who are physically aggressive.

45. Brackenridge told HDC that there are no approved personal restraints in place for Master A. Brackenridge said that there are instances when a decision to restrain (physically touch) Master A personally is made in the moment to protect him or others from harm, and for the self-defence of staff members. Brackenridge stated that staff may also intervene to protect him if another resident lashes out. Ms C told HDC that when Mr D had worked with Master A previously, Mr D would lift Master A under his arms to assist him to walk.

46. The behavioural support plan, the ISP, and the safety plan do not provide any authorisation or specific instructions or guidance on when and how to manage physical interventions with Master A.

### Brackenridge policies

47. Brackenridge's prevention and management of abuse and neglect policy states:

> "Prevention is the first defence against abuse and neglect. Providing effective behaviour support can help prevent abuse. Some people may present with behaviours that challenge that can increase their level of risk, as support staff may struggle with managing some of these behaviours. Positive behaviour support follows a cycle of: undertaking an intervention; evaluating the intervention; adapting the approach to reduce behaviours of concern; and teaching alternative behaviours to replace

[17] The service provides behaviour support and safety plans that reflect the individual needs of the person.
[18] Brackenridge told HDC that the behavioural support plan is reviewed annually.
[19] It is recorded in Oranga Tamariki's review of the social work report service specifications that this occurs twice a day or up to ten times a day.

challenging ones. This is particularly important in situations where a restraint protocol is in place as any hands-on intervention will always involve a risk of harm."

48. Brackenridge's restraint policy states the following:

- The use of any restraint intervention is implemented as an emergency measure only to protect at-risk individuals from injury to themselves, others, and/or property.
- Staff are to provide informed choice for the individual by explaining to the individual the implications of the behaviour and offering planned alternatives.
- Personal restraint is defined as where a service provider (staff) uses their own body to intentionally limit the movement of a person. This involves a deliberate restriction of movement for longer than five seconds of specified parts of a person's body, for as long as necessary to prevent the person from causing harm to him/herself or to other people and to minimise damage to property. This will be documented in the person's ISP.

49. Brackenridge's behaviour support policy states:

> "All activities related to behaviour support will be supportive and respectful of the individual needs and goals of the individual, as identified through an Individual Plan, and based on current and comprehensive assessment. [Brackenridge's] Behaviour Support Programme is based on Positive Programming and non-aversive reactive strategies. Practice is guided by ethical principles that include acting for the individual's good, avoiding harm to the individual … respecting the dignity of the client and preserving their human rights. Behaviour support intervention may be appropriate where:
>
> - There are reasonable concerns over risk of harm or serious injury to the individual or to others.
> - Existing strategies have not been effective in managing the behaviour.
> - There are concerns over the use of existing strategies for other reasons.
> - The challenging behaviour appears to prevent other significant needs being met …"

50. Brackenridge's incident management policy states the following:

- All events should be reported, including near miss where no harm was caused to staff, client, or other, all the way through to serious or sentinel events, where significant harm or death may have occurred.
- An incident is any event that could have, or did, cause harm to a person Brackenridge supports, or to employees, family/whānau, or other members of the community. "Incident" is used generically to also include events that stand outside expected standards and practice.
- A near miss is an incident that under different circumstances could have caused harm to a client or other person but did not, and that is indistinguishable from an adverse event

in all but outcome — for example, an attempted assault towards a person or persons that does not cause harm.

**Training**

51. Mr D undertook organisational orientation (which included a section on challenging behaviour and behaviour support) and positive behaviour support in 2017, but had not undertaken MAPA training before the incident. Mr D reported that he was a third-year nursing student at the time of the event, which would suggest that he had completed at least two years of professional development toward his nursing registration.

52. Brackenridge apologised that Mr D had not undertaken MAPA training, and stated that it was its aim that all staff working with people with high and complex support needs would complete a specialised training programme within the first three months of employment, but this did not happen in Mr D's case.

53. In response to the provisional opinion, Brackenridge stated that ensuring that staff feel appropriately trained and supported in their work, including assessment and coaching, is a key focus for Brackenridge as it continually evolves the onboarding and staff learning and development programmes. Brackenridge stated that staff training, assessment, and coaching has been particularly difficult over the past couple of years as it navigates its response to the COVID-19 pandemic and unprecedented shortages of skilled staff.

**Further information**

*Brackenridge*

54. Brackenridge stated that it does not encourage staff to yell at people, but it is clear that there is a need for a change of tone of voice with Master A to get his attention or to get through to him when he is escalated. Therefore, there is a need to increase volume moderately and to talk in a bigger voice, but this is not the same as yelling.

*Mr D*

55. Mr D stated that Master A is very challenging to work with, but he would never be abusive or unprofessional with a client.

56. Mr D told HDC that he has reflected on the event, and now has more options to use in a future similar situation. However, he does not feel that his actions on 5 November 2019 were a restraint, as he was trying to prevent Master A from hurting himself. Mr D said that if he had undergone MAPA training prior the incident, it would have helped him to manage the situation better, and he may have recognised the need to record the incident.

**Responses to provisional opinion**

57. Brackenridge was given an opportunity to respond to the provisional opinion. Where relevant, its response has been incorporated into this report. Brackenridge accepted that ultimately it was responsible for the services delivered to Master A, and that it had breached Right 4(1) and Right 4(2) of the Code, and it accepted the proposed recommendations.

58. Brackenridge stated that in the five years it has known Mr D, it has found him to have acted with the utmost professional integrity. Brackenridge noted that Mr D is a well-liked and respected member of the team.

59. Mr D was given an opportunity to respond to the provisional opinion. Where relevant, his response has been incorporated into this report.

60. Mr D stated that there are some aspects of the care he provided to Master A on 5 November 2019 that could have been better. He stated that in particular, it is likely that Ms E would have been reassured if he had communicated better and worked more collaboratively with her. He said that Ms E's inexperience with Master A influenced both how he responded to the situations that arose, and how his response was interpreted by Ms E.

61. Mr D stated that it is unfair to criticise him for failing to adhere to Master A's ISP when the ISP did not give him any practical options for safe interventions to remove Master A from the kitchen for his own safety, and did not provide sufficient guidance on how to intervene with Master A physically to keep him and others safe. Mr D said that he accepts that he should have communicated with Ms E to make a plan on how to keep Master A safe, but it was Ms E's first time working with Master A, and Mr D was used to intervening for female staff, and in that context it was understandable that he felt a responsibility to manage Master A on his own. Mr D's legal counsel submitted that there is insufficient evidence to find, on the balance of probabilities, that the events occurred as described by Ms E.

