HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC01165)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Miss A while she was residing in a Te Roopu Taurima O Manukau Trust (Te Roopu Taurima) secure facility.

3. Miss A's complaint to the Health and Disability Commissioner (HDC) concerns improper restraints being used by staff, poor medication administration practices, inadequate medical attention, mental abuse, and the provision of substances by staff.

4. The following issues were identified for investigation:

- *Whether Te Roopu Taurima O Manukau Trust provided [Miss A] with an appropriate standard of care between 17 [Month1][1] to 29 [Month2] 2019 (inclusive).*
- *Whether [Ms B] provided [Miss A] with an appropriate standard of care between 17 [Month1] to 29 [Month2] 2019 (inclusive).*
- *Whether [Ms C] provided [Miss A] with an appropriate standard of care between 17 [Month1] to 29 [Month2] 2019 (inclusive).*
- *Whether [Ms D] provided [Miss A] with an appropriate standard of care between 17 [Month1] to 29 [Month2] 2019 (inclusive).*
- *Whether [Ms E] provided [Miss A] with an appropriate standard of care between 17 [Month1] to 29 [Month2] 2019 (inclusive).*

5. The parties directly involved in the investigation were:

Miss A	Consumer
Mrs A	Consumer's mother
Te Roopu Taurima O Manukau	Provider
Ms B	Provider
Ms C	Provider
Ms D	Provider
Ms E	Provider

[1] The relevant months are referred to as Month1 and Month2 to protect privacy.

6. Independent advice was obtained from a disability support specialist, Mr John Taylor (Appendix A).

How complaint arose

Introduction

7. Miss A has a complex social and mental health history and has had ongoing contact with mental health services since childhood.

8. In Month1 2019 the court found that Miss A was unfit to stand trial for charges relating to criminal offending that occurred in 2018. Miss A was to reside in a secure facility[2] so that further inquiries could be made, including psychological assessment, to determine whether she was fit to stand trial at her next hearing in Month2 2019.

9. Miss A was residing in Te Roopu Taurima, which was selected as a temporary secure facility to house her while arrangements were made for her psychological assessment. Miss A was placed under the High and Complex Framework[3] and entered Te Roopu Taurima's care on 20 Month1 2019. Ms F was assigned to coordinate Miss A's care,[4] and Miss A remained at the facility until 29 Month2 2019.

Te Roopu Taurima O Manukau Trust

10. Te Roopu Taurima is a tier two Regional Intellectual Disability Supported Accommodation Service (RIDSAS) provider that offers a specialised service to support people with intellectual impairments. Te Roopu Taurima takes referrals from Forensic Coordination Services Intellectual Disability (FCSID) to provide secure facilities for people who require assessment under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

11. Te Roopu Taurima's facility has external locks on all doors and windows and has a six-foot-high perimeter fence. The facility is in a community setting where the activities of care recipients are supervised by staff, with overnight visual confirmation checks by staff to confirm that residents are safe and accounted for.

Specialist assessor review report

12. Clinical psychologist and specialist assessor Dr G completed a specialist assessor report dated 24 Month2 2019. The report assessed Miss A's fitness to attend her court appearance. Dr G interviewed Miss A, Mrs A, and Ms B. In completing her report, Dr G also interviewed Ms F, and a staff member from FCSID, Mr H.

13. Dr G's report notes that Miss A engaged in ongoing challenging behaviour between 17 Month1 and 23 Month2 2019, including verbal and physical aggression towards staff and

[2] Under section 23 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.
[3] The High and Complex Framework supports people under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and other relevant legislation. It provides a diversionary pathway for people with an intellectual disability who are engaged with the criminal justice system towards more appropriate services with a strong rehabilitative focus.
[4] In accordance with section 141 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

self-injurious behaviours. Dr G recorded that Miss A absconded from the premises six times during the period she was in Te Roopu Taurima's care.

14. Dr G's report concluded that Miss A did not meet the criteria for a diagnosis of an intellectual disability, and she was fit to stand trial. Accordingly, Dr G recommended that the court consider Miss A's immediate release from Te Roopu Taurima in accordance with relevant provisions in the Criminal Procedure (Mentally Impaired Persons) Act 2003. Miss A was released from Te Roopu Taurima's care after her court appearance in 2019.

Events leading up to complaint

Care and Rehabilitation Program

15. Miss A was admitted to Te Roopu Taurima's care on 20 Month1 2019. On admission, Te Roopu Taurima staff drafted a Care and Rehabilitation Program (CARP) for Miss A, outlining her needs and the way Te Roopu Taurima staff could support her during her time at Te Roopu Taurima. This document includes five core sections, namely: 'understanding the person within their context'; 'managing risks'; 'addressing support needs'; 'supporting cultural and spiritual needs'; and 'developing a balanced and satisfied life without offending'. Sections include details on Miss A's social and mental health history, her support and rehabilitation needs, and management strategies to minimise risk. In response to the provisional opinion, Te Roopu Taurima emphasised that the CARP is not a document that fulfils the requirements of a Care Plan for a Proposed Care Recipient but rather a document that directs the support provided to a care recipient. Te Roopu Taurima said that because Miss A was pending assessment, there was no care plan for her as she was not a care recipient.

16. Te Roopu Taurima told HDC that the template for the CARP is provided to Te Roopu Taurima by FCSID. Te Roopu Taurima said that as Miss A was not known to Te Roopu Taurima when the CARP was drafted, it was prepared from information provided by FCSID employee Mr H.

17. The CARP states that Miss A is at risk of harming herself and others, damaging or stealing property, and leaving the Te Roopu Taurima premises unauthorised, and that she is vulnerable. Included in her history are prior incidents of self-harm, suicidal ideation, and huffing.

18. The CARP outlines management strategies for Te Roopu Taurima staff to minimise these identified risks, including that Miss A would be supported by staff for daily responsibilities, with one-to-one support monitoring, Te Roopu Taurima staff would remove objects from the facility that could be used to self-harm or as a potential weapon, all incidents of self-harm would be reported to the senior staff member, and Miss A would be supported to maintain regular contact with her family. Ms F was assigned as Miss A's care manager in the CARP.

19. De-escalation techniques recommended for staff in the CARP included positive redirection of Miss A to other activities, engaging with Miss A to listen to and address her concerns,

setting specific and reasonable limits, and using restraint as 'an extreme measure or last resort' where Miss A's behaviour endangered the safety of herself, others, or property.

20. Regarding restraint, the CARP states that personal restraint should be avoided and occur only in the event that Miss A was endangering the health or safety of herself or others, seriously damaging property, or seriously compromising the care and wellbeing of herself or others. The CARP also states that only the restraints and methods approved by Te Roopu Taurima are to be utilised, and only as a last resort.

Incidents

21. During the six weeks that Miss A was in Te Roopu Taurima's care, Te Roopu Taurima recorded more than 20 incidents.

Restraint event — 29 Month1 2019

22. At 10.00pm on 29 Month1 2019 Ms D and Ms E completed an incident report describing Miss A absconding and exhibiting violent behaviour that required the use of restraint holds. It is recorded that Ms C was present during the incident.

23. The incident report records that Miss A had attempted to abscond from Te Roopu Taurima's facility four times that day. It notes that at dinner Miss A had become verbally abusive, and when staff tried to redirect her to her room, Miss A's behaviour escalated, and staff had to apply a restraint hold to take her inside. It is documented that Miss A began to swear at, verbally abuse, kick and punch the staff. The type of restraint used is not recorded.

24. Ms C told HDC that Miss A was attempting to abscond and had become verbally abusive towards her, Ms D, and Ms E. Ms C said that in the process of trying to redirect Miss A back to her room in the secure facility, Miss A lashed out and kicked Ms E in the stomach. Ms C stated that when Miss A attempted to kick Ms E again, she managed to stop that from happening, but it resulted in Miss A kicking her in the right thigh. Ms C said that at this point, she witnessed Ms E spin around and hit Miss A in the face. Ms C said that she cannot remember whether it was a slap or a punch, but 'there was more than just a little force used'.

25. Te Roopu Taurima commissioned an independent investigation into this incident. Ms D stated that she tried to hold both Miss A's arms while Miss A was hitting Ms E, and Ms C held Miss A's legs. The investigation was unable to establish whether Ms D's holding of Miss A's arms and Ms C's holding of her legs occurred simultaneously.

26. Ms D acknowledged that at some point Ms E retaliated, at which point Ms D asked her to stop and call for further assistance from two senior staff members. Ms D also acknowledged that the hold she used was not an approved hold.

27. After this restraint, Miss A returned to her room and began to tear down the curtains and punch the windows. Staff again applied a restraint hold until Miss A calmed down, and Ms C contacted a senior staff member for assistance. Miss A attempted to pull the alarm from the room and tried to rush past staff to the door. Staff applied another restraint hold

to prevent Miss A from absconding. Staff contacted the Police, who came to Te Roopu Taurima and arrested Miss A for assaulting staff.

28. The incident report completed in relation to these events notes that staff applied approved Managing Actual and Potential Aggression (MAPA) holds. No reference is made to the type of hold used or to Ms E striking Miss A.

29. Te Roopu Taurima reviewed the incident report and completed a restraint review form. The restraint review recorded that prior to restraints being applied, Miss A had become verbally abusive, had tried to throw furniture, and had refused to eat her food. The review stated that the restraints used were approved MAPA holds that staff had been trained in, but the type of hold was not specified.

