HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Poor management of incidents by provider of supported living services

Summary of events

1. In Month11 YearG, HDC received a complaint from Ms A[1] about the care provided to her by IDEA Services (IDEA), Ms B (IDEA service manager), and Ms D (IDEA area manager). The complaint concerns IDEA's management of Ms A[2] allegedly being verbally and sexually abused by her flatmate, Mr C, in supported living during a period of public health restrictions.[3] Ms A has an intellectual disability and was supported by IDEA under a supported living agreement from YearB to YearH. Ms A lived with three male flatmates (including Mr C), who were also supported by IDEA.

2. Ms A said that Mr C had sexually assaulted her two years prior to the events discussed in this case and that IDEA was aware of this. However, IDEA said that it was aware only of a physical altercation[4] between the two in Month3 YearE. During the period of public health restrictions, Ms A had less support from IDEA than usual[5] and met with her support worker only virtually.

3. IDEA's records show that during the restrictions there was regular reporting to the Ministry of Health on the status of other clients, which included reference to clients requiring additional support or risk assessment. Ms A was not included in this reporting. IDEA told HDC that its public health restrictions guidance had to be developed quickly in a fast-moving environment, and different levels of reporting were required depending on the support service involved and individuals' assessed needs and risks. IDEA said that Ms A was assessed as capable of living independently, and therefore she was not considered to be at any serious risk that would require specific monitoring or reporting.

4. In response to the provisional opinion, IDEA advised that there were no such broad reporting requirements by the Ministry of Health at the time, and the assessment of Ms A's independence and support requirements was completed by the Needs Assessment and Service Coordinator (NASC)[6] and not IDEA.

[1] Ms A was 51 years of age at the time of the events.
[2] Ms A was moved out of the flat and, as of Month3, YearH, no longer receives services from IDEA.
[3] The country experienced nationwide restrictions lasting approximately two months to manage public health concerns.
[4] Mr C had allegedly yelled at Ms A and hit her over the shoulder with a closed fist.
[5] Ms A would usually have been seen face-to-face, five days a week.
[6] A NASC organisation helps individuals to identify their support needs and access appropriate services.

5. Welfare checklists were also used for some clients, but there was no completed checklist for Ms A. IDEA told HDC that the checklist tool was developed to assist where it was considered necessary, and it was not considered necessary for Ms A.

6. Between Month4 and Month5 of YearG, progress notes (mainly authored by support workers) show that Ms A raised some concerns about the flatmates 'getting a bit frustrated with each other'. Midway through Month5, a support worker filed an incident report as she had heard arguing and yelling between flatmates. The report was closed in late Month5 by Ms B, noting that Mr C was being monitored. Another incident report was filed mid Month5 by a support worker who had heard a voicemail message of the flatmates arguing.[7]

7. Three days later in Month5, a support worker made a further incident report following concerns raised about Mr C bullying Ms A in the way he spoke about her.[8] Another incident report[9] was made by a support worker on the same date, as a flatmate had said they had witnessed Mr C shouting at Ms A. Ms B was made aware of this incident via text message from the support worker. A further incident report[10] was lodged on the same day by a support worker following a discussion with Ms A about her safety in the flat.

8. An incident report[11] was lodged by a support worker on the following day as Ms A had expressed fear about Mr C and fear for her personal safety. Ms B was on a period of sick leave between Month6 and Month7 YearG.[12] It is unclear when during these periods Ms B was working, as often she was attending meetings and answering emails and phone calls but was on sick leave.[13] In late Month5, a support worker heard Mr C yelling at Ms A during a phone conversation with her and so the support worker escalated her concerns to Ms B and lodged another incident report the following day. About a week later in Month6, a further incident report[14] was submitted by a support worker as another flatmate had told her that Ms A had been 'attacked' by Mr C 'years ago' and they were concerned about Mr C hurting Ms A. The support worker contacted Ms D by email, as Ms B was on sick leave at the time.