## Opinion: Brackenridge Services Limited — breach

62. As a disability service, Brackenridge is responsible for providing services in accordance with the Code.

**Lack of planned physical intervention in Individual Support Plan (ISP)**

63. Within the information and statements provided to HDC there are examples of staff members restraining Master A. For instance, Ms C said that Mr D used to pick up Master A under his arms to help him to walk. However, Master A's Oranga Tamariki support plan, his specialist behaviour support plan, and his safety plans do not contain any authorisation, or any specific instructions or guidance on when and how staff are to manage physical interventions. Brackenridge's restraint policy states that any personal restraints will be documented in the person's ISP.

64. Brackenridge's behaviour support policy states that behaviour support interventions may be appropriate where there are reasonable concerns over risk of harm or serious injury to the individual or to others, where existing strategies have not been effective in managing the behaviour, or there are concerns over the use of existing strategies for other reasons, or the challenging behaviour appears to prevent other significant needs being met.

65. My independent advisor, Ms Paus, said that clearly Master A has a history of significant challenging behaviour that has required an individualised package of care to be provided by one of the Ministry of Health's "high and complex" disability services providers. High and complex services are reserved for people with developmental disability who have serious behavioural dysregulation — generally referred to in the disability sector as "challenging behaviour".

66. Ms Paus acknowledged that physical interventions are used only as a last resort, and that the focus is on positive behavioural intervention, ie, prevention, early intervention, and de-escalation, but as Master A had a history of serious challenging and unsafe behaviours, it was therefore predictable that he would require physical interventions in the form of safe holding and safe moving. Clear staff guidelines on the type of physical intervention and under what circumstances it can be used is vital, and should have been part of Master A's ISP, and should have been signed by all involved in his care.

67. Ms Paus advised that the lack of specific instructions in the ISP to guide staff on when and how to manage physical interventions was a departure from acceptable practice. She stated that whilst in itself, this could be considered a severe departure from acceptable standards, Brackenridge had an overarching organisational restraint policy to act as a safety net and guide staff on physical restraint practice, whether or not a person had a specific plan, and all staff were trained in this method of safe restraint. Ms Paus advised that in this case, the failure was in not copying the specific instructions into Master A's ISP, and therefore this was a moderate departure.

68. Ms Paus stated that Brackenridge deviated from its own restraint policy and ISP policy by not authorising when and what physical interventions could be used on Master A. She advised that as Master A's legal guardian, Oranga Tamariki should also have been involved in developing the ISP and the final sign-off. Ms Paus commented that it is unfortunate that the behaviour support service did not pick up on the omission and include a "reactive" component to Master A's ISP along with the proactive and positive programming components.

69. I agree, and I am critical of Brackenridge. As a facility responsible for supporting residents with a range of complex and extremely challenging behaviours, it is important that Brackenridge provide its staff with adequate guidance and training on how best to respond to inevitable challenging behaviours. An agreed set of proven interventions for a resident such as Master A would help staff to feel supported and confident in safely dealing with such behaviours, and would reduce the occurrence of disturbing situations such as this.

**Training**

70. Brackenridge stated that its aim was for all staff working with people with high and complex support needs to complete a specialised training programme within the first three months of employment, but this did not happen in Mr D's case. It is also unclear to what extent Ms E was equipped to work in such a challenging environment at the time, as she had completed

her orientation shift only three weeks earlier on 12 October, and this was her first shift caring for Master A.

71. The Home and Community Support Sector Standard 8158:2012 outlines that a disability service is required to ensure that consumers receive services that are planned, coordinated, and appropriate to their needs; timely and safe through efficient and effective service management; and from service providers who are trained and assessed as competent to provide services.

72. Ms Paus advised that it is Brackenridge's responsibility to ensure that its staff have the necessary training to use physical interventions appropriately and safely.

73. I agree with this advice, and I am concerned that Mr D was working in high and complex services without appropriate training.

**Delay in informing Oranga Tamariki**

74. When an allegation of assault against a child or young person has been made, the agreement between Brackenridge and Oranga Tamariki (as Master A's legal Guardian) required Brackenridge to contact Oranga Tamariki's call centre (within one hour), contact Oranga Tamariki's Executive Manager, Manager High Needs, and the Contract Manager, and complete an incident report form and email it to Oranga Tamariki's Executive Manager or a social worker within 24 hours of the event occurring.

75. The incidents took place on 5 November 2019. Ms E reported the incident to Ms C two days later on 7 November 2019, and Ms C emailed the residential home duty managers on the same day and said that she would follow up the next day. Brackenridge informed Oranga Tamariki of the incident in the monthly report in February 2020. Brackenridge told HDC that the delay in informing Oranga Tamariki was because Mr D was on leave overseas, and Brackenridge wanted to speak to him before reporting the incident to Oranga Tamariki, and, in addition, members of management were on annual leave.

76. Ms Paus advised that the failure to inform Oranga Tamariki "in a timely manner" was a mild departure from acceptable standards of practice.

77. I acknowledge this advice. However, the agreement between Brackenridge and Oranga Tamariki created a legal agreement whereby the residential home had an obligation to notify Oranga Tamariki of the incident within an hour and provide Master A's social worker with an incident form within 24 hours. This did not occur, and Brackenridge did not inform Oranga Tamariki until February 2020. Taking into account that Ms E did not report the incident until two days after it occurred, in my opinion Brackenridge should have informed Oranga Tamariki within an hour of Ms E raising the incident to Ms C, and an incident form should have been provided concerning the incident involving Master A within 24 hours. I also consider that there were further missed opportunities to inform Oranga Tamariki, as the allegations could have been raised at Brackenridge's monthly meeting with Oranga Tamariki or at one of the social worker's visits on 30 January 2020. Master A is a vulnerable consumer, and the obligations on Brackenridge to inform Oranga Tamariki of an alleged

assault are in place to ensure his safety. By not carrying out its contracted obligations, Brackenridge denied Master A the opportunity of Oranga Tamariki being involved.

78. It is also worth highlighting that the delay in reporting of the incident prevented an opportunity for Master A to be physically assessed for possible injury following the restraint Mr D applied. Bruising, grazing, and carpet burns may have been evident if Master A had been examined by a medical practitioner at the time. It was also not unreasonable to assume that Master A was at increased risk of harm on account of his physical health problems. Appropriate follow-up actions should have been taken in a timely manner.

**Conclusion**

79. Ultimately, Brackenridge is responsible for the service delivered to Master A. By not ensuring that information regarding physical interventions was contained in his ISP, Brackenridge did not provide services to Master A with reasonable skill and care, and breached Right 4(1) of the Code.[20]

80. Furthermore, Brackenridge did not provide Mr D or Ms E with appropriate training, and did not inform Oranga Tamariki of the allegations in a timely manner. Accordingly, I find that Brackenridge Services Limited failed to comply with legal and professional standards, and breached Right 4(2) of the Code.[21]

**Scheduling — other comment**

81. On 5 November 2019, Master A was unable to attend school, and Brackenridge required two additional members of staff to assist Master A and one other resident whilst they remained at home. Mr D had previously outlined to Brackenridge that he found it difficult to work with Master A because of his challenging behaviour, and he felt that Master A did not like him, and Mr D had asked not to work with Master A. However, on 5 November 2019 it was decided that Mr D would work with Ms E as she was new to Brackenridge. Mr D told HDC that he agreed to switch to Home 2 to help with the boys.