30. The independent investigation focused on the first hold used by staff and concluded that Ms D participated in an unauthorised restraint by holding Miss A's arms in the manner she did, as admitted by Ms D during the investigation. The investigation also concluded that it was more likely than not that Ms E had slapped Miss A, although it was unable to determine the level of force used.

Self-harming and use of substance incidents

31. On 5 Month2 2019 a Ministry of Health Critical Incident Reporting Form records that staff noted cuts on Miss A's face and left arm when she came out of her room. The incident report states that Miss A advised staff that the cuts had come from her shaver. The cuts were assessed as superficial and were treated with an adhesive bandage. It was deemed that no further medical attention was required, and that Miss A would be monitored and provided with one-to-one therapeutic rapport by 'check[ing] in with [Miss A] to ensure that she was ok'. Te Roopu Taurima said that Miss A was noted to be laughing, and she slept in the lounge that night, closely monitored by staff. The incident was escalated to the senior staff member present on site, and no further concerns were noted overnight. Te Roopu Taurima said that Mrs A was notified the next morning, and first aid was applied as needed.

32. On 22 Month2 2019 an incident report was completed recording that Miss A had been swearing at staff before absconding from Te Roopu Taurima's facility. The incident report states that Mrs A was called, as well as Ms F and the Police. Te Roopu Taurima said that Miss A was picked up at her mother's house and returned to the facility.

33. A second incident report was completed by Ms B on 22 Month2 2019, which recorded an incident of solvent abuse and harm to self. The incident report describes Miss A 'getting high on [an aerosol]' and using her razors for self-harm.

34. Staff contacted Miss A's parents, who attended Te Roopu Taurima and attempted to retrieve the spray cans and razors but were unsuccessful. Ambulance services, the Crisis Assessment Team, and Police were contacted. The incident report states that the Police attended and took the aerosol cans and razors from Miss A, and paramedics cleared her of any medical issues. The Police told Miss A that if she absconded from Te Roopu Taurima again, they would arrest her for breach of bail conditions.

35. As part of the independent investigation, a senior staff member, Ms B, was interviewed regarding how Miss A obtained the aerosol cans for huffing. Text exchanges between Ms B and Mrs A after the events on 30 Month2 2019 indicate that Ms B had supplied Miss A with the aerosol cans so that she would give up her stockpiled sharps and medication.

36. A text from Mrs A reads:

> '[Miss A] said u brought her cans a couple of times while with u as she needed them. I swear and give u my word this goes no further its just between u and I. Im not setting u up girl. Just trying to understand???'

37. Ms B responded saying:

> 'Ill be honest with you. I did and I told her I would never do it again … I didn't condone that choice but she said it made her feel better … I hated what I had done and it went against all my morals and standards … sorry … she tried to have more but I said no … she said she would just take off and steal it anyway and I didn't want her to have another cha[n]ce.'

38. Further messages in the text exchange with Mrs A thank Ms B for her honesty. Ms B goes on to state:

> '[I] looked at it as an addiction … [S]ome people are addicted to drugs and alcohol and some are addicted to solvents … [I]t was the only way to get all the tablets she had stored and blades that she had.'

39. Ms B told the independent investigator that the texts referring to 'cans' referred to soft drinks, and her apologies were for allowing Miss A to finish an aerosol can, not for providing it to her. Miss A confirmed in her response to my provisional opinion that Ms B would buy her aerosol cans, not soft drink cans as suggested by Ms B.

40. In response to the provisional opinion, Ms B told HDC that upon further consideration, it likely was spray cans that she was referring to in her texts with Mrs A. Ms B said she suggested that it was soft drink cans as a way of trying to make sense of the messages that make it sound as if she supplied Miss A with spray cans, which she says is simply not true.

41. Ms B also said in response to the provisional opinion that she is now aware that there were other text messages both sent and received in the text exchange with Mrs A, and these were not included in the messages provided by Mrs A as part of the independent investigation conducted by Te Roopu Taurima. Ms B said that after the text outlined at paragraph 36, she sent a message stating that she did not supply Miss A with any cans but confirming that Miss A did have cans. Ms B said that there was then a message from Mrs A asking whether she had seen Miss A inhaling cans, and that is what her response outlined at paragraph 38 is regarding. Ms B said that she does not have evidence of the text exchange and cannot confirm the exact nature of the communication, but she can state with confidence that she 'did not engage in any interaction where [she] took responsibility for actions [she] did not commit'.

42. In internal correspondence reviewed during the independent investigation, Ms B stated that she suspected that Miss A had obtained the razors and aerosol cans by stealing them from the nearby supermarket during the period between absconding and being picked up from her mother's house.

43. The independent investigation concluded that it was more likely than not that Ms B gave Miss A the aerosol cans as a means of getting the medication and razors from her, as set out in her text: '[I]t was the only way to get all the tablets that she had stored and blades that she had off her.'

44. In response to my provisional opinion, Ms B said that whilst she did not provide Miss A with the cans, she did prioritise removing the items that were presenting a greater risk of harm (razor blades and medication), rather than demanding that Miss A return all the contraband items (which would have included the cans), which she assessed at the time as being unrealistic. Ms B said that she did not feel it was safe to await further parties or services to attend to remove the items from Miss A, who was becoming increasingly distressed. Ms B said that she was concerned that Miss A could seriously harm herself with the items she had in her possession, so she did the best she could with the resources available.

45. There was a further incident on 23 Month2 2019 whereby Miss A was taken to a public hospital for assessment, as staff had observed a bleeding cut on her neck when she had returned approximately an hour after she had absconded by jumping the fence. Two doctors from a nearby health service were contacted to assess Miss A. Police and ambulance services were also contacted. Ms B accompanied Miss A to the hospital in the ambulance, and she was discharged later that evening.

Medication dispensing incidents

46. Miss A raised concerns about the management of her medication, stating that staff had 'double dosed [her] medication'.

47. Te Roopu Taurima told HDC that Miss A absconded from Te Roopu Taurima on 11 Month2 2019. On her return, she requested the morning dose of her PRN[5] quetiapine[6] medication. When Ms C took the medication from the locker, Miss A grabbed the box and ran to her room, where she barricaded herself against the door and took an unknown quantity of quetiapine. Miss A was taken to a public hospital for observation, accompanied by a Te Roopu Taurima staff member. Miss A was discharged at approximately 7.30pm that day.

48. In a follow-up email to staff sent that evening, Ms F detailed new support measures to address Miss A's behaviour. Staff were to notify Ms F when Miss A requested medication; staff should not refuse Miss A's medication requests; Miss A was not to be permitted outside unless she was being taken to an appointment; and staff were not permitted to restrain Miss A if she was swearing, but they were permitted to restrain her with MAPA holds if she became agitated, aggressive, or violent.

[5] Pro re nata — 'as needed'.
[6] An antipsychotic medication used to treat schizophrenia.

49. On 22 Month2 2019, separate to the incident noted above regarding inhaling aerosol cans, Miss A returned excess quetiapine pills and razors after extra pills had been distributed by a Te Roopu Taurima staff member deliberately over the previous week. According to an email from Ms B sent regarding the incident the next morning, Miss A had 900mg of quetiapine in her possession. The incident report does not state from where Miss A had obtained the razors.

50. When questioned by senior staff members, the staff member admitted having provided Miss A with medication on request, as the staff member had felt unable to say no to her. When management became aware of this, they asked Miss A to return all excess pills, along with the shavers, and Miss A complied.

Absconding incidents

51. Miss A's absconding events involved her either jumping the fence or gate of the facility or simply walking out the front door. Te Roopu Taurima stated that as per Miss A's CARP, staff were to ensure that Miss A was supported one-on-one at all times while also ensuring their own safety. When Miss A was clearly intending to abscond, staff were encouraged to employ de-escalation techniques as recommended in MAPA training and try to convince Miss A to stay in the facility. Te Roopu Taurima's stance was that it was better for staff safety to allow Miss A to abscond and then escalate the matter to Police. Police were contacted on multiple occasions when Miss A absconded from Te Roopu Taurima's premises.

Other incidents

52. Multiple other incidents involved Miss A damaging property, acting anti-socially, and racially abusing Te Roopu Taurima staff.

53. The independent investigation noted that Miss A had made personal comments about staff, and the implication was that staff were sensitive to these comments, as they would not otherwise need to be included in an incident report.

54. In her complaint to Te Roopu Taurima, Miss A said that staff were mentally abusive and would threaten her with her father, as they knew she was scared of him. Miss A said that staff would also threaten to get male staff to manage her if she did not calm down, and they would threaten to cancel visits from her family.

55. Staff reported that Miss A's behaviour was more controlled around her father. When asked about this by Te Roopu Taurima's investigator, Ms F said she thought it was likely that staff did tell Miss A that they would get her father to come to the facility as a means of managing her behaviour.

Group provider responses

56. Te Roopu Taurima provided HDC with responses on 21 August 2020 and 12 November 2020, and provided a further response on 19 May 2022.

57. In all responses, Te Roopu Taurima acknowledged that its staff experienced a significant challenge in managing Miss A's behaviour, while also recognising that it was a time of

immense distress for Miss A. Te Roopu Taurima is a support service for intellectually disabled people. Managing Miss A, who ultimately was assessed as not having an intellectual disability, was a complex situation, and Te Roopu Taurima's responses acknowledged the challenge for Miss A residing in a facility alongside other people who present with intellectual disabilities. Staff reported that Miss A did not feel she belonged at Te Roopu Taurima's service for this reason.

