Community Service Worker, Ms A

Community Service Worker, Ms C

Disability Service Provider

A Report by the

Deputy Health and Disability Commissioner

(Case 09HDC02149)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

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

Background

2. At 1.55pm on 21 August 2009, the Police responded to a report that a disabled man, strapped into a wheelchair, had been left unattended in a van. The van, owned by a disability service provider was parked in the driveway of the home of one of the disability service provider's Community Service Workers, Ms A. The man left in the van was Mr B. Ms A was not authorised to use the van to go home, nor to leave a service user unattended.

3. Ms A was employed by the disability service provider as a Community Service Worker (CSW) to support people with disabilities to live in the community. She had completed an induction programme and participated in ongoing training in the disability service provider's policies and procedures. Ms A did not provide an adequate explanation for leaving Mr B unattended.

Decision summary

4. This report examined not only the actions of Ms A, but also whether the disability service provider took sufficient steps to ensure service users' safety.

5. Ms A breached Rights 1,[1] 4(2)[2] and 4(3)[3] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to treat Mr B with respect, failing to comply with the disability service provider's policies and the Health and Disability Services Standards, and by failing to provide services in a manner consistent with Mr B's needs.

6. Ms A will be referred to the Director of Proceedings for the purpose of deciding whether proceedings should be taken against Ms A.

7. Ms C was employed by the disability service provider as a House Leader. Her role was to coach and support CSWs, as well as monitoring compliance with organisational and legislative standards. Ms C was performance counselled by the disability service provider for failing to adequately supervise Ms A. However, in my view, this omission by Ms C did not amount to a breach of the Code.

8. The disability service provider provides its staff with an induction programme which includes guidelines for new staff on the health, safety and security of the service users they are supporting. Ongoing training is provided to staff who have easy access to the policies and procedures via the organisation's intranet.

[1] Right 1 of the Code states: "Every consumer has the right to be treated with respect."
2 Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 4(3) of the Code states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."

9. The disability service provider took reasonable steps to prevent Ms A's actions and was not vicariously liable for her breaches of the Code.

Investigation process

10. On 24 November 2009 the Health and Disability Commissioner (HDC) received a complaint from a Police Constable, Mr D, about the services provided by the disability service provider caregiver, Ms A. An investigation was commenced on 8 March 2010.

11. The parties directly involved in the investigation, and who provided information were:

Ms A	Provider/community service worker
Mr B	Consumer
Ms C	House Leader/Acting service coordinator
Mr D	Complainant/Police constable
Mr E	Police constable
Ms F	Community service worker

Also mentioned in this report:

Mr and Mrs G	Ms A's neighbours
Mr and Mrs H	Ms A's neighbours
Mr I	CEO, Disability service provider
The disability service provider	Provider

12. Additional information was provided by four neighbours of Ms A, and community service worker, Ms F. The disability service provider provided copies of the relevant policies and procedures.

13. Independent disability services advocate, Margaret Boyes, provided independent advice. Ms Boyes' advice is attached as **Appendix A**.

14. The following issues were identified for investigation:

The adequacy of the services provided to Mr B by caregiver Ms A in 2008/2009.

The adequacy of the services provided to Mr B by Acting Service Co-ordinator Ms C in 2008/2009.

The adequacy of the services provided to Mr B by the disability service provider in 2008/2009.

Information gathered during investigation

The disability service provider

15. The disability service provider provides services for children, young people and adults with disabilities, and their families. The services include 24-hour support for people living in residential homes. Several of the homes have specially adapted vans, which allow service users in wheelchairs to be transported for outings in a secure and safe manner.

Mr B

16. Mr B has a severe intellectual and physical impairment. He lives at one of the disability service provider's houses with three other men with similar support needs. Mr B is completely dependent on caregivers for his daily needs. Mr B is unable to communicate verbally and uses facial expressions and head and arm gestures to express his needs.[4]

17. Mr B requires the use of a wheelchair and someone to push the wheelchair to mobilise. If he leaves the house, he is always accompanied, and if he is being transported in the specially adapted van, he needs to have the wheelchair clamped in place. Once inside the van, Mr B is unable to move the wheelchair unless assisted.

18. Mr B has an outcomes plan which details his lifestyle goals for a year. The plan includes the choices and opportunities provided to him daily, such as outings for personal shopping and dining out at fast food restaurants, and notes, "Although he is non-verbal, [Mr B] is included in every day conversations". The plan also notes, "Staff advocate on [Mr B's] behalf and he relies on them to ensure that no harm or mistreatment comes to him". The plan in March 2009 notes, "[Mr B] would benefit from having an advocate or a Welfare Guardian to further assist in ensuring his rights are met".

21 August 2009

19. On 21 August 2009, Mrs G was off work because she was sick. At 9.30 that morning, when she glanced out her window she saw a van parked in the driveway of her next door neighbour's house. She noticed "lots of movement" in the van, and could see there was a disabled man, who was of a big build and wearing a blue jumper, rocking backwards and forwards. Mrs G was aware that her neighbour was a caregiver, and that the person in the van was a disabled person in a wheelchair. Mrs G and other members of her family had observed a van parked in the driveway of the house next door on numerous occasions, for varying periods of time. Sometimes the van would be there for 10 minutes and at other times up to an hour and a half, always with a person inside.