82. Ms Paus stated that whilst far from ideal, and assuming that Mr D had the right of refusal, and as he was not working alone, she would not consider the scheduling of Mr D to work with Master A during a time of unexpected staff shortages to be a departure from an acceptable level of care.

83. I accept this advice. I note that Brackenridge's investigation concluded that Mr D would no longer work with Master A. I remind Brackenridge of the importance of listening to and acknowledging a staff member's concerns about working with particular residents, and of assessing whether further training or coaching of the staff member is required.

[20] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[21] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

## Opinion: Mr D

### Raised voice and physical intervention — adverse comment

84. Later in the day on 5 November 2019, Master A was in the kitchen and was removed by Mr D. The way in which Master A was removed from the kitchen, and whether Mr D raised his voice or "yelled", is disputed.

85. Ms E's account of events (which she outlined in her conversation with Ms C, and in her complaint to HDC) is that Mr D immediately yelled at Master A to leave the kitchen, and when he did not comply, Mr D grabbed him by his ankles and dragged him to the dining room. Ms E also reported that Mr D placed his arms across Master A's chest and applied his weight onto him, and this happened up to five times.

86. Mr D stated that he raised his voice, but denies yelling at Master A. Mr D's account of events changed. In his interview with Brackenridge he stated that he possibly may have held Master A's ankles to stop him kicking him and other people, and that he definitely would not have dragged him or pushed his weight onto Master A, and he is not sure what Ms E saw. Mr D stated: "I could have held him by his hands however I cannot remember." However, in communication to HDC he said that he picked up Master A and dragged him on the floor (because he was heavy), as Master A was at risk of hitting the kitchen island and bench with his legs.

87. Notwithstanding the response from Brackenridge (at paragraphs 34 and 58) in support of their employee Mr D, I am mindful of the serious nature of the allegations made about Mr D in terms of how he responded to Master A's challenging behaviour on 5 November 2019. I am obliged to take allegations of this nature extremely seriously, and I have endeavoured to investigate fully whether Master A received the standard of care to which he was entitled. Whether Mr D yelled at Master A or whether he raised his voice, and whether Mr D applied weight onto Master A's chest, is disputed. I have carefully considered all of the information provided by both parties. There is no evidence other than Ms E's and Mr D's account of the events, and, as no one else was present, I am not able to verify the accounts with a third person. I have considered the information provided by both parties, and from the available information I cannot make a finding on whether Mr D "yelled" at Master A or applied weight to his chest.

88. In his response to HDC, Mr D admitted to picking up Master A and dragging him on the floor. Ms E's evidence is that Mr D dragged Master A by his ankles. Mr D stated that he cannot recall what occurred but told HDC that he picked up Master A and brought him out of the kitchen. As explained above, as I cannot verify the accounts with a third person, I cannot establish whether Mr D picked up Master A under his arms or by his ankles.

89. Master A's ISP outlines: "It is important to walk away and do not engage in my behaviour." There is no instruction about raised voices in Master A's ISP, but Brackenridge told HDC that it is clear that there is a need for a change of tone of voice with Master A to get his attention or get through to him when he is escalated, and there is a need to increase volume moderately and talk in a bigger voice.

90. Mr D stated that Master A was trying to use the food processer (a piece of equipment with sharp blades) and that he asked Master A to leave the kitchen using his raised voice but Master A did not follow his instructions. Mr D stated that he acknowledges that Master A's ISP advises support workers to walk away and not engage when Master A is behaving badly, but Master A's ISP also advises staff to "provide the necessary support as required to keep me and others safe". Mr D said that it was necessary to remove Master A from the kitchen for his own safety. Mr D also stated that Master A's ISP did not have practical options for safe interventions to remove Master A from the kitchen.

91. Ms Paus, a mental health and intellectual disability nurse practitioner, stated that if a person with a developmental disability was at risk of harm to themself, and there was a failure of listening, verbal negotiations, and instruction, it would be acceptable practice to use a physical intervention to move them from the area of danger. Ms Paus stated that as there were two staff available, this should have been done in a safer manner using safe holds and supported movement away from the danger. If Master A was at risk being in the kitchen, then both staff should have used physical intervention to assist him out of the kitchen (the process for physical interventions should have been outlined in his ISP). Ms Paus stated that yelling is not reasonable practice; however, changing tone and volume by using a firm tone with mildly raised voice to reinforce clear boundaries can be appropriate for some people with disabilities at times — for example, it is used for some people with autism to gain their attention against other external/environmental stimuli.

92. Master A has a complex medical history and can exhibit challenging behaviours, but he has the right to be treated with dignity and respect and to receive an appropriate standard of care. I am concerned that in the first instance Mr D did not follow the instructions in Master A's ISP (to walk away and not engage), and if that did not work to use a safer manner, together with his colleague, Ms E, to perform a physical intervention. I accept Ms Paus' advice that after attempting the instructions in Master A's ISP, it would have been reasonable for two members of staff to use physical intervention. However, I also acknowledge that it was the first time Ms E had worked with Master A.

93. I have taken into account Mr D's submissions, and I acknowledge that Mr D could have been better supported in his role by Brackenridge facilitating his attendance at MAPA training, and that Master A's ISP did not contain information regarding safe interventions to assist Mr D (as discussed above). I have also considered Brackenridge's response to the provisional opinion that Ms C had mentored Mr D and found him to be a big asset, that Mr D "made sure that the boys were fairly treated at all times on his shift", that no other concerns had been raised in relation to Mr D, and that he had received positive reports from his service managers.

94. After careful consideration of the feedback received and the supportive statements from Brackenridge, I am prepared to accept that Mr D was placed in a difficult situation without adequate training. However, I remind Mr D of the importance of ensuring that physical interventions are carried out with the assistance of a colleague and in accordance with the instructions in the consumer's ISP. I also remind Mr D that if he is aware that a consumer

requires physical interventions and there are no instructions in the consumer's ISP, this should be raised with his employer.

**Incident reporting — adverse comment**

95. Brackenridge's incident reporting policy states that all events should be reported, including near misses where no harm was caused to staff, the client, or another person. On 5 November 2019, Master A climbed the fence at Brackenridge and ended up on the other side, near the road. Despite this, neither Mr D nor Ms E completed an incident form for the event.

96. Brackenridge's policy is clear that all events, even if no harm was caused, are to be reported. I consider that an incident report should have been completed regarding Master A climbing over the fence, and I am concerned that this was not done. I remind Mr D of the importance of completing incident forms in such situations, as per Brackenridge's policy.

