Decision 21HDC02726
10 August 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Tetraplegic man left without support worker care for over 12 hours

1. On 2 November 2021, the Health and Disability Commissioner (HDC) received a complaint from Mr A about the failure by HealthCare New Zealand Limited (HealthCare NZ) to arrange support worker care for him for an overnight shift on 26 October 2021. Mr A was 51 years old at the time of the event.

Information gathered

2. Mr A has been a tetraplegic since an accident in his early twenties. He lives in a fully modified home. His family live out of town, and he is totally reliant on support from HealthCare NZ. Mr A cannot be left alone and needs 24-hour care. Accident Compensation Corporation (ACC) contracted HealthCare NZ to provide 24-hour care for Mr A. At the time of the event, HealthCare NZ had been providing support to Mr A for over 14 years.

3. On Tuesday 26 October 2021, Mr A was left overnight in his sofa chair with no support[1] from 7pm until 7am[2] the following day. He was unable to turn or move to receive pressure relief[3] to prevent pressure injuries, and he experienced painful spasms throughout the night, which caused him to overheat. The spasms persisted for the remainder of the week. In addition, Mr A's catheter bag was not emptied for over 13 hours.

4. The HealthCare NZ service plan identified the following support risks for Mr A:

- Poikilothermia:[4] Mr A is at risk of being cold or overheated and needs support with appropriate clothing and regulating environmental temperature (ie, heaters, fans, air conditioning, etc).
- Autonomic dysreflexia:[5] Mr A needs assistance to manage the causes of autonomic dysreflexia proactively, and he requires support to access emergency medical assistance should it be triggered.
- Pressure areas/skin integrity issues: Mr A has a history of pressure areas to the sacrum and a mild risk for pressure injuries. He needs support with regular turns while in bed and assistance to relieve pressure while seated.

[1] Mr A had no food, water, or medication.
[2] The apology letter to Mr A from HealthCare NZ states that Mr A was left unattended for 13 hours from 7pm on 26 October 2021, which would make the finishing time of the shift 8am on 27 October. However, a staff member made a call from Mr A's house at 7.10am.
[3] Pressure relief involves changing position regularly to minimise pressure on specific areas of the body, particularly for individuals who are bedridden or use a wheelchair. This helps to prevent pressure injuries.
[4] The inability to regulate core body temperature. Clinically, poikilothermia can be manifested by hypothermia (core temperature less than 35°C) or hyperthermia (core temperature more than 37.8°C).
[5] A dangerous syndrome that can occur in people who have had a spinal cord injury. It involves an overreaction of the autonomic nervous system, leading to a sudden and severe rise in blood pressure and other symptoms.

5. HealthCare NZ told HDC that Mr A was supported by a team of eight support workers.[6] One of his main support workers gave three months' notice to take four weeks' leave in October 2021 (HealthCare NZ policy requires staff to give two weeks' notice). Her shifts were to be covered by another staff member. However, on Friday 1 October 2021 that staff member also gave more than three weeks' notice to take leave, which included the day Mr A was left without support.

6. As of Friday 1 October 2021, HealthCare NZ was aware that cover had not been arranged for Mr A's 5pm shift on Tuesday 26 October 2021.[7] When Mr A became aware that the shift was not covered, he called the HealthCare NZ Service Centre to enquire about the arrangements in place to cover the shift.[8] In his complaint, Mr A stated:

> 'The shift wasn't filled [,] the agency had known about for weeks that it needed covering. I had rung earlier that week to make sure it was filled and that someone was coming. They told me a carer named […][9] would be working and not to worry.'

7. In its response to HDC, HealthCare NZ stated that it was aware on 1 October 2021 that the shift on Tuesday 26 October needed to be covered and that on 19 October it had arranged for the shift to be covered by Ms B. However, on Monday 25 October Ms B advised that she was no longer available to cover the shift the following day. HealthCare NZ told HDC that attempts to cover the shift resumed on Tuesday 26 October 2021.[10] HealthCare NZ noted that there were limited staffing resources at the time, due to COVID-19 restrictions and mandates.[11] The attempts made on 26 October to cover the shift included a request to other staff in the team to cover the shift, as well as trying to source staff from partner providers.

8. In response to the provisional opinion, HealthCare NZ told HDC that when it called Mr A on Tuesday 26 October 2021, the Service Facilitator offered Mr A a support worker, Ms C, who had recently joined the team, to provide cover for the shift. HealthCare NZ told HDC that Mr A had made it clear to the Service Facilitator that he considered Ms C inexperienced and did not wish to have her cover the shift.