20. Mrs G telephoned the police at 11.33am and told them that she was concerned about a disabled person who had been sitting unattended in a van for over two hours. Mrs G recalls that the van left between 11.45am and midday. At 12.30pm, Mrs G left her

[4] Mr B was spoken to by HDC staff as part of the investigation process, but it was unclear whether he understood that a complaint had been made on his behalf or that an investigation was proceeding.

house to go to a doctor's appointment. The police did not send anyone to the address in response to Mrs G's complaint.

21. Mrs G arrived back home at 1.45pm and saw the same van, again parked in her neighbour's driveway. Mrs G telephoned the police at 1.48pm, to report that the van had returned to the address with a disabled person in the back. Mrs G described the man in the van as wearing a long-sleeved, green jersey and said he was waving his arms. She described the van.

22. At 1.55pm, Constables Mr D and Mr E were directed to the house to inquire into the welfare of a disabled person who was sitting inside a van parked in the driveway at the address. The police constables arrived at the address shortly after being dispatched and spoke to Mrs G and, at about 2.37pm, checked on the person sitting in the van. Constable Mr E recorded:

> "A male Caucasian aged in his thirties was in the back of the van sitting in a wheelchair secured firmly to the van's floor. The doors were closed and the driver's window wound half down. I opened the van's sliding door to speak to the occupant and noticed that it was warm and stuffy in the van.
>
> I spoke to the male but he was unresponsive verbally to anything said. He was squirming around in his wheelchair and looked uncomfortable. I then noticed that the male's black cotton cloth tracksuit pants were wet from his upper right leg down to his ankle."

23. At this time, a woman and man came out of the house, spoke to Constables Mr E and Mr D, and asked what the problem was. The constables said there was concern about the welfare of the man in the van.

24. The woman the police spoke to identified herself as Ms A. She said she was a Community Support Worker at the disability service provider's house, and the man in the van was one of the residents, Mr B. She said that she had parked the van in the driveway ten minutes earlier and there was no problem.

25. The Police escorted Ms A to the disability service provider's house where they spoke to Ms C, the House Leader. Ms C was very concerned about the situation, and advised the Police that it was unacceptable for staff to go home with a resident without permission. The Police took statements from Ms C and the staff member working at the house with Ms A that day, CSW Ms F.

Ms A

26. Ms A advised HDC that on the morning of 21 August, she started work at the house at 7am. She was rostered to work a 12-hour shift, finishing at 7pm. She said that when she finished her work that morning, including household tasks and showering service users, she took one of the service users to purchase some shampoo. She denied that she had gone home that morning. She said that she took the man shopping and went straight back to the house. Ms A said that the man is able to push himself in his wheelchair, but it takes a long time for him to do his shopping.

27. Ms A stated that receipts of resident's purchases are given to the house leader. Ms A said she had a receipt that proved she had purchased the shampoo, and told the police this, but they didn't look at the receipt.

28. Ms A advised HDC that when she left the house on the afternoon of 21 August with Mr B, she had intended taking him for a bush walk. However, when she was driving, she realised that she had a problem with her menstrual period. Ms A said she went home to change her clothing. She stated that it would take her about 15 minutes to drive from the disability service provider's house to her home. Ms A recalled that when she arrived at her home, she parked the van in the driveway and went inside, got undressed, went to the bathroom to clean herself up, and re-dressed. She estimated that this would have taken her about 10 minutes. Ms A said she left Mr B in the van because her driveway slopes steeply and it is too hard to push a wheelchair up the slope. She believed that it was safe to leave Mr B in the van, and she said she left the van windows open for him.

29. Ms A accepted that she was at fault for going home without telling her House Leader and getting permission. She said she should not have gone home and left Mr B in the van.

30. Ms A advised HDC that she knew the rules about taking service users out in the van, which included that CSWs are not allowed to leave service users alone in the van, in case they have a seizure. Ms A stated that she was given two weeks' training, such as first aid, when she started working for the disability service provider. She said she was taught about service users' rights and how to care for them. Ms A confirmed that there are monthly meetings at the house, where policies are discussed and staff sign that they have attended. She said that she did not know that she had to contact the House Leader, Ms C, if she had an emergency and needed to go home. Ms A said this was the first time she had had an emergency.

31. Ms A was invited by HDC to provide a statement from her husband and family to support her version of events, but declined to do so.

Ms A's employment and training

32. The disability service provider advised HDC that Ms A was recruited in July 2008, and was initially employed as a casual staff member. Although Ms A had no experience in the disability sector, at her interview it was considered that she would be a good prospect for training as a casual staff member, with a view to becoming a permanent staff member when she was more confident.

33. Ms A attended all the Induction Schedule and Positive Practices training prior to commencing work. The Induction Schedule is a three-week programme and covers such topics as incidents and accidents, abuse and neglect, the Code of Rights, informed choice and consent, and the Code of Conduct. The Positive Practices Schedule, a four-day programme, includes "Behaviour, what is it?", "Behaviour as communication", and topics such as risk assessments, client care plans and team development.

34. Ms A became a full-time staff member in March 2009. The disability service provider advised HDC that prior to the incident on 21 August 2009, there was no indication that Ms A was not adequately performing her duties within the organisation's policies and procedures.

35. The disability service provider provided HDC with a copy of Ms A's training record which showed that between 4 August 2008 and 30 June 2009 she completed the following courses:

4 August:	Induction course	attended entire course[5]
6 August:	Emergency First Aid	attended entire course
7 August:	CPI Non-violent Crisis intervention	attended entire course
13 August:	Positive Practices	attended entire course
15 August:	Back Care	attended entire course
30 June:	Personal Outcomes	attended entire course

36. On 10 February 2009, Ms A's practice was assessed and she was judged to be competent in relation to the requirements of the Induction Manual.