9. In early Month6 YearG, Ms A raised further concerns with a support worker about her experience in the flat, and the support worker organised for her to stay with a friend. The

[7] Ms B closed the incident later in Month9, noting that no further action was required.
[8] Closed later in Month9 by Ms B following an internal review conducted by IDEA.
[9] Closed in late Month4, YearH following Ms B's resignation from IDEA.
[10] Closed in late Month5, noting that there had been an increase in tension in the flat, which had been brought to Ms B's attention in Month4 and Month5, and that staff were continuing to monitor the situation.
[11] The report noted that Ms A's wellbeing was being impacted by Mr C and that staff would continue to monitor the situation.
[12] Some records state early Month6 to late Month7 YearG, and others state six days in early Month6 and then late Month6 to late Month7, YearG.
[13] Ms B told HDC that she was on sick leave from early Month6 to late Month7 YearG and that she did attempt to work for a few days in the middle of the sick leave. A medical certificate was provided (retrospectively) in late Month6 for leave taken from early Month6 to late Month6.
[14] Closed in late Month9 YearG following IDEA's internal review.

support worker documented that she contacted Ms D to update her and lodged an incident report.[15]

10. In response to the provisional opinion, Ms D said that when she was advised of the concerns, her understanding was that Mr C was being verbally aggressive and shouting at Ms A. She said that these concerns were first brought to her attention in an email from a support worker at 6.51am early in Month6. Ms D said that she was travelling to a meeting that morning and spoke briefly with a support worker about the incident report before leaving. She said that she then called Ms B, but she did not answer. Ms D stated that following her meeting, she contacted the support worker who had emailed her that morning to obtain further information. She then discussed plans for Ms A to be relocated that day and offered further support to the support worker.

11. The support worker completed another incident report on the day of the email to Ms D following a discussion with Ms A, who reported that Mr C had tried to force her to give him money and had said that if she refused, he would tickle her. The support worker documented that she discussed the events with Ms D that night, but the incident was not closed until late Month9 YearG.[16] The support worker also sent an email to Ms D and Ms B (later forwarded to the regional manager) outlining her concerns about Ms A's safety and wellbeing. Ms D told HDC that when she was made aware of the issues between Ms A and Mr C on the day of the email, she 'immediately took steps to assist [the support worker] to support Ms A out of the flat'. Ms D said that she tried to contact Ms B but received no response, she spoke with a senior support worker to obtain further information, and she briefed her regional manager.

12. The next day, a support worker filed an incident report following Mr C disclosing that another flatmate would take off his clothes and ask others in the flat to do the same, and that the flatmate would ask Ms A to massage him when they were naked. The support worker contacted Ms D, who told her to file an incident report.[17] In response to the provisional opinion, Ms D told HDC that around that day or the next day, she further escalated the matter to the National Manager of Quality, the lead psychologist, and the regional manager, and she sent an email to the involved support workers to thank them for their support of Ms A. Ms D said that she then ensured that Ms A was supported to go to the doctor, and she followed up to ensure that the appointment had occurred. Ms D said that she was speaking with the regional manager about this matter, and she understood that she was managing the matter appropriately. Ms D said that she met with Ms B that week and reiterated that all incidents had to be reviewed and progressed by Ms B as part of her role.

13. Four days after this meeting, a support worker sent an email to Ms B advising that Ms A had told her that Mr C had touched Ms A's breasts during the period of public health restrictions, and that they had had sex the previous year without her consent. Ms B did not respond to

[15] Closed late Month9 YearG following IDEA's internal review.
[16] Following an internal review conducted by IDEA.
[17] Closed at the beginning of Month5 YearH.

this email, and an incident report was not completed. IDEA said that given the nature of what was disclosed, it would expect staff to complete an incident report in accordance with its Incident Reporting Policy and guidelines.

14. In late Month6 YearG, a support worker sent an email to the regional manager raising concerns about the support for the flatmates and the support that had been provided to staff to manage the situation. The regional manager advised that a member of the Quality team would be conducting an internal review. In late Month6, the support worker forwarded the email that she had sent to Ms B earlier in Month6 to Ms D, as she still had not received a response from Ms B.