58. Te Roopu Taurima told HDC that Ms E, Ms B, and Ms C no longer work for Te Roopu Taurima.

Incident management

59. After the initial complaint was received from Mrs A, Miss A requested a meeting with Te Roopu Taurima's management, accompanied by support people including her mother, a friend, her legal representatives, and her mental health support worker. The meeting was confirmed for 11 August 2020, but that morning Miss A asked for the meeting to be cancelled or postponed. Te Roopu Taurima agreed and waited to hear back from Miss A with a new date and time, but heard nothing further.

60. Te Roopu Taurima believes it has taken Miss A's complaint very seriously, including commissioning an independent investigator to review the complaint. Te Roopu Taurima said that it took all appropriate measures to support Miss A, with the concerns raised in the complaint being the result of individual decisions made by staff in challenging circumstances. Te Roopu Taurima also believes that it took all appropriate measures to support staff. Miss A's family dynamics and needs as a person with mental health concerns presented a complex case for a service whose core purpose is supporting people who present with intellectual disabilities.

Attempts to contact individual providers

Ms B

61. An email was sent to Ms B on 17 December 2021 advising that HDC had correspondence to send to her and asking for confirmation of her email address. Ms B responded the same day confirming her email address.

62. An email was sent to Ms B on 28 April 2022 advising that HDC had commenced a formal investigation into Miss A's complaint, on the basis that Ms B's actions appeared to be in breach of the Code of Health and Disability Services Consumers' Rights (the Code). HDC sought further information from Ms B under section 62 of the Health and Disability Commissioner Act 1994 (the Act),[7] which was to be provided by 19 May 2022.

63. A follow-up email was sent on 3 May 2022 as Ms B had not confirmed receipt of the 28 April email. On the same date, Ms B asked what the 28 April email related to and was advised on 4 May 2022 that the details were enclosed in the letter that had been attached to the email.

[7] Section 62 of the Act allows the Commissioner to require a person to give information that is relevant to an investigation.

On 4 May 2022 Ms B advised that she had deleted the 28 April email and asked for it to be re-sent. The correspondence was re-sent to her that day.

64. A follow-up email was sent to Ms B on 10 June 2022, advising that if HDC had not received her response by 17 June 2022, it would be assumed that she had no comments. On 13 July 2022 an email was sent to Ms B noting that as a response had not been received despite the follow-up attempts made, our investigation would continue without her input.

65. On 18 September 2023 a copy of the independent advice obtained from Mr Taylor was emailed to Ms B for comment. A follow-up email was sent to Ms B on 21 September asking whether she had received the 18 September email.

66. On 24 October 2023 a phone call was made to Ms B to ascertain whether she had received HDC's emails. Ms B confirmed that she had received the emails and said that she felt that the complaint was unfair because of how hard she had worked and the good overall care she had provided as a support worker. Ms B explained the stress of the investigation process as well as some of her own personal circumstances. These concerns were acknowledged, but Ms B was encouraged to review the information that had been sent to her and respond to HDC, as the information gathered would form the basis for my provisional opinion. Ms B was also advised that failing to respond would be taken into consideration when making findings in this case. The documents previously sent to Ms B were re-sent to her with a due date of 7 November 2023 for her response. Ms B confirmed receipt of these documents and advised that she would read the information and respond. Further information was requested by Ms B and this was provided by HDC on 25 October 2023.

67. Ms B did not provide a response by 7 November 2023. Accordingly, HDC relied on information from Te Roopu Taurima's independent investigation.

68. On 18 March 2025 an email was sent to Ms B advising that the provisional opinion was to be issued later that week. On 20 March 2025 Ms B provided her response to the notification and was advised that it would be taken into consideration along with any response she had to the provisional opinion.

69. The provisional opinion was sent to Ms B on 24 March 2025 for comment. Ms B provided a response on 14 April 2025 and a further response on 2 May. These responses and the response provided on 20 March have been incorporated into the report where relevant.

Ms E

70. An email was sent to Ms E on 17 December 2021 advising that HDC had correspondence to send to her and asking for confirmation of her email address. A further two emails were sent to Ms E on 18 January and 16 March 2022. Ms E did not respond to any of these attempts to contact her.

71. On 31 March 2022 a phone call was made to Ms E. During this call, Ms E said that she does not check her emails often but confirmed that the email address HDC has on file is correct. It was explained to Ms E that HDC had correspondence to send to her about the care she

provided to Miss A at Te Roopu Taurima. Ms E asked whether this was in relation to the events that had occurred a few years ago and, when this was confirmed, Ms E terminated the phone call.

72. An email was sent to Ms E on 28 April 2022 advising that HDC had commenced a formal investigation into Miss A's complaint, on the basis that Ms E's actions appeared to be in breach of the Code. HDC sought further information from Ms E under section 62 of the Act, to be provided by 19 May 2022. A follow-up email was sent on 3 May 2022. No response was received to either email.

73. On 10 June 2022 an HDC staff member left a voicemail message asking Ms E to contact HDC. A physical copy of the notification was also sent via courier to the physical address HDC had on file for Ms E. A follow-up email was also sent to Ms E advising her of the attempted phone call, stating that a physical copy of the correspondence had been sent to her and asking that she respond to HDC by 17 June 2022. Ms E was advised that if no response had been received by this date, it would be assumed that she had no comment to make.

74. On 13 July 2022 an email was sent to Ms E noting that as a response had not been received despite the follow-up attempts made, our investigation would continue without her input.

75. On 18 September 2023 a copy of the independent advice obtained from Mr Taylor was emailed to Ms E for comment. A follow-up email was sent to Ms E on 21 September asking whether she had received the 18 September email. Ms E did not respond to either attempt to contact her.

76. Another phone call was made to Ms E on 6 November 2023 and again a voicemail was left asking her to contact HDC regarding the previous attempts to contact her. Ms E did not contact HDC.

77. An email was sent to Ms E on 18 March 2025 advising that the provisional opinion was to be issued later that week. The email failed to deliver to the email address held by HDC. Three phone calls to Ms E were made on 19 March, and a further call was made on 20 March 2025 in efforts to obtain her new email address, but she was unable to be contacted.

78. A copy of the provisional opinion was delivered to Ms E's physical address on 27 March 2025, which provided a due date for her response. Ms E has not contacted HDC.

Ms D

79. An email was sent to Ms D on 17 December 2021 advising that HDC had correspondence to send to her and asking for confirmation of her email address. A further two emails were sent to Ms D on 18 January and 16 March 2022. Ms D did not respond to any of these attempts to contact her.

80. Two phone call attempts were made on 31 March 2022, but HDC was unable to reach Ms D.

81. On 22 April 2022 another phone call was made, but Ms D could not be contacted. An email was also sent to Ms D, advising that HDC had correspondence to email her and asking Ms D to confirm her email address. Ms D responded the same day confirming her email address.

82. An email was sent to Ms D on 28 April 2022 advising that HDC had commenced a formal investigation into Miss A's complaint, on the basis that Ms D's actions appeared to be in breach of the Code. HDC sought further information from Ms D under section 62 of the Act, to be provided by 19 May 2022. A follow-up email was sent on 3 May 2022. Ms D responded the same day confirming that she had received the email sent from HDC.

83. A follow-up email was sent on 10 June 2022 advising that if HDC had not received her response by 17 June 2022, it would be assumed that she had no comment. On 13 July 2022 an email was sent to Ms D noting that as a response had not been received despite the follow-up attempts made, our investigation would continue without her input.

84. On 18 September 2023 a copy of the independent advice obtained from Mr Taylor was emailed to Ms D for comment. A follow-up email was sent to Ms D on 21 September asking if she had received the 18 September email. Ms D did not respond to either attempt to contact her.

85. A phone call was made to Ms D on 6 November 2023, and a voicemail message was left asking her to contact HDC regarding the previous attempts to contact her.

86. On 18 March 2025 an email was sent to Ms D advising that the provisional opinion was to be issued later that week. On 24 March the provisional opinion was sent to Ms D for comment. On 14 April Ms D requested an extension of time to provide her response, which was granted until 22 April. Ms D did not provide a response, despite follow-up emails being sent on 24 April and 29 April.

87. As Ms D failed to engage further with HDC, HDC has relied on the information Ms D provided during Te Roopu Taurima's independent investigation.

RIDSAS service specifications

88. Included in its funding of RIDSAS services, Whaikaha|Ministry of Disabled People (Whaikaha) provides overarching service specifications for providers, outlining Whaikaha's general expectations for RIDSAS providers.

89. The specifications provide objectives for service providers, guidance for care planning and staffing, and security specifications for buildings and fixtures. The specifications require all providers to ensure that staff receive training to the best practice standard, which should allow for care recipients to receive support that meets their security, safety, and support needs. When there is a significant change in a person's needs, the specifications recommend a review of the person's CARP through co-ordination of the Care Manager or the Care Coordinator.

