Decision 25HDC00221
23 March 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Vulnerable teenager in care absconded multiple times due to lack of supervision

Executive summary

1. In December 2024, Mindfull Support Ltd (Mindfull Support) received a referral from Oranga Tamariki (OT) and, in January 2025, began providing support to Mr C, who was 16 years old at the time. During the two weeks of this support, Mr C absconded four times, scheduled appointments were missed, and Mr C sustained minor injuries to his feet. After these incidents, Mr C's mother, Mrs B, submitted a complaint to the Health and Disability Commissioner (HDC) related to the standard of care Mindfull Support provided to Mr C, which she alleged was inadequate and put her son at serious risk.

2. I have found that Mindfull Support breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[1] for failing to provide services to Mr C with reasonable care and skill.

Recommendations

3. I support and endorse the changes Mindfull Support has already implemented as a result of these events, which are discussed further in this report.

4. Given the changes that have already been made and the additional appropriate apology provided to Mrs B, my recommendations are that Mindfull Support:

   a. Amend its Intake Policy to include guidance related to support of consumers with high and complex needs, intellectual disability (ID), autism traits and absconding risks. The policy should include that immediate whānau should be involved as early as possible in the intake process. A copy of the amended policy should be provided to HDC within three months of this final report.

   b. Develop and implement a training schedule for existing support staff. This should include subjects such as support of consumers with high and complex needs, ID, autism traits, and absconding risks. The schedule and evidence that existing staff have attended the training should be provided to HDC within six months of this final report.

Background

5. Mr C has a diagnosis of duplication 8q11.2 chromosome/15q micro deletion, foetal alcohol syndrome, attention-deficit/hyperactivity disorder, autism spectrum disorder, ID, and oppositional defiant disorder.

6. In 2024, OT received numerous reports of concern regarding Mr C's behaviour, including that he was threatening and being violent towards his parents and his siblings, offending,

[1] Right 4(1) states that '[e]very consumer has the right to have services provided with reasonable care and skill.'

and absconding. His parents struggled with his behaviour, and this resulted in multiple short-term OT care orders. On 12 December 2024, a family group conference was held, during which it was agreed that Mr C would be placed in a specialist one-to-one placement.

7. On 24 December 2024, OT referred Mr C to Mindfull Support for short-term care support while awaiting the one-to-one placement. Mindfull Support was contracted to provide one-to-one placement support, oversight, and supervision of Mr C, which included providing a staff member to supervise Mr C at all times. On 7 January 2025, Mr C moved into an OT care home and Mindfull Support commenced their support. During the two weeks Mr C was supported by Mindfull Support, he absconded four times, and Mindfull Support failed to attend two scheduled appointments.

The complaint

8. On 22 January 2025, this Office received a complaint from Mrs B, who raised concerns that during the period Mr C was supported by Mindfull Support the staff were incompetent and negligent and that their lack of placement support (for Mr C's very high and complex needs) was inadequate and put her son at serious risk.

Mindfull Support's response

9. Mindfull Support responded that it had reviewed Mrs B's complaint and acknowledged that 'there were shortcomings in the care it provided to [Mr C] in January 2025.' In particular, it acknowledged that:

    a. 'Mr C absconded from the whare several times during his stay, causing himself minor injuries to his feet.

    b. Mindfull Support staff failed to take Mr C to a scheduled paediatrician appointment on 14 January 2025.

    c. A Mindfull Support staff member agreed to attend a scheduled meeting with Mrs B and a representative from [OT] to discuss Mr C's care but failed to advise those parties when the staff member became unable to attend the meeting and failed to arrange for someone else [to] attend the meeting.'

10. Mindfull Support took responsibility for these shortcomings and told HDC that it had learned a great deal from its experience in providing care to Mr C and has therefore taken a range of steps to avoid similar issues arising in the future. In addition, Mindfull Support outlined some contributing factors to the issues that arose during Mr C's stay with Mindfull Support.

Changes made since events

11. Mindfull Support provided an extensive list of identified gaps in its system and processes, which have been addressed. This includes processes related to tamariki who attend holiday programmes and steps it has taken to ensure attendance at external appointments and meetings. In addition, training provisions have been put in place so that kaimahi who support vulnerable tamariki with high and complex needs understand the significance of

maintaining continuous supervision. It will also seek input from the whānau of the tamariki as early as possible in the intake process.