**Use of interventions — other comment**

97. Ms C told HDC that she recalls that Mr D would assist if a female member of staff was seen to be hurt, and would remove Master A to a safe place by lifting him under his arms and helping Master A to walk.

98. Ms Paus advised that any use of physical interventions/restraint should be clearly documented in Master A's Individual Behaviour Support/Risk plan.

99. I agree. I remind Mr D to ensure that he uses only physical interventions or restraints that are approved in a resident's Individual Support Plan or risk plan.

**Communication regarding pulling Master A from fence**

100. Master A's ISP records that he has a high level of upper body strength and requires watching because he is able to climb over the fence. On 5 November 2019, it is documented that Master A climbed a fence. In her Brackenridge interview, and in her complaint to HDC, Ms E's evidence is that Mr D said, "Just pull him down, no one will see you," and in Ms C's email dated 7 November 2019, she outlined that Ms E said that Mr D had said, "Just pull him off." In Brackenridge interview, Mr D denied telling Ms E to pull Master A down, and he told Brackenridge that he had worked with Master A previously, and Master A was unable to climb very high and there was little risk in leaving Master A on the wall.

101. Ms C told HDC that she saw that Master A had climbed over onto the other side of the fence, and Mr D was speaking to Master A in a gentle tone, and Master A was aggressive and shuffling on his buttocks towards the road. She stated that Mr D picked up Master A under his arms and supported him back to Home 2.

102. It is apparent that the accounts from Ms E and Mr D are at odds. To make a finding of fact in favour of one account, I must be satisfied that there is sufficient evidence to meet the standard of proof required, namely whether, on the balance of probabilities, the alleged events occurred. Ms E's allegation that Mr D told her to pull Master A down from the fence is serious.

103. Other than Ms E's and Mr D's accounts of the events, there is no other evidence available, and I cannot verify the accounts with a third person. It can be difficult to make a factual finding when the parties involved give conflicting accounts of events and there is an absence of other evidence. I have considered the information provided by both parties, and from the available information I cannot make a finding on the allegation that Mr D told Ms E to pull Master A from the fence.

## Changes made

104. Brackenridge has undertaken the following:

a) Introduced a team leader to Home 2 to provide more oversight.

b) Identified places where it wants to reduce the number of unfamiliar staff who work in the home, and decrease the use of casual staff in these homes.

c) Reminded its service managers about the need to ensure that all ISPs are formally authorised by Oranga Tamariki.

d) Advised HDC that it will consider whether to include more specific details regarding how to respond to Master A in the event of a crisis. Consideration of whether this is appropriate will be made with input from the behaviour support service and Brackenridge's Restraint Committee (which includes a senior clinical psychologist).

e) Included details about how to respond in a crisis into the Individual Support Plan.

105. Mr D told HDC that since these events he has completed the MAPA training and Safe Practice Effective Communication (SPEC) training.

## Recommendations

106. I recommend that Brackenridge:

a) Ensure that there are clear guidelines in Master A's ISP outlining when and how staff should respond to predictable types of challenging situations and risky behaviours with Master A, for example, if there is risk associated with him climbing the wall, how staff should respond to this behaviour. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

b) Ensure that all residents' ISPs include clear guidelines that outline when and how staff should respond to predictable types of challenging situations and risky behaviours.

c) Ensure that all managers are aware of the physical interventions that have been approved for each resident in their care.

d) Ensure that all members of staff have undertaken MAPA training. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

e) Undertake an audit of all complaints received over the past six months and the time from the complaint to informing Oranga Tamariki, to ensure that Oranga Tamariki is informed of any complaints within the timeframe specified in the shared agreement. Evidence that this has been done is to be sent to HDC within six months of the date of this report. Where the audit does not show 100% compliance with the shared agreement, Brackenridge is to provide HDC with details on how it plans to address this issue.

## Follow-up actions

107. A copy of this report will be sent to Oranga Tamariki.

108. A copy of this report with details identifying the parties removed, except Brackenridge Services Limited and the expert who advised on this case, will be sent to Whaikaha Ministry of Disabled People and Te Whatu Ora, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Ms Bernadette Paus:

> "This report is being provided to the Commissioner following a request for an independent expert opinion on case number 20HDC00043 regarding the standard and appropriateness of care provided to [Master A] in November 2019.
>
> I am a Mental Health Nurse Practitioner with 35 years' experience in the subspecialty area of Intellectual Disability Mental Health. Over this time I have held clinical, leadership, educator and advisory roles in the intellectual disability area. My role is closely aligned to NGOs providing disability support, hence I have a broad understanding of the standards and principles on which the current service is based. At the time of writing this report I am employed as a Nurse Practitioner by the Southern DHB with 0.5 of my clinical role being Intellectual Disability Mental Health.
>
> I have no personal or professional conflict of interest in this case. I have read and agreed to follow the Commissioner's 'Guidelines for Independent Advisors'. I have read the documents provided and offer the following opinion on the questions requested in your letter dated 26th July 2021.
>
> **The pertinent Standards that apply to this incident are:** Restraint Minimisation and Safe Practice Standards NZ Bill of Rights Crimes Act, Brackenridge's Organisational Policies and Procedures, The Code of Health and Disability Services Consumers' Rights 1996 (The Code), and the Health and Disability Services 'General' and 'Core' Standards.
>
> **Significant Background Context**
>
> As a lead in to this opinion, as I believe it is an important factor in this case, I could not find anything in the information provided from any of the services involved in [Master A's] care that authorised the use of 'physical interventions' or provided direct-care staff with specific instructions and guidance on the types of physical interventions that could be used, and under which circumstances they should be used to maintain safety for [Master A] and/or others. [Master A] clearly has a history of significant challenging behaviour which has required an individualised package of care to be provided by one of the Ministry of Health's 'High and Complex' disability providers. High and Complex services are reserved for people with developmental disability who have serious behavioural dysregulation — generally referred to in the disability sector as 'challenging behaviour'.
>
> I acknowledge that physical interventions are only used as a last resort and that the focus is on positive behavioural intervention i.e., prevention, early intervention and de-escalation, but as [Master A] had a history of serious challenging and unsafe behaviours, it is therefore predictable that he would/will require physical interventions in the form of safe-holding and safe moving as he has for some time. Clear staff guidelines on the type of physical intervention and under what circumstances they can be used is vital

and should have been part of [Master A's] Individual Support Plan (ISP) and signed by all involved in his care. This then provides the necessary legal framework for providing physical interventions and keeping direct-care safe in their practice. I will discuss this further in some of the questions in this report.

**Expert Advice Requested**

**[MR D]**

1. **The appropriateness of [Mr D's] actions when [Master A] was outside in the yard on 5 November 2019:**

Scenario a) If [Ms E's] account of the events is accepted

[Ms E's] account of the events was that she requested assistance from [Mr D] to bring [Master A] back inside as he was trying to climb the fence. She reports that [Mr D] refused, stating that [Master A] would only go back outside again and that he could not actually climb the fence. [Ms E] responded by saying that he could climb and she reports that [Mr D] then said 'pull him down, no one will see you'.