Relevant policies and procedures

Te Roopu Taurima policies and procedures

90. Te Roopu Taurima advised HDC that all staff receive an induction that includes its policies and procedures. Te Roopu Taurima provided HDC with the following relevant policies and procedures:

- Incident Reporting Policy (27 July 2017 version)
- Medication Management Policy (August 2018 version)
- Challenging Behaviour Policy (27 July 2017 version)
- Restraint Minimisation Policy (December 2018 version)
- Open Disclosure Policy (27 July 2017 version)
- Critical incident reporting procedure flow chart (March 2019 version)

Incident Reporting Policy

91. The 2017 Incident Reporting Policy states that staff priority is to ensure safety; line or on-call managers must be notified of any incidents immediately; and it is the responsibility of the line or on-call manager to make the appropriate notifications in relation to the incident and to review the incident.

92. The Incident Reporting Policy maintains that all restraints will be reviewed using an approved review template.

93. The Policy defines an incident as 'Any event which could have or did result in harm to people and/or damage to property'.

94. A critical incident is defined as:

> 'An incident in which a tangata/tangata whaiora/kaimahi is injured and/or is hospitalised, death, missing persons, physical assault, contact with police and/or adverse contact with the public, an allegation of abuse, and any event which may involve a media risk is considered a critical incident.'

95. All completed incident reports are to be audited by Te Roopu Taurima's Quality, Safety and Risk Advisor, who is tasked with producing a summary report for the monitoring of patterns or trends, and with making recommendations based on the issues identified. Feedback is to be given to staff regarding any recommendations or action plans developed as a result of any incident reviews.

Medication Management Policy

96. The aim of Te Roopu Taurima's 2018 Medication Policy is to ensure that all medication is provided in a safe and timely manner. The Medication Policy places the responsibility for the appropriate and safe administration of PRN medication on all staff, with priority to be given to consideration of whether the medication is being provided for the right reason, with staff being required to document the rationale for providing the medication.

97. All medication errors or refusals require an incident report to be completed, and the appropriate manager must be notified. The Medication Policy outlines that when medicine is administered, staff are to stay with the person until the medication has been swallowed, and a signing sheet is to be signed recording that the medication has been administered.

98. Regarding PRN medication specifically, the Medication Policy states that these are not to be used as regular medications, and appropriate documentation should be in place for instructions on how to use PRN medication, with house leaders and service managers to monitor usage and refer the person if use becomes frequent.

Challenging Behaviour Policy

99. The Challenging Behaviour Policy defines challenging behaviour by a care recipient as behaviour that places those around them at risk and/or impacts a person's ability to join in everyday activities. The policy details that all persons residing at Te Roopu Taurima will be provided with a behavioural support plan. The purpose of the policy is to ensure that all staff are provided with tools to prevent and manage challenging behaviour, whilst maintaining safety, comfort, and dignity for all.

Restraint Minimisation Policy

100. As restraint holds are considered to be a serious intervention with a risk of harm, they are a last resort to remedy challenging behaviour. To ensure that any use of a restraint is minimised, it is necessary that restraints are planned and managed and that any recording of a restraint is transparent and comprehensive. The principle of greater–lesser harm is central to the policy and describes that when staff are faced with a situation where they are required to select an action from two unpleasant options (eg, using a restraint or being harmed), the least harmful option should be chosen.

101. Restraint should be used only when a person's behaviour or conduct indicates that the person is at serious risk of harm to themself or others. After a restraint has been used, the policy requires an incident form to be completed, and persons involved in applying the restraint should be offered a debrief.

Open Disclosure Policy

102. Under the Open Disclosure Policy, care recipients and their families should be informed of any adverse events or staff errors, and an acknowledgement and a sincere apology should be made when an incident occurs. All disclosures should be made in a timely manner, usually within 24 hours of the relevant event occurring.

Staff Training

103. Te Roopu Taurima informed HDC that all core training for Te Roopu Taurima is delivered externally or by Te Roopu Taurima employees who are accredited trainers. At the time of the events complained about, all staff involved were up to date with their training requirements. Ms E was due for HDC Code of Rights and medication administration refresher training around the time of the events.

Relevant Service Standards

104. In addition to the RIDSAS service specifications, Whaikaha also requires all service providers to comply with relevant Health and Disability Services Standards. NZS 8134.1:2008[8] provides generic guidance for providers to be clear about their responsibilities, with the overarching goal being for providers to give effect to the Code. NZS 8134.2:2008 details more specific guidance for providers around restraint minimisation.

105. The relevant version of NZS 8134 in place at the time required that service providers meet a consumer's assessed needs and that consumers are kept safe and are not subjected to abuse or neglect. This includes providing training to staff to ensure that they are responsive when a consumer's needs change and consumers who require a greater degree of supervision receive a necessary level of support.[9]

106. NZS 8134 also provides that support extends to having a medicines management system in place that manages the appropriate dispensing and administration of medicines, including that service providers are competent at each stage of medicine management, including the detection and management of all medication errors.[10]

107. In relation to restraint and restraint minimisation, NZS 8134 sets an expectation that restraint should be used only when all other less-restrictive interventions have proven inadequate. When restraints occur, each episode of restraint should be documented in sufficient detail, and a review of all restraints used should be undertaken by the service provider.[11]

Further information

108. Regarding policy and procedure deficiencies identified by Mr Taylor, Te Roopu Taurima told HDC:

- Measures to manage behaviour and support care recipients are covered by care recipient support plans and MAPA training for staff.
- Te Roopu Taurima has always employed a registered nurse for clinical oversight.
- Inadequacies identified in the 2017 Medication Policy for PRN medication have been addressed in the updated version of the policy.
- Details relating to security are covered in the RIDSAS environmental security specifications for buildings provided by Whaikaha through FCSID. Miss A's multiple absconding events indicate that security measures cannot eliminate the risk of absconding, only mitigate them.

[8] The 2008 version of NZS 8134 was the standard in place at the time of events. This has been replaced by an updated 2021 version.
[9] Standard 8134.1:2008 at 1.3.4, 1.3.7, 3.6.2, 4.7.7, accessed August 2024.
[10] Standard 8134.1:2008 at 3.12.1, 3.12.2, accessed August 2024.
[11] Standard 8134.2:2008 at 2.3.4, 2.4.1, accessed August 2024.

- Incident reporting processes have been improved with digitisation, which has allowed for better staff support.

Response to provisional opinion

Miss A

109. Miss A was given an opportunity to comment on the 'how complaint arose' and 'background leading up to complaint' sections of my provisional opinion, and her response has been incorporated into this report where relevant.

110. Miss A said that she was physically and emotionally abused while she was at Te Roopu Taurima, and she wants the responsible individuals to be held accountable to prevent it happening to others.

Te Roopu Taurima O Manukau Trust

111. Te Roopu Taurima was given an opportunity to comment on the provisional opinion, and its response has been incorporated into the report where relevant.

112. Te Roopu Taurima said that it agrees that in some respects it failed to provide services of an appropriate standard to Miss A.

Ms B

113. Ms B was given an opportunity to comment on the relevant sections of my provisional opinion, and her response has been incorporated into this report where relevant.

114. Ms B said that the complaint made against her is not accurate, and because she had been busy, she did not think this investigation warranted much of her time. Ms B said that she found contact from HDC to be distressing, and she apologised for being 'problematic to reach at times'.

115. Regarding the CARP, Ms B said that it addresses risk on a superficial level and does not provide the depth of planning needed. Ms B said that the task of managing Miss A's behaviours was 'challenged by her presentation being quite different to those commonly managed at Te Roopu Taurima'. In Ms B's view, there was no provision for realistic interventions that would sufficiently address Miss A's presentation and risk, and the Te Roopu Taurima facility was not suited to providing Miss A with the care she needed.

116. Ms B stated that staff were 'forced to try [to] manage and contain' self-injurious and violent behaviours displayed by Miss A without the necessary tools and with minimal oversight and support provided by Te Roopu Taurima.

117. Ms B said that there were several ways in which Miss A could have accessed spray cans, none of which required her input. Ms B denies providing Miss A with spray cans at any stage. Ms B said that it is 'entirely illogical' that she would have supplied inhalants to Miss A given that such substances 'are known to exacerbate behavioural disturbances', which would likely have exacerbated the potential for Miss A to act violently toward staff as well as being in contradiction with the therapeutic goals staff were working toward at the time.

Ms D

118. Ms D was given an opportunity to comment on the relevant sections of my provisional opinion but did not provide a response.

Ms E

119. Ms E was given an opportunity to comment on the relevant sections of my provisional opinion but did not provide a response.

Ms C

120. Ms C was given an opportunity to comment on the relevant sections of my provisional opinion and advised that she had no comments to add.

Opinion: Te Roopu Taurima O Manukau Trust — breach

121. To assist my assessment of this case, I sought independent advice from disability support specialist Mr John Taylor (Appendix A).

Policies, procedures, and CARP — breach

122. At the time of the events, Te Roopu Taurima had in place comprehensive policies and procedures that outline Te Roopu Taurima's expectations of staff. Te Roopu Taurima said that all staff receive an induction that includes its policies and procedures, and all policies and procedures are available to staff on the intranet. Te Roopu Taurima also said that during induction, staff are provided with MAPA restraint training, and that all the staff members involved in the restraint incident had received MAPA safety intervention refresher training.