Resolution proposal

12. On 5 December 2025, I notified Mindfull Support of HDC's investigation of this matter. I proposed that HDC find Mindfull Support in breach of Right 4(1) of the Code, based on a review of the complaint and Mindfull Support's response. Mr John Taylor provided expert advice about the standard of care Mindfull Support provided to Mr C (attached as **Appendix A** in this report). Mr Taylor's advice supported my reasoning for proposing this finding.

13. On 23 January 2026, Mindfull Support agreed to the proposed finding of a breach of the Code. Mindfull Support reiterated its deep regret that it failed to support Mr C in the way he needed and recognised that its staff were not adequately trained to care for someone with Mr C's needs.

Responses to provisional decision

14. In the response to the provisional decision, Mindfull Support commented that it 'will not ordinarily accept placements requiring specialist high-complexity disability support' and that exceptions would only be considered if appropriate safeguards are in place. This approach has been incorporated into its intake process.

15. In addition, Mindfull Support stated that it does 'not wish to dispute any of the facts gathered during the investigation nor your conclusions set out in the provisional decision.'

16. Mrs B did not provide any comments.

Decision

17. Mindfull Support has a duty of care to ensure that its vulnerable consumers are receiving an adequate standard of care and support in line with their individual needs while adhering to the Code.

18. Right 4(1) of the Code states that 'every consumer has the right to have services provided with reasonable care and skill.' Unfortunately, in Mr C's case, this did not occur for the following reasons.

Policies, procedures, and staff training

19. Mr Taylor advised that Mindfull Support's policies:

> 'provided very little useful guidance for working with someone like Mr C. They were very general policies that appeared to match with supporting people with mental health needs. They did not focus on the support I would want to see for people with [ID], autism, and related impairments.'

20. Mr Taylor stated that:

> 'In relation to accepting a referral for Mr C having followed a robust process and ensuring the support would be safe and effective, I think there was a **moderate to severe departure** from the expected standard of care.
>
> In relation to the apparent staff training, there were performance gaps that indicate a **moderate departure** from the accepted standard.'

21. I accept Mr Taylor's advice and am critical that Mindfull Support's policies contained very little guidance for supporting consumers with high and complex needs, ID, autism traits, and absconding risks. It is my view that Mindfull Support failed to follow a robust intake process when they accepted the referral from OT, and I consider that this failure and the lack of experienced and well-trained support staff exacerbated the service delivery failures.

Standard of care

22. Mr Taylor advised that, in relation to Mindfull Support staff failing to attend agreed appointments, 'It is my opinion that this is below the expected standard of how an organisation should operate but did not put anyone in any immediate risk.'

23. I accept Mr Taylor's advice and am concerned that Mindfull Support's staff failed to attend agreed appointments, although I note that this did not put Mr C in any immediate risk of harm.

24. Mr Taylor advised that, in relation to Mr C's absconding events, 'these are much more serious as they did put Mr C in some immediate danger of harm and they happened four times within a two-week period without any obvious change in how support was offered to prevent recurrence.'

25. Mr Taylor noted two relevant standards related to Mindfull Support's care of Mr C:

> 1. 'The expected standard of care in a situation where one is looking after a vulnerable child is that the child is not left to escape their environment on their own and wander around with no support or protection.
>
> 2. The accepted practice is for organisations to ensure they have the necessary experience to support the person they accept as a referral regardless of any sense of urgency.'

26. Mr Taylor advised that:

> 1. 'In relation to the first standard, because of the potential risk the poor support exposed Mr C to, and because it happened on four occasions within a two-week period, I consider this to be a **severe departure** from the expected standard of care.
> 2. In relation to the second standard, I consider this to be a **moderate departure**, and it probably relates to naivety and misplaced goodwill.'

27. I accept Mr Taylor's advice and am critical that Mr C was able to abscond multiple times, because of poor oversight while in Mindfull Support's care, without Mindfull Support altering their approach to supporting him.