9. Around 4.50pm on Tuesday 26 October 2021, the HealthCare NZ Regional Service Facilitator called to ask the support worker (who was finishing her shift at 5pm) to stay until 7pm so that the Service Facilitator had time to find cover for the shift that was meant to start at 5pm (cover would be needed from 7pm until the next morning). This call took place in the presence of Mr A. The Service Centre then followed HealthCare NZ practice and passed the task (to find cover for the shift) to the After-Hours Team Leader. Mr A told HDC that during

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[6] HealthCare NZ initially provided a list of seven regular staff members who assisted Mr A, but HealthCare NZ stated in its response to HDC that Mr A had eight regular staff members assisting him.

[7] The HealthCare NZ Service Continuity policy at the time placed Mr A in the 'Priority 1: URGENT/HIGH Highly Dependent — Needs urgent intervention' category, which means that the shift on 26 October 2021 had to be covered.

[8] HealthCare NZ said that this call was made on 19 October 2021, which would make it the week before and not earlier in the week as stated by Mr A.

[9] The name of this staff member does not appear anywhere else in the information provided to HDC.

[10] The HealthCare NZ apology letter to Mr A dated 6 December 2021 states that the Service Facilitator 'started attempting to source cover on 25 October yet having no positive response from your regular support staff, the process was continued the following day'. This was repeated in a letter to HDC dated 18 January 2022.

[11] COVID-19 mandates led to many support workers across the disability sector having to leave the workforce as they were not vaccinated and were not eligible for exemptions.

the phone call, he was advised that HealthCare NZ was waiting to hear back from other staff about their availability to cover the shift.

10. HealthCare NZ told HDC that at approximately 5.15pm on Tuesday 26 October 2021, the Regional Service Centre Team Leader conducted a verbal handover with the After-Hours Team Leader. This was followed by a written handover using the HealthCare NZ template at 7.15pm, and another call at 7.20pm. In response to the provisional opinion, HealthCare NZ told HDC that although the Regional Service Centre's working hours finished at 5pm, both the Service Facilitator and the Regional Team Leader continued working overtime to try to source cover for Mr A.

11. At 6.30pm, the Service Facilitator discussed the contingency plan[12] with Mr A should they be unable to source a suitable support worker. This phone call took place in the presence of the support worker who had stayed on after her shift ended at 5pm. HealthCare NZ later told HDC that the phone call occurred at 7pm.

12. HealthCare NZ told HDC that the SDM[13] contacted the Service Centre on the evening of 26 October 2021 and was advised that Mr A had declined the support from the relief support worker and that an ambulance would be called to take Mr A to a rest home/hospital, as per the contingency plan.

13. In response to the provisional opinion, Mr A told HDC that he does not believe he refused the support from Ms C. He says that while there was a discussion about calling an ambulance, HealthCare NZ did not have a rest home or hospital arranged for him to go to.

14. The After-Hours Team Leader said that she received a call at 7.20pm on Tuesday 26 October 2021 from the Regional Team Leader to say that she and the Service Facilitator had worked all day to try to find cover for the shift and had managed to find only Ms C, but there was a possibility that Mr A would refuse support provided by Ms C. The Regional Team Leader is reported to have said that should this occur: '[W]e[14] will call the ambulance instead.' The After-Hours Team Leader believed this conversation meant that the Regional Team was still working to cover this shift, and she was unaware that she was being tasked with calling Ms C[15] and Mr A to confirm whether cover had been arranged or whether the contingency plan was to be put in place. The After-Hours Team Leader confirmed that the handover template contained the same information as the phone call, but she acknowledged that she had misunderstood the information provided to her and that she should have double-checked and monitored the database. She apologised for having misinterpreted the handover conversation.

15. In response to the provisional opinion, HealthCare NZ said that while this conversation reflected 'extra efforts being made in difficult circumstances to source alternative cover, it

[12] The contingency plan if a shift could not be covered by a support worker was for an ambulance to be called to transport Mr A to a rest home/hospital where care had been prearranged.
[13] This is the acronym used in the HealthCare NZ 'Event Notes date 27 October 2021, time: 11:57:34 AM'. In its response to HDC dated 7 August 2025, HealthCare NZ said that it did not have a Service Delivery Manager from 4 October 2021.
[14] 'We' meaning the Regional Team.
[15] In the 'initial call', the Service Facilitator had confirmed with Mr A that he did not wish to be supported by Ms C. The After-Hours Team Leader misunderstood this point as well.

was outside of HealthCare NZ's standard processes and unfortunately may have contributed to the two teams being unclear as to who would implement the contingency plan'.

16. The After-Hours Team Leader stated that although the database showed that Mr A would be without support worker cover at 5pm, she carried on with her other work due to her understanding that the Regional Team was still trying to find cover for the shift and because she was on her own without a 'senior' who would help her and also monitor the database for any updates.

17. In response to the provisional opinion, HealthCare NZ said that even if the 'explicit written hand-over' was misinterpreted, it was unusual for the After-Hours Team Leader to assume that the daytime Service Centre would take responsibility for Mr A overnight, and 'to neither follow this up at any point nor monitor the database for updates'. HealthCare NZ said that while improvements have been made to its systems and training, 'there was also a key element of human error which deviated from [its] protocols'.