123. Miss A clearly presented with very challenging and, at times, violent behaviour while she was in the care of Te Roopu Taurima. However, in my view, staff resorting to threatening Miss A as a means of managing her challenging behaviour is concerning. I consider that this behaviour by multiple staff represents a systemic issue. Te Roopu Taurima is responsible for ensuring that staff have sufficient training, support, and guidance on de-escalation tactics. Failure to do so can result in staff using threats and unauthorised restraints in order to manage challenging behaviour, as occurred in this case.

124. While Mr Taylor acknowledged that Te Roopu Taurima and its staff may have found it difficult to support Miss A, he considered that the resulting overall care and support Te Roopu Taurima provided to her was below the minimum accepted standard.

125. Te Roopu Taurima informed HDC of improvements made to its policies and procedures since Miss A left its care in Month2 2019. Although these changes and improvements are acknowledged, Mr Taylor identified gaps in Te Roopu Taurima's policies and procedures at the time of the events, noting an oversight around security and the lack of a policy relating to the security of its facilities; an emphasis on restraint minimisation rather than avoidance; inadequate basic incident reporting; and insufficient incident review and follow-up practices in order to learn from the incidents that involved Miss A while she was still in Te Roopu Taurima's care.

126. Mr Taylor also advised that Miss A's CARP acted as a poor guide for staff on how to best support her, and the follow-up process for incidents was insufficient. In Mr Taylor's opinion, the wording of the plan was too generalised to assist staff in providing any care that was specific to Miss A.

127. I acknowledge Te Roopu Taurima's comments that the CARP was not intended as a care plan for Miss A. However, in my view it remains the responsibility of Te Roopu Taurima to ensure that there is adequate guidance in place for staff on how to manage individuals in Te Roopu Taurima's care, whether they are a care recipient or awaiting assessment, as was the case with Miss A. Several staff involved in the care of Miss A resorted to inappropriate means of managing her behaviour. In my view, this reflects the fact that there was insufficient guidance and support in place for staff on how Miss A's behaviour should be managed. This is further evidenced by the response to the provisional opinion provided by Ms B, which states that staff were forced to try to manage and contain self-injurious and violent behaviours without the necessary tools.

128. Overall, I consider that the failures of individual staff in the provision of care to Miss A were exacerbated by deficiencies in training and guidance, indicating that there were broader systems and organisational issues that resulted in Te Roopu Taurima failing to provide Miss A with adequate support. Accordingly, I find that Te Roopu Taurima failed to provide services of an appropriate standard to Miss A and therefore breached Right 4(2) of the Code.[12]

Medication management — adverse comment

129. Miss A also raised concerns about the management of her medication, stating that staff had 'double dosed [her] medication'.

130. Te Roopu Taurima's independent investigation found that Miss A was being given double doses of her medication, and also that she was able to request medication and this would be provided without question. In respect of the latter, a casual staff member was unsure of the protocol for medication management and felt that she was unable to refuse Miss A's request for medication.

131. I am concerned by this. Te Roopu Taurima has a responsibility to ensure that all staff, including those employed on a casual basis, are well acquainted with all policies and procedures. It is particularly important that all staff are competent at administering medication to ensure that there are no instances of any consumer receiving the incorrect dose of medication, and to ensure that staff understand the importance of strict medication management in a facility of vulnerable consumers.

Medical attention following events of harm — no breach

132. Miss A raised concerns that there were occasions where she had self-harmed and medical attention was not sought for her.

[12] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

133. On 5 Month2 2019 an incident report notes that Miss A had cuts on her face and left arm when leaving her room, which she stated had come from her razor. Emergency services were not contacted in this instance, and monitoring of Miss A with therapeutic rapport was carried out instead.

134. A report on 22 Month2 2019 records that Miss A was 'getting high on [aerosol cans]' and self-harming. Te Roopu Taurima said that Miss A's parents were contacted and later ambulance services, the Crisis Assessment Team, and the Police.

135. On 23 Month2 2019 Police and ambulance services were called because Miss A had a bleeding cut on her neck. Miss A was taken to a public hospital for observation.

136. From the incident reports available, I am satisfied that appropriate action was taken and that sufficient medical attention was sought for Miss A when required. In line with Te Roopu Taurima's Incident Reporting Policy, the appropriate notifications were made in relation to the incidents on 22 and 23 Month2 2019, with the Police and ambulance services being called to manage the situation.

Conclusion

137. I consider that overall, the support Te Roopu Taurima provided to Miss A fell below the accepted standard. While I acknowledge the efforts made by Te Roopu Taurima to improve its systems since the events, including engaging an independent investigator to address the complaints and meeting with Miss A and Mrs A, Miss A's experience while with Te Roopu Taurima raised sufficiently serious issues that warranted earlier intervention.

Opinion: Ms B — breach

138. To assist my assessment of this case, I sought independent advice from disability support specialist Mr John Taylor (Appendix A).

Care provided to Miss A — breach

139. Ms B was a support worker at Te Roopu Taurima at the time of the events. She was required to provide Miss A with an appropriate standard of care in accordance with the Code.

140. The RIDSAS service specifications and Health and Disability Services Standards require service providers and their staff to provide support to care recipients that responds to their needs and prevents them from suffering from abuse or neglect.

141. On 22 Month2 2019 an incident report recorded that Miss A self-harmed using sharps and huffing spray cans. During Te Roopu Taurima's independent investigation, Ms B was interviewed regarding how Miss A obtained the spray cans for huffing. Text exchanges between Ms B and Mrs A (provided by Mrs A) indicated that Ms B admitted supplying Miss A with the spray cans so that Ms B could get the razors and medication from Miss A. When interviewed, Ms B said that the cans she was referring to were soft drinks.

142. In response to my provisional opinion, Ms B said that on reflection it was not soft drinks that she was referring to in the text messages. Rather, there were further texts in the exchange

with Mrs A that have not been provided and that provide additional context. Ms B said that she is adamant that she did not supply Miss A with the cans, and that the omitted text messages support this. Ms B was unable to provide HDC with these additional text messages. Ms B did not raise concerns that there were missing text messages at the time, rather her explanation at that time was that her text messages with Mrs A were about soft drinks and not spray cans.

143. Te Roopu Taurima's independent investigation concluded that based on the text exchanges between Ms B and Mrs A and the independent investigator's interview with Ms B conducted shortly after the events of this complaint, it was more likely than not that Ms B gave Miss A spray cans as a means of getting the medication and blades from her.

144. I have not been provided with any evidence to support Ms B's claim that not all text messages in the exchange with Mrs A about cans were provided. Based on the information I have obtained in this investigation, and the conclusions Te Roopu Taurima made following its independent investigation, I am satisfied on the balance of probabilities that Ms B more likely than not provided Miss A with the spray cans she used that day.

145. Whilst I note Ms B's reason that she did so in order to retrieve Miss A's stockpiled razors and medication due to concerns for her immediate safety, under no circumstances is it acceptable for a disability support worker to provide anyone with substances.

146. Mr Taylor advised that Ms B was a senior staff member and, as such, he does not believe that supplying spray cans was the only way to achieve the stated objective of obtaining the other items. Mr Taylor found the actions of Ms B to be a severe departure from accepted standards.

147. I accept Mr Taylor's advice. In providing the spray cans to Miss A, which on admission to Te Roopu Taurima's service Miss A was known to abuse, Ms B exposed Miss A to opportunities to self-harm in an environment where this should not have been possible. In doing so, Ms B did not adhere to Miss A's CARP and increased the likelihood of harm occurring to Miss A. I accept Mr Taylor's view that this was a severe departure from the accepted standard of care. Accordingly, I find that Ms B breached Right 4(4)[13] of the Code for failing to provide Miss A with services that minimised any potential harm to her, despite Ms B's stated objective in supplying the cans.

Engagement with HDC investigation — adverse comment

148. In her complaint to HDC, Miss A outlined her concerns about the care provided to her by Ms B between Month1 and Month2 2019. Throughout the course of the investigation, several attempts were made to contact Ms B to obtain a response and further information to aid in the resolution of Miss A's complaint.

149. After confirming Ms B's email address on 17 December 2021, an email was sent to Ms B on 28 April 2022 advising that HDC had commenced a formal investigation and asking for a

[13] Right 4(4) states: 'Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

response to be provided by 19 May 2022. A follow-up email was sent on 3 May 2022, and Ms B responded and advised that she had deleted the previous email and attachment sent to her, so this information was re-sent the same day. Further emails were sent to Ms B on 10 June and 13 July 2022 to follow up on Ms B's response to the investigation, and she was advised that the investigation would continue without her input. An email was sent to Ms B with a further opportunity to engage in the investigation process by allowing her the opportunity to comment on the advice from Mr Taylor. A further email sent on 21 September 2022 was also not responded to.

150. Ms B was contacted again on 24 October 2023 via phone in an effort to obtain her input into the investigation and the information gathered. Ms B raised concerns about the complaint and the stress it had caused her. She requested that the relevant documentation be re-sent to her. This was done the same day, and a new due date of 7 November 2023 was given. Ms B acknowledged this and advised that she would read the information and respond.

151. On 20 March 2025 Ms B provided her response to the notification following an email advising that the provisional opinion was to be issued that week. In response to the provisional opinion, Ms B provided a further two responses, on 14 April and 2 May.

152. The correspondence sent to Ms B through the course of the investigation represented an opportunity for her to clarify and resolve the issues raised in Miss A's complaint. Whilst I acknowledge that Ms B provided three responses from 20 April 2025, I am of the view that overall, she showed a lack of engagement with HDC's investigation process. I acknowledge her reasons for this limited engagement, but I remind Ms B of her obligation under the Code and am critical that for a significant period of the investigation there was limited engagement from Ms B. I encourage her to reflect on my comments in this respect.

Opinion: Ms E — breach

153. To assist my assessment of this case, I sought independent advice from disability support specialist Mr John Taylor (Appendix A).

Care provided to Miss A — breach

154. At the time of the events, Ms E was employed by Te Roopu Taurima as a support worker and, as such, she was required to provide Miss A with services in accordance with the Code, Te Roopu Taurima's policies, and professional standards. NZS 8134 of the RIDSAS service specifications requires that service providers meet a consumer's assessed needs and are kept safe and are not subjected to abuse or neglect.

155. Te Roopu Taurima's Challenging Behaviour Policy states that staff are provided with the tools to prevent and manage challenging behaviour, whilst maintaining safety, comfort, and dignity for all.

156. On 29 Month1 2019 Ms E was involved in an incident alongside Ms D and Ms C, during which Miss A was restrained after she was verbally and physically abusive. Ms C told HDC that Miss A began to lash out and kicked Ms E in the stomach during their attempts to redirect her to her room. Ms C said that Miss A continued to lash out and attempt to kick staff, and she

then witnessed Ms E spin around and hit Miss A in the face. In Ms D's statement during Te Roopu Taurima's independent investigation, Ms D acknowledged that Ms E hit Miss A. The investigation concluded that during one of the restraints used on Miss A, Ms E struck Miss A in the face in response to Miss A assaulting her.

157. Based on this evidence, I am satisfied that Ms E did strike Miss A in the face in an attempt to manage her behaviour, although it is unclear what level of force was used. I acknowledge that working with an uncooperative consumer is extremely challenging, and Miss A was displaying behaviours that were violent and dangerous. However, the use of force to strike a consumer is unacceptable regardless of the behaviour being exhibited by the consumer.

158. Mr Taylor advised that Ms E's conduct in these circumstances represents a severe departure from the accepted standard. The fact that this was in response to Miss A hitting Ms E does not diminish the fact that a support worker should never respond in such a manner.

159. I accept Mr Taylor's opinion. Ms E's response to the situation was clearly inappropriate. In my view, Ms E failed to provide services to Miss A that complied with professional standards and Te Roopu Taurima's Challenging Behaviour Policy and, accordingly, Ms E breached Right 4(2) of the Code.

Engagement with HDC investigation — breach

160. The role of HDC is to promote and protect the rights of consumers of health and disability services. The Rights are set out in the Code, together with the obligations of providers. Right 10(3) of the Code requires providers to facilitate the fair, simple, speedy, and efficient resolution of complaints.

161. In her complaint to HDC, Miss A outlined her concerns about the care provided to her by Ms E in Month1 and Month2 2019. Despite several attempts to contact Ms E to obtain a response and further information, she has not provided any information to HDC to aid in the resolution of Miss A's complaint.

162. Emails were sent to Ms E on 17 December 2021 and 18 January and 16 March 2022, in an effort to confirm her email address. Ms E did not respond to any of these emails. On 31 March 2022 a phone call was made to Ms E. During this call Ms E said that she does not check her emails often but confirmed that the email address HDC had on file was correct. When it was confirmed that the correspondence HDC had to send to her related to the care she had provided to Miss A, Ms E terminated the phone call.

163. An email was sent to Ms E on 28 April 2022 advising that HDC had commenced a formal investigation into Miss A's complaint, and a follow-up email was sent on 3 May 2022. No response was received to either email. Further attempts to contact Ms E were made on 10 June 2022 via a phone call, email, and a physical copy of the correspondence being sent, and an extension was given until 17 June 2022 for Ms E to provide the requested information to HDC. Ms E was advised on 13 July 2022 that the investigation would continue without her input. A copy of the independent advice obtained from Mr Taylor was sent to Ms E on 18 September 2023. Further attempts to contact Ms E were made on 21 September and 6

November 2023 without success. Ms E was also given an opportunity to respond to my provisional opinion and chose not to.

164. The correspondence sent to Ms E throughout the course of this investigation represented an opportunity for her to clarify and resolve the issues raised in Miss A's complaint. In my view, Ms E has shown an unwillingness to engage in the investigation of the complaint and has actively avoided doing so, evidenced by the fact that she terminated a phone call and failed to respond to any email correspondence, despite confirming her email address. As such, Ms E contributed to delays in Miss A's right to have her complaint handled in a speedy, efficient, and simple manner. I consider this delay unacceptable. Accordingly, I find that Ms E breached Right 10(3) of the Code.

Opinion: Ms D — breach

165. To assist my assessment of this case, I sought independent advice from disability support specialist Mr John Taylor (Appendix A).

Care provided to Miss A — breach

166. Ms D was one of the three staff involved in the incident on 29 Month1 2019. The incident report completed by Ms D noted that Miss A had attempted to abscond four times that day/evening, and that staff applied an approved MAPA hold to get her back inside the house. The incident report records that Miss A became physically and verbally abusive toward staff, and two more approved MAPA holds were required to manage Miss A's behaviour.

167. When an independent investigation into this incident was carried out, in relation to the first restraint used, Ms D said that she tried to hold both Miss A's arms while Ms C held Miss A's legs. Ms D acknowledged that Ms E hit Miss A. The incident report contains no reference to the type of hold used or to Ms E striking Miss A. The independent investigation into this incident concluded that Ms D participated in an unauthorised restraint when holding Miss A's arms in the manner she did.

168. Mr Taylor advised that Ms D was doing the best she could to limit harm when she restrained Miss A. However, he accepted the evidence from Te Roopu Taurima's external investigation that the restraint was unauthorised, and he considered Ms D's actions a departure from the accepted standard of care.

169. I accept Mr Taylor's advice. Given that Miss A was being verbally and physically abusive, it is clear that she presented a danger to herself and others. However, the method of restraint Ms D used fell outside what was appropriate, regardless of the challenging circumstances she faced.

170. I am also concerned that the incident report completed by Ms D did not mention Ms E striking Miss A and attempted to present all the restraints used as approved MAPA holds, when later she admitted that one of the holds used was not MAPA approved.

171. Te Roopu Taurima's 2017 Incident Reporting Policy states that staff priority is to ensure safety, and line or on-call managers must be notified of any incidents immediately, and it is

the responsibility of the line or on-call manager to make the appropriate notifications in relation to the incident and to review the incident. The Open Disclosure Policy also states that care recipients and their families should be informed of any adverse events or staff errors, usually within 24 hours of the relevant event occurring.

172. The failure to record the incident accurately and notify management of the incident was contrary to Te Roopu Taurima's Incident Reporting, Open Disclosure, and Restraint Minimisation Policies and professional standards. Furthermore, Ms D used an unauthorised restraint on Miss A, although I acknowledge the challenging circumstances faced by Ms D. I consider Ms D's actions to have been contrary to Te Roopu Taurima's policies and the relevant service standards, and cumulatively I find that these actions amount to a breach of Right 4(2) of the Code.

Engagement with HDC investigation — breach

173. The role of HDC is to promote and protect the rights of consumers of health and disability services. The rights are set out in the Code, together with the obligations of providers. Right 10(3) of the Code requires providers to facilitate the fair, simple, speedy, and efficient resolution of complaints.

174. In her complaint to HDC, Miss A outlined her concerns about the care provided to her by Ms D in Month1 and Month2 2019. Despite several attempts to contact Ms D to obtain a response and further information, Ms D has not provided any information to HDC to aid in the resolution of Miss A's complaint.

175. Emails were sent to Ms D on 17 December 2021 and 18 January and 16 March 2022 in an effort to confirm her email address. Ms D did not respond to any of these emails. Phone calls were made on 31 March (two calls) and 22 April but contact with Ms D could not be made. A further email was sent to Ms D on 22 April, and Ms D responded confirming her email address.

176. An email was sent to Ms D on 28 April 2022 advising that HDC had commenced a formal investigation into Miss A's complaint. A follow-up email was sent on 3 May 2022, and Ms D responded the same day confirming that she had received the email sent from HDC. On 10 June 2022 a follow-up email was sent to Ms D advising that if her response was not received by 17 June 2022, it would be assumed that she had no comment to make. On 13 July 2022 an email was sent advising that the investigation would continue without Ms D's input.

177. Ms D did not respond to the email sent to her on 18 September 2023 providing Mr Taylor's independent advice for her comment, or the follow-up email sent on 21 September 2023. A phone call was made to Ms D on 6 November 2023, and a voicemail message was left asking her to contact HDC regarding the previous attempts to contact her.

178. The correspondence sent to Ms D throughout the course of this investigation represented an opportunity for her to clarify and resolve the issues raised in Miss A's complaint. In my view, Ms D has shown an unwillingness to engage in the complaints process despite numerous attempts by HDC to allow her to do so. As such, Ms D contributed to delays in

Miss A's right to have her complaint handled in a speedy, efficient, and simple manner. I consider this delay unacceptable. Accordingly, I find that Ms D breached Right 10(3) of the Code.

Opinion: Ms C — adverse comment

179. To assist my assessment of this case, I sought independent advice from disability support specialist Mr John Taylor (Appendix A).

180. Ms C was one of the three Te Roopu Taurima staff members on shift on 29 Month1 2019 when an unauthorised restraint was used on Miss A, and she was struck in the face by Ms E. Ms C told HDC that on that date, Miss A attempted to abscond and became verbally and physically abusive and kicked both Ms C and Ms E. Ms C told HDC that during this incident she witnessed Ms E hitting Miss A in the face.

181. Mr Taylor did not identify that Ms C did anything outside expected standards during her employment with Te Roopu Taurima. However, I am concerned that Ms C acknowledged that Ms E struck Miss A in the face when Miss A was being restrained, but Ms C did not report this to senior staff.

182. Te Roopu Taurima's 2017 Incident Reporting Policy states that staff must prioritise safety, and line or on-call managers must be notified of any incidents immediately, and it is the responsibility of the line or on-call manager to make the appropriate notifications in relation to the incident and to review the incident. The Open Disclosure Policy states that care recipients and their families should be informed of any adverse events or staff errors, usually within 24 hours of the relevant event occurring.

183. The incident report completed by Ms D on 29 Month1 2019 made no reference to Miss A being struck in the face. No records have been provided to HDC that record staff reporting Ms E's action to Te Roopu Taurima management.

184. Whilst I acknowledge that Ms C did not complete the incident report for this event, she still failed to report the physically abusive behaviour of a staff member, as is required by Te Roopu Taurima's policies and NZS 8134. Acknowledging that Ms C was not the most senior staff member present during this incident, I remind Ms C of the importance of reporting any events of abuse or neglect to maintain the safety of vulnerable consumers.

Changes made since events

185. Te Roopu Taurima advised that the following changes have been implemented:

- Improvements to incident reporting, including moving from a paper-based system to a digital system, implementing a learnings register linked to the new digital system, and more timely notifications to care recipients' legal guardians or whānau;
- Improvements to debriefing critical incidents, including a guide for senior staff to provide structure for debriefs;

- Updates to Te Roopu Taurima's Medication Management Policy to include regular competency reviews of all staff and reviews of medication errors identified in incident reports, allowing for an investigation to be conducted where appropriate;
- Annual MAPA refresher training and the addition of Positive Behaviour Support training for all staff to assist with staff management of challenging behaviour;
- With the new digital system, critical incident reports are forwarded to senior management immediately;
- Reference to the concept of greater or lesser harm that previously was included in Te Roopu Taurima's 'Restraint Minimisation and Safe Practice Policy' has been removed and the policy simplified;
- When an incident involving a restraint is reported, Te Roopu Taurima's restraint coordinator is notified automatically, and the use of restraint is reviewed by the coordinator;
- External security experts were engaged to assess the security of Te Roopu Taurima's facility, and work has been undertaken alongside the Ministry of Health to develop a programme for improvements to the secure facilities Te Roopu Taurima operates; and
- Policy quizzes are circulated amongst staff every three weeks.

Recommendations

Te Roopu Taurima O Manukau Trust

186. I recommend that Te Roopu Taurima O Manukau Trust provide a formal written apology to Miss A for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Miss A, within three weeks of the date of this report.

Ms B

187. I recommend that Ms B:

a) Provide a formal written apology to Miss A for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Miss A, within three weeks of the date of this report; and

b) Complete the HDC online module on complaints resolution and provide HDC with evidence of completion within three weeks of the date of this report.

Ms D

188. I recommend that Ms D:

a) Provide a formal written apology to Miss A for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Miss A, within three weeks of the date of this report; and

b) Complete the HDC online module on complaints resolution and provide HDC with evidence of completion within three weeks of the date of this report.

Ms E

189. I recommend that Ms E:

a) Provide a formal written apology to Miss A for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Miss A, within three weeks of the date of this report; and

b) Complete the HDC online module on complaints resolution and provide HDC with evidence of completion within three weeks of the date of this report.

Follow-up actions

190. A copy of this report with details identifying the parties removed, except Te Roopu Taurima O Manukau Trust and the advisor on this case, will be sent to Whaikaha|Ministry of Disabled People and the Ministry of Social Development 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 independent advice was obtained from disability support specialist Mr John Taylor:

> 'I have been asked to provide an opinion on case number 20HDC01165 that relates to the care provided by Te Roopu Taurima O Manukau Trust to [Miss A]. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.
>
> I have the following qualifications and experience to fulfil this request. Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh.
>
> Experience: over 35 years of working within the disability sector including the following roles: direct support worker, agency management (over 15 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses.
>
> I have been asked to provide my opinion to the Deputy Health and Disability Commissioner as to whether I consider the care provided to [Miss A] by Te Roopu Taurima O Manukau (Te Roopu Taurima) was reasonable in the circumstances, and why.
>
> The specific areas I have been asked to comment on are:
>
> 1. The reasonableness of the care provided to [Miss A] by Te Roopu Taurima between 17 Month1 2019 and 29 Month2 2019, including any specific episodes of care provided by the following staff during that period:
>
>   a. [Ms B]
>   b. [Ms C]
>   c. [Ms D]
>   d. [Ms E].
>
> 2. The adequacy of Te Roopu Taurima's support/care plan for [Miss A], dated 17 Month2 2019.
>
> 3. Whether relevant national and/or local guidance, policies and/or procedures were followed by Te Roopu Taurima/Te Roopu Taurima staff.
>
> 4. The adequacy of Te Roopu Taurima's policies and procedures concerning restraint minimisation (December 2018); challenging behaviour (July 2017); medication management (August 2018); and incident reporting (July 2017).
>
> 5. Te Roopu Taurima's statement that it does not have a policy relating to the security of its facilities (refer response dated 19 May 2022).
>
> 6. The adequacy of Te Roopu Taurima's documentation of [Miss A's] stay, including the reported incidents.

7. The findings of Te Roopu Taurima's independent investigation of [Miss A's] care.

8. Any other matters in this case that you consider warrant comment.

I have based my opinion on the information I have been provided which is listed below:

1. Complaint form dated 1 July 2020
2. Te Roopu Taurima's responses to HDC dated: 15 September 2020, 12 November 2020 and 19 May 2022.
3. [Ms C's] response to HDC dated 20 June 2022.
4. Te Roopu Taurima documents supplied to HDC including:
   a. Rehabilitation Plan and Care Programme (17 [Month2] 2019)
   b. Incident reports
   c. Te Roopu Taurima policies including: Restraint minimisation (December 2018), Challenging Behaviour (July 2017), Medication Management (August 2018) and Incident Reporting (July 2017).

The reasonableness of the care provided to [Miss A] by Te Roopu Taurima between 17 [Month1] 2019 and 29 [Month2] 2019, including any specific episodes of care provided by specific staff during that period:
I have found it difficult to assess this given the different accounts. If the account of [Miss A] is accepted as the most accurate then Te Roopu Taurima did a very poor job of supporting her, exposing her to numerous abuses and for which their peers would think was well below the required standard of service.

If the account of Te Roopu Taurima's external investigation is the more accurate assessment of what occurred then it would appear that [Miss A] received "clumsy" support rather than abusive support. Certainly support below the standard they would have wanted. For example, [Miss A] was given [aerosol] cans to huff, regardless of why. She was restrained in a non-approved way and things were said to her that she took negatively.

Given that [Miss A] did present a high level of challenges to the staff, I suspect Te Roopu Taurima's peers would be sympathetic to their failures and judge them to have departed only moderately from the expected standard in their overall performance. But, some of the actions by individual staff members would be, I imagine, received less favourably.

[Ms B]
It does appear that [Ms B] gave [Miss A] [spray] cans to huff and then denied this. I consider this a severe departure from the expected standard. Te Roopu Taurima have chosen to assume that this happened so [Ms B] could take away self-harming opportunities. [Ms B] was a senior staff person and I very much doubt that this was the only way to achieve the objective used to justify the supply of the cans to huff. Te Roopu Taurima stated that they did plan to take her *"through the appropriate HR process"* for this inappropriate action.

[Ms C]
Although [Miss A] complained about [Ms C] it does not look like [Ms C] did anything specifically wrong during her employment with Te Roopu Taurima, assuming that her personal relationship with specific family members commenced post her time with Te Roopu Taurima.

[Ms D]
[Ms D] is accused of using a non-approved restraint. From reading the accounts, I would say that she was doing the best she could at that time given the way things were playing out. That does not mean I condone it, but sometimes, in these sort of difficult situations, one reacts to limit harm in ways that make sense at the time so I consider this a mild departure from the expected standard.

[Ms E]
[Ms E] does appear to have lashed out and struck [Miss A]. The fact that this was associated with [Miss A] hitting her does not diminish the fact that this should never happen. Actions of this nature should lead to a disciplinary outcome and likely dismissal and would be considered a severe departure from the expected standard.

The adequacy of Te Roopu Taurima's support/care plan for [Miss A], dated 17 [Month2] 2019.
In my opinion the "Care and Rehabilitation Plan" (CARP) dated 17 [Month2] 2019 is inadequate as a guide to staff on how to personalise support for [Miss A]. It reads as a very generalised or stock plan rather than a specific plan. There are specific entries that relate to [Miss A] but, most of the guidance provided for the staff are broad statements that offer little clarity about what one has to actually do, or offer only one, limited strategy.

For example, the de-escalation strategies listed on page 11 of the "CARP" could fit almost anyone. I do not see anything that is particular to [Miss A]. Such things as: breaking tasks into small and manageable sizes, providing a lot of praise for participation, ensuring she has cigarettes available, etc.