28. In addition, I am critical that Mindfull Support agreed to care for Mr C even though they did not have the expertise and trained staff to support someone with his high and complex needs. I consider that it was Mindfull Support's responsibility to ensure that, when it accepts a referral, it has sufficient knowledge and experienced staff to safely support its vulnerable consumers, which did not occur in this case.

Conclusion

29. It was appropriate for Mindfull Support to have considered how it could mitigate the risk of this type of adverse event re-occurring. I commend it for taking steps to ensure that systems are now in place to prevent another similar event, as evidenced by the changes made as a result of this complaint.

30. For these reasons, I consider that Mr C was not provided services with reasonable care and skill, and accordingly I find Mindfull Support in breach of Right 4(1) of the Code. I note that Mindfull Support has acknowledged and accepts the shortcomings in the care they provided to Mr C.

Follow-up actions

31. A copy of the final report will be sent to the Ministry of Social Development (Disability Support Services (DSS)) and OT.

32. A copy of the final report with details identifying the parties removed, except Mindfull Support and my expert advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Ms Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from Mr Taylor.

Independent expert advice to Health and Disability Commissioner

Complaint:	**[Mr C]**
Our ref:	**C25HDC00221**
Independent advisor:	**Mr John Taylor ONZM**

I have been asked to provide clinical advice to HDC on case number C25HDC00221. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved.	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: 38 years of working within the disability sector, including the following roles: direct support worker, agency management (over 20 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the [Ministry of Health] New Model, National Leadership Team for Enabling Good Lives, and a range of contracted roles, and I have helped set up a number of support agencies and disability-related businesses.
Documents provided by HDC.	1. Letter of complaint dated 23 January 2025 2. Mindfull Support's response dated 23 April 2025 3. Mindfull Support's appendices: a. Referral for Residential Services and High Needs Placements, OT, dated 13 December 2024. b. Supported Care Referral Form, Mindfull Support, undated – also available at the following link: https://mindfull.jotform.com/213621328256856 c. Child or young person's details, OT, undated. d. [Mr C] Support Plan, dated 8 January 2025. e. [Mr C] Medical Profile, dated 7 January 2025. f. Going Out or Absconding, Mindfull Support, undated.

Names have been removed (except Mindfull Support and the expert advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	g. Records held by Mindfull Support in relation to incidents, dated 9 January, 17 January, 19 January, 20 January, and 21 January 2025. h. Written complaint from Mrs [B] to Mindfull Support and enclosed photographs, dated 23 January 2025. i. Email from [Mr D] to Mrs [B], dated 23 January 2025. j. Letter from [Mr D] to OT, dated 29 January 2025. k. Email and enclosed letter from [Mr D] to Mrs [B], dated 31 January 2025. l. Child and Vulnerable Individuals Protection Policy, Mindfull Support, dated September 2024. m. Clinical Risk Management Policy, Mindfull Support, dated June 2023. n. Complaints Policy, Mindfull Support, dated July 2024. o. Handover Policy, Mindfull Support, dated June 2023. p. Health and Safety Manual, Mindfull Support, dated September 2024. q. Referral Policy, Mindfull Support, dated July 2024. r. Service Delivery Policy, Mindfull Support, dated July 2024. s. Support Planning Policy, Mindfull Support, dated July 2024. t. Whānau Resource Guide, Mindfull Support, dated February 2025. u. Flyer for Summer Holiday Programme, dated December 2024. 4. OT response 10 June 2025 5. OT appendices: a. Incident-related reports b. Email communication c. Referral-related documentation
Referral instructions from HDC.	

Factual summary of clinical care provided complaint

Brief summary of clinical events.	OT referred [Mr C] to Mindfull Support in late December 2024 due to difficulties his family was having with him at home. The intent was to commence one-on-one support in an OT home in the early new year (the actual commencement was 7 January 2025) until a more permanent arrangement could be developed. [Mr C] absconded from care on 8 January 2025 when he was dropped off at an Out of School programme without any handover. On 14 January, Mindfull Support failed to take [Mr C] to a scheduled and agreed paediatrician appointment. On 16 January, Mindfull Support's Clinical Manager did not attend a meeting held to discuss these previous issues due to a family

	emergency and failed to notify OT and [Mr C]'s mother that they could not attend the meeting. On each of the 17th, 19th and 20th of January, [Mr C] absconded again from care. On the final occasion, his mother found him and took him home and did not return him to Mindfull Support. [Mr C] remained in the care of Mindful Support for 14 days (7 to 20 January 2025 inclusive).