**What is the standard of care/accepted practice?**

If a person with a developmental disability like [Master A] was in fact climbing the fence and at risk of harm to himself or others, AND there had been a failure of verbal negotiations and instruction, it would be acceptable practice to use a physical intervention to manually assist him down and to maintain safety by physically removing him away from the dangerous situation. As there were two staff available this could have been done in a safe manner using safe holds and safe, moving/shepherding away from the danger/fence. As stated above in my introductory comment, I could not find information that provided specific guidelines to staff on how physical intervention should occur if required for [Master A]. I note the following in [Master A's] care plan re climbing

| | |
|---|---|
| **Climbing Fences** | Watch me even though I am in a wheelchair I can climb |
| *I am very strong in my upper body and will climb* | (page 161) |

**If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?**

The instruction to '*pull him down*' from a fence when there were two staff rostered on in a High and Complex facility is a severe departure from acceptable practice. This should have been done in a manner consistent with acceptable standards of physical intervention and safe restraint. The only situation I could envisage this being an understandable action would be from a staff member who did not ordinarily work with people with complex and challenging behaviour i.e. did not have the behavioural intervention skills, who found themselves in a completely out-of-character situation and was acting impulsively to manage a risky behaviour.

**How would it be viewed by your peers?**

To 'pull someone down from climbing a fence' when there were two staff available would be viewed by my peers as unacceptable practice and a deviation from organisation policies and procedures.

**Recommendations for improvement that may help to prevent a similar occurrence in future.**

Clear guidelines in [Master A's] ISP which outline when and how staff should respond to predictable types of challenging situations and risky behaviours with [Master A], for example, if there is risk associated with him climbing up the wall and if so how this should be responded to.

Scenario b) If [Mr D's] account of the events is accepted.

[Mr D's] account of the events were that — he knows [Master A's] behaviours well and that [Master A] is incapable/unable to climb a fence and that he liked being outside, so there was no need to try and bring him inside. If [Master A] was not at risk, then there was no reason for physical intervention of any kind. However, it would have been good practice to acknowledge with [Master A] that trying to climb the fence was not a good thing for him to be doing as he may hurt himself. And if it was thought that he was trying to get to the neighbouring house an explanation that this was not possible, whilst acknowledging his disappointment (empathic but boundary setting) would be reasonable, albeit [Master A] would likely not have liked to hear such a response.

**2. The appropriateness [Mr D's] actions when [Master A] was in the kitchen on 5 November 2019.**

Scenario a) If [Ms E's] account of the events is accepted.

[Ms E's] account and thoughts on this situation were that [Master A] went into the kitchen with the intention of trying to tell staff that he required his food to be moulied through the food processor. [Ms E's] account is that he was immediately yelled at by [Mr D] to leave the kitchen and when he did not comply that [Mr D] grabbed him by his ankles and dragged him out to the dining room. [Ms E] reports that this occurred about five times. [Ms E] also reports that [Mr D] kicked [Master A] and that he placed his arms across his chest and applied weight on top of [Master A] and that this also happened up to five times.

**What is the standard of care/accepted practice?**

As above, if a person with a developmental disability was in a kitchen area and at risk of harm to themself, AND there had been a failure of listening, verbal negotiations and instruction, it would be acceptable practice to use a physical intervention to move them from the area of danger. As there were two staff available this should have been done in a safer manner using safe holds and supported movement away from the danger. I am unsure if [Master A] being in the kitchen was risky, but I do note that he was a high risk for choking, thus getting access to un-moulied food could be dangerous for him. A

reasonable response would have been for staff to firstly try and find out what [Master A] was trying to communicate. Secondly to have removed themselves from the kitchen if there was no safety issue and waited for [Master A] to follow — his care plan states '*It is important to walk away and do not engage in my behaviour*'. It would then have been reasonable for one staff member to have worked in the kitchen with the door closed (if there was an actual danger) whilst the other staff member was supervising [Master A]. If he was at risk being in the kitchen, either from getting access to un-moulied food or throwing/damaging items, then both staff should have used physical intervention to assist him out of the kitchen. But as stated above the process for this should be outlined in his ISP.

**If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?**

To yell or grab someone by their ankles and drag them and/or to place force on them is a serious departure from an acceptable standard of care and practice. In my opinion it is a severe departure from an acceptable level of care and accepted practice, and constitutes criminal assault.

**How would it be viewed by your peers?**

This would be viewed by my peers as unacceptable practice and a severe deviation from acceptable practice and organisation policies and procedures.

Scenario b) If [Mr D's] account of the events is accepted.

[Mr D] said that he has raised his voice with [Master A] before, but he denies 'yelling' in order to 'get [Master A] to listen to instructions'. [Mr D] indicated that he has held [Master A's] ankles on occasions to stop him kicking others, but he was unclear if he had done this on the day in question. [Mr D] denies dragging [Master A] or placing his weight on [Master A] on that day. [Mr D] was observed by the Team Leader earlier in the day, whilst in the van managing a difficult situation with [Master A] when he had broken his harness, to have managed the situation appropriately.

**What is the standard of care/accepted practice?**

Yelling is not reasonable practice; however, changing tone and volume by using a firm tone with mildly raised voice to reinforce clear boundaries can be appropriate for some people with disabilities at times, for example, it is used for some people with Autism to gain their attention against other external/environmental stimuli. Whilst not outlined in [Master A's] care plan I note in the response by [Ms B] indicates this type of response is helpful for [Master A], *6.1 Raised voice strategy when dealing with [Master A]. We of course do not encourage staff to yell at the people we support. In discussion with our Practice Leader it is clear that there is a need to change the tone of voice with [Master A] to get his attention when he is escalated. This is designed to break through his attention to try and redirect or distract him as he is not always able to calm himself down when he becomes escalated. The Practice Leader reports that if you spoke to [Master A] with a normal voice when he is elevated this would not get through to him*

*so there is a need to moderately increase volume and talk in a 'bigger voice'. This is not the same as yelling at [Master A].* Restraining/holding a person by the limbs/ankles to prevent harm to self or others can be acceptable at times, but should only be done if they are at risk of harming to self or others and as part of an identified Individual Behaviour Support/Risk Plan. As above I could not ascertain if there was actual risk related to the kitchen incident. If there was then as above, both staff members could have used a physical intervention to move him from the area of danger.

**b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?**

Does not apply to this question as [Mr D] denies yelling at [Master A] and he cannot recall if he actually used restraint on [Master A's] ankles on the day in question. He denies dragging [Master A] out of the kitchen or applying bodily pressure to him.

**a. Recommendations for improvement that may help to prevent a similar occurrence in future.**

As above staff should have clear guidelines as part of an Individual Behaviour Support/Risk Plan for [Master A] on how they deal with aggressive behaviour. I will discuss this in my conclusion.

**3. Any other matters in relation to the care provided to [Master A] by [Mr D] that you consider warrant comment/amount to a departure from the accepted standard.**

**[Brackenridge]**

[Mr D] reports using restraint on [Master A] at times in the form of restraining his ankles and his hands when he is kicking out or hitting out. As above any use of physical interventions/restraint should be clearly documented in [Master A's] Individual Behaviour Support/Risk Plan.

**4. Whether [Master A's] behaviour was managed appropriately including whether appropriate plans and interventions were in place.**

As noted in my opening remarks, I could not find anything in the information provided, including in the Oranga Tamariki support plan, the … Specialist Behaviour Support Plan and Safety Plan March 2019 and December 2019 (provided in Appendix 5) or the Brackenridge ISP for [Master A], that authorises and provides direct-care staff with specific instructions and guidance on when and how to manage physical interventions with [Master A]. [Master A's] risk of harm to himself and others is clearly documented — as listed below and occurs on a regular basis, particularly in the taxi.

| | |
|---|---|
| *Early warning signs* | Making myself the victim,<br>Throwing things round,<br>Slamming doors,<br>Becoming a bully to others,<br>Will plank,<br>Will destroy things,<br>Will tip myself out of the wheelchair,<br>Will keep repeating the same thing and target staff,<br>Will tell lies if not been sighted by staff<br>Take seat belt off and will not listen<br>Will yell and scream<br>Will put myself in harm's way where he gets hit or kicked |
| *Crisis* | Will attack other clients then become the victim<br>Slam doors<br>Throw furniture<br>Hit staff and pull their clothes<br>Undo seat belt and open the doors in a moving car<br>Climb over the front seat<br>Climb over the fence |

Staff are clearly using physical interventions on [Master A] on a regular basis. The statement from [Ms C] the team leader [at the facility] (at the time of the incident) reported that staff had to regularly *'break fights up between the boys*'.

[Ms B] also reports that physical restraint/safe handling was often required for [Master A]. — '*There are instances however, when a decision is needed to be made in the moment where personal restraint (physically touching [Master A]) will be used to protect others or [Master A] from harm … it is also worth noting that sometimes staff will physically intervene for self-defence of themselves or others. They may also physically intervene when [Master A] is goading someone else he is living with to protect him from the consequences of his action in the form of a flatmate lashing out at him. The other situation when staff may physically intervene is if he takes other people's food due to the choking risk that [Master A] has. Food does need to be prepared in a special way for him and if he takes food that has been prepared normally his chance of choking is increased'.* [Ms B] also acknowledges that '*there are no approved personal restraints in place for [Master A]*'.

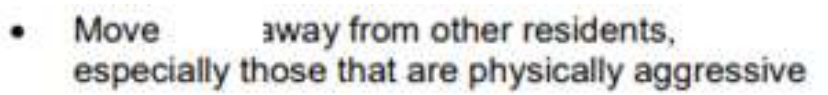
The only non-specific statement I could find in [Master A's] ISP was '*provide the necessary support as required to keep [Master A] and others safe'.*

**Oranga Tamariki** outline in their service specifications (Appendix A: G) that their role is to ensure that *'Information be provided to prospective carers*' and that it includes:

(g) the appropriate behaviour management to be provided by the Caregiver

They point out in the 'Behaviour' paragraph (pg 94 of 241) that [Master A] will throw himself out of his chair on a daily basis and that this can occur up to 10 times per day and they would have had a good understanding of all his challenging behviours. Despite acknowledging his potential for aggression and behavioural dysregulation there is no guidelines on how direct-care staff should manage this if he requires physical intervention. [The] behaviour support service are tasked with providing Behaviour Support and Safety plans that reflect the individual needs of the person. The [behaviour support service] plan describes good proactive interventions aimed at preventing physical aggression, however, it would be reasonable that they would refer to the types

of physical interventions to be used when [Master A] is acting in a risky or dangerous manner — even if this simply noted that Brackenridge's safety management plan regarding safe handling and restraint is to be utilised. The only instruction, shown below is similar to that shown in the care plan above which is nonspecific — shown in dot-point 2




NGOs and in this case Brackenridge, as a High and Complex contract holder, are responsible for ensuring that the service-user's ISP meets their individual needs and in [Master A's] case this should include guidelines for staff on how and when to use physical interventions. It is noted in the response to the Health and Disability Commissioner by [Ms B] that there was no '*approved personal restraints in place for [Master A]*' but an acknowledgment that there are times when personal restraint will be required. [Brackenridge has] appropriate Policies and Procedures in place that cover the concerns relating to this complaint i.e., for supporting people like [Master A] who have challenging behaviour which is going to require physical intervention in the form of restraint and safe movement at times: Child Protection Policy, Restraint policy, Behaviour Support policy — [Mr D] would have been introduced to these policies and procedures in his orientation programme. It is also the responsibility of the NGO/Brackenridge to ensure their staff have the necessary training to ensure they can use physical interventions appropriately and safety. Brackenridge trains staff in the MAPA training which is a nationally recognised behaviour management programme that teaches skills for assessing, managing, and responding to risk behaviour. Whilst the focus is on verbal de-escalation, prevention, and early intervention it also teaches safe physical interventions. I note that [Mr D] had undertaken a 'Positive Behaviour Support' training early on in his orientation but did not undertake the MAPA until after the incidents at the centre of this inquiry, despite him working in High and Complex services.

**If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?**

Brackenridge deviated from their own Restraint Policy and Individual Support plan policy by not authorising when and what physical interventions could be used on [Master A]. Oranga Tamariki as [Master A's] legal Guardian should have also been involved in developing this plan and final sign off. It is unfortunate that [the behavior support service] did not pick up on this and include a 'reactive' component to [Master A's] ISP along with the proactive and positive programming components. In my opinion there has been a departure from acceptable practice by [Master A] not having an individualised plan that provides staff with specific instructions and guidance on when and how to manage physical interventions. Whilst in itself, this could be considered a severe departure from acceptable standards, there is an overarching organisational restraint policy which acts as a safety net as it guides staff on physical restraint practice,

whether a person has a specific plan or not, and all staff are trained in this method of safe restraint. Based on these factors the failure is to copy these specific instructions into [Master A's] individual plan, therefore, I would consider this a moderate departure.

**Recommendations for improvement that may help to prevent a similar occurrence in future**

I would recommend that Brackenridge review all the Individual Behaviour Support and Risk Plans for individuals who are likely to require the use of physical interventions to ensure they are incorporated into their plans when (under what circumstances) and what (specific types of restraint) can/should be used. I would recommend that Oranga Tamariki review all the Individual Behaviour Support and Risk Plans for individuals they have placed in NGO care, who are likely to require the use of physical interventions to ensure that they have been signed off regarding when (under what circumstances) and what (specific types of restraint) can/should be used.

**5. The appropriateness of scheduling [Mr D] to work with [Master A] when he had made a previous request not to work with [Master A].**

This was an unfortunate situation, but unfortunately these situations happen when there are unexpected staff shortages, for example, due to sickness or several staff resigning at once. It is noted on the day of the incident under inquiry, that [Master A] was not attending school due to issues with transportation. This meant additional staff had to be found at short-notice, to support him during the day. This was further compounded when a staff member called in sick at the last minute. It is important to note that NGOs such as Brackenridge often have difficulties with recruitment and the time involved in recruitment of appropriate staff, in conjunction with the time the extensive induction training takes, does at times lead to situations where staff have not received the full training modules before they start working or in this case they end up working in an area/or with a person they would prefer not to. These situations are unfortunate but at times unavoidable for the reasons outlined above. In regard to the decision for [Mr D] to work with [Master A] when he had made a previous request not to work with him; this would have come down to — either two staff who were unfamiliar working with [Master A] (like [Ms E]), knowing that he does not respond well to unfamiliar staff i.e. this would have increased his risk for discontentment and behavioural dysregulation versus [Mr D], who was familiar with [Master A], having worked with him in a previous residential home, filling the gap. Whilst far from ideal and assuming that [Mr D] had the right of refusal AND as he was not working alone, I would not consider scheduling [Mr D] to work with [Master A] during a time of unexpected staff shortages a departure from an acceptable level of care.

**6. Whether you would have expected any further actions from Brackenridge after this incident was reported? If so please provide any guidelines.**

This situation was difficult as the internal investigation, which involved all the staff outlined in Brackenridge's policy (team leader, service manager and general manager) found that there was clear disagreement between what each staff member reported, and that [Mr D] denied telling [Ms E] to pull [Master A] off the wall and he also denied

dragging him or placing weight on him. He agreed that he would have 'raised' his voice. A deeper investigation into [Mr D's] behaviour by talking with other staff revealed that he did not have any history of behaving unprofessionally or abusively and had no former complaints of this nature. Additionally, he had been observed managing other residents and [Master A] behaving in a challenging way in a professional manner, including his team leader on the morning of the incident currently under investigation. [Mr D] also displayed self-awareness by asking not to work with [Master A] as he found him challenging. The outcome of the investigation was that it was not possible to determine what actually happened. But it was agreed that [Mr D] would not work with [Master A] again. I am not an expert on serious staff complaints where it is one employee's word against the other and where there are no witnesses. I would advise that you seek a specialist opinion from a person in a Management position or Human Resources on whether Brackenridge should have taken further actions in these circumstances — i.e. circumstances that involve potential/alleged serious misconduct and assault (criminal behaviour). This incident did however, provide an opportunity to pick-up on the lack of detail in [Master A's] ISP.

**7. The adequacy of [the] restraint policy for [Master A].**

The overarching restraint policy appears adequate and the MAPA training is appropriate. Brackenridge's Restraint Policy clearly states in the sections on 'Personal Restraint', 'Physical Restraint' and 'Environmental Restraint' that if these strategies are to be used on an individual *'This will be documented in the person's Individual Support plan'*. There was a failure by Brackenridge, which was a deviation from their own Restraint Policy, to authorise and endorse these forms of restraint in [Master A's] ISP, despite it being obvious that he regularly required a level of physical intervention.

**8. The appropriateness of Brackenridge's 'raised voice strategy'.**

As outlined previously, raising speech volume, mildly (but not yelling) in conjunction with a clear, firm tone, is sometimes appropriate for some individuals, particularly when there is a safety issue. It is generally used for individuals who have perceptual/sensory difficulties, for example autism, as it helps individuals who have difficulty moving their focus of attention. Mildly raised volume can help the person to re-focus their attention to the issue that requires dealing with. [The] specialist behaviour support service [is] ideally placed to provide specialist advice and guidelines to NGOs on whether this is an appropriate strategy for a particular individual. From the documentation available it appeared that this may have been a helpful and beneficial strategy for [Master A].

**9. The appropriateness of the policies in place at Brackenridge.**

Brackenridge's policies (which were provided) appear appropriate and are consistent with the type of policies used in Disability NGOs. Whilst limited policies and procedures were provided I could see from those that were provided that they had 'associated documents', which staff would have to familiarise themselves with during orientation, for example, the Code of Health and Disability Services Consumers' Rights 1996 (The Code) and the Health and Disability Services 'General' and 'Core' Standards which whilst

not provided in the bundle of information provided they are outlined in 'associated documents' to the documents provided.

**10. The adequacy of the communication with [Master A's] social worker regarding the incident. Please provide any relevant guidance relevant to when a social worker should be contacted.**

The agreement between Brackenridge and Oranga Tamariki as [Master A's] legal Guardian, for such incidents was to inform the Oranga Tamariki Social Worker immediately as shown in the contract below:

**Table 1A: Description of Serious and Significant Incidents**

| Serious Incidents | Incident Category | Who must the Provider contact |
|---|---|---|
| • Death of any Child or Young Person<br>• Absconding where it is likely to result in danger or risk to the Child or Young Person or to the community<br>• Any serious assault (violence and/or sexual) committed (or alleged to be committed) by a Child or Young Person<br>• Any other serious offence committed (or alleged to be committed) by a Child or Young Person<br>• Use or supply of class A drugs | A | Within one hour of any of these listed incidents occurring:<br>• The Police, and the Purchasing Agency via the Call Centre (0508 FAMILY)<br>• The Executive Manager, Manager High Needs and the Contract Manager<br>• Complete an incident report form and email to the Purchasing Agency's Executive Manager, the Child or Young Persons Social Worker and the Contract Manager within 24 hours of event occurring |
| • Attempted suicide<br>• Allegations of assault against the Child or Young Person | B | • Reporting as Category A but do not include the Police |

This did not happen and was therefore a deviation from the agreement in place with the Oranga Tamariki and Brackenridge. I note that as part of the investigation, Brackenridge acknowledge their failure and deviation from the agreement — *'we acknowledge that in this case the reporting and our communication with the Social Worker regarding this issue was not up to our usual standard. While this was in part due to the time of year (over the Christmas and New Year period when the employment investigation was being finalised) we accept that the Social Worker should have been informed earlier about [Ms E's] complaint and been kept up to date with the progress of our investigation. We have reminded all of our Service Managers of the importance of early notification and ongoing communication with a person's guardian/s, including Oranga Tamariki, following any incident or complaint about their care'.* In my opinion the failure to inform Oranga Tamariki 'in a timely manner' was a mild departure from acceptable standards of practice. I base this on their response to the H&DC that it was not reflective of their typical communication and was affected by being caught up in the holiday period when a lot of people are on leave.

**11. Any other matters in relation to the care provided to [Master A] by Brackenridge that you consider warrant comment/amount to a departure from the accepted standard**.

No.

**15. Whether Brackenridge has considered making any changes to the service it provides following this incident and, if so, what.**

The following changes have been made and are appropriate: Increasing the leadership by having a Team Leader in both [Home 1 & 2] rather than it being a shared role. Changing their recruitment plan to recruit specifically for these houses and ensuring casual and permanent reliever staff are well orientated and familiar with [Home 2] (and [Home 1]). An acknowledgement and apology that they did not keep [Ms E] adequately informed of the progress regarding her complaint i.e. she was not responded to in a timely manner. Additionally, but not specifically related to the incident, the Brackenridge team continue to explore residential options that will work better for [Master A].

**CONCLUSION:**

There is a clear disagreement of opinion between [Ms E] and [Mr D] about what occurred on the day of the incidents involved in this investigation, and there are no witnesses. [Mr D] had no former complaints about his performance and had been observed to manage residents' dysregulated behaviour appropriately. He had not been witnessed by any other staff as acting unprofessionally. Whilst there can be a tendency in disability services to focus on the positive and minimise the negative, [Master A] clearly engages in challenging behaviours that are serious and risky enough that he will require physical intervention and restraint in the form of safe holds, restraint and safe moving on a regular basis.

There was a failure by Oranga Tamariki as [Master A's] legal Guardian and Brackenridge, to authorise and outline in [Master A's] ISP under which circumstances restraints should/could be used. Their restraint policy outlined to staff what type of physical interventions were allowed. Specific identification of when and what type of physical interventions can be used, minimises the chances of physical interventions being used unnecessarily or inappropriately by support staff. This case highlights this point, in the case of the fence climbing — maybe [Master A] did not require any intervention at all, as maybe [Mr D] was correct in saying he cannot actually physically climb the fence. Having this outlined in his ISP would have guided. It is important that all individuals who will require physical intervention have clear guidelines in their ISP/Risk Plan to guide staff specifically on when (under which circumstances) and what specific forms of restraint can be used, sitting alongside the proactive strategies. To not have this legal framework in place leaves direct-care staff vulnerable legally.

I would like to note that Brackenridge teams' ability to assist [Master A] with a goal of [special outings] is heartening. These types of achievements, for folk with serious challenging behaviour like [Master A], do not occur without a dedicated staff team. The managers at Brackenridge should all be aware of the reporting responsibilities to Oranga Tamariki for 'children' under their care as outlined in the service specifications.

**Limitations** This opinion is based on information provided and with the understanding that I am not an expert in acute medical conditions.

Bernadette Paus *RCpN; BN; MHSc, PGDip*.
Mental Health & Intellectual Disability Nurse Practitioner"

## Incident Reporting

The Provider will notify all the individuals as listed below of any serious or significant incidents and in particular any that might compromise the Child or Young Person's eligibility to remain with the Service. Where your contract is for Service for the High Needs Services Team then include the Manager High Needs in your reporting of the incidents.

**Table 1A: Description of Serious and Significant Incidents**

| Serious Incidents | Incident Category | Who must the Provider contact |
|---|---|---|
| • Death of any Child or Young Person<br>• Absconding where it is likely to result in danger or risk to the Child or Young Person or to the community<br>• Any serious assault (violence and/or sexual) committed (or alleged to be committed) by a Child or Young Person<br>• Any other serious offence committed (or alleged to be committed) by a Child or Young Person<br>• Use or supply of class A drugs | A | Within one hour of any of these listed incidents occurring:<br>• The Police, and the Purchasing Agency via the Call Centre (0508 FAMILY)<br>• The Executive Manager, Manager High Needs and the Contract Manager<br>• Complete an incident report form and email to the Purchasing Agency's Executive Manager, the Child or Young Persons Social Worker and the Contract Manager within 24 hours of event occurring |
| • Attempted suicide<br>• Allegations of assault against the Child or Young Person | B | • Reporting as Category A but do not include the Police |
| **Significant Incident** | **Incident Category** | **Who must the Provider contact** |
| • Inappropriate Sexual Behaviour<br>• Suicide Ideation or self harm not requiring hospitalisation<br>• Misuse of alcohol or drugs<br>• Medical illnesses or conditions or injuries to a Young Person requiring hospitalisation | C | Within 24 hours of event occurring:<br>• Report incident to the Child or Young Persons Purchasing Agency's Social Worker<br>• For absconding follow Table 3 Missing Child or Young Person process |

## Appendix B: Relevant policies

Brackenridge's prevention and management of abuse and neglect policy states:

> "Prevention is the first defence against abuse and neglect. Providing effective behaviour support can help prevent abuse. Some people may present with behaviours that challenge that can increase their level of risk, as support staff may struggle with managing some of these behaviours. Positive behaviour support follows a cycle of: undertaking an intervention; evaluating the intervention; adapting the approach to reduce behaviours of concern; and teaching alternative behaviours to replace challenging ones. This is particularly important in situations where a restraint protocol is in place as any hands-on intervention will always involve a risk of harm."

Brackenridge's restraint policy states:

> "
> - The use of any restraint intervention is implemented as an emergency measure only to protect at-risk individuals from injury to themselves, others and/or property.
> - To provide informed choice for the individual by staff explaining to the individual the implications of the behaviour and offering planned alternatives.
> - Personal restraint is defined as where a service provider (staff) uses their own body to intentionally limit the movement of a person. This involves a deliberate restriction of movement for longer than five seconds of specified parts of a person's body, for as long as necessary to prevent the person from causing harm to him/herself or to other people and to minimise damage to property. This will be documented in the person's ISP."

Brackenridge's behaviour support policy states:

> "All activities related to behaviour support will be supportive and respectful of the individual needs and goals of the individual, as identified through an Individual Plan, and based on current and comprehensive assessment. Brackenridge Behaviour Support Programme is based on Positive Programming and non-aversive reactive strategies. Practice is guided by ethical principles that include acting for the individual's good, avoiding harm to the individual … respecting the dignity of the client and preserving their human rights. Behaviour support intervention may be appropriate where:
>
> - There are reasonable concerns over risk of harm or serious injury to the individual or to others.
> - Existing strategies have not been effective in managing the behaviour.
> - There are concerns over the use of existing strategies for other reasons.
> - The challenging behaviour appears to prevent other significant needs being met …"

Brackenridge's incident management policy states:

"
- All events should be reported, including near miss where no harm was caused to staff, client or other all the way through to serious or sentinel events, where significant harm or death may have occurred.
- An incident is any event that could have or did cause harm to a person we support, employees, family/whānau or other members of the community. Incident is used generically to also include events that stand outside expected standards and practice.
- A near miss is an incident which under different circumstances could have caused harm to a client or other person but did not and which is indistinguishable from an adverse event in all but outcome. For example: an attempted assault towards a person(s) not causing harm."