Another example of this is (p15):

Problem: *"[Miss A] has a history of refusing to take her medication."*

Strategy: *"Staff will ensure [Miss A] takes her medication. They will hand her medication and [Miss A] will take her medication in front of staff with a full glass of water"*

It is not at all clear to me what I should do if she refuses when I hand her the medication and hand her the full glass of water.

The plan was signed off by the Compulsory Care Coordinator, an external position, so it may be that this level of planning has become acceptable within the RIDSAS/RIDCA sector. However, I think it would generally be seen as a mild departure from the

expected standard by the wider sector, even though the stay was only agreed to as a short-term stay.

Whether relevant national and/or local guidance, policies and/or procedures were followed by Te Roopu Taurima/Te Roopu Taurima staff.
In general, Te Roopu Taurima had most of the policies in place that one would expect. They were not all of a high standard and Te Roopu Taurima has acknowledged this and made some improvements. Other than that I cannot comment on this question as there was insufficient information supplied for me to do so.

The adequacy of Te Roopu Taurima's policies and procedures concerning restraint minimisation (December 2018); challenging behaviour (July 2017); medication management (August 2018); and incident reporting (July 2017).
Restraint minimisation policy (December 2018): This policy has a lot of good information in it however it reads as primarily setting limits on personal restraints, that is, the staff — kaimahi — personally restraining a disabled person — tangata. As such it is a very poor "Restraint Minimisation" policy and would be considered as a moderate departure from the expected standard. It does not adequately discuss all of the ways to avoid using personal and other forms of restraint, nor is there any process to agree to restraints prior to their use; only review subsequent to their use. As such, restraints appear to be accepted as something that just needs to happen from time to time.

A policy of this nature, to reach a good practice level, needs to include a number of things this policy does not. Such things as:

- the potential for a restraint/enabler is first identified within the overall support plan for that individual and is specific to that individual.
- The restraint for that individual is approved prior to use by some oversight group.
- Checking the restraint has been deployed appropriately and checking its applicability for that individual is regularly reviewed, whether or not it is activated.
- Consent is sought for every restraint even when the court allows it to be used.
- De-escalation and other preventative strategies are outlined as part of the support plan.
- A plan to use the restraint less frequently, or not at all, is developed.
- Staff are trained in any restraints/enablers for each individual. This is where generalised training such as MAPA tends to fail people if that is the prime/only training staff receive. They assume a "one size fits all" approach to restraint.

Te Roopu Taurima's new Restraint Minimisation Policy 2020, is an improvement on the 2018 version. In particular it acknowledges most of the items in the list above under its "General Principles" section. I think it still provides poor guidance on what the average staff person should do, although this may be covered by an associated procedures/process document.

Challenging behaviour policy (July 2017): This policy has since been discontinued and the contents covered under their new "Support Planning and Goal Planning" policy. The 2017 version provided appears inadequate to me. It provides an outdated view of challenging behaviour (outdated even in 2017) with no real discussion of the causes of challenging behaviour. It is overly brief on potential responses and fails to include some very important features such as non-aversive responses, building rapport, building competence, etc.

The 2020 replacement policy "Support Planning and Goal Planning" does not pick up on any of these deficiencies. In fact it only addresses planning and not challenging behaviour. On that basis I am not sure why it is considered a replacement. I note that there was no other policy offered that covered off this critical element of their role.

Even without reference to challenging behaviour, the "Support Planning and Goal Planning" policy needs to include a section on safety planning for the individuals receiving service. There does not appear to be any section that covers plans that are written to both keep the person safe and mitigate any safety issues they may present to others.

Having said that though, Te Roopu Taurima said in their 19 May 2022 response that the management of challenging behaviours was covered in their "Management of Actual or Potential Aggression" (MAPA) training. It is possible that many of the features missing from the challenging behaviour policy and the new "Support Planning and Goal Planning" could be covered off here. No copy was included to assess this.

Medication management policy (August 2018): This looks like a reasonable and well thought out policy. It is clear, covers most situations and contains sufficient safety measures. The exception to that is the PRN section.

In the policy, PRN is the kaimahi's responsibility to decide and record. I would want to see the process for oversight of this so that it didn't breach the "no chemical restraint" part of the policy. Currently it just says: "It is the responsibility of Kaitaataki and Kaiarahi to monitor usage and refer tangata to the GP if they are being used frequently." How frequently is this checked? It may not be a medication issue but could be poor support that is causing the high usage.

The other potential shortfall evident from the policy is that it appears Te Roopu Taurima does not employ a nurse or other internal clinical manager/consultant. Given the frequency and extent to which medication is likely to be involved, this seems like a risk to good practice.

The 2020 medications policy is an improvement in that it is easier to read and offers the Healthline number for advice. The PRN section is still inadequate in my opinion and I am not convinced using Healthline provides sufficient clinical oversight.

Incident reporting (July 2017):
In their responses, Te Roopu Taurima noted that there is a difference between "incidents" and "critical incidents". The latter are those occurrences that the Ministry of Health — the funder at the time — requires all support providers to report to them on. There is therefore a different set of processes that need to happen for critical incidents and therefore the need for the two policies. Te Roopu Taurima, quite correctly, has both forms.

The 2017 and 2020 policies for critical incidents and other incidents are all adequate to a basic level. The 2020 critical incident reporting process looks like an improvement to me in that it is broken into sections that each layer of the organisation needs to attend to.

The 2020 incident reporting policy adds in a flowchart which is a great quick reference guide.

However, all versions lack a few features. These are:

1. There are only general comments about the need to learn from the incident. There is no specific reference to the incidents altering the person's support plan or safety plan. This is vital to reduce the chances of repeat incidents and improve their wellbeing.
2. The staff are offered EAP support, but this could also mention such things as: time off, doctor's visits and other ways to ensure their wellbeing.
3. There is no mention of formal debriefing post the incident; something that is very useful for critical incidents.
4. Serious and critical incidents should have a person assigned as "Incident Manager" whose role it is to ensure everything occurs as it should. (This is hinted at in the 2017 policy but left out in the 2020 update.)

Te Roopu Taurima's statement that it does not have a policy relating to the security of its facilities (refer response dated 19 May 2022).
Although Te Roopu Taurima did not have a specific policy on the security of its facilities, it did offer its Asset Management policy that includes this area in its brief. However, the Asset policy did not offer any guidance as to what "secure" might mean for Te Roopu Taurima, how to achieve it, how to ensure security does not breach human rights, etc.

In Te Roopu Taurima's third response to the HDC written on 19 May 2022, they comment about the secure facility where [Miss A] resided: *"[The facility], had a locked gate approximately six feet tall with a fully fenced perimeter and locks on all external doors and windows. We understand that it was often less of a risk to [staff's] own safety to allow [Miss A] to abscond …"*

I do struggle to understand this situation in terms of providing a "secure facility". One of the purposes of a secure facility is to allow staff to support the person without the

concern of the person absconding, hence the locked doors etc. This reduces pressure on the support relationship and assists it to become more positive and therapeutic, so the above explanation does not make sense to me. "Secure" does not need to equate to "Prison" as suggested in the 19 May 2022 response. It can be seen as an enabler to reduce pressure at the times one needs to.

The lack of a policy relating to the security of its facilities is a significant oversight by Te Roopu Taurima given that the core service they are operating requires that they provide secure accommodation for people. They really do need to have a view on what secure looks like and how they will achieve it. Their 2020 updated policy does not address these failings.

The findings of Te Roopu Taurima's independent investigation of [Miss A's] care.
Te Roopu Taurima had attempted to resolve a similar complaint about the same incidents at the time they occurred; in [Month2] 2019. There was a hui and Te Roopu Taurima had the impression that things were resolved to the extent that they would go no further.

However, once the complaint was lodged in a more formal manner on 1 July 2020, Te Roopu Taurima senior management does appear to have taken this complaint very seriously. In their response letter of 21 August 2020 they state that they received this complaint on the same day as the HDC did. They acknowledged the complaint the following day (2 July 2020) and appointed an external investigator to look into the complaint on 6 July 2020.

The independent investigation of this nature would be considered best practice within the sector. It is not a common practice unfortunately so it would likely be lauded by their peers.

Its findings seemed reasonable to me given the delay in the complaint that prompted it and the staff turnover that had occurred. It does appear to me that they have accepted the findings, attempted to make changes to avoid similar occurrences and provided an apology to [Miss A] and her mother.

The adequacy of Te Roopu Taurima's documentation of [Miss A's] stay, including the reported incidents.
As mentioned above, I think the support plan was inadequate for the staff to take clear guidance from. The incident reports are written in the manner that many incident reports are written, which is basic and less than most managers would want. The follow up process is what appears to have been lacking with these reports. Again, Te Roopu Taurima reported that they have taken this onboard and improved their internal process. I cannot comment having not seen the improved version. Overall though, the documentation would be considered only a mild departure from the usual standard although it would be also considered a moderate departure from the aspirational standard.

Final Comments

My overall impression of this situation is that Te Roopu Taurima was presented with an individual who they found difficult to support. It has exposed a number of deficiencies in some of their processes but Te Roopu Taurima management have been prepared to engage openly and honestly to find a solution, prevent a repeat event and have apologized appropriately to [Miss A] and her mother.

Yours sincerely,

John Taylor ONZM'