1. Question 1: Whether Mindfull Support provided [Mr C] with a reasonable standard of care.	
List any sources of information reviewed other than the documents provided by HDC.	https://www.mindfullsupport.co.nz/
Advisor's opinion	The complaint to HDC contained the two events from the above factual summary where Mindfull Support staff failed to attend a meeting and two of the absconding events. In my opinion, these pairs of events are quite different in their nature, so I will comment on them separately. 1. The two events where Mindful staff failed to attend agreed appointments. It is my opinion that this is below the expected standard of how an organisation should operate but did not put anyone in any immediate risk. These instances fall into the "poorly organised and somewhat annoying" category of failures. They speak of poor processes and, potentially, lack of engagement in their work. I view them as mild departures from the expected standard of care, particularly as they happened for different reasons, and I think Mindfull Support has since put in better systems to ensure they are not repeated. 2. The absconding events. In my opinion, these are much more serious as they did put [Mr C] in some immediate danger of harm, and they happened four times within a two-week period without any obvious change in how support was offered to prevent recurrence. To their credit, Mindfull Support have acknowledged their poor support in their letter to HDC, in a letter they wrote to [Mr C]'s

mother and in their communication with OT. In these documents, Mindfull Support refer to this lack of appropriate support as "shortcomings in the care it provided to [Mr C]."

However, I do not think they have acknowledged, nor in all likelihood fully understood, the extent of this failure in relation to the absconding. On at least four occasions, [Mr C], described as a vulnerable boy, was left to wander the streets of [his local town] alone. This put him at serious risk given his lack of road sense, impulsivity, and the potential for bad actors to take advantage of him.

What has concerned me as I have read through the documentation provided is that Mindfull Support have not appeared to understand the risk to [Mr C] of these situations nor done anything to prevent its recurrence.

They claimed that the absconding was not made obvious to them from OT except as a "past behaviour." I quote from Mindfull Support's response:

> "[Mr C]'s referral documentation highlighted violence towards family members as the primary concern. While absconding was mentioned as a past behaviour, no specific absconding plan was included and it wasn't the focus of any discussions."

I think it is likely that the discussions Mindfull Support was involved in did focus on the immediate concerns involving violence that faced the family. However, in the documents I read, and this includes Mindfull Support's own intake documentation, absconding was listed as a current issue in every document except one. In their own document, absconding was listed as an alert. It should have been obvious that this was a current and problematic behaviour from such descriptions provided to them as:

> "Absconding risk – [Mr C] leaves his home through his window and is often found out in the street."
>
> "They [his family] have a fully modified front section, with fencing and specialised entrance to the house to reduce absconding."
>
> "[Mr C] wears a Hi Vis vest most of the time when in the community, as he is known to run off if given the opportunity."

Mindfull Support was engaged to provide a "specialist one-to-one placement" for [Mr C] within an OT facility. In the referral from OT they were told: "There will be other children in and out of the

	home, but we are only asking for Mindful to provide care for [Mr C]." Given that they had one-to-one staffing, I struggle to understand how line-of-sight or other methods could not have been employed to ensure [Mr C]'s safety. Clearly this didn't happen, although it was suggested in one of the incident reviews. He left the 'out of school' programme on the first day he was there and then subsequently left the house where he was supported three times. (I accept that the occasion when [Mr C] left the house before 7am was likely a structural/ rostering issue, but I consider the other three occasions were poor support.) From what I read, I think it is likely that the reason Mindfull Support staff failed to support [Mr C] in the manner that he needed was that they were more used to working with a different profile of person, namely young people with mental health issues as their primary support need. Mindfull Support also stated that some of the issue for them was that [Mr C] had been an emergency placement so they did not complete all of their usual processes before commencing with him. They commented that this meant they did not perform as well as they might have otherwise. I understand that the staff at Mindfull Support likely did this as they were keen to assist OT and [Mr C]'s family. Even so, organisations should not take on people they are not confident they have the capacity and capability to support. By doing so, they can, as happened in this case, put that person and others at risk of harm. This is even more the case when the person concerned presents support requirements that differ from the organisation's usual practice, as I suspect was the case here.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	As with many things within disability support, there are few written standards. Notwithstanding this, there are expectations with contracts and common practice that guide us in what an appropriate response might be. There are two relevant standards here. The expected standard of care in a situation where one is looking after a vulnerable child is that the child is not left to escape their environment on their own and wander around with no support or protection. The accepted practice is for organisations to ensure they have the necessary experience to support the person they accept as a referral, regardless of any sense of urgency.

Was there a departure from the standard of care or accepted practice? ● No departure; ● Mild departure; ● Moderate departure; or ● Severe departure.	In relation to the first standard, because of the potential risk the poor support exposed [Mr C] to, and because it happened on four occasions within a two-week period, I consider this to be a severe departure from the expected standard of care. In relation to the second standard, I consider this to be a moderate departure and it probably relates to naivety and misplaced goodwill.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I checked this with three peers, who agreed with my assessment and commented that it can be very hard to support a person who absconds if there are not robust processes and experienced staff in place. The peers I consulted on this also thought that organisations that generally dealt with Mental Health support were not necessarily well placed to support people with ID and vice versa.
Please outline any factors that may limit your assessment of the events.	It is possible that Mindfull Support have supported a number of people with ID in the past. In which case, I would revise naivety to very poor practice.
Recommendations for improvement that may help to prevent a similar occurrence in future.	1. For Mindfull Support to ensure that they have a robust intake process that they follow regardless of the urgency of the referral. 2. That Mindfull Support consider staff training for working with people with ID. 3. Ensure they work within their capability.

Question 2: Whether Mindfull Support had appropriate policies and procedures (including staff training) in place at the time of the events in order to provide comprehensive and safe care for [Mr C].	
List any sources of information reviewed other than the documents provided by HDC.	https://www.mindfullsupport.co.nz/
Advisor's opinion	I was provided with eight policies from Mindfull Support that they considered relevant to this matter, as well as a "Whānau Resource Guide" and some process documents. It is difficult to answer this question with complete confidence on that small sample as I would assume that they have many more policies that I haven't seen. However, what I can say is that, from the policies I did read, they provided very little useful guidance for working with someone like [Mr C]. They were very general policies that appeared to match with supporting people with Mental Health needs. They did not focus on the support I would want to see for people with ID, autism, and related impairments. Three examples of this are: 1. Mindfull Support's Child and Vulnerable Individuals Protection Policy refers to neglect as something to look out for. It does not refer to how they will avoid it within the organisation. I would expect that they had processes and practices in place to keep young people safe from harm while they are being supported. 2. Mindfull Support's Clinical Risk Management Policy appears to be focused on risk that the client may pose to the staff or to themselves rather than mitigating risk for the client's vulnerabilities, inappropriate interventions, or other causes. 3. Mindfull Support's "Talking About Absconding" (In their "Mindfull Intro and Resource for Whānau" booklet) is not fit for the purpose of supporting someone like [Mr C]. It assumes that one can rationalise the need to not abscond with the individual. Mindfull Support offered no information about their staff training, so I can only make comments based on inference from the staff's actions. From these actions, it does appear that the staff were not well equipped to work with someone like [Mr C]. (I have no view on their expertise with other groups of people.)