Ms F

37. Ms F, another CSW, told the Police that on the morning of Friday 21 August 2009, she and Ms A had showered the service users. Ms A then took one of the service users out in the house van. Ms F said, "We showered the patients and at about 9.30am [Ms A] took [the man] out in the home's van. … I didn't know where they were going, but they came back about 11.40am. She had brought back some medication for [Mr B]." Ms F stated that Ms A left the house in the van again between 1pm and 1.30pm. This time she took Mr B.

Additional information

Mr G

38. Mr G lives next door to Ms A. He had major surgery in early 2009 and was at home recovering from the surgery for eight weeks. Mr G said that he spent a great deal of time in his bedroom which overlooks the next-door house, the home of Ms A, whom he knew only by sight. Mr G stated that he had a clear view of the driveway, and had seen Ms A park a van in the driveway of her house on a number of occasions. He said that sometimes Ms A would park for just 10 minutes, but at other times it would be longer. Mr G said he had no problem when the van was parked for a short time, and to begin with did not think anything about it. However, when it kept happening, and the van was parked for 45 minutes to an hour and half, and the person in the back of the van was obviously distressed, he became concerned. Mr G discussed the matter with his wife and his parents, Mr and Mrs H.

Mrs H

39. Mrs H stated that she and her husband moved to live with their son and daughter-in-law in April 2009. She remembers first seeing the van parked in the driveway of the

[5] The Induction course includes: Understanding your Role (Code of Conduct), Rights and Responsibilities, Safety and Security and Restraint and Seclusion.

next-door house, shortly after they moved in. She was not able to be specific about the number of times she noticed the van parked in the driveway. She said that it was "very frequently and for long periods, over an hour at times".

40. Mrs H said that the driveway is on a slope, and the woman would drive in with the front of the van pointing down the slope. Mrs H could see someone sitting in the van and getting agitated, rocking backwards and forwards. She said the windows were always up and sometimes the sun was shining into the van.

41. Mrs H said that she spoke to her daughter-in-law and asked her why someone would leave a person sitting in the van. Mrs G told her that the people in the back of the van were in wheelchairs, and she was also concerned about this. Mrs G asked Mrs H to watch when it happened and tell her.

Mr H

42. Mr H confirmed that that he and his wife had noticed a van parked in the driveway of the house next door on a number of occasions. He said that they could see that it was a disability van. Sometimes the van was parked in the driveway with a person in the back, for 10 to 15 minutes. At other times it would be there for hours. Mr H did not see the person driving the van. He said that the style of van was similar to the van he owns. He was not able to describe the colour of the van.

43. Mr H and his wife were worried about the person left in the van, because sometimes it was "terribly hot", and Mr H felt the persons left in the van were "going through torment". He said that there was one occasion when he and his wife came home and saw a person in the van who was "in a bad way". They wanted to go and see what was going on but were "too scared". Mr H said that he spoke to Mrs G and told her that "something was going on over there". He said that he and his wife had recently moved here from another country and were unfamiliar with the systems in New Zealand for reporting these issues. He said he "felt bad" that they had taken so long to do something about the situation.

Ms C

44. Ms C confirmed that Ms A had undertaken a three-week induction course with the disability service provider in 2008. She stated that the disability service provider has clear policies and procedures about taking service users home. It is not allowed unless prior permission had been given.

45. Ms C said that Ms A appeared to work well as part of the team. She had natural skills with the people she supported, and was "always keen to take the boys out on trips".

46. The disability service provider requires staff to keep a log of the van's mileage. Ms C checked the odometer on the van on one occasion when Ms A had been out in the van with a service user and found that she had travelled 60kms that day. Ms C asked Ms A where she had been. Ms A said she had taken the service user to a park on the other side of town. Ms C told her that was too far and she was not to travel that distance again. Ms C said that it is very difficult to monitor where the staff go. She said that the distance from the disability service provider's house to where Ms A lived is about the same as to a shopping centre where service users are frequently taken shopping.

Ms C said that the time the staff and service users are away from the house varies depending on where the service user wants to go and their mobility abilities. Other staff would not necessarily notice whether a trip was unduly long.

47. In her statement to the Police on 21 August 2009 Ms C stated, "I did wonder if she calls in at home in work time but I did not have any proof of this."

The disability service provider — staff training

48. All the disability service provider staff are trained in outcomes planning, which includes a strong emphasis on an individual service user's rights. The plans and the service user's progress towards achieving goals are monitored by checks of the resident's diaries, weekly planner and the monthly key worker reports.

49. The disability service provider Chief Executive, Mr I, advised HDC that when all new staff members join the disability service provider they are required to attend a three-week induction. There are a number of unit standards within the three-week induction schedule that deal specifically with abuse and neglect. These issues are further reinforced by the disability service provider's Code of Conduct and Code of Rights. The training schedule also covers Positive Practices training, which relates to service users' rights.

50. In 2009 the disability service provider introduced a Level Two Certificate in Community Support Work which all new employees were expected to complete. The Level Two certificate training was rolled out throughout 2009. Ms A did not undertake this training.