18. The support worker who stayed on after her shift finished at 5pm told HDC that she received a phone call from 'Auckland'[16] at 6.30pm letting her know that she could leave at 7pm. She was advised that they were finding another person to support Mr A, and they were fully aware that he would be alone from 7pm onwards.

19. On the morning of Wednesday 27 October 2021, a support worker arrived to find that Mr A had been left without support overnight. The support worker reported this to HealthCare NZ's Service Centre at 7.10am. At 11.57am the support worker made a second call to the Service Centre on behalf of Mr A reiterating that he had been left without support overnight and intended to make a formal complaint to ACC.

20. The HDC investigation has identified several inconsistencies between the responses from HealthCare NZ, its investigation report, the statement of the support worker who stayed until 7pm, Mr A's complaint, and the statement by the After-Hours Team Leader. The main inconsistency relates to the handover with the After-Hours Team Leader and whether it was made clear that it was her responsibility to call Ms C and Mr A to finalise the cover or put in place the contingency plan.

21. In any event, the communication breakdown meant that Mr A was left waiting for the next support worker to arrive after 7pm or for an ambulance to arrive. He was unable to raise the alarm that he was on his own without any support.

22. A home visit report by the HealthCare NZ registered nurse who visited Mr A on Thursday 28 October 2021 notes that neither of the two local registered nurses, nor the on-call registered nurse, were advised that the shift was not, or potentially would not be, covered. The report states that they could have provided essential cares for Mr A if they had been notified.

23. Mr A told HDC that the incident on 26 October 2021 was not an isolated one, and this had happened three times in the preceding week. In his meeting with the HealthCare NZ registered nurse on 28 October 2021, Mr A said that he was aware that HealthCare NZ considered it hard to get support staff to support him, and he had witnessed Service Centre staff pleading with support staff to stay or extend shifts in the past. HealthCare NZ told HDC

[16] This refers to the Regional Service Centre.

that it believes that Mr A is referring to instances where support workers have been unavailable or there has been a scheduling error, and it has had to source relief cover. HealthCare NZ told HDC that its records show that the previous periods on which Mr A was left without support were for much less than eight hours.

Responses to provisional opinion

24. *HealthCare NZ*
HealthCare NZ was given the opportunity to respond to my provisional report. Where relevant, HealthCare NZ's comments have been incorporated into my final report.

25. *Mr A*
Mr A was given the opportunity to respond to the 'Information gathered' section of my provisional report. Where relevant, Mr A's comments have been incorporated into my final report.

Opinion

26. HealthCare NZ had a responsibility to ensure that its staff cooperated to ensure that Mr A received continuity of care and a quality service in accordance with Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code).

27. Mr A is physically incapacitated and as such is a vulnerable consumer who cannot be left alone and relies on 24-hour care from HealthCare NZ. There was a clear failure by HealthCare NZ to ensure that he received the continuous care that he required on 26 October 2021 as set out in his service plan. While I acknowledge that the COVID-19 pandemic posed challenges for all healthcare providers and disability support providers in particular, HealthCare NZ still had a responsibility to ensure the safety and wellbeing of its clients.

28. Given the number of staff and different teams involved in the management of Mr A's roster and the provision of his cares, I am holding HealthCare NZ responsible for the systemic failures that led to Mr A being left unattended for an extended period of time and at risk of harm. The shortcomings in the care provided to Mr A included ineffective communication of critical information between staff and a lack of accountability by the staff responsible for planning Mr A's roster.

29. I am concerned that HealthCare NZ did not have a full and appropriately trained support team to provide 24-hour care to Mr A, and the responsible Team Leader failed to escalate the issue to the senior registered nurse, the two locally based registered nurses, or the on-call nurse.

30. I have also considered the fact that there was ineffective communication between Service Centre staff, principally the team leaders and managers. Options such as deploying the relief support worker or implementing the contingency plan were available and known to senior staff in the Service Centre but not actioned.

31. I am also of the view that none of the senior staff in the Service Centre took responsibility at the time for ensuring that Mr A was not left alone. There was an absence of clear leadership and direction, which resulted in confusion as to who was responsible for finalising care for Mr A.

32. There were several missed opportunities for HealthCare NZ to ensure that Mr A had continuous support on 26 October 2021. Accordingly, for the reasons outlined above, I find that HealthCare NZ breached Right 4(5) of the Code.