	I take this view from the following observations. 1. A staff person dropped [Mr C] off at the 'out of school' programme and assumed that once he was through the gate he would be OK. I would expect all staff who work with young people with ID to assume a handover would be necessary. 2. The same staff person, shortly afterwards, saw [Mr C] walking down a street out of the centre he was supposed to be at. Instead of immediately stopping to pick him up, she chose to continue on her way and phone a colleague. This is not what I would expect from staff trained to work with people [who] present as [Mr C] did. 3. A staff person had a discussion with [Mr C] about the importance of not absconding and considered this a useful outcome. That would be considered extremely naïve by people experienced with working with people with ID and [attention-deficit/hyperactivity disorder] ADHD/[autism spectrum disorder] ASD. 4. Once [Mr C] had absconded two or three times, neither the staff nor the organisation displayed the necessary experience to alter how they supported [Mr C] to prevent future occurrences. In the letter to HDC, Mindfull Support says the kaimahi (staff person) was not their first choice but the urgency impacted this. However, their Child's policy says: "Staff members will not assume responsibilities beyond their level of experience and training. Mindfull Support is committed to providing staff with the necessary training to ensure they are equipped to fulfil their responsibilities." From this, it appears that Mindfull Support did not follow its own policy.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The expected standard of care for agreeing to support a disabled person is to have the necessary experience, appropriately skilled staff, and the appropriate policies and procedures that guide staff to deliver effective and safe support.
Was there a departure from the standard of care or accepted practice? ● No departure; ● Mild departure;	In relation to accepting a referral for [Mr C] having followed a robust process and ensuring the support would be safe and effective, I think there was a moderate to severe departure from the expected standard of care. In relation to the policies, I consider there was a mild to moderate departure from the accepted practice.

• Moderate departure; or • Severe departure	In relation to the apparent staff training, there were performance gaps that indicate a moderate departure from the accepted standard.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The peers I consulted agree that organisations should be well equipped to work with the people they agree to work with, while acknowledging that organisations sometimes over-extend themselves until they learn this is counterproductive and potentially dangerous.
Please outline any factors that may limit your assessment of the events.	I did not see their staff training records, so I am making assumptions based on the staff performance.
Recommendations for improvement that may help to prevent a similar occurrence in future.	That Mindfull Support either remains within the field where they have the competence to provide good support or develop the policies, practices, and staff expertise to work with people such as [Mr C].

Question 3: Whether Mindfull Support received sufficient referral documentation from OT to safely provide care for [Mr C].	
List any sources of information reviewed other than the documents provided by HDC	Nil
Advisor's opinion	From the material I read, I think Mindfull Support did receive sufficient information to safely support [Mr C]. As mentioned in question 1, there were plenty of references to his propensity to abscond to alert them to this issue. They were not provided with a plan of how to deal with this; however, an organisation that is used to working with people such as [Mr C] should have the internal capability to create a safety plan for this behaviour.
What was the standard of care/accepted practice at the time of events? Please refer	The accepted standard of care is for the referring agency to provide full and unbiased information about the person being referred.

to relevant standards/material	
Was there a departure from the standard of care or accepted practice? ● No departure; ● Mild departure; ● Moderate departure; or ● Severe departure	I do not think there was a departure from this standard.

Question 4: Any other comment you may wish to make.	
List any sources of information reviewed other than the documents provided by HDC	The NZ Ombudsman's office 2012 "Effective Complaint Handling" "Suggestions for Disability Providers when Developing their Complaints Process": Disability Support Services 2024
Advisor's opinion	My impression is that Mindfull Support took the complaint seriously and have adapted some of their processes in ways that will reduce the likelihood of recurrence, particularly with scheduling meetings, etc. They have admitted failings and have hopefully learned from this situation. In my view, they had a relatively good complaints policy and followed it well. The missing piece was an apology. They did not apologise to [Mr C]'s mother, even though they agreed that their support had not been as it should have been. This omission is contrary to current best practice. To find current best practice, one can look to the DSS or Whaikaha website and to the Ombudsman's website. The DSS guidance says: "When a complaint is upheld, an apology and/or other form of redress or restorative practice must be built into the system." Similarly, the New Zealand Ombudsman's Office says:

	"If a complaint is upheld, [good practice suggests that] the agency is able to provide an appropriate remedy" and that "Mistakes should be admitted and put right … [including] providing an apology."
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The current standard is to have a robust complaints policy, apologise for mistakes and consider other forms of restorative measures.
Was there a departure from the standard of care or accepted practice? ● No departure; ● Mild departure; ● Moderate departure; or ● Severe departure	Most of their policy was well written and well followed, so I consider this a mild departure from the accepted practice.

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature:
Name: Mr John Taylor ONZM
Date of Advice: 3 December 2025