Policies

Code of Rights

51. The disability service provider's Care and Support Manual contains a Code of Rights which refers to relevant legislation, including the Code of Health and Disability Services Consumer's Rights and the Health and Disability Sector Standards. The Code of Rights states that its purpose is to ensure:

- all service user rights are respected
- service users are informed regarding the complaints policy and procedures
- the disability service provider complies with the requirements of the Code of Health and Disability Services Consumer Rights Regulations 1996.

Code of Conduct

52. The disability service provider Code of Conduct Policy states, "the disability service provider requires a high level of trustworthiness and cooperation from all employees at all times and a high standard of respect and consideration towards service users and employees alike." The Code of Conduct states that all staff must read and comply with the disability service provider's policies, and that employees will be liable to dismissal without notice for serious breaches of the Code of Conduct.

53. The "Reporting of Abuse and/or Neglect" section of the Code of Conduct states, "Any employee who believes that any person supported by the disability service provider

has been, or is likely to be harmed (whether physically, emotionally or sexually), ill treated, abused, neglected or deprived, must report the matter to a Coordinator, Service Manager or other manager."

54. The Code of Conduct specifies the disability service provider's expectations in relation to "Behaviour" stating, "All employees will act to safeguard the people they support and co-workers to ensure their healthcare and safety are not affected by the incompetent, unethical or illegal practice of any person", and "Any behaviour endangering the life, health, safety, or security of people we support (or any other stakeholders including employees, suppliers etc) is strictly prohibited. Only authorised behaviour management techniques may be utilised. Assaulting, threatening, or grossly neglecting any person associated with the disability service provider is grounds for instant dismissal."

55. The Code of Conduct also states that staff are expected to be familiar with the vehicle policy.

Vehicle Policy

56. The section of the vehicle policy that relates to the use of the disability service provider fleet vehicles states that private use of vehicles is only permitted for staff who have been provided with a company vehicle in accordance with their employment agreement. The policy states, "The employee may not use the vehicle for travel to, or travel associated with, other employment unless specifically approved by the CEO. If private use is not part of the individual's employment agreement, staff using the disability service provider vehicles for unauthorised non-work purpose may be subject to costs of damage, disciplinary action and/or dismissal."

Policy training

57. The disability service provider ensures that all staff are familiar with current policies and procedures through four separate processes. All policies and procedures are freely available to staff via the intranet. Changes in policy are published on the intranet and staff are briefed on the changes at the monthly house meetings. Each house has a computer so that the intranet is "freely available" to staff. The monthly house meetings all have a standard agenda. Specific policies are read at these meetings and discussed, and staff sign that they have attended, or "made up" if they did not attend the meeting. One of the items on the agenda is 'Incident and Accident reporting', when the previous month's incidents are reviewed, and the staff are reminded what should be reported and how.

58. The bi-weekly staff newsletter always issues a reminder to staff about reporting abuse and neglect and the availability of an 0800 service for reporting concerns anonymously.

Job descriptions

59. The disability service provider provides staff with job descriptions. The CSW's role includes providing the "right level of support to each service user's ability, needs, wants, expectations and desires", which promotes the services user's "self confidence, independence and choice". The CSW is expected to ensure that the people in his or

her care are "treated with respect and dignity and that each individual's rights are adhered to".

60. The House Leader's role "combines direct support for people with intellectual disabilities, with a range of administrative and supervisory functions". The House Leader works under the direction of the Service Coordinator, to coach and supervise the work of the other staff to ensure that the house operates in compliance with relevant standards. The House Leader is expected to "monitor staff compliance with organisational and legislative standards", and one of their tasks is vehicle management.

61. The Service Coordinator is responsible for the management and oversight of a group of residential homes for people with disabilities. Service Coordinators are directly responsible for staff and the coordination of services. Included in the Service Coordinator's tasks are the organisation of "regular staff meetings and other communication forums with the homes to ensure that all staff are kept informed of relevant issues", and the requirement to "promptly" investigate allegations of misconduct "following the standard organisational process".

Evaluation report for Ministry of Health — January 2009

62. On 20 January 2009, the disability service provider's house was revaluated and an Outcome Focus Development Evaluation Report for the Ministry of Health was produced. The tool used in the evaluation was developed by the Ministry of Health, based on the Provider's National Contract (DSS 1031) and the New Zealand Health and Disability Sector Standards.

63. The Executive Summary "Introduction/Background/General observations" noted:

> "The home was occupied by five people, four males and one female aged 24 to 45 years. The home was a high dependency multi-disabled home. All of the male occupants are immobile and are wheelchair-bound, all have an intellectual disability, two have cerebral palsy (one was an injury from birth), two have epilepsy, one was deaf, and they all had other medical needs also. … All of the people are non-verbal, but can make some of their needs known using gestures and various noises."

64. Section 6 of the report, Health and Wellness, point 6.2, "People Are Free From Abuse and Neglect" states:

> "Staff spoken with indicated that they understood that the people in this home required maximum protection from neglect and abuse, as they were non-verbal and unable to protect themselves. Further training identified on briefing schedule for April 2009 with the outcomes identified as People are Connected to Natural Support Networks and People are Safe."

65. The issues the report identified as requiring action did not relate to the concerns raised by this complaint.

Actions taken regarding the incident

66. The Service Manager advised HDC that on 27 August 2009 a meeting was held at the head office, attended by Ms A and her support persons to discuss Ms A's actions in taking a service user home without authority. At the meeting, Ms A admitted that she had taken Mr B to her home on 21 August 2009. The meeting was adjourned until the following day, so that the Service Manager could discuss the matter further with senior management.

67. On 28 August, Ms A again met with the Service Manager at the head office. Ms A presented a three-page submission to the management explaining the reasons for her actions. However, her explanation was not accepted. Ms A was told that her actions amounted to serious misconduct and that she was dismissed without notice, effective from 28 August.

Follow-up actions

68. The Chief Executive, Mr I, advised HDC that as a result of this incident, the disability service provider has taken the following steps to ensure that these circumstances do not recur. The actions taken are:

- Ms C has been performance counselled regarding the reporting of suspicious behaviour, as it was considered that she should have advised her Service Manager that she was suspicious that Ms A may have been using the van for her own use, and should have more closely monitored Ms A's outings.
- Instructions have been issued to all Service Coordinators and House Leaders to monitor the vehicle log books and ensure that the odometer readings match the expected mileage distances to particular venues used for one-on-one outings. The vehicle log books now record the journey destination, and staff have been instructed to take photographs of particular outings to provide evidence of the activity and support tracking that the individual's Outcome Plan goals have been achieved.
- All activities, including one-on-one outings are to be planned for the week/month and support staff are required to report on these on a monthly basis.
- In early 2009, an 18-month plan to develop a team-orientated approach to improve the service delivery in the region was introduced, which has led to better reporting of incidents and accidents. The effectiveness of the plan is being monitored on a regular basis by the Service Manager and the General Manager – Operations.

- The disability service provider is currently investigating the installation of GPS tracking devices in all its vehicles, to allow the organisation the ability to accurately track all outings.

Relevant standards

New Zealand Standard NZS 8134.0:2008
Health and Disability Services (General) Standards

"NZS 8134 *Health and disability services Standards* are designed to establish safe and reasonable levels of services for consumers, and reduce the risk to consumers from those services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001.

The Standards provide the foundation for describing good practice and fostering continuous improvement in the quality of health and disability services. They set out the rights for consumers and ensure services are clear about their responsibilities for safe outcomes. …"

New Zealand Standard NZS 8134.1.2:2008
Health and Disability Services (Core) Standards — Organisational management

"NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes.

"NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation.

…

Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

…

2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and

service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. …

Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

…

3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes."

Responses to provisional opinion

The disability service provider

69. Mr I agreed with the HDC finding that Ms A had acted outside the disability service provider's organisational policies and the Code.

70. Mr I stated that the disability service provider has taken the opportunity to use the findings in the provisional opinion to send a clear message to all staff to remind them of their individual responsibilities under the Code. He advised HDC that these events will be an agenda item at every house meeting over the following month to ensure that it is brought to the attention of all staff so that they are aware of the consequences of their personal actions. Mr I stated that the following has been posted on the disability service provider intranet:

> **"**We bring this to your attention as **a reminder of the importance of organisational policies and training and** a specific reminder of **the importance of being person-centred in all our actions and activities**.
>
> If a staff member acts in their own interests, acts outside the parameters of organisational policy and training, and ignores the rights and dignity of a person with disability, then this may deemed to be a failure of a staff member's duty of care **for which they will be personally liable in the eyes of the law**.
>
> Our policies, procedures and training are specifically aimed at giving you the skills you need to provide person-centred, Values-driven support for the people we serve. …"

Ms A

71. Ms A advised HDC:

> "I'm very sorry for that happened. The only thing I want to clarify is the time I stayed at home was around 25 minutes until the policemen came. But it is not important now. The important thing is that is a big lesson for me.

I regret that I didn't get permit [sic] to go home during work time by company vehicle, and left the service user in the van. I'm very much regret.

It will not happen again, as I was dismissed and bearing serious distress."

Opinion: Breach — Ms A

Introduction

72. On 21 August 2009, Ms A breached Rights 1, 4(2) and 4(3) of the Code, when she left Mr B unsupervised in the van in the driveway of her house for around 45 minutes. This showed a lack of respect for Mr B, breached the disability service provider's policies and the Health and Disability Services Standards, and failed to provide Mr B with services that were consistent with his needs. Ms A's actions were contrary to her training as a community service worker and the organisation's policies regarding abuse and neglect of individuals in its care, and vehicle use. My reasons for this opinion are as follows.

Standards

73. The disability service provider's Code of Conduct is clear about its expectations for employees' behaviour. The Code of Conduct states that all employees will act to safeguard the people they support and ensure that their safety is not affected by incompetent, unethical or illegal practice, and that any behaviour that endangers the health and safety of the service users is "strictly prohibited". The disability service provider also expects that its employees have a high level of "trustworthiness" and a high standard of respect and consideration towards service users. The Code of Conduct states that all staff must read and comply with policies. Employees are advised that the consequence of any employee exhibiting behaviour that might seriously endanger the life, health, safety and the security of the people the disability service provider is supporting, is dismissal without notice.

74. Additionally, the Vehicle Policy states that employees are not permitted to use vehicles for unauthorised non-work purposes. Although Ms A was acting in the course of her work when she took Mr B on an outing, to divert to her home was a non-work purpose which was not authorised. These matters are covered in the CWS Induction modules, which Ms A completed, and were reinforced at monthly training meetings held at the disability service provider houses. The information is also available to employees in every disability service provider home via the Intranet.

75. Standard 3.6.4 of the Health and Disability Services Standards requires that the "consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes". In light of the risks of overheating and seizures, Mr B was not safe in the van. It was not respectful and showed a lack of regard for his welfare to leave an incontinent person alone in a distressed condition.

Training

76. Ms A advised HDC that she had completed the Induction and Positive Practice training modules and was made a full-time staff member on 16 March 2009. Her training covered care and support of service users, abuse and neglect, and vehicle use. Ms A was authorised to take the van out so that the service users could go shopping. However, she knew that private use of the vehicles was only permitted if it was part of the staff member's employment agreement or approved by the CEO. Ms A knew that she was not authorised to go to her home in the van with a service user, and that she was not to leave service users alone because of the risk of seizures.

77. Independent disability services advocate Margaret Boyes advised HDC that the disability service provider provided adequate induction training to Ms A for the CSW position, and her training records indicate that she was provided with further training. Ms Boyes advised that the disability service provider had comprehensive policies in place, and these policies gave clear guidelines to staff on their responsibilities when supporting service users, and what is classified as being abusive or neglectful behaviour.

Ms A's explanation

78. Ms A admitted that she had gone home with Mr B in the afternoon of 21 August, but maintained that she had been in the house for only a short time. She stated that she had gone home to attend to an urgent personal problem and had been home for only a few minutes. In her response to the provisional opinion, Ms A admitted that she had been at home for 25 minutes which is a longer period than she had first stated. However, the Police log and the witness, Mrs G, make it clear that the van was parked at Ms A's home for just over 45 minutes on the afternoon of 21 August 2009. Mr B was left alone in the back of the van and was observed to be in a distressed state. Only one window was partially open and the Police Officer stated the vehicle was "warm and stuffy".

79. Ms A was clearly at her house for a longer period than was reasonable, even in light of the circumstances she described. Although Clause 3 of the Code provides that a provider is not in breach of the Code if he or she has taken reasonable actions in the circumstances to comply with the rights and duties in the Code, I do not accept that Ms A's actions were reasonable in the circumstances.

80. Ms A's statements to the police and HDC indicate dishonesty and a lack of integrity.

Summary

81. Ms A had been informed in her Induction course about the staff responsibilities outlined in the disability service provider's Code of Conduct. These specified that behaviour endangering the health and safety of the service users is strictly prohibited, and that any gross neglect results in instant dismissal. Ms A acknowledged that she had been trained how to treat service users appropriately. She also stated that she knew it was against policy to go home in a disability service provider vehicle without prior authority, and to leave a service user in her care unsupervised, thus endangering the service user's health and safety. By leaving Mr B in the van in these

circumstances, Ms A failed to meet his needs. By her disregard for his feelings, she breached his right to be treated with respect.

82. Ms A's conduct demonstrated flagrant disregard for Mr B's wellbeing, and breached his right to be treated with respect. In my opinion, Ms A's breaches of Rights 1, 4(2) and 4(3) of the Code were serious departures from expected standards.

Opinion: No Breach — Ms C

83. In 2008/09, Ms C was House Leader at the disability service provider's house. Her responsibilities included direct support for the people in the house she was working in, as well as coaching and supervising the other staff at the house. As House Leader, she was expected to monitor staff compliance with organisational and legislative standards.

84. In August 2009, Ms C was the acting Service Coordinator for four homes in the region. As the Service Coordinator she was directly responsible for the staff, coordination of services and oversight of a group of homes.

85. One of Ms C's responsibilities was vehicle management. Independent disability services advocate Margaret Boyes noted that whilst senior level staff are responsible for managing staff at each of the disability service provider's homes, there was an expectation that all staff would monitor and report any concerns about colleague performance. This was specified in the Detecting and Reporting Abuse and Neglect policy. As discussed above, the disability service provider has a Vehicle Policy that clearly sets out the responsibilities of staff using the vehicles. The policy advises staff that employees contravening the policy may be subject to disciplinary action or dismissal.

86. The disability service provider requires the CWSs to keep a log of the house van's mileage, and it was the responsibility of the House Leader to keep a check on the mileage. On one occasion, when Ms C checked the mileage of an outing Ms A had undertaken and found that the mileage was greater than would be expected, she asked Ms A for an explanation. Ms C considered that Ms A's explanation at that time was reasonable, but instructed her not to drive that far again. Ms C stated that it was difficult to monitor the outings, as the service users had individual needs which were taken into account, and the time taken for the outings varied depending on where a service user wanted to go, and his ability to mobilise. The four male service users at the house were not able to verbalise and provide details about their outings.

87. Ms C advised the Police on 21 August that she was suspicious that Ms A "calls in at home in work time", but had no proof that that was the case. Ms C should have raised this matter with Ms A at the time.

88. Following the incident in 21 August 2009, Ms C was performance counselled by the disability service provider management, as they considered that she should have reported her suspicions about Ms A going home in the van to her line supervisor. Ms C was told that she should have been closely monitoring Ms A's outings.

89. Ms C was suspicious that Ms A was not complying with the vehicle policy, but did not address this as she had no proof that this was the case. I note the disability service provider's view that Ms C should have reported her suspicions to her manager. Although I agree with the disability service provider management that Ms C should have spoken to her line manager or Ms A about this matter, in my opinion, her omission is not sufficient to warrant a breach of the Code.

Opinion: No breach — Disability service provider

90. The disability service provider provides all staff with job descriptions which specify their roles and responsibilities. All staff, permanent and casual, are given a three-week induction. This training specifically covers the critical policies relating to care and support, and abuse and neglect. The training also includes the use of vehicle policy. The organisation ensures that all staff are familiar with current policies and procedures by providing each house with access to the policies and procedures via intranet. The policies and procedures are reinforced, and changes notified, at the monthly house meetings.

91. Ms A started work for the disability service provider in July 2008 as a casual community support worker. She completed the three-week disability service provider Induction course in August 2008, and in February she was judged to be competent in relation to the Induction Manual. In March 2008, Ms A was appointed to a full-time position. Her House Leader noted that she had natural skills with the people she supported and worked well as part of the team.

92. Within a week of being advised about the 21 August 2009 incident, the disability service provider management conducted an internal inquiry into the circumstances of Ms A's actions. Ms A admitted that she had taken Mr B home when not authorised to do so. Ms A was advised that her conduct, which was contrary to policy, amounted to serious misconduct. Ms A was dismissed without notice.

93. It is clear that despite the systems in place to monitor staff use of vehicles, it is difficult to check on staff once they leave the house. In many cases the service users are unable to tell anyone if the outing was not conducted according to their personal choice and as written up in the log. The disability service provider had to rely on the honesty and trustworthiness of staff.

94. As noted above, independent disability services advocate Margaret Boyes advised HDC that the disability service provider had adequate induction training for the CSW position, and provided ongoing training. She noted that there were adequate systems in place to supervise staff, and the disability service provider has endeavoured to

make the reporting of abuse and neglect as easy as possible by providing an anonymous reporting line. Ms Boyes stated:

> "In my opinion, [the disability service provider] had taken reasonable steps to ensure staff were aware of their responsibilities and put a number of checks in place to support the reporting of any abuse or neglect. It was the actions of one individual staff member rather than the organisation itself which led to the event under investigation."

95. In my view, the disability service provider took reasonable steps to prevent the Ms A's actions, and is therefore not vicariously liable for her breaches of the Code.

96. I note that as a result of this incident, the disability service provider has evaluated its systems, and has identified areas where it considers its systems and processes could be enhanced. I do not consider this to be an admission that the policies it had in place were not adequate to ensure safety, but a recognition of the difficulties in monitoring CSW behaviour when on unsupervised outings with service users. I commend the disability service provider for its honest evaluation of this incident and the changes that have been implemented as a result, and are being planned, to ensure that service users' safety is not compromised in future.

Other comment

97. The neighbouring family did the right thing by reporting this abuse. I commend others to do the same when abuse is suspected. The family's actions reinforce the belief that we live in a caring society.

Recommendation

98. I recommend that the disability service provider update HDC by **30 November 2011** on the progress made in investigating the installation of GPS systems in its fleet vehicles.

Follow-up actions

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

- A copy of the final report with details identifying the parties removed (except for the name of the independent expert who advised on this case), will be sent

to the Ministry of Health Disability Support Service, the New Zealand Police and the District Health Board.

- A copy of the final report with details identifying the parties removed, (except for the name of the independent expert who advised on this case), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz. for educational purposes.

Addendum

The Director of Proceedings decided to issue a proceeding in the Human Rights Review Tribunal. The disability services provider agreed to pay the man $5,000 compensation for humiliation, loss of dignity and injury to feelings, and forms part of orders made by the Human Rights Review Tribunal.

The Tribunal also made a declaration that the provider breached the rights of the man she was caring for by failing to provide services with reasonable care and skill, failing to provide services in a manner which complied with legal, professional and ethical standards, and failing to provide services in a manner consistent with his needs.

Full details of the decision are available at
http://www.nzlii.org/nz/cases/NZHRRT/2012/

Appendix A: Disability Services advice — Margaret Boyes

"I have been asked to provide an opinion to the Commissioner on case number 09HDC02149. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have worked in the Disability Sector for the past 17 years and have held a range of positions. I have worked as an Early Intervention Teacher, Social Worker, Manager of a Child Development Service, Supported Independent Living Coordinator, and as an Independent Contractor reviewing services and providing individual service designs. For the past four years I have worked as an independent advocate for people with disabilities.

I have been requested to advise the Commissioner whether in my opinion, [the disability service provider] provided services to [Mr B] of an appropriate standard. I have been asked to comment on the following:

1. Did [the disability service provider] have adequate orientation and training systems in place to ensure that [Ms A] provided [Mr B] with an appropriate standard of care?

2. Did [the disability service provider] have adequate systems in place to supervise its community care workers?

3. Were there any systemic or provision of service issues of note that affected the service provided to [Mr B] that I consider warrants comment?

4. Is there anything else [the disability service provider] should have done to prevent this incident?

In forming my opinion I have reviewed the following documents:

- Complaint to the Commissioner from the New Zealand Police, received 24 November 2009, marked with an 'A' (Pages 1 to 10)
- Response received from [the disability service provider], received 18 January 2010, marked with a 'B'. (Pages 11 to 62)
- Response received from [the disability service provider], received 18 February 2010, marked with a 'C'. (Pages 63 & 64)
- Response received from [the disability service provider], received 19 March 2010, marked with a 'D'. (Pages 65 to 138)
- Notes taken during an interview with [Ms C] on 20 March 2010, with attached documents, marked with an 'E'. (Pages 139 to 158)
- Notes taken during an interview with [Ms A] on 1 April 2010, marked with an 'F'. (Pages 159 to 162).