Changes made since events

33. HealthCare NZ advised that following the incident involving Mr A on 26 October 2021, the following actions have been completed or are underway:

- A formal written apology was provided to Mr A dated 6 December 2021.
- An enhancement to the client management system is being developed, which will notably reduce the possibility of shifts being without cover and allow more time for rostering and sourcing staff.
- The handover template sent to the After-Hours Team has been updated to highlight work that needs to be completed to ensure that all shifts are covered.
- There has been an increase in the After-Hours Team resource that will be focused on working on 'Priority 1: URGENT/HIGH Highly Dependent — Needs urgent intervention' category clients.
- Mr A has been provided with access to the HealthCare NZ 'My Homecare' platform, which allows him to view information related to his service provision and to request a change.
- Mr A's care was transitioned from the Regional Team to the Kaitiaki (Specialist/Complex) Team in late 2021. This transition was designed to improve oversight, consistency and management of Mr A's complex care package. HealthCare NZ advised on 20 March 2026 that Mr A's care had remained under the same Kaitiaki SF and Team Manager for over a year.
- There has been liaison with partner providers to increase the pool of appropriately trained support staff available.
- More relief support workers have been introduced to Mr A so that he builds rapport with more people.
- There have been targeted recruitment drives to increase the number of permanent staff on Mr A's support team.

34. These changes indicate that HealthCare NZ has taken responsibility for the failure in the provision of services to Mr A. The improvements identified by HealthCare NZ are appropriate.

35. On 7 December 2021, Mr A told HDC that the apology letter from HealthCare NZ gave him no confidence that things would change. He was worried that the letter was, yet again, just words that would not lead to any substantial or tangible actions, like the other occasions on which he had been assured that there would be an improvement in the quality of the service delivered to him, but this had not occurred.

36. HDC contacted Mr A on 4 April 2025 to find out whether the service provided by HealthCare NZ had improved since he made his complaint. He advised that there had been improvements in the quality of service. He confirmed that he has not been left unsupported

overnight, although occasionally he has experienced missed care for a couple of hours.[17] Mr A informed HDC that he is somewhat familiar with the My Homecare platform but feels that little has changed when it comes to service delivery. He mentioned that there have been four new Service Centre team leaders recently, and the quality of service varies depending on the team leader's skill. While acknowledging an increase in his staffing team, Mr A pointed out that some staff members are not trained in using hoists. This lack of training means that when these staff members are on shift, his personal care needs are not met, which he finds unsatisfactory. He also mentioned that his requests to replace these staff members with those who are trained to use hoists have not been addressed.

37. In response to the provisional opinion, Mr A told HDC:

> 'There are still constant ongoing issues with finding suitable cover when regular support workers are away. There still seems to be an issue with HCNZ's internal system in communicating with new support workers and organising training and sign offs and shifts for them. They have reported to me that they are subsequently becoming frustrated and seeking work elsewhere.'

Recommendations

38. Given Mr A's ongoing concerns, HealthCare NZ is to report back to HDC with evidence that the changes made in response to this complaint have occurred, including any additional changes that have been implemented since 2023. This information is to be provided within six months of the date of this report.

39. Further to the changes already introduced, I recommend that HealthCare NZ also report back on the progress made to implement the following recommendations, within six months of the date of this report:

a) Provide an update on the measures implemented to strengthen communication, accountability, and escalation processes within HealthCare NZ to prevent systemic breakdowns in care delivery and ensure that duty of care obligations to clients like Mr A are met consistently;

b) Provide an update on the progress and outcomes of the client management system enhancement, with a focus on its effectiveness in reducing missed cares and improving rostering and staffing efficiency;

c) Provide an update on the steps being taken to ensure that all staff assigned to Mr A are trained adequately in essential care tasks, particularly hoist use, to ensure that his personal care needs are met consistently;

d) Provide the policy and process developed by HealthCare NZ that ensures that all staff supporting any client in the same category as Mr A sight the next support worker commencing their shift as well as the escalation pathway that will be implemented in the event that the next support worker does not attend. This will provide a safeguard to eliminate any communication issues at the service coordination level;

[17] In response to this statement from Mr A, HealthCare NZ completed a roster review from 1 January 2025 to 31 May 2025. They identified two instances when Mr A was left without care. These occurred on 7 February 2025 and 22 April 2025, and Mr A was without care for 27 and 24 minutes, respectively.

e) Provide the escalation process that is used at a service coordination level to ensure that the clinical team, the local nurses, and the on-call nurse are notified about any potential instances where a highly vulnerable client could be left unsupported for any period of time. This will provide an additional safeguard utilising the existing registered health professional resource that is available;

f) Provide HDC with Mr A's updated contingency plan showing arrangements that will be made by HealthCare NZ in the event an ambulance is called; and

g) Use an anonymised version of this report to provide education to staff on the importance of not leaving vulnerable clients unattended, even for a short period of time.

40. An anonymised copy of this decision (naming only HealthCare NZ) will be sent to ACC and the Disability Support Services team within the Ministry of Social Development and placed on the HDC website (www.hdc.org.nz) for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner