Timata Hou Ltd

Community Support Worker, Mr D

Community Support Worker, Mr F

Life Skills Co-ordinator, Mr E

Care Manager, Ms C

A Report by the

Health and Disability Commissioner

(Case 11HDC00384)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 30 September 2010, Mr A, a young man with Attention Deficit Hyperactivity Disorder, an intellectual impairment, and behavioural issues, was attending a work skills programme run by Timata Hou Ltd (Timata Hou). On that day, Mr A was working at a woodshed on the "kindling activity". The kindling activity involved converting old wooden pallets into kindling and firewood ready for sale. Tools and machinery, including power saws, were used for that purpose.

2. Mr A had been assessed for the work skills programme by his Care Manager, Ms C. It was Timata Hou policy that, for the kindling activity, there needed to be a minimum of two staff to attend and supervise the activity when clients were involved, and that only staff and clients who had completed training and passed certain safety assessments could participate in the activity and use power tools. Mr A was known to Timata Hou staff for his distractibility and poor attention to instructions.

3. On 30 September 2010, Acting Life Skills Co-ordinator Mr E allowed Mr A to use a circular saw for the kindling activity under the supervision of Community Support Worker (CSW) Mr F. Neither Mr A nor Mr F had been trained and signed off as competent to use the circular saw. CSW Mr D was also at the woodshed that day supervising two other clients removing staples from wooden pallets and stacking firewood. Mr D had not been trained and signed off as competent to use the circular saw either.

4. At 10.15am, Mr A had an accident with the circular saw when his clothing became tangled in the saw blade. It was decided that it was not safe for him to continue using the saw, and he was asked to help Mr D. An incident form for this incident was never completed.

5. A short time later, Mr D was called away to assist another staff member with a difficult client, leaving Mr F to supervise three clients in the woodshed. Mr F stopped the circular saw, but left it plugged in while he stacked wood. Mr F heard Mr A start up the circular saw, but did not intervene. Five minutes later, at approximately 11.30am, Mr F heard Mr A scream. He turned around to see that the circular saw blade had penetrated Mr A's abdomen. Emergency services were notified at 11.52am. Mr A was treated at the scene then taken to hospital for emergency surgery.

Decision

Timata Hou

6. Timata Hou did not have rigorous assessment and review processes in place, and Mr A's suitability for the kindling activity was not adequately assessed or reviewed. Additionally, Timata Hou did not have adequate quality and risk management systems in place, which meant that the risks of the kindling activity were not appropriately identified and responded to. Timata Hou did not ensure that staff were adequately trained and supported, and failed to respond decisively to concerns about staff–client ratios. There was a culture of non-compliance with Timata Hou's policies, particularly policies relating to supervision requirements, training, hazard identification, and

incident reporting. Timata Hou's documentation also fell below expected standards. Timata Hou breached Rights 4(1)[1] and 4(4)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

7. Timata Hou will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994.

Ms C

8. In September 2010, Ms C was Mr A's assigned Care Manager. Ms C did not ensure that Mr A was adequately assessed for his suitability for the kindling activity, and she did not adequately reassess his suitability for that activity when potential risks were identified. Ms C failed to take steps to minimise the potential harm to Mr A and, accordingly, she breached Right 4(4) of the Code.

Mr E

9. Mr E was employed as Acting Life Skills Co-ordinator by Timata Hou. On 30 September 2010, Mr E did not fulfil the obligations in his job description or as set out in Timata Hou's policies for the kindling activity, and he made a number of errors of judgement. Mr E allocated Mr D and Mr F to work on the kindling activity using power saws to cut up pallets with Mr A when neither Mr F nor Mr D nor Mr A had met all the required competencies for that activity. Mr E's decision to allow staff and clients to work in the woodshed (using electrical equipment) when it was raining and the woodshed was exposed to the weather was poorly judged. Mr E's actions placed staff and clients at risk and, accordingly, he failed to take steps to minimise the potential harm to Mr A and breached Right 4(4) of the Code.

Mr F

10. On 30 September 2010, CSW Mr F made a number of errors of judgement and failed to take steps to minimise the risk of harm to Mr A. In particular, Mr F did not take appropriate action to mitigate the risk to Mr A following Mr A's first incident with the circular saw on 30 September, and did not respond appropriately to the risk posed to Mr A when Mr A started up and began using the circular saw for a second time after having been instructed not to use it. For these errors, Mr F breached Right 4(4) the Code.

11. I am critical of Mr F for failing to comply with Timata Hou policies, in that he used, and supervised clients using, power saws in the woodshed when he had not been trained to do so, and he never completed an incident report for Mr A's first incident on 30 September 2010. I am also critical of Mr F for continuing to allow clients to work in the woodshed using electrical equipment when the woodshed was exposed to increasing levels of rain.

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[1] Right 4(1) of the Code of Health and Disability Services Consumers' Rights 1996 states: "Every consumer has the right to have services provided with reasonable care and skill."

[2] Right 4(4) of the Code of Health and Disability Services Consumers' Rights 1996 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."

Mr D

12. On 30 September 2010, CSW Mr D made a number of errors of judgement, in that he continued to allow clients to work in the woodshed using electrical equipment when the woodshed was exposed to increasing levels of rain, and he left Mr F alone in the woodshed to supervise three clients, which impacted on safe client–staff ratios for those clients. Mr D also did not comply with Timata Hou policies, in that he used, and supervised clients using, power saws in the woodshed when he had not been trained to do so, and an incident report was never completed for Mr A's first incident on 30 September 2010. I am critical of Mr D's actions in these regards.

Complaint and investigation

13. The Commissioner received a complaint from Mr B about the services provided by Timata Hou Ltd to Mr A. An investigation was commenced on 13 October 2011. The following issues were identified for investigation:

- *The adequacy of the service provided to Mr A by care manager Ms C between 16 March 2010 and 30 September 2010.*
- *The adequacy of the service provided to Mr A by Life Skills Co-ordinator Mr E between 16 March 2010 and 30 September 2010.*
- *The adequacy of the service provided to Mr A by community support worker Mr D on 30 September 2010.*
- *The adequacy of the service provided to Mr A by community support worker Mr F on 30 September 2010.*
- *The adequacy of the service provided to Mr A by Timata Hou Ltd between 16 March 2010 and 30 September 2010.*

14. The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant/Department of Labour health and safety inspector
Ms C	Provider/Care manager
Mr D	Provider/Community support worker
Mr E	Provider/Life skills co-ordinator
Mr F	Provider/Community support worker
Timata Hou Ltd	Provider

Also mentioned in this report:

Ms G	National manager

Mr H	Care manager
Mr I	Community support worker
Mr J	Independent consultant

15. Independent expert advice was obtained from disability support specialist Margaret Boyes. Ms Boyes' report is **attached** as **Appendix A**.

Information gathered during investigation

Introduction

16. On 30 September 2010, Mr A, a client of Timata Hou, was injured while participating in one of Timata Hou's Life Skills programmes. The Department of Labour investigated the accident, and referred the matter to HDC.

17. This section of the report discusses the policies, roles and responsibilities of Timata Hou and its employees in respect of the Life Skills programme, the assessment of Mr A's suitability for that programme, and the events leading up to the incident that occurred on 30 September 2010. HDC was provided with a copy of the Department of Labour investigation file and, where relevant, information from that file has been incorporated into this report.

Timata Hou

Introduction to services offered

18. Timata Hou Ltd was established in 1997 as a rehabilitation-focused service subsidiary of IHC NZ Incorporated. Timata Hou operates under a funding agreement with the Ministry of Health. It is a designated Regional Intellectual Disability Support Accommodation Service (RIDSAS) for approximately 55 clients (male and female). Clients are referred to Timata Hou through an agency (the referral agency) following an assessment by the referral agency that Timata Hou's activities are suitable for the client being referred.

19. Timata Hou's primary purpose is to provide secure and supervised care and/or rehabilitative support to intellectually impaired clients (principally for individuals subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act)), or to clients who have high and complex behaviour needs. For these purposes, it provides residential accommodation, assessment, and life skills and day activities.[3]

20. When a client is referred to Timata Hou, Timata Hou is provided with details of the client's background, intellectual disability and other relevant factors. That information

[3] Timata Hou staff includes social workers, psychologists, occupational therapists and community support workers.

is assessed by a Care Manager, management team and other staff, who then make decisions about the client's support, activities and supervision needs. Timata Hou uses the information accompanying a client's referral to prepare its own service plan for the client. The referral agency reviews clients every six months, and Timata Hou also reviews clients six-monthly. Timata Hou's National Manager, Ms G, advised the Department of Labour that the reviews are holistic in nature, and cover client risk and rehabilitation, and whether client goals are being met.

The Life Skills programme

21. The Life Skills programme that Timata Hou operates includes reading, writing, arts and crafts, horticulture and general farm work. The programme operates on the basis of the needs of the individual client, and aims to develop clients' social interaction skills and work experience in a range of tasks. The "Footprints" programme is a precursor to the Life Skills programme, and includes literacy, numeracy, and craft programmes, as well as indoor activities.

22. Timata Hou stated that Life Skills staff receive comprehensive training on supervising clients, health and safety, and on Timata Hou's policies and procedures. This includes a Life Skills Programme Action plan, which outlines improvements in processes including the orientation plans for new staff and development plans, and documentation to guide staff on Safe Behaviour Assessments for Clients, Activity Risk Assessment & Management, and Hazard Identification.

23. Timata Hou also said that staff are provided with core training, and regular follow-up training on different topics, including the use of power tools.

Policies and procedures

24. Part of the Life Skills programme includes a range of activities, such as horticultural and woodworking activities where power tools/machines are used.

25. The activity at the centre of this investigation is the "kindling programme". Timata Hou's Chief Executive advised HDC that the Timata Hou kindling programme was introduced in 2004 by the then Vocational Manager. The activity was based around converting old wooden pallets into kindling and firewood ready for sale. The activity was designed to provide clients with an opportunity to develop disciplined work skills through meaningful activity, including working as part of a team, learning to use tools and machinery, taking instructions and developing a work ethic.

26. Timata Hou's March 2008 Activity Risk Assessment & Management Form (the Form) for the kindling activity stated that there needed to be a minimum of two staff to attend and supervise the activity when clients are involved. The Form noted that the client's support level with specific tasks should be set in accordance with the client's skill and competency sign-off for training related to the activity (which would be detailed in the client's Life Skills activity support plan). The Form set out the tasks associated with the kindling activity, and stated: "Only staff and clients who have completed training, passed the Safe Behaviour Assessment and have appropriate staff support available can participate." The Form listed the risks associated with the kindling activity, including the risk of physical harm, and the steps to be taken to

control the risks. Those steps included the Life Skills Co-ordinator ensuring that suitable staff were assigned to the programme, and that staff had been trained and were willing and able to support clients. A further step identified was that the "Co-ordinator [was] to ensure all staff and clients [had] been trained in Hazard ID and Control Register for power tool used".

27. Timata Hou has a Competency Record Staff & Clients document which also specifies that before any staff member or client uses machinery, they must receive training and show that they are competent to use the machinery safely. This includes the motor-mower, weed-eater, rotary hoe, chainsaw, circular saw (sometimes also referred to as the skill saw) and bench saw.

28. The Timata Hou Health and Safety Manual required hazards for tasks to be identified and assessed, and appropriate controls put in place and recorded on a Hazard Identification and Control Sheet. The Health and Safety Manual's "Hazard Identification — Vocational Service" section required that hazard identification and control sheets should be reviewed whenever changes to the existing process were planned. The Manual also stated: "[C]onduct a hazard identification before purchasing any new equipment, and ensure appropriate controls are in place before operating new equipment." Timata Hou advised the Department of Labour that Hazard Identification Registers and documented safe operating procedures were in place for machinery; however, no Hazard Identification Register or documented safe operating procedure had been developed for the skill saw.

Staff

29. Several staff were involved in providing services to Mr A at the time of the events under investigation.

30. Care Manager Ms C[4] was responsible for liaising with other staff and services to comprehensively assess clients' needs, for ensuring that adjustments were made to client plans to reflect assessed risk and client progress, and also for ensuring that client plans were approved by the Care Co-ordinator (if the client was subject to the IDCC&R Act). Ms C was also responsible for training staff in "positive and safe support and rehabilitation practices", and was expected to contribute to staff training, particularly when related to the needs of a specific client, and to report staff training needs to the Regional Manager.

31. Ms C described her role as taking care of the clinical needs of clients, including their spiritual, emotional and physical needs. Ms C advised HDC that once a week she would meet with staff and read through clients' notes. She advised that if anything caught her attention (i.e., if there had been a problem), she would follow it up. She advised, however, that she was reliant on the information provided by the supervisors and support staff, and that "[a] lot of stuff goes on in a day and often staff notes were brief".

[4] Ms C has a background in social work.

32. Acting Life Skills Co-ordinator Mr E[5] was responsible for implementing and monitoring all aspects of health and safety within the Life Skills programme. In addition to the responsibilities set out in the Form (see paragraph 27), this included ensuring that all competencies were met by staff and clients before equipment was used, and that all staff were trained in "Timata Hou Core Training".[6] As Acting Life Skills Co-ordinator, Mr E was also responsible for co-ordinating and monitoring all rehabilitation programmes within the Life Skills programme.[7]

33. Mr E said that he did not receive any training for his position as Acting Life Skills Co-ordinator, but that he had spent some time with the previous co-ordinator and went through the "Ops" manual, which contained the organisation's policies and procedures. Mr E said that the Life Skills Co-ordinator role was a general administrative role — he was responsible for ensuring that "everything was working properly". However, he advised that he did not have any input into client programmes.

34. The Competency Record provided to HDC shows that in 2008 Mr E was signed off to use the motor-mower, weed trimmer and rotary hoe.

35. Mr F and Mr D were working at Timata Hou as Care Support Workers (CSWs). Mr F had worked at Timata Hou as a CSW for some years. The CSW job description stated that it was the role of the CSW to undertake and complete required training, and to identify risk and take appropriate action. The CSW was not usually involved in the development of client care plans, but Mr D said that he would provide feedback on client progress, both orally and in writing.

36. Mr F advised HDC that his duties mostly involved supervising clients in the house, but that he was occasionally asked to supervise clients with outdoor work. He stated that when he started work at Timata Hou he received training in: how to deal with clients who had epilepsy; CPR; and an introduction to IT. Timata Hou's Record of Learning for Mr F identified that Mr F had undertaken learning and development in 2009 and 2010 in several areas including Austism Spectrum disorder, "prevention of physical crises", infection control, "safety and security", and the "Timata Hou Induction Module 1". In addition, it was noted that in April 2010 Mr F completed Health and Safety training.

37. Mr F confirmed that he was aware that only clients and staff who had been trained to use the power tools, or had had training in health and safety, were allowed to use those tools. On 22 April 2010, Mr F was signed off to use the motor-mower and weed-eater, but he advised HDC that he had had no formal training in the use of power tools. Mr F said: "I am very careful when I use it. I watch people use it first."

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[5] Mr E advised that he had been working for Timata Hou for some years, and was appointed Acting Life Skills Co-ordinator in November 2009.

[6] National Manager Ms G advised the Department of Labour that "Core Training" is training that is related to the wider organisation.

[7] See Life Skills Co-ordinator Job Description, provided to HDC by Timata Hou.

38. The records show that Mr D was competent in [the relevant outdoor] Skills.[8] Mr D advised the Department of Labour that he was involved in training clients at Timata Hou in the use of the power saws, and that he believed that that was expected of him. Mr D further advised the Department of Labour that Timata Hou did not provide him with any instructions or support materials to guide his training and assessment of clients' use of the saws. In respect of client training in the use of power tools, he stated: "We do it to the best of our ability to make sure that they are safe." He also stated: "[T]here's no training around skill saws it's just our experience, our life experiences …"

39. There is no record that Mr E, Mr F and/or Mr D were signed off as competent to use power saws.

Assignment of activities to clients

40. Mr E advised HDC that initially new clients would work for only a few hours a week, and move incrementally from more simple tasks such as weeding, to more complex activities, if and when they were assessed as being safe and competent to do so.

41. Mr E also said that every client would be assessed for the level of supervision required. Supervision would be either "constant" (one-on-one, where the client was to be within reach of the supervisor), "close" (one-on-one, but not as close as "constant"), or "awareness" (supervisor needed to be aware of where the client was). Mr E said that the level of supervision required was reviewed six monthly.

42. Mr D stated that staff arrived each day at 8am. The CSWs would meet with the Life Skills Co-ordinator to discuss any issues that had occurred with any of the clients the previous day. There was a list of tasks that needed to be done each day, such as taking care of tools, preparing firewood, and general farm work. The staff and the Life Skills Co-ordinator would decide what needed to be done that day, and which clients would be assigned to the various tasks. The Life Skills Co-ordinator would then allocate staff to clients. Mr E confirmed that each day he discussed the jobs that needed to be done with the team of CSWs rostered on. He said that he had the power to say that he disagreed with a client working in a particular area.

43. Mr E said that the staff working with clients had various skills and experience, and worked with clients by demonstrating tasks. Staff would use their judgement about each client's abilities and allocate tasks accordingly. Mr E said that he did not have any issues with the tasks or safety.

44. Timata Hou advised HDC that clients were assessed during the course of each day in terms of mood and behaviour, through behavioural notes, direct observations and team discussions, so that decisions could be made each day on the activities they would undertake.

[8] It is not clear from the documentation what it means to be competent in [the relevant outdoor] Skills specifically.

Mr A

Remanded to Timata Hou

45. On 16 March 2010, Mr A was remanded to the care of Timata Hou subject to a Court Order under the IDCC&R Act. Mr A has an intellectual impairment, Attention Deficit Hyperactivity Disorder (ADHD), post traumatic stress disorder, and other behavioural issues. He is able to comprehend simple instructions but is easily distracted. Mr A had been under the care of a consultant paediatrician, and was a client of the Child, Adolescent and Family Mental Health Service. At the time of these events Mr A was under the care of a psychiatrist, and was taking fluoxetine 20mg daily for depression, and Concerta, two 36 mg tablets daily, for ADHD.

46. On 5 March 2010, prior to his remand to Timata Hou, Mr A's Care Manager and the referral agency's Care Co-ordinator formulated an Individual Care and Rehabilitation Plan (the Plan) for Mr A. The Plan noted that Mr A often had difficulty in maintaining attention to a discussion/task, and was easily distracted by stimuli and movement around him. The Plan further noted that Mr A "can communicate his needs verbally at a very basic level" and "appears to have a limited ability to express his needs or wants". It was also noted that Mr A:

> "can comprehend simple concrete instructions, but appears to become confused or misinterprets conversations that involve abstract discussion. For example, during the interview if questions were not broken down into smaller parts, he had difficulty trying to understand. He often acted as if he understood something, but when asked to clarify his understanding it was sometimes evident that he did not."

47. The Plan recommended that staff "deliver instructions/information step-by-step, one piece at a time with repetition as required", and that staff use clear and simple language. The Plan also noted that staff will "check back to ensure [Mr A] has understood" the information they have given him.

48. On 11 March 2010, Mr A was seen by a Clinical Psychologist for the referral agency, for a specialist assessment under section 23 of the Criminal Procedure (Mentally Impaired Persons Act) 2003. The Clinical Psychologist reported his assessment and recommendations for the ongoing management of Mr A. One of his recommendations was:

> "Opportunity should be provided for [Mr A] to develop his skills for independent living. This should initially include occupational therapy assessment and input."

49. Timata Hou's contract with the Ministry of Health separates out the responsibility for the delivery of specific services from the identification and approval of those services for any individual. The referral agency has responsibility for accessing any occupational therapy assessment and input for Mr A. Timata Hou recommends and supports such assessments, but does not directly provide them.

50. Mr A is deemed to be legally competent to manage his own affairs. He does not have a welfare guardian, and does not have a personal order in place.

Assessment for Life Skills Programme and kindling activity

51. Mr A's Timata Hou Service Plan was developed on 26 April 2010. The Service Plan included a "risk management" section, and encouraged "consistent, positive support" for Mr A. No mention is made in the Service Plan of Mr A's comprehension capabilities.

52. Mr A initially participated in Timata Hou's Footprints programme. At some stage after Mr A's remand to Timata Hou, Ms C assessed Mr A in response to his request to transfer from the Footprints programme to the Life Skills programme.[9] Ms C discussed Mr A's request with Mr E, who suggested entering Mr A incrementally to the work skills programme.

53. The proposal that Mr A enter the work skills programme was then discussed with the Life Skills management team, which included all of the care managers, team leaders, the Clinical Leader, and the co-ordinators.[10] Ms C advised that it was agreed at that meeting that Mr A would gain valuable experience and skills from the work skills programme. Mr A's application was approved, and he began attending the Life Skills programme in May 2010. Initially, when Mr A started work there, he also attended Footprints.

54. On 22 April 2010, Mr A was signed off by Mr E as being trained and competent in the use of the motor-mower and weed-eater.

55. Timata Hou advised the Department of Labour that Mr A first engaged in the kindling activity in July 2010, and that the decision was made by his Care Manager, Ms C. There is no record of that decision.

56. Ms C initially advised the Department of Labour that she and Mr E discussed suitable activities for Mr A, and that she was involved in the decision to allow Mr A to use the circular saw to cut pallets into firewood. Ms C advised the Department of Labour that by approving Mr A for work activities she was aware that it would involve the kindling activity, and the use of the circular saw as part of that activity. Ms C said she considered that the kindling activity would be a safe activity for Mr A after he received training. She advised the Department of Labour: "I knew he would have training. They wouldn't just put him … just throw him in and say right use the circular saw. So I know that's our process." Ms C stated that if concerns had been raised about Mr A's use of the circular saw during training then that would have been discussed with her.

57. Ms C said that before any decision was made she would have considered all the documentation relating to Mr A, but she did not recall involving anyone with independent expertise in decisions about Mr A's activities. She said: "[Mr A] has a psychiatrist who he sees because he has a couple of medications and we would have

[9] It is unclear at what point in time that assessment took place.
[10] HDC was not provided with the date this meeting occurred or the minutes from the meeting.

discussed that." However, Ms C was unable to confirm that Mr A's psychiatrist knew that Mr A was using a circular saw.

58. In April 2012, when Ms C was interviewed by HDC staff, she stated that she was not aware that Mr A had been using the circular saw.[11] She said she believed that Mr A was using only the lawn mower and weed-eater. When asked who made the decision to allow Mr A to use the circular saw, she said: "That is the problem, I don't know." Ms C advised HDC that she believed the decision was made by the team. She said that there were no processes in place at that time for this type of decision-making or for feedback to the Care Manager. However, she stated that had it been suggested to her that Mr A use the circular saw, she would have taken that to Mr A's psychiatrist for discussion.

59. In response to the provisional opinion, the Timata Hou Chief Executive stated that it is Timata Hou's role to indicate where specialist assessment is required, and it is for the referral agency to source such an assessment. The Chief Executive further stated:

> "As we understand it, the issue was [Mr A's] known distractibility and poor attention to instruction. Our expectation is that our Care Manager would be able to interpret this information without recourse to an external specialist. Organisational scrutiny (or lack thereof) of assessment processes remains however a management responsibility."

60. Care Manager Mr H advised the Department of Labour that it was not Ms C's decision to allow Mr A to use the circular saw; rather it was a team decision. However, National Manager Ms G advised the Department of Labour that ultimately Ms C had overall responsibility for the decision to permit Mr A to engage in the activities of the woodshed, which included the specific activity involved in the accident. Ms G added that the decision "… would have been made with the input of the wider team. But [Ms C] would have made that decision based on consultation of the wider team. But it would have been a decision that she would have made." Ms G advised the Department of Labour that by "wider team", she meant the Clinical Leader, other care managers and the team leaders. Ms G also advised the Department of Labour that, in her view, the decision to permit Mr A to engage in the kindling activity "was correct at the time".

61. Timata Hou advised the Department of Labour that Mr A was trained by Mr D to use the circular saw. However, there is no record that Mr A received training in the use of the saw, including the hazards of using the saw, safe operating procedure, or competence related to the use of the saw. There is also no record that Mr A understood the hazards and steps to take to safely perform the task of using the saw.

62. In August 2010, Care Managers Ms C and Mr H updated Mr A's Individual Care and Rehabilitation Plan (the Plan), and recorded:

[11] Ms C reiterated this in her response to the provisional opinion.

> "[Mr A] has enjoyed working [here], and has an excellent work ethic. This has resulted in a decreased level in supervision, although he still requires active support as his enthusiasm around some machinery can be a potential risk."

63. At that time, the Plan had Mr A there on Monday to Friday, and under "close supervision at all times". The Plan also noted that staff were responsible for ensuring they were familiar with the Plan, Mr A's risk assessment, and Mr A's Service Plan.

64. Timata Hou stated that Mr A had demonstrated aptitude and the development of skills, and was consequently introduced to the wood kindling activity. Mr E stated that he believed that Mr A was quite capable of working cutting up pallets. Mr E said: "[H]e was responsible. … [H]e was doing it pretty good. You know he wasn't rushing it or anything. Safe."

65. Mr D advised the Department of Labour that he had not had "any troubles" with Mr A using the saws. Mr D stated: "I've always thought he was quite robust, but he's quite safe as well." However, Mr D also advised the Department of Labour that on a morning before the accident on 30 September, it was agreed by staff that Mr A should not use the drop saw, based on the fact that he had "shown sign of being unsafe on there". Mr D explained: "He's a real rushing young man and you know you try explain something to him and he'll, he'll listen for a little bit and then he'll go off."

Concerns about activity

66. On 14 September 2010, the Life Skills Team staff meeting minutes record that three of the staff (including Mr E and Mr D) were to undertake Health and Safety training on 21 September 2010, and that the Life Skills programme was being restructured by the Project Manager. It was noted that the first task of the restructure was to: "Establish programmes and more structure. Giving clients more responsibility. Will provide training for all staff, also use skills from staff/wood work etc." At that meeting, CSW Mr I reported that clients were using power tools without a staff member being present.

67. The minutes from the Timata Hou Health and Safety Committee meeting on 20 September 2010 record staff-to-client ratio concerns, and that Ms G would be responsible for following up on the issue.

68. On 28 September, there was concern noted that the team was stretched managing clients, "due to overflux of other clients working [there]". It is not clear from the documentation who raised that concern, and no action item was identified in response to the concern.

69. There is no record that these concerns about the activity there were addressed by Timata Hou.

Events of 30 September 2010

Assigned activities at the woodshed

70. On 30 September 2010, Mr A was part of a group of Timata Hou clients who went for work experience. The clients, support workers, and Mr E arrived at approximately 8.30am.

71. Mr E drew up the rosters for the day and checked on the day-to-day issues. Mr E stated that he met with the staff and discussed the clients there that day and the activities available.

72. As it was raining, Mr E, Mr F and Mr D decided that Mr D's and Mr F's clients could work in the woodshed that day cutting up wooden pallets for kindling and removing screws from plywood panels in preparation for cutting into kindling. Mr D was allocated two clients, and Mr F was allocated two clients, one of whom was Mr A. Once Mr E had allocated the tasks, he left to return to the Timata Hou office.

73. Mr E advised HDC that the staff member who usually supervised Mr A did not arrive for work that day. However, as Mr F had worked with Mr A on a number of occasions, the team decided that Mr A could work in the woodshed cutting up pallets, supervised by Mr F.

74. Mr E was unable to confirm whether Mr A or Mr F had had any training in the use of a circular saw, but said he believed that Mr A had an appreciation of the dangers of using the circular saw. Mr E said that this had been explained to Mr A, and he had been able to repeat the information. Mr E said he thought that Mr A was trained to use the circular saw and had used it in the past. Mr E also recalled that Mr A "was in a good space" on 30 September 2010.

75. Mr F advised HDC that he asked one of the senior staff whether Mr A was allowed to use power tools, and was told that he was.

76. Mr F's second client did not want to work in the woodshed, so he went to the meeting/activities room to do artwork, while the other three clients, Mr D and Mr F went to the woodshed.

77. Mr F said that he did not need to supervise his second client in the activities room as the client was not working with tools. However, Mr F did check on the client in the activities room several times during the morning. When Mr F left the woodshed to check his client, he asked Mr D to supervise Mr A.

78. Mr D stated that his clients, who required "close" supervision, were working with him removing the brackets and screws from plywood panels, while he used the drop saw, one of the two saws in the woodshed, to cut up the panels.

79. Mr A was working with Mr F, using a circular saw to cut up pallets. Mr A was also under "close" supervision. Mr D stated that Mr A had been using the circular saw for some months without any problems.

Client difficulties

80. During the morning of 30 September, CSW Mr I returned with a client who had been displaying difficult behaviour. Mr I sought assistance from Mr D. Mr D stopped work in the woodshed, turned off his saw, and went to assist Mr I. Mr D left his two clients removing brackets from the plywood panels under the supervision of Mr F. Mr D returned to the woodshed when Mr I's client was settled, and Mr I left at approximately 9.35am.

Mr A's first accident

81. At approximately 10.15am, shortly before the morning tea break, Mr A was using the circular saw when the saw-guard became entangled in the top of his overalls. Mr D assisted Mr F to disentangle Mr A. Mr D advised the Department of Labour that Mr A "wasn't paying attention to his own safety at the time". Mr D said he and Mr F decided that Mr A was not to use the saw again, as he was not listening to what he was told about operating the saw, and Mr D recalled telling Mr A that. Mr F said he did not tell Mr A not to use the saw again, but he did tell him to put away the saw. This incident was never reported, and neither Mr D nor Mr F could explain why that did not happen.[12]

82. After Mr A was disentangled from the saw, Mr D went back to working with his two clients and cutting up the plywood panels. Mr D recalls that Mr A was helping him and Mr F, by carrying firewood over to the table to stack for chopping, or helping Mr D put off-cuts into the box. Mr D said that during this time he left the woodshed twice to check on other clients.

83. Mr D said that the rain increased during the morning, and work in the woodshed was becoming difficult, as the front of the shed was open and exposed to the rain. Mr D said he had planned to stop work for the day and play cards with the clients, but before this could happen, Mr I's client started displaying difficult behaviour again. Mr D turned off his saw and went to intervene. While Mr D was engaged with Mr I's client, his two clients continued to remove brackets from the plywood panels under the supervision of Mr F. Mr F was also supervising Mr A at that time.

Injury accident

84. Mr F finished using the circular saw while Mr D was away assisting Mr I's client. Mr F turned off the saw, but left it plugged in and positioned on top of a pile of pallets, while he was stacking wood.[13]

85. Mr F said that he heard Mr A start the circular saw, but that he "… didn't do anything because I saw him cutting the wood, so what I did was bring the firewood and put it on the table". Mr F advised the Department of Labour that he noted that Mr A was

[12] Mr D advised that the oversight in reporting the incident may have been because it happened close in time to the second accident, and because of all the other things that were happening at that time.

[13] According to the Department of Labour report into the incident: "After approximately 15 minutes [Mr F] departed the shed to check on his other client." When he returned, he found that Mr A was using the saw again. At that time, "[Mr A] was holding the saw with one hand only". Mr F does not recall what time he left the shed.

holding the saw with one hand only. About five minutes later, Mr F heard Mr A scream. He turned and saw Mr A lying on the stack of pallets with the saw lodged in his abdomen.

86. The time that this accident occurred was not recorded, but Mr I said he returned at about 11.25am. Shortly after arriving, while going about his duties in the garage, he heard one of the clients shouting for help from the woodshed.

87. The woodshed is about 40 metres from the garage. Mr I said he immediately ran to the shed, and saw Mr F standing in the woodshed in an obvious state of shock. Mr I then saw Mr A lying on top of a single pallet with a "skill saw" in his lap, and realised that he could see Mr A's intestines through his boiler suit. Mr I assessed Mr A for level of consciousness, instructed staff to call the emergency services, and asked a staff member to comfort Mr A, while Mr I went to the house to gather first aid equipment.

88. Emergency services were notified at 11.52am. Mr A was treated at the scene then taken to hospital for emergency surgery.

89. Mr E was contacted and advised that Mr A had sustained a serious injury, and Mr A's family was notified.

90. Mr A recovered well and is back working.

Additional information

Mr A

91. On 12 October 2010, Ms C assisted Mr A to complete an Incident Report for the 30 September incident. In his report, Mr A noted: "The wood was too hard to cut and the skill saw just flipped back and it went straight towards my overalls and it cut me in my pelvis and my pelvis was sticking out. [Mr F] didn't even [indecipherable] me. [Mr F] turned his back on me to put some cut wood on the table."

92. On 23 March 2012, HDC staff spoke to Mr A. Mr A was able to recall the incident, and indicated where he had been working cutting pallets with Mr F. Mr A showed HDC staff how he cut pallets using the circular saw. He said that the saw blade hit a nail and jumped back and caught him in the stomach.

Department of Labour

93. The Department of Labour staff who inspected the site of the accident found that the work environment in the woodshed was unsafe. It had an uneven dirt floor, was exposed to the elements, and was unsafe for clients and staff to be working there when it was raining because of the risk of water reaching the electrical appliances and extension cords.

94. Department of Labour Health and Safety Inspector Mr B investigated the accident. Mr B's report of his investigation identified systemic failures at Timata Hou; a poor understanding and application of health and safety processes as they related to the service; a lack of training, particularly in the use of the circular saw; and a lack of

understanding of the risks involved. The investigation identified issues of staff supervision, and staff choices and actions, and concluded that Mr D's and Mr F's failure to follow the incident reporting process for the first accident contributed greatly to subsequent events. The investigation report stated that this, plus a lack of close oversight of the Life Skills programme at Timata Hou, contributed to the events.

95. Timata Hou responded to the findings of the Department of Labour on 29 March 2011. Timata Hou stated: "Lifeskills staff receive comprehensive training on supervising clients, health and safety, and Timata Hou's policies and procedures … staff were also experienced in the use of power tools." It also stated: "As part of his introduction, [Mr A] received training on the use of a circular saw, through staff member [Mr D] and others." Timata Hou submitted to the Department of Labour: "The issue is a documentation one, not a training or assessment one in fact."

96. When questioned by the Department of Labour, Timata Hou National Manager Ms G conceded that Timata Hou would not have known with a reasonable level of certainty whether safety in relation to the circular saw was being ensured by Timata Hou employees, given the lack of records of training or knowledge and experience with the task.

97. Mr B's report concluded:

> "The Department of Labour alleged that Timata Hou Ltd had breached the Health and Safety in Employment Act 1992 in relation to the accident, in that there were practicable steps which it could have taken to prevent it.
>
> Timata Hou Ltd responded to the allegation in a letter dated 29th March 2011. It is receptive to improving its Health and Safety Systems in general, but did not accept that there was an incorrect process or decision when they decided to permit [Mr A] to use a circular saw.
>
> The Department of Labour maintains that the process and decision were faulty, however, there were issues that mitigated against prosecution."

98. The Department of Labour investigation report made a number of recommendations to address the failings it identified. However, the Department of Labour decided not to pursue prosecution, in favour of forwarding the matter to HDC.

Timata Hou Ltd

Incident Reporting Policy

99. Timata Hou's August 2010 Safe Handling Policy and Procedures stated that the aim of the policy was "[t]o create an environment where staff are trained, equipped and supported to manage safe handling tasks to avoid personal injury". One of the procedures listed was that "[a]ll safe handling incidents will be reported and investigated as per Incident reporting and Response System Policy and analysed for trends".

100. The Incident Reporting policy (the Policy) July 2002 (reviewed October 2011) stated that the aim of the policy was to ensure that all accidents, incidents and near misses are reported, that they are responded to quickly and appropriately, and that the system leads to improvement of services. The Policy set out guidelines for incident reporting. It required the person who identified the incident to ensure that any urgent action needed to be taken to ensure the safety of those directly involved was taken. It stated: "This is a first priority and is paramount at all times." The Policy stated that the person who identified the incident had a responsibility to complete an incident report within 24 hours of the incident and preferably before staff finished work for the day. The Policy also provided guidelines for managers responding to incidents, and set out the criteria for investigating the circumstances of the incident, including the process of Sentinel Event investigation.

Sentinel Event Report

101. In February 2011, an independent consultant, Mr J, conducted and reported his Sentinel Event Investigation into the incident on 30 September 2010. Mr J identified several root causes of the incident, including: the lack of a manager able to focus on the vocational area and implement robust hazard and risk assessment and to oversee training; gaps in the way policies and procedures were implemented; poor risk identification; poor links between care managers and the Life Skills programme; that the range of activities on offer did not necessarily reflect client needs, skills, and/or interests; that staff had different understandings of the levels of observation required; that there was no evident specific training on the use of equipment; and that there was poor staff judgement and competence on the day, including insufficient responses to the earlier incident.

102. Mr J made a number of recommendations to address the failings he identified, including: to increase the level of direct management of the Life Skills programme; to review risk assessment and health and safety procedures; and to examine staff responsibilities for incident reporting and staff understanding of levels of client observation.

103. Timata Hou developed an action plan in response to the recommendations, and a dedicated project manager was put in place to address the shortcomings identified through the Sentinel Event investigation. Timata Hou advised HDC that changes had been implemented to increase health and safety at Timata Hou, including the appointment of a full-time Life Skills Manager, revised Risk Assessment and Management and Hazard Identification and Control Register sign-off forms, and more comprehensive documentation around orientation and training. Timata Hou provided HDC with an updated Hazard Identification and Control Register for the skill saw and weed-eater, and a revised training and competency record.

104. A memo to Timata Hou senior management from the IHC National Manager Human Resources dated 25 May 2011, set out further information about steps taken to improve health and safety processes in response to the 30 September 2010 accident. The steps included: a review of health and safety management with a focus on processes and risks; improvements in staff training; a review of the capacity of the current site for the wood kindling activity; and a clarification of the purpose of the

activity, the skills gained in the activity, and how the risks involved in the activity may be mitigated. The document did not include any specific action to be taken in relation to training staff in the safe use of tools.

Responses to Provisional Opinion

Timata Hou Ltd

105. The Timata Hou Ltd Chief Executive provided a response to the provisional opinion, and his requested changes have been noted where relevant. He further stated:

> "We fully accept there were lapses in managerial oversight that failed to support staff to make good decisions and judgments on the day. But we consider this was isolated and that there was not a 'culture of non-compliance'. In our experience staff had implemented the need for incident reporting. The review undertaken did not expose a history of similar staff responses."

106. The Chief Executive submitted that the provisional opinion implied that the side effects of Mr A's medications were not considered in the risk assessments relating to Mr A. He stated:

> "From our inquiry into this matter through [the] Clinical Director of IDEA Services is that [Mr A's] medication regime was stable, and any immediate risk to [his] use of machinery was only potentially of relevance in the first period while his medication regime stabilised."

107. The Chief Executive also stated that Timata Hou holds information about medication side effects in each resident's medication folder.

108. The Chief Executive stated:

> "I was and I am very disappointed that our service failed to support [Mr A] and that he suffered such a severe injury.
>
> As you will be aware, the accident had a significant impact on the service and led to significant changes within the service. … Action was taken to strengthen the clinical leadership and management of Timata Hou through a major restructure of the service in early 2011."

109. The Chief Executive provided a letter of apology to Mr A.

Ms C

110. Ms C advised HDC that she was unaware that Mr A was using a circular saw. Ms C provided a written apology for Mr A.

Mr D, Mr F and Mr E

111. Mr D, Mr F and Mr E did not provide a response to the provisional opinion.

Opinion: Breach — Timata Hou Ltd

Introduction

112. I consider that there are several areas where the care that Timata Hou provided to Mr A fell well short of the expected standard. Those areas include: the assessment of Mr A's suitability for the kindling activity; ensuring staff were adequately trained to provide safe services to Mr A; failing to ensure Mr A's supervision needs were met; failing to identify the risks associated with the kindling activity and to take steps to minimise those risks; failing to ensure staff compliance with policies; and poor documentation and incident reporting practices.

113. I am particularly concerned that Timata Hou was on notice of potential risks to its clients, including concerns about safe staffing levels, and it had failed to respond to, and manage, those risks. An organisation aware of risks to its clients must respond promptly and decisively to minimise those risks, to protect its clients. As an organisation, Timata Hou seriously failed Mr A, and placed not only him, but other clients and staff, at risk of harm. The incident on 30 September 2010 was an incident that was waiting to happen.

114. I accept that Timata Hou has taken steps to improve its services to prevent a similar event recurring. However, I am concerned that, in response to the Department of Labour investigation, Timata Hou asserted that this case was about poor documentation and not poor practices. In my view, that attitude demonstrates a lack of insight into the clear failures in its systems, and the risky situation in which it placed Mr A and its other clients on 30 September 2010.

115. In my opinion, Timata Hou breached Mr A's rights under the Code, as set out below.

Assessment of Mr A's suitability for the kindling activity

116. The disability sector expert who advised me on this case, Margaret Boyes, opined that Timata Hou's assessment and documentation processes were inadequate, and that Timata Hou did not have rigorous assessment and review processes in place. I agree with my advisor.

117. Mr A has an intellectual impairment and ADHD, and has been described as having a "chronic defiance of authority". Despite Timata Hou holding documentation that should have prompted concerns about Mr A's ability to use machinery safely, he was allowed to use power tools. The documentation that should have prompted concern about Mr A's ability to use machinery safely included the 5 March 2010 notation in his Individual Care and Rehabilitation Plan that he often had difficulty in maintaining attention to a discussion or task, and was easily distracted by stimuli and movement

around him. It also included documentation about Mr A's ability to comprehend instructions.

118. That documentation should have prompted Timata Hou staff to exercise a high degree of caution when assessing Mr A's suitability to use power tools. There is no evidence that it did so. Timata Hou did not provide HDC with any documentation confirming when Mr A started participating in the activities, and what assessments, if any, were undertaken to assess his suitability for certain tasks, including his suitability for the kindling activity and for using power tools. Ms Boyes noted the following inadequacies in the assessment of Mr A's suitability to use power tools:

- Timata Hou should have sought an expert opinion on Mr A's suitability to use power tools. A training programme, risk assessment analysis, and competency tool specific to Mr A's needs should have been developed in consultation with suitably skilled individuals.

- There is no recorded risk assessment by a trained professional in relation to Mr A's use of power tools, taking into consideration his intellectual disability, ADHD diagnosis and current medication regimen. The space in Mr A's Individual Care and Rehabilitation Plan to record possible side effects to his prescribed medication was not completed. If it had been completed, it would have acted as an alert to the suitability of Mr A operating power tools and machinery, given the medication he was taking.

- There is no indication that Mr A's supervision requirements were made with input from his support team, who may have had relevant information to enable the staff to make more informed decisions about Mr A's participation in certain activities.

119. In response to the provisional opinion, the Chief Executive stated that it is Timata Hou's role to indicate where specialist assessment is required, and it is for the referral agency to source such an assessment. He also stated that the case manager was expected to be able to interpret Mr A's known distractibility and poor attention to instruction without recourse to an external specialist. I have considered Timata Hou's submissions, and it remains my opinion that Timata Hou should have exercised greater caution in assessing Mr A's suitability for the kindling activity.

120. Timata Hou policy required clients to be signed off as trained and competent in the use of tools before using them. On 22 April 2010, Mr A was signed off by Acting Life Skills Co-ordinator Mr E as competent in the use of the motor-mower and weed-eater. Although staff advised that Mr A had been using the circular saw for some time before the incident on 30 September 2010, and had been trained to use it by Mr D, there is no evidence that Mr A was signed off as trained and competent in the use of the circular saw.

121. I do not accept Timata Hou's submission that Mr A was trained to use the circular saw, and that the issue is one of documentation and not poor training or assessment. Timata Hou has not provided any evidence to support its assertion that training

occurred. When questioned by the Department of Labour, Timata Hou National Manager Ms G conceded that Timata Hou would not have known with a reasonable level of certainty whether safety in relation to the circular saw was being ensured by Timata Hou employees given the lack of records of training or knowledge and experience with the task.

122. Timata Hou's submission also underestimates the importance of documentation in a client's care and treatment. The importance of good record-keeping cannot be overstated. It is the primary tool for continuity of care and it is a tool for managing clients. In addition, as noted by the High Court, it is through the medical record that providers have the power to produce definitive proof of a particular matter.[14] In the circumstances, I find that it is more likely than not that Mr A, Mr D, Mr F and Mr E were not adequately trained as competent in the use of the power saws at Timata Hou.

123. I note and accept my advisor's comments that the documented training elements in respect of Mr A's training to use the weed-eater and lawn mower are "broad based and do not give enough detail to ascertain how comprehensive the instruction was". It does not appear that competency was regularly reviewed, as it should have been.

124. Timata Hou missed several opportunities to review Mr A's appropriateness for certain activities. In August 2010, Care Manager Ms C noted that Mr A "still requires active support as his enthusiasm around some machinery can be a potential risk". In addition, as noted by Ms Boyes, there were reports that Mr A did not follow instructions as per the use of the lawn mower, which he had been deemed competent to use. I agree with Ms Boyes that "[t]his in itself should have indicated a need to review [Mr A's] competency in relation to the use of the lawn mower and acted as an alert around his use of further mechanical/electrical equipment". In addition, Mr A had reportedly been banned from using the drop saw only a few days before the 30 September 2010 incident.

125. Decisions regarding Mr A's participation appear to have been made on a casual basis, rather than through an informed process such as comprehensive risk assessments, by staff who had no formal training in risk assessment, or who were themselves untrained in the use of the equipment. This was clearly inadequate.

Compliance with policies

126. In response to the provisional opinion, the Chief Executive accepted that there were lapses in managerial oversight that failed to support staff to make good decisions and exercise good judgement on 30 September 2010. However, he submitted that these events were isolated and there is not a "culture of non-compliance" with policies at Timata Hou. Nevertheless, it is clear that in September 2010, staff were not compliant with Timata Hou's policies.

[14] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).

127. There was not always a minimum of two staff in attendance to supervise Mr A and the two other clients at the woodshed on 30 September 2010. At times, either Mr D or Mr F left the woodshed. This meant that, at those times, there was only one staff member supervising three clients, which fell short of the "close" supervision requirements for those clients, and Timata Hou's 2008 Activity Risk Assessment & Management Form for the kindling activity, which states that there was to be a minimum of two staff supervising the activity. This is particularly significant when viewed in the context of Mr A being known to be impulsive with a "chronic defiance of authority", and that he had had a non-injury accident with the circular saw earlier that morning. Furthermore, Timata Hou was on notice of concerns about safe supervision levels (see below).

128. There is no evidence from the written documentation outlining staff competencies that the CSW staff using power tools and supervising clients in the woodshed on 30 September 2010 had received any formal training in the safe use of the power tools, including the circular saw. In addition, there is no evidence that the CSW staff supervising Mr A (or indeed Mr A himself) had passed the Safe Behaviour Assessment, or were trained in Hazard ID or Control Register for power tool use. This was contrary to Timata Hou policy, as set out in the 2008 Activity Risk Assessment and Management Form and the Competency Record Staff & Client, both of which require staff to be trained and competent in the use of power tools before using such tools.

129. The Health and Safety Manual required hazards for tasks to be identified and assessed, and appropriate controls put in place and recorded on a Hazard Identification and Control sheet. As at 30 September 2010, no Hazard Identification Register or documented safe operating procedure had been developed for the skill saw, contrary to Timata Hou policy as set out in the Health and Safety Manual.

130. An incident report was never completed for Mr A's first incident with the circular saw on 30 September 2010, which was also contrary to Timata Hou policy. The Timata Hou Incident Reporting Policy also required the person who identified an incident to ensure that any urgent actions needed were taken to ensure the safety of those involved. Limited steps were taken in this case to ensure the safety of Mr A following the first event. The circular saw was not removed from the area.

131. I remain concerned that Timata Hou allowed a culture of non-compliance with its policies to develop, and that by September 2010 this culture of non-compliance put Timata Hou's clients at risk of being harmed.

Staff training

132. Ms Boyes noted that there was no evidence of sufficient oversight of health and safety issues and relevant staff training within the organisation. I agree with my advisor that Timata Hou did not have adequate training and management systems in place.

133. As stated, there is no evidence that staff were adequately trained and competent in the use of power tools, which was contrary to Timata Hou policy.

134. Mr E advised HDC that he received no training when he was promoted to Acting Life Skills Co-ordinator in November 2009.

135. There is no evidence that staff received any formal training in providing people with disabilities with work skills instruction. Anecdotal evidence was that staff learnt by observing other staff members. This was inadequate. Staff providing such services to clients with disabilities should be adequately trained in providing services to those clients to ensure that the care provided is suitable to the client's needs, and is safe. Timata Hou's lack of adequate staff training put both its clients and staff at risk of being harmed.

136. Furthermore, I accept my advisor's advice that the Health and Safety Audit Tool was generic in format and not adequately targeted to the activities involved in the Life Skills programme.

Notice of concerns about supervision levels

137. Alerts about safe supervision levels were recorded in a range of documents. In particular, on 14 September 2010 concern was documented as having been raised at a staff meeting that clients were using power tools without a staff member being present. On 28 September 2010 further concerns were raised about the Life Skills Team being stretched when managing clients.

138. My advisor noted that those alerts "… should have informed staff of supervision issues" and "… heightened the risk of an accident occurring".

139. There is no evidence that these concerns were acted on, or that there was any change in practice in response to the concerns. As noted by my advisor, "on the day of the incident supervisory requirements were clearly breached with clients being left alone and staff left to supervise clients above ratios deemed necessary for safe supervision".

Conclusion

140. In a previous opinion,[15] this Office noted that "a provider who accepts the responsibility for a [consumer] with known risk factors … has always been required to take reasonable steps to minimise risk". In my view, Timata Hou had a similar responsibility to protect Mr A, and it failed in that responsibility.

141. Timata Hou did not have rigorous assessment and review processes in place, and the management systems at Timata Hou did not adequately identify risk or respond to identified risks.

142. There appears to have been a lax approach to compliance with policies by staff at Timata Hou, and a casual attitude to staff and client use of power tools. The inadequacies included assessment of clients' suitability for power tool use, staff and client training, supervision, risk management, documentation, and incident reporting.

[15] Opinion 10HDC00356, page 19.

That attitude and approach to client use of power tools was inappropriate. Timata Hou was on notice of the potential risks, and failed to adequately respond to and manage those risks. In my view, by 30 September 2010 it was foreseeable that an incident such as occurred on 30 September 2010 could occur.

143. A previous HDC opinion about the service provided to the client of another disability support organisation noted that "… a specialist organisation … should have systems in place to provide their staff with the resources and support required to provide their clients with a service appropriate to their needs".[16] In my view, Timata Hou failed to ensure it had adequate systems in place to provide its staff with the resources and support required to provide services to their clients appropriate to their needs, and did not have an established documented and maintained quality and risk management system to ensure that its clients received safe services of an appropriate standard.

144. I find that Timata Hou failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code. I also find that Timata Hou did not provide Mr A with services in a manner that minimised the potential harm to Mr A and, accordingly, Timata Hou also breached Right 4(4) of the Code. I consider that Timata Hou's departure from accepted practice in relation to the service provided to Mr A was severe.

Opinion: Breach — Ms C

145. Ms C was employed by Timata Hou as a care manager. Her responsibilities included providing client assessments, training staff in the specific needs of clients, and adjusting care plans to reflect any changes in clients' needs. A key objective of care managers was to achieve a comprehensive assessment of client needs through liaison with other staff and services, and to ensure that adjustments were made to care plans to reflect the assessed risk and client progress. I am satisfied that, as Mr A's care manager, Ms C had ultimate responsibility for making decisions about his care and rehabilitation at Timata Hou, including the decision that he participate in the Life Skills programme and kindling activity.

146. Ms C discussed Mr A's suitability for the Life Skills Programme with Acting Life Skills Co-ordinator Mr E, who proposed that Mr A be incrementally introduced to the work skills programme. That proposal was taken to the Life Skills management team, who agreed.

147. Ms C advised HDC that before any decision was made about work skills training activities for Mr A, she would have considered all the documentation in his file, and she would have consulted with independent experts. However, there is no record that Ms C consulted with Mr A's psychiatrist about the plan for Mr A to work and be trained to use power equipment, and whether, given Mr A's known behavioural

[16] Opinion 06HDC04441, page 21.

issues, this was a sound plan. There is also no evidence that a thorough clinical and risk assessment was carried out in respect of Mr A's suitability for certain activities, or that Ms C satisfied herself that staff were trained in the specific needs of Mr A. Ms C was responsible for ensuring that a comprehensive assessment of Mr A's needs was undertaken, and that his care plan reflected the assessed risk to him and his progress. In my view, in this case, Ms C failed to do so.

148. Ms C provided inconsistent information to HDC and the Department of Labour about her knowledge that Mr A was using power tools. However, in her response to the provisional opinion, she stated that she was unaware that Mr A was using a circular saw. Regardless, in my view, Ms C should have been aware that activities included the kindling activity and, with training, the use of power tools.

149. I am concerned about the level of communication in relation to the expectations and risks of Mr A's participation in the Life Skills programme. As noted by my advisor, Ms Boyes, decisions made around Mr A's participation in activities appear to have been made on a casual basis rather than through any informed process, including comprehensive risk assessments. It was Ms C's responsibility to ensure that Mr A's care plan adequately reflected his assessed risk and progress.

150. Ms C stated that she relied on feedback from the staff working with Mr A to identify any problems. Ms C should have been more proactive and more involved in her client's progress in the Life Skills programme. By 30 September 2010 information was available to Ms C that suggested that a review of Mr A's suitability for some activities was warranted. In particular:

- On 5 March 2010, an Individual Care and Rehabilitation Plan was developed for Mr A. The plan noted that Mr A had difficulty in maintaining attention to discussion and task, and recommended consistent and positive support to manage this problem.

- When Ms C updated Mr A's plan in August 2010 she noted that although Mr A had enjoyed working there, he required active support as his "enthusiasm around some machinery can be a potential risk". Ms C also noted that Mr A had a history of "chronic defiance of authority".

151. As Care Manager, Ms C was also expected to contribute to staff training relating to the needs of specific clients. It appears that Mr A's support staff were not provided with clear information about his risk factors when participating in some of the activities. For example, each of the staff involved in this incident had a different view of Mr A's competence to use power tools.

152. Ms Boyes advised that the structure, practices and processes in place at Timata Hou, and the fact that staff were not provided with sufficient information and/or training to make informed decisions, make it difficult for her to assign individual responsibility.

153. Although it is clear that there were deficiencies in Timata Hou's systems for staff training and assessment, the organisation provided staff with policies relating to risk

assessment and management and incident reporting, and Ms C's job description clearly set out her roles and responsibilities. In my view, Ms C did not fulfil her responsibilities to Mr A, as set out in her job description. She did not ensure that he was adequately assessed for his suitability for activities there, including the use of power tools, and she did not adequately reassess his suitability for certain programmes when certain risks were identified. In my view, Ms C failed to take steps to minimise the potential harm to Mr A and, accordingly, breached Right 4(4) of the Code.

Opinion: Breach — Mr E

154. On 30 September 2010, Mr E was the Acting Life Skills Co-ordinator (LSC). He had been working for Timata Hou for some years, and had been the Acting LSC for approximately 10 months.

155. The Timata Hou LSC job description stated that the LSC was responsible for implementing and monitoring all aspects of health and safety within the Life Skills programme. This included ensuring that all competencies were met by staff and clients before equipment was used, and that all staff were trained in "Timata Hou Core Training". Mr E advised HDC that he did not have input into client programmes. However, according to the Activity Risk Assessment and Management Form (the Form), Mr E, as Acting LSC, was responsible for ensuring that suitably trained staff, who were willing and able to support clients, were assigned to the programme, and that all staff and clients had been trained in Hazard ID and Control Register for power tool use.

156. Mr E stated that he met with staff each morning to discuss the clients, the activities available, and the allocation of staff and clients to activities. He said that clients were assessed during the course of the day for any changes in mood and behaviour, and programmes were adjusted if required.

157. Mr F, Mr D and Mr A were not trained to use power saws in the woodshed, and had not received the other training required by Timata Hou policies before such machinery was used. However, on 30 September, Mr E allocated Mr D to work with two clients, and Mr F to work with Mr A in the woodshed using power saws to cut up pallets for kindling. It was Mr E's responsibility to ensure that all competencies were met by staff and clients before equipment was used, and he failed to do so on 30 September 2010.

158. Mr E stated that he, Mr D and Mr F decided that it would be appropriate for the clients to work in the woodshed that day. I note that it was raining on 30 September 2010, and the woodshed work area and electrical equipment were exposed to the rain. Mr E was responsible for health and safety, and, in those circumstances, his decision to assign staff and clients to work in the woodshed using electrical equipment on that day was poorly judged. It was Mr E's responsibility to provide clear direction to the

staff to ensure the safety of staff and clients engaged in activities. On 30 September 2010, he failed to do so.

159. Ms Boyes advised that the structure, practices and processes in place at Timata Hou, and the fact that staff were not provided with sufficient information and/or training to make informed decisions, make it difficult for her to assign individual responsibility.

160. Although it is clear that there were deficiencies in Timata Hou's systems for staff training and assessment, the organisation provided staff with policies relating to risk assessment and management and incident reporting. It is apparent that on 30 September 2010, Mr E did not follow these policies, and made a number of errors of judgement. Mr E was responsible for the health and safety of clients and staff, and his decision-making regarding the assignment of activities on that day was poor, and placed staff and clients at risk. Accordingly, in my view, Mr E failed to take steps to minimise the potential harm to Mr A and breached Right 4(4) of the Code.

Opinion: Breach — Mr F

161. Mr F had been working as a community support worker at Timata Hou for some years. In September 2010 he was responsible for supervising Timata Hou clients participating in Life Skills programmes. His duties mainly involved supervising clients in the house, but he was occasionally called upon to supervise clients with activities. According to Mr F's job description, it was part of his role to undertake and complete required training, and to identify risk and take appropriate action.

162. Timata Hou provided its staff with a number of documents to guide them in the assessment of client suitability for activities, safe client behaviour, and activity risk assessment and management. In particular, Timata Hou's 2008 Activity Risk Assessment & Management policy for the kindling activity stated that there was to be a minimum of two staff supervising the activity, and that only staff and clients who had completed training and passed the Safe Behaviour Assessment could be involved in the activity.

163. There is no record that Mr F was signed off as being trained and competent in the use of power saws. Mr F advised that he was aware that only clients and staff who had received training in the use of power tools and health and safety issues were allowed to use power tools in the woodshed. However, on 30 September 2010, Mr F agreed to supervise Mr A in the woodshed, and for that purpose he used a power tool (the circular saw), which he had not been trained to use. This was contrary to Timata Hou policy, as set out above.

164. There were concerns about Mr A's ability to take direction, and that he could be easily distracted. Mr A had not been signed off to use power tools, and there is no record of Mr A having passed a Safe Behaviour Assessment. However, Mr A used the

circular saw at the woodshed on 30 September 2010. Mr A did this with Mr F's knowledge, and contrary to Timata Hou policy.

165. At about 10.15am on 30 September 2010 Mr A had a non-injury accident with the circular saw. Mr D instructed Mr A not to use the circular saw again. Mr F failed to ensure that an incident report was completed in relation to the incident. This was in direct contravention of Timata Hou's August 2010 Safe Handling Policy and Procedure, which stated that "[a]ll safe handling incidents will be reported and investigated as per Incident reporting …", and its Incident Reporting policy, which specified that all accidents, incidents and near misses were to be reported within 24 hours of the incident/accident occurring.

166. It is concerning that when Mr F finished using the circular saw around 11.10am to start stacking the kindling, he left the saw plugged into the electrical outlet where Mr A had access to it. It is even more concerning that when Mr F noticed that Mr A had started up and was using the circular saw again, he did not intervene. Mr F had worked with Mr A previously, and would have been aware of the concerns regarding his ability to take direction and that he could be easily distracted. Mr F was also aware that Mr A had been instructed not to use the circular saw after the first incident, and yet he allowed Mr A to continue using it. Mr F should have been more vigilant in ensuring that Mr A did not use the circular saw again. His poor judgement in this case demonstrates a lack of appreciation of Mr A's known behaviours, and a disturbing lack of awareness of health and safety issues and risk management.

167. Mr F was an experienced CSW at Timata Hou. However, on 30 September 2010 Mr F failed to comply with his responsibilities to identify and mitigate risk, as set out in his job description. The risks that Mr F should have identified and responded to included:

- It was raining on 30 September 2010 and the work area and electrical equipment were exposed to the rain.

- Following Mr A's first incident with the circular saw he should have identified the risk to Mr A and taken appropriate action to mitigate that risk. This should have included ensuring that a change was made to the activity that Mr A was engaged in.

- Mr F should have responded when Mr A started up and began using the circular saw for a second time, after having been instructed not to use it. I appreciate that at the time the injury occurred, Mr F was supervising three clients in the woodshed, which was contrary to policy. However, he still had a responsibility to respond to the immediate risk that presented when Mr A began using the circular saw. The evidence is that Mr F did not make any attempt to respond to that risk; rather, he continued with his activities in the shed even when he noticed that Mr A was using the saw with only one hand.

168. Ms Boyes advised that the structure, practices and processes in place at Timata Hou, and the fact that staff were not provided with sufficient information and/or training to make informed decisions, make it difficult for her to assign individual responsibility.

169. It is clear that there were deficiencies in Timata Hou's systems for staff training and assessment, and for ensuring that staff were aware of, and compliant with, policies. I am critical that Mr F failed to comply with Timata Hou policies regarding the use of, and supervision of, clients using power tools when he was not trained to do so, and that he never completed an incident report for Mr A's first incident with the circular saw. However, I accept that his failures in these regards were in part attributable to poor organisational practices. I am also critical that Mr F continued to allow clients to work in the woodshed using electrical equipment when the woodshed was exposed to increasing levels of rain.

170. Mr F's responsibility to identify and respond to risk was clearly set out in his job description. On 30 September 2010, Mr F made a number of errors of judgement and failed to respond to risks to minimise the potential harm to Mr A. In particular, Mr F did not take appropriate action to mitigate the risk to Mr A following his first incident with the circular saw, and did not respond appropriately to the risk posed to Mr A when he started up and began using the circular saw for a second time after having been instructed not to. In my view, Mr F is individually responsible for those failures and, accordingly, breached Right 4(4) of the Code.

Opinion: Adverse comment — Mr D

171. Mr D had been employed by Timata Hou for some years, in a variety of positions. In September 2010, he was working as a community support worker, and was responsible for supervising Timata Hou clients participating in the Life Skills programme. According to Mr D's job description, it was part of his role to undertake and complete required training, and to identify risk and take appropriate action.

172. Timata Hou provided its staff with a number of documents to guide them in the assessment of client suitability for activities, safe client behaviour, and activity risk assessment and management. In particular, Timata Hou's 2008 Activity Risk Assessment & Management policy for the kindling activity stated that there was to be a minimum of two staff supervising the activity, and that only staff and clients who had completed training and passed the Safe Behaviour Assessment could be involved in that activity.

173. There is no record that Mr D was signed off as being trained and competent in the use of power saws. However, on 30 September 2010, Mr D agreed to supervise two clients who required "close" supervision in the woodshed, and for that purpose Mr D used a power saw, which he was not trained to use. This was contrary to Timata Hou policy, as set out above.

174. There were concerns about Mr A's ability to take direction, and that he could be easily distracted. Mr A had not been signed off to use power tools, and there is no record of Mr A having passed a Safe Behaviour Assessment. However, Mr A used the

circular saw at the woodshed on 30 September 2010. Mr A did this with Mr D's knowledge, and contrary to Timata Hou policy.

175. At about 10.15am on 30 September 2010 Mr A had a non-injury accident with the circular saw. Mr D instructed Mr A not to use the circular saw again. Timata Hou's August 2010 Safe Handling Policy and Procedure stated that "[a]ll safe handling incidents will be reported and investigated as per Incident reporting …", and its Incident Reporting policy specified that all accidents, incidents and near misses were to be reported within 24 hours of the incident/accident occurring. The incident reporting policies do not set out who is responsible for reporting incidents; however, in my view, there was a responsibility on both employees "in the room" to ensure that a report was completed and appropriate actions taken. That did not happen in this case.

176. At around 11.15am, Mr D was called away from the woodshed to manage a client who had returned with his supervisor because of behavioural issues. Contrary to policy that a minimum of two staff are required to supervise clients in the woodshed, and contrary to the supervision level assigned to the clients he was caring for that day, Mr D left CSW Mr F to supervise all three clients working in the woodshed. It was during this time that Mr A started up the circular saw and the accident occurred.

177. Mr D was an experienced CSW at Timata Hou. However, on 30 September 2010 Mr D failed to comply with his responsibilities to identify and mitigate risk, as set out in his job description. The risks that Mr D should have identified and responded to included:

- It was raining on 30 September 2010 and the work area and electrical equipment were exposed to the rain. Mr D stated that on 30 September 2010, he had planned to stop work in the shed for the day, as the work area and electrical equipment were exposed to the rain. However, before he could action this plan, he was called away.

- When an additional client was brought along, which impacted on safe staff–client ratio, there were options open to Mr D to manage the need to assist with the additional client, other than leaving Mr F alone in the woodshed to supervise three clients. For example, he could have ceased the woodshed activity for all clients and relocated the clients to the activity room, or he could have taken one of his clients with him.

178. Ms Boyes advised that the structure, practices and processes in place at Timata Hou, and the fact that staff were not provided with sufficient information and/or training to make informed decisions, make it difficult for her to assign individual responsibility.

179. It is clear that there were deficiencies in Timata Hou's systems for staff training and assessment, and for ensuring that staff were aware of, and compliant with, policies. Although I am critical of Mr D for failing to comply with Timata Hou policies regarding the use of, and supervision of, clients using power tools when he was not trained to do so, and for never reporting and responding to Mr A's first incident on 30

September 2010, I accept that these failures were in part attributable to poor organisational practices.

180. Mr D made a number of errors of judgement on 30 September 2010, in that he continued to allow clients to work in the woodshed using electrical equipment when it was exposed to increasing levels of rain, and he left Mr F alone in the woodshed to supervise three clients, which impacted on safe client–staff ratios for those clients. I am critical of Mr D's actions in this regard; however, in the circumstances, I do not find Mr D in breach of the Code in respect of the care provided to Mr A.

Recommendations

181. I note that Timata Hou has already apologised to Mr A for its breach of the Code. In addition, I recommend that Timata Hou Ltd:

- review the issues identified by Mr J in his Sentinel Event report of February 2011, and report back to HDC by **22 July 2013** on steps taken to address the issues highlighted by this report and the Department of Labour's investigation;
- arrange an external peer review of site hazards and risk assessment plans, and an audit of key health and safety requirements and adherence to individual risk assessment plans, and report back to HDC by **22 July 2013** on the outcome of the review and audit; and
- review its documentation, communication, work place settings, staff supervision, and staff skills levels in relation to the provision of a safe environment for its clients, and report back to HDC by **22 July 2013** on the outcome of this review.

182. I recommend that Mr F:

- apologise to Mr A for his breach of the Code. The apology is to be sent to HDC by **22 July 2013** for forwarding; and
- advise HDC if he is working with, or is intending to work with, consumers with intellectual impairments and, if so, undertake health and safety and risk assessment training, and report back to HDC by **22 July 2013** on the training undertaken.

183. I recommend that Mr E:

- apologise to Mr A for his breach of the Code. The apology is to be sent to HDC by **22 July 2013** for forwarding; and
- undertake health and safety and risk assessment training, and report back to HDC by **22 July 2013** on the training undertaken.

184. I note that Ms C has already apologised to Mr A for her breach of the Code. In addition, I recommend that Ms C:

- advise HDC if she is working with, or is intending to work with, consumers with intellectual impairments and, if so, undertake risk assessment training and report back to HDC by **22 July 2013** on the training undertaken and any additional steps taken to review her practice.

Follow-up actions

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

- A copy of this report will be sent to the Department of Labour.

- A copy of this report with details identifying the parties removed, except the name of Timata Hou Ltd and the name of the expert who advised on this case, will be sent to the Ministry of Health and IHC NZ Incorporated and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent disability sector advice to the Commissioner

The following expert advice was obtained from Margaret Boyes:

"I have been asked to provide an opinion to the Commissioner on case number 11HDC00384. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have worked in the Disability Sector for the past 18 years and have held a range of positions. I have worked as an Early Intervention Teacher, Social Worker, Manager of a Child Development Service, Supported Independent Living Coordinator, and as an Independent Contractor reviewing services and providing individual service designs. For the past five years I have worked as an independent advocate for people with disabilities.

I have been requested to advise the Commissioner whether in my opinion, Timata Hou Ltd, [Ms C], [Mr E], [Mr D] and [Mr F] provided services to [Mr A] of an appropriate standard. I have been asked to comment on the following:

1. Did Timata Hou Ltd have adequate assessment systems in place to ensure that [Mr A] was provided with an appropriate work skills programme?

2. Did Timata Hou Ltd have adequate training and management systems in place to ensure that staff provided [Mr A] with appropriate supervision?

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

4. Is there anything else Timata Hou Ltd should have done to prevent this incident?

In forming my opinion I have reviewed the following documents:

- Complaint to the Commissioner from [Mr B], Department of Labour Inspector, dated [date], marked with an 'A'. (Pages 1 to 18)
- [Specialist Assessment Report] on [Mr A], dated 11 March 2010, marked with a 'B'. (Pages 19 to 68)
- Response from Timata Hou Ltd, dated 8 November 2011, marked with a 'C'. (Pages 69 to 242)
- Transcript of Department of Labour interview with [Mr F] on 5 November 2010, marked with an 'E'. (Pages 270 to 287)
- Transcript of Department of Labour interview with [Mr E] on 7 March 2011, marked with an 'F'. (Pages 288 to 302)
- Transcript of Department of Labour interview with [Ms C] on 7 March 2011, marked with a 'G'. (Pages 303 to 337)
- Transcript of HDC interview with [Mr E] on 23 February 2012, marked with an 'H'. (Pages 338 &339)

- Transcript of HDC interview with [Mr D] on 23 February 2012, marked with an 'I'. (Pages 340 & 341)
- Record of a meeting with [Mr A] on 23 February 2012, marked with 'J'. (Page 342)
- Transcript of HDC telephone interview with [Mr F] on 15 March 2012, marked with a 'K'. (Page 343)
- Transcript of HDC telephone interview with [Ms C] on 17 April 2012, marked with an 'L'. (Page 344)

Background

[Mr A] has Attention Deficit Hyperactivity Disorder. In 2003 he was diagnosed as having a moderate intellectual disability. He receives medication daily for depression and attention deficit disorder.

On 30 September 2010 when [Mr A] was aged […] years, he was attending a work skills programme run by Timata Hou Ltd (a subsidiary of IHC) at its outdoor site woodshed. [Mr A] was assigned a supervision ratio of 2:1 (two clients to one staff member).

[Mr F] was the supervisor for [Mr A] and one other client that day. [Mr F's] second client refused to work in the woodshed and stayed in the meeting room. Community Support Worker [Mr D] was also at the woodshed that day supervising two other clients removing staples from wooden pallets and stacking firewood.

During the morning meeting on the 30 September, which involved all the staff [present] that day, the decision was made to permit [Mr A] to use a circular saw at the woodshed that day to cut up wooden pallets for firewood.

At 10.15am, [Mr A] had an accident with the circular saw, when his clothing became tangled in the saw blade. It was decided that it was not safe for him to continue using the saw, and he was asked to help [Mr D].

Shortly after this incident, [Mr D] was called away by another staff member to assist with a difficult client. [Mr F] alternated with using the circular saw and stacking firewood with the clients. About 15 minutes after [Mr D] left the shed, [Mr F] also left to check his client in the meeting room, leaving the three clients unattended.

When [Mr F] returned, he found [Mr A] using the circular saw. [Mr F] didn't intervene but continued stacking wood. Five minutes later, at approximately 11.30am, [Mr F] heard [Mr A] scream. He turned round to see the saw in [Mr A's] abdomen.

Emergency services were notified at 11.52am. [Mr A] was treated at the scene then taken to [the public] Hospital for emergency surgery.

The Department of Labour commenced an investigation into the accident.

Did Timata Hou Ltd have adequate assessment systems in place to ensure that [Mr A] was provided with an appropriate work skills programme?

The Investigation Report completed by the Department of Labour and the Sentinel Event Investigation Report completed by [Mr J] identify inadequacies in relation to assessment systems used to identify appropriate activities for [Mr A] to be involved with.

Despite the provision of documentation which indicated issues which should have prompted concern around the use of machinery by [Mr A] he was allowed to use power tools. This included the [Specialist Assessment Report], excerpts of which were included in [Mr A's] Individual Care and Rehabilitation Plan. e.g.

> '*[Mr A] can comprehend simple concrete instructions, but appears to become confused or misinterpret conversations that involve abstract discussion. For example during interviews if questions were not broken down into smaller parts, he had difficulty trying to understand. He often acted as if he understood something, but when asked to clarify his understanding it was sometimes evident that he did not.'*
>
> *'Reports indicate that [Mr A] often struggled to sustain his attention during interviews or in the class room he would easily get distracted by stimulus and movement around him.'*

The Individual Care and Rehabilitation Plan has space to record possible side effects of prescribed medication, this section was not completed and would have acted as an alert to the suitability of [Mr A] operating power tools and machinery without further investigation.

There is no recorded risk assessment by a trained professional in relation to the use of power tools by [Mr A] taking into consideration his intellectual disability, ADHD diagnosis and current medication regime.

Individual staff members have given verbal feedback that [Mr A] received training in the use of the skill saw but there is no record of this having being completed.

There is documentation relating to [Mr A] receiving training and being deemed competent around the use of a weed-eater and lawn mower. The training elements are broad based and do not give enough detail to ascertain how comprehensive the instruction was, also competency would then only be reviewed on an annual basis.

There are reports that [Mr A] did not follow instructions as per use of the lawn mower, a piece of equipment he was deemed competent in using. This in itself should have indicated a need to review his competency in relation to use of the lawnmower and acted as an alert around his use of further mechanical/electrical equipment.

In my opinion Timata Hou Ltd's assessment and documentation processes were inadequate, the cumulative impact of [Mr A's] intellectual disability, ADHD

diagnosis and medication regime were not considered in relation to his safe use of machinery and power tools. Choice of activities was related to those on offer [there].

Did Timata Hou Ltd have adequate training and management systems in place to ensure that staff provided [Mr A] with appropriate supervision?

Again both the Investigation Report completed by the Department of Labour, and the Sentinel Event Investigation Report completed by [Mr J], identify inadequacies in relation to training and management systems to ensure that staff provided [Mr A] with appropriate supervision.

Training appears to be through observation of other staff using equipment. While a Draft Activity Risk Assessment & Management Form (note this document was dated March 2008 and remains in draft format) has been provided as part of the documentation to review there is no clear pathway to indicate this has been read or understood by staff.

Written documents outlining staff competencies show no indication of staff having any formal training in the safe use of a circular saw and there is no indication that staff have received any formal training in the instruction of people with disabilities.

Decisions made around participation of [Mr A] in activities appear to have been made on a casual basis rather than through any informed process including comprehensive risk assessments.

Supervision requirements are based on observation and made without the full input of [Mr A's] support team who may have relevant information to provide to enable a more informed decision to be made about the participation of [Mr A] in certain activities.

On a daily basis it appears this decision can be left to staff who have no formal training in risk assessment or who themselves are untrained in the use of the equipment to be used.

While it is indicated there are a range of supervision levels allocated to individuals dependent on their support needs and behaviour, on the day these levels were not maintained.

Alerts were recorded in a range of documentation which should have informed staff of supervision issues but do not appear to have been acted upon or well communicated to support staff, including both those related to [Mr A] and supervision in general which heightened the risk of an accident occurring.

[Mr A's] Individual Care and Rehabilitation Plan was updated in August 2010, with the following information:

> *'[Mr A] has enjoyed working [here], and has an excellent work ethic. This has resulted in a decreased level in supervision, although he still requires active support as his enthusiasm around machinery can be a potential risk.'*

The Life Skills Team Meeting Staff minutes dated 14.09.10 included the following statement:

'[Mr I] brought up clients using power tools without staff around'

Two weeks later, only two days prior to [Mr A's] accident the Life Skills Team Meeting Staff minutes, dated 28.09.10, included the following statement indicating concerns around capacity to supervise clients adequately:

'Team managing clients due to overflux of other clients working [here]'

Despite these concerns there appears to have been no change in practice and in fact on the day of the incident supervisory requirements were clearly breached with clients being left alone and staff left to supervise clients above ratios deemed necessary for safe supervision.

Staff did not complete an incident report for the earlier incident which led to a decision being made that [Mr A] was not to use the circular saw. Policy was not followed and the lack of records such as this means that decisions are based on anecdotal evidence rather than clearly documented incidents which may indicate a pattern of unsafe behaviour/practice and lead to change in either practice or participation in activities.

In my opinion Timata Hou Ltd did not have adequate training and management systems in place to ensure that staff provided [Mr A] with appropriate supervision. Staff were not trained in the safe use of the power tools themselves and management systems did not adequately identify risks or respond to identified risks.

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

The Health and Safety Audit Tool was generic in format and not targeted to the activities involved in the Life Skills Programme.

The lack of documentation indicates that there was insufficient oversight of health and safety issues and relevant staff training.

Staff interviews indicate that some staff have been promoted from within the service rather than having been recruited for specific skills around tasks being provided and as a result do not necessarily have the knowledge required to make informed decisions around client participation in activities with an element of risk nor to train them in skills related to the activities provided.

The positions of: Care Manager, Life Skills Manager, Life Skills Coordinator and Support Worker purport to have functional relationships with each other within the Job Descriptions provided, in practice communication between each of these positions was not optimal and people were not fully informed of relevant information.

These positions all included elements of risk identification and risk management within their job description but this was not well established in practice.

The work environment was unsafe with an uneven dirt floor, the risk of water reaching electrical appliances and the use of an unsafe extension cord being some of the identified hazards not addressed within the work environment. Even though it was noted that it was unsafe to continue working due to the wet weather conditions, work was allowed to continue.

In my opinion Timata Hou Ltd did not have rigorous assessment and review processes in place which would have mitigated some of the risk factors which were evident upon review of the documentation.

Is there anything else Timata Hou Ltd should have done to prevent this incident?

Timata Hou Ltd should have sought expert opinion on the suitability of [Mr A] using power tools and if he was to, in consultation with suitably skilled individuals develop a training programme, risk assessment analysis and competency assessment tool specific to [Mr A's] needs.

Improved communication between staff and comprehensive training in relation to the tasks being undertaken would have improved the level of service provided to [Mr A] and other clients.

Margaret Boyes
Advocate
Voice Advocacy Trust"

Additional advice

"With regards to the degree of Timata Hou Ltd's departure from accepted practice in relation to the service provided to [Mr A] I would consider it to be severe. There were too many indicators of risk factors which were either not taken into consideration or were not acted upon when they became apparent for it to be considered anything less than a severe departure from accepted practice.

I believe these events were systems issues, while each individual had responsibility for risk identification and management it was clear that there was no clear oversight as to the efficiency and enactment of service policy and procedures and that there was insufficient communication between parties to make and act upon decisions relating to individuals needs. The severe lack of robust systems contributed to the events which led to this unfortunate incident.

Margaret Boyes
Advocate
Voice Advocacy Trust"

Further additional advice

"The organizational structure, practice and processes at the time make it difficult to assign individual responsibility. Individual staff were not provided with sufficient information and/or training to make informed decisions about the tasks [Mr A] participated in and to provide competent supervision.

Timata Hou Ltd needs to review documentation, communication, work place settings, staff supervision and staff skill levels to ensure they can provide a safe environment for the people that they support which allows them to participate in meaningful activity, while also giving them the opportunity for personal growth and development.

Margaret Boyes
Advocate
Voice Advocacy Trust"