Background:

On 24 November 2009 the New Zealand Police advised HDC about a concerning incident involving a disability service user.

The circumstances were that at 1.30pm on 21 August 2009, the Police were called to [an] address by a concerned neighbour, [Mrs G]. [Mrs G] advised the Police that a disabled man had been left for about an hour, unsupervised, in the back of a van in a neighbouring driveway.

The call that [Mrs G] made to the Police at 1.30pm was the second occasion that day that she had observed the van with a person sitting in the back. [Mrs G] also contacted the Police at 11.33am when she observed the van parked in the neighbouring driveway for more than two hours with an unsupervised disabled man in the back.

When the Police attended they spoke to a woman and man at the house. The woman, [Ms A], stated that she was the driver of the van, but denied that the van had been parked there for more than 10 minutes. She stated that she was a community service worker employed by [the disability service provider] at [one of its houses]. [Ms A] confirmed that the man in the rear of the van was a service user, [Mr B].

The Police escorted [Ms A] back to [the house] and advised her supervisor [Ms C] about the complaint.

[Ms A] was interviewed by [the disability service provider] about this breach of policy. [Ms A] admitted that she knew she was not authorised to take a work vehicle home, and that service users were not to be left unsupervised. She said that this occasion was an emergency. She had a personal problem that required her to change her clothing, and it was the only time she had gone home in the [disability service's] van.

[Ms A] was dismissed on 28 August 2009 for serious misconduct. Her supervisor, [Ms C], was performance counselled by [the disability service provider] for failing to adequately supervise [Ms A].

1. Did [the disability service provider] have adequate orientation and training systems in place to ensure that [Ms A] provided [Mr B] with an appropriate standard of care?

The Induction Schedule in place at the commencement of [Ms A's] employment included sections on the Code of Rights, Abuse and Neglect and Incidents and Accidents.

[Ms A] attended an Induction Course in August 2008 and was also deemed to be competent regarding the Induction Manual in February 2009.

Community Support Workers as part of their Job Description are to use organisational policies and procedures to inform day by day activities.

Comprehensive Policies were in place and the following policies were all issued prior to this incident: Vehicle Policy, Detecting and Reporting Abuse and Neglect Policy, Incident/Accident Policy and Code of Conduct Policy.

These policies gave clear guidelines to staff on their responsibilities when supporting service users and what is classed as either being abusive or neglectful.

In an interview with HDC [staff] [Ms A] herself stated that she was aware she was not to use the van to go home and that they were not to leave service users alone in the van which demonstrates she was aware of the content of the aforementioned [disability service provider] Policies.

There is evidence of regular review of policies at staff meetings and if staff are uncertain of appropriate action they have access to all policies and procedures via [the disability service provider's] Intranet System.

In my opinion [the disability service provider] provided adequate Induction Training for [Ms A] for a basic entry level Community Support Worker position. There is evidence in [Ms A's] training records that further training was provided, indicating a commitment to providing Community Support Workers with ongoing training opportunities relevant to their position.

2. Did [the disability service provider] have adequate systems in place to supervise its community care workers?

From the documents submitted it would appear that the House Leader had the day to day responsibility of supervising and coaching staff working within a particular house. Service Coordinators also monitored staff performance as did the Service Manager.

Formal appraisals are completed on an annual basis. Accident and Incidents are defined into four categories depending on the severity of the event. Analysis of the Accident and Incident Forms should alert the service to any trends or issues of concern.

Whilst senior level staff have the responsibility of managing staff within each home [the disability service provider] had also placed an expectation and responsibility on all staff to monitor and report on any concerns they have with a colleague's performance. This was reiterated in the Detecting and Reporting Abuse and Neglect Policy and specific examples of what constitutes abuse and neglect could be found in the Incident/Accident Policy.

To facilitate this process they have also provided a phone-in complaints service for staff to call – [phone number]. Staff can use this service to report anonymously any incidents of abuse or neglect that they observe.

It would appear that while staff had their suspicions they did not follow the organisation's procedures which would have instigated a formal investigation at a much earlier time.

In my opinion [the disability service provider] has adequate systems in place to supervise staff, they have endeavoured to make the reporting of abuse and neglect by peers as easy as possible by providing an anonymous reporting line and were let down by individual staff members neglect to follow organisational policy rather than through lack of supervision.

3. Were there any systemic or provision of service issues of note that affected the service provided to [Mr B] that I consider warrants comment?

… No matter what policies and procedures are in place the numbers of people supported and the number of staff required to support them will mean it is difficult to supervise all staff at all times.

…

[The disability service provider] endeavours to screen applicants during the formal interview process; but the reality is that many applicants come with no experience or knowledge of the disability sector and seek employment in the sector as it is seen as an area that they can gain employment with no qualifications, rather than a making a choice to work in this field because of a personal desire to support disabled people to have a better quality of life.

…

It is noted that [Ms C] was acting up in the role of Service Coordinator while the incumbent staff member was on leave, there is no indication as to what period of time this was for or if this was her first time in this position so I do not feel able to comment in relation to this point.

4. Is there anything else [the disability service provider] should have done to prevent this incident?

In my opinion [the disability service provider] had taken reasonable steps to ensure staff were aware of their responsibilities and put a number of checks in place to support the reporting of any abuse or neglect. It was the actions of individual staff members rather than the organisation itself which led to the event under investigation.

Margaret Boyes"