15. Late in Month6 YearG, Ms D sent an email to the NASC informing it about the sexual assault allegations, and a connector[18] was organised to assist Ms A in seeking further support. In early Month7, the Police were notified about the allegations but decided that no further Police action was required because all the individuals involved had severe intellectual disabilities and would not be considered reliable or capable of attending court. In early Month8 YearG, Ms A made a formal complaint to the regional manager, but this was not responded to, or acknowledged, until late Month8. The response included an apology to Ms A but concluded that there was insufficient information held by IDEA to have intervened beyond supporting the change in accommodation, despite the critical findings of the internal investigation (discussed below).

16. An internal investigation was undertaken by IDEA in Month7 YearG and finalised in mid-Month7. The investigation found that 11 of the 14 incident reports remained at 'awaiting update from manager' status at the time of the review and had not been followed up adequately or in a timely manner; the lack of action from Ms B led to staff escalating concerns to Ms D, and there were eight incidents recorded where staff had gone directly to Ms D but only one incident report outlined the outcomes of the discussions between Ms D and the support worker involved; support staff felt burdened with the responsibility of having to find solutions to incidents and were desperate for guidance; and there was no evidence of the complaint process being followed for two of the incidents reported in Month5 YearG.

Responses to provisional opinion

Ms A

17. Ms A was given the opportunity to comment on the provisional opinion. Her representative, who responded to HDC on Ms A's behalf, said that Ms A thought the recommendations were 'good' and would ensure that other people are safe and 'not at risk'. Ms A's representative also told HDC: 'Ms A connected this outcome with her initial hope that what happened to her would not happen to anyone else.'

[18] A role that supports people with disabilities and their families in achieving their goals by connecting them with resources, services, and community opportunities.

IDEA Services

18. IDEA was given an opportunity to comment on the provisional opinion. IDEA advised that overall, it accepted the proposed findings and recommendations.

19. IDEA advised that it commissioned an independent review of Supported Living services in the specific region (completed in Month12 YearK). IDEA said that the review found the following:

> 'Not one person complained about their staff or the value of support provided by [IDEA] which is remarkable given the openness of the discussion, reassurance that anything [that] arose would be confidential and the challenge for any service to be able to get the right people at the right place at the right time every time.'

Ms B

20. Ms B was given an opportunity to comment on relevant sections of the provisional opinion. She advised that she was instructed not to report the sexual assault allegations notified by the support worker in mid Month6 YearG to the Police until IDEA's lawyers had spoken to Ms E. Ms B said that she went to the general manager when she heard of the allegations and was told that as the residents of the flat were adults, 'they are free to do whatever they want', which she contested.

21. Ms B stated that she was on sick leave for six weeks in the relevant time period, and she returned to work only for one day. She said that when she returned, she had to deal with another serious situation and was told that Ms E would deal with the situation concerning Ms A. Ms B said that she was not involved with the IDEA internal review and was read only one page that she was told concerned her. Ms B noted that IDEA has been the subject of many complaints of abuse and neglect but personally in her 30-year career she has had no complaints made against her.

Ms E

22. Ms E was given the opportunity to comment on relevant sections of the provisional opinion. Ms E noted that she was responsible for around 228 staff, and it was not possible for her to liaise directly with all support workers. Ms E said that it was the role of the service managers to liaise directly with the support workers and the people they support, and she was 'heavily reliant on those Service Managers, who reported directly to [Ms E], to keep [her] relevantly updated, including about any sick-leave (so [she] could arrange cover), and to bring matters of concern to [her] attention'.

23. Ms E stated that she took appropriate steps in the processing and completion of relevant incident reports and in directing Ms B to complete other open incident reports, but incident reports that were not flagged as 'high' or 'critical' risk would not automatically come to her attention. Ms E said that Ms B had ample opportunity to bring these matters to her attention, but she did not. Ms E stated that IDEA's internal investigation confirmed that she took all appropriate steps as an area manager. She stated:

> 'Based on the information I had at the time, I do consider that I took appropriate action to manage and escalate the concerns that were raised with me, and I showed leadership and support.'

24. Ms E said that she felt that she did not receive appropriate support from the Quality team when she raised concerns about incident reporting with them.

25. Ms E said that she would hold weekly meetings with service managers, and it was the responsibility of the service managers to attend the meetings. She stated that she would also hold monthly meetings with the service managers, where they were expected to raise any matters considered medium or high risk or 'cumulative low risk incidents'.

26. Ms E told HDC:

> 'On a heartfelt level, I am devastated that despite my dedication to those we supported at IDEA, this incident occurred and I was not made aware of Ms A's disclosure of mid Month6, YearG.'

Opinion

27. As part of my investigation, I sought independent clinical advice from disability services expert Dr Christine Howard-Brown (Appendix A) about the care provided to Ms A by IDEA, Ms B, and Ms E.

28. In considering the circumstances of this case, I acknowledge that the situation New Zealanders were confronted with during the public health restrictions was extenuating with the impact keenly felt by everyone. I also recognise that the ramifications of the public health restrictions were challenging for health and disability service providers across the board to navigate and manage. IDEA's ability to support its clients was significantly hampered during the restriction periods and in the period following. However, notwithstanding this challenging situation, ultimately IDEA was responsible for ensuring that its clients were safe. This investigation has identified shortcomings in IDEA's management of reported incidents and complaints over this period, which ultimately compromised the wellbeing of Ms A. I am critical of IDEA for not taking appropriate action at the time. With the compromised engagement IDEA staff had with its clients on a day-to-day basis, IDEA needed to be vigilant to its clients' circumstances and to have in place an effective system for assessing and responding to issues of concern.

29. During the public health restriction periods, IDEA did not report to the Ministry of Health on Ms A, and no welfare checklist for her was in place, despite both actions being taken with respect to other clients. IDEA said that this was not necessary for Ms A as she was not considered to be at serious risk. While I acknowledge that Ms A was largely independent, I do not consider that there were no risks to be considered in relation to her wellbeing during the restrictions period. There had been previous reports of violence between Ms A and Mr C, and public health restriction periods presented a unique living situation that could have presented additional risk factors. Specifically, the 'house mates' were forced to live in close proximity to each other for extended periods with, it seems, little opportunity for reprieve.

Dr Howard-Brown advised that the failure both to have in place a welfare checklist and to report to the Ministry of Health on Ms A represents a moderate departure from accepted standards. I note Dr Howard-Brown's comment that had it not been for the restrictions, this would have been followed up by the Ministry of Health.

30. In response to the provisional opinion, IDEA advised that there were no such broad reporting requirements by the Ministry of Health at the time, and the assessment of Ms A's independence and support requirements was completed by the NASC and not IDEA. IDEA stated that, with this in mind, it does not consider that there was any departure from an accepted standard of care. While I acknowledge IDEA's comments, it is my view that it was the responsibility of IDEA (as the service with regular day-to-day contact with Ms A) to assess and manage any risks specific to Ms A and to report to the Ministry of Health on any such risks.

31. Regarding the management of Ms A's formal complaint to the regional manager in early Month8 YearG, Dr Howard-Brown advised that it is unclear whether the complaints investigation process had been followed, and the response from IDEA to Ms A and investigation of the complaint were not linked to the internal investigation completed in Month7. This is particularly concerning, as the response to Ms A concluded that there was insufficient information held by IDEA for it to have intervened. On the contrary, there was ample evidence held by IDEA from Month5 YearG that the environment in the flat was becoming dangerous to Ms A's health and wellbeing, and the internal investigation completed in the month preceding the formal complaint confirmed that these concerns had not been acted on appropriately at the time.

32. It is also of note that although Ms A's complaint was made in early Month8, it was not acknowledged or responded to until late Month8. Dr Howard-Brown advised that overall, the appropriateness of the complaint responses would be considered a major departure from accepted standards, as the lack of action by IDEA 'clearly demonstrated increasing risk to kiritaki safety'. Right 10(3) of the Code of Health and Disability Services Consumers' Rights (the Code) states that 'every provider must facilitate the fair, simple, speedy and efficient resolution of complaints'. In my view, by failing to acknowledge or respond to Ms A's complaint in a timely manner and failing to acknowledge that there were shortcomings in the care provided to her (as identified in the internal investigation), and because of the overall poor management of Ms A's increasing concerns during YearG, IDEA failed to facilitate the resolution of Ms A's concerns and breached Right 10(3) of the Code.

33. With respect to the care provided by Ms B, Dr Howard-Brown advised that Ms B's response to concerns raised, including incident reports, progress notes and emails, did not meet an acceptable standard. Dr Howard-Brown also advised that Ms B failed to escalate concerns to Ms D or the regional manager. I note that it is unclear when Ms B was on sick leave due to the conflicting accounts. However, Dr Howard-Brown advised that despite this period of extended leave, the actions and inactions of Ms B represent a moderate departure from accepted practice. I agree. While I acknowledge that Ms B was on leave for some time, concerns were raised by support workers as early as Month5, and I note that as identified in the internal investigation, there were 11 of 14 incident reports awaiting update by Ms B.

For these reasons, I am satisfied that Ms B was aware of the support workers' escalating concerns for Ms A and failed to take the appropriate action.

34. Right 4(2) of the Code states that 'every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards'. IDEA had in place an Incident Management Policy, which outlines the incident management responsibilities of service managers. The policy states:

> 'Once notified of an incident follow up as required. Immediately assess the situation and provide support or advice that puts people's safety first … Investigate all reported incidents and near-misses.'

35. The policy also states what investigation steps need to be taken, including providing support to support workers if needed, completing the investigation, closing the incident in the system, and checking incident reports for patterns and themes. In my view, by failing to respond appropriately to the frequent incident reports and concerns raised with her as the service manager, Ms B failed to provide services to Ms A that complied with relevant standards and breached Right 4(2) of the Code.

36. Regarding the care and oversight provided by Ms D, Dr Howard-Brown noted that Ms D had been contacted by both support workers and the regional manager about Ms A, but there was confusion about when Ms B was on sick leave. Dr Howard-Brown advised that Ms D did not respond swiftly enough to the concerns raised with her in early Month6, and that this failure constitutes a moderate departure from accepted standards. However, I also note the mitigating factors, including the confusion in Ms B's sick leave, that the incident about which Ms D was aware on two days in early Month6 formed only part of the picture of escalating concerns, and that Ms B did not inform Ms D about the remainder of the concerns (as reflected in Dr Howard-Brown's advice). I note that there is also evidence that Ms D did take steps to assist support workers in managing Ms A's safety in early Month6, and that she escalated concerns appropriately. I also acknowledge Dr Howard-Brown's advice that Ms D did act appropriately in relation to the concerns raised with her in late Month6 YearG. Accordingly, I do not consider that Ms D breached the Code.

Changes made

37. IDEA told HDC that it has reflected on the complaint but does not consider that changes are needed to the service. Ms D told HDC that she continues to ensure the appropriate escalation of concerns and that important learnings and messages are communicated. In response to the provisional opinion, Ms D noted that she also continues to ensure that there are succinct 'next steps' notes visible to those present in meetings and that she takes part in actively escalating and/or leading and developing organisational working processes.

Recommendations

38. I recommend that IDEA and Ms B provide separate written apologies to Ms A for the failures identified in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A. I recommend that IDEA use an anonymised version of this report to conduct training for all staff on the importance of creating and updating

incident reports and conduct an audit of its incident reporting for a six-month period, to assess whether the reports have been managed in accordance with IDEA's Incident Management Policy. Results of the audit are to be sent to HDC within six months of the date of this report, with any remedial actions.

39. Notwithstanding that IDEA Services has said that it does not consider that changes are needed to the service, I encourage it to take this opportunity to review the workload and responsibilities carried by individual IDEA service managers and area managers to ensure that these are appropriate. As Ms B no longer works for IDEA Services, I recommend that she provide a written reflection to HDC on the care she provided in this case, which is to be provided to HDC within three months of the date of this report.

40. A copy of this report with details identifying the parties removed, except IDEA Services and the advisor on this case, will be sent to the Ministry of Health (HealthCert), Disability Support Services, and the Ministry of Social Development. The anonymised report will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Addendum

41. Ms B did not comply with the Deputy Commissioner's recommendations.

Appendix A: Independent advice to Commissioner

'Month10 YearJ

[…]
Complaints Investigator
Health and Disability Commissioner
Private Bag
Auckland

Kia ora […]

Re: Complaint: 20HDC02164/IDEA Services Limited

I agreed to provide an opinion to the Commissioner on case number **20HDC02164**. I have read and followed the Commissioner's Guidelines for Independent Advisors and am not aware of any conflicts of interest in relation to this case.

My qualifications are a Bachelor of Nursing (Massey University); Master in Business Administration (merit) (Victoria University of Wellington) and Doctor of Philosophy in Medicine (University of Otago). I have extensive experience working in the health and disability sector in a variety of roles, including executive and senior leadership, quality audit, service design and service improvement.

I received instructions from the Commissioner to review documents and provide an opinion on whether the care provided to Ms A by IDEA Services in YearG was reasonable in the circumstances, and why. In particular, there were six parts to the Commissioner's request.

Comment was requested in relation to the following items.

1. Whether the care provided to Ms A by IDEA Services between late Month3 to mid Month5 YearG (including that Ms A only saw her support worker virtually) was appropriate in the circumstances, including whether it was in line with the Ministry of Health Guidelines regarding disability service provision.
2. The appropriateness of the response from IDEA Services to the concerns raised by Ms A and support workers about Mr C's behaviour in YearG.
3. The appropriateness of the response from Service Manager Ms B to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms B appropriately escalated those concerns.
4. The appropriateness of the response from Area Manager Ms D to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms D appropriately escalated those concerns.
5. The appropriateness of the response from Regional Manager Ms E to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms E appropriately escalated those concerns.

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

The following documents were provided for review.

1. Letter of complaint dated late Month11 YearG.
2. Timeline of service provision by IDEA Services for Ms A.
3. Initial response from IDEA Services dated mid-Month1 YearH, and relevant attachments:
   - Needs Assessment (Month8 YearB)
   - Support Packages from Month10 YearB to Month9 YearC)
   - Referral for Supported Living (Month9 YearB)
   - Proposal Setup and Drafting Hours (Month8 YearB)
   - Formal Cease Notification (Month9 YearB)
   - Service Authorisation (Month9 YearB)
   - Property Brokers records (Month8 YearB, Month3 YearE)
   - Informed Consent Agreement (Month8 YearB)
   - Incident form (Month5 YearE)
   - Response to complaint letter (Month8 YearG)
   - Investigation report (Month7 YearG)
   - Investigation notes (Month7 YearG)
   - Risk and Control Information and Support Plan
4. Further information relating to public health restrictions (internal communications from YearG)
   - All incident reports for Ms A (beginning Month1 YearE – mid Month1 YearH)
   - Personal Support Information (Month1 YearC)
   - Personal Support Information (Month3 YearF)
   - MyPlan (Month12 YearG)
   - Funding details (YearA–YearH)
   - Internal correspondence regarding the closure of New Zealand Police investigation
   - Internal correspondence with Mana Whaikaha
   - Internal correspondence (Month6 YearG)
   - IDEA Services Supported Living Policy YearD
   - Information on essential and non-essential services for disability support service providers Month4 YearG
5. Further response from IDEA Services dated Month6 YearI, and relevant attachments:
   - Daily notes for Ms A dated Month3–Month10 YearG
   - Support plan
   - Email correspondence
   - Health Note for Dr appointment following sexual abuse allegation
   - Updated incident report table
   - Incident reports
   - Statement from Ms F (Support worker)
   - Training records for Ms B (Former Service Manager)

- Training records for Ms D (Former Area Manager)
- Service manager Position description (YearF)
- Service manager Position description (YearH)
- Area manager Position description (YearF)
- Area manager Position description (YearG)
- Protection of Vulnerable Children and Adults Policy
- Protection of Vulnerable Children and Adults Policy Quick Reference
- Incident Reporting and Response System Policy
- Incident Reporting and Response System Quick Reference
- Service User Complaints Policy
- Incident Management section in SM Ops Manual
- Incident Reporting section in Support Worker Manual
- Risk Assessment and Management Protocol section in SM Ops Manual
- Preventing Abuse and Neglect section from Support Worker Manual
- Ministry of Health DSS Supported Living Service Specification
- Service Managers Response to Acting Area Manager Month9 YearG
- Information relating to the complaint about the Area Manager

6. Information provided by IDEA staff member (previously employee of IDEA Services at the time of these events), including Formal complaint about IDEA Services Area Manager Ms D (sent to Regional Manager Ms E).
7. Response from Service Manager Ms B dated Month6 YearI.
8. Response from Ms D dated late Month8 YearI.
9. Official guidance from Whaikaha Ministry of Disabled People regarding disability service provision during public health restrictions.

To support the opinions I have expressed, I have relied on the following:

Health and Disability Services Standards — Health and Disability Services (core) Standards NZS8134:2008 NZS 8134.1:2008 :: Standards New Zealand[1]

Health and Disability Services (Infection Prevention and Control) Standards NZS8134:2008, available at: NZS 8134.3:2008 :: Standards New Zealand

The Code of Health and Disability Services Consumers' Rights, available at: Code of Health and Disability Services Consumers' Rights - Health and Disability Commissioner (hdc.org.nz)

Background

Ms A (aged 51 years at the time of these events) has an intellectual disability and has been supported by IDEA Services under supported living since YearB. Prior to this, she had been in IDEA Services' residential care. At the time of the agreement since events, Ms A lived with three male flatmates who were also being supported by IDEA Services. IDEA Services told HDC that Ms A chose her own flatmates in YearB.

[1] Note: now superseded by NZS8134:2021, but NZS8134:2008 was current at the time

During the public health restrictions in YearG, from Month3 to mid Month5, Ms A told HDC that she was sexually and verbally abused by one of her flatmates (Mr C, 55 years old, who she had been living with since YearB). She alleges that this flatmate had previously sexually assaulted her two years prior and that IDEA Services were aware of that incident. IDEA Services told HDC that while they were aware of a physical altercation (Mr C yelled at Ms A and hit her on the shoulder with a closed fist) between Ms A and Mr C in Month3 YearE, this was the first they had heard about any sexual activity (consensual or otherwise) between the two consumers.

Over the restrictions period, Ms A had less support from IDEA Services than usual and only met with her support worker virtually. She would usually have been seen face-to-face, five days a week. She told HDC that she was unable to express her concerns during these calls as her flatmate was always nearby.

IDEA Services explained that it was following the Ministry of Health Guidelines and was restricted in sending staff to visit service users who were independent and receiving limited support, referring to Month4 YearG guidance and a teleconference with MOH at the end of Month3 YearG. It noted at least 36 phone or video calls with Ms A during the restrictions, and the first time they became aware of more significant (non-sexual) abuse concerns was in May, and the sexual abuse disclosure was made after she moved out.

Ms A was moved out of the flat and, as of late Month3 YearH, no longer receives services from IDEA Services.

Advice

Comment is made in respect of questions raised by the Health and Disability Commissioner as below.

1. Whether the care provided to Ms A by IDEA Services between Month3 and mid Month5 Year G (including that Ms A only saw her support worker virtually) was appropriate in the circumstances, including whether it was in line with the Ministry of Health Guidelines regarding disability service provision.

During the first public health response restrictions, the government issued a range of orders and guidance that impacted health and disability providers. Disability Support Services, which was at that time part of the Ministry of Health, provided regular communications to providers to assist in navigating through what was a rapidly changing environment.

There was little time for health and disability providers to prepare for public health restrictions, where it was required that all non-essential businesses had to close. Public health restrictions were in place from later Month3 YearG to mid Month5 YearG.

The Ministry of Health was clear in its guidance to disability support providers, issuing more detailed correspondence the day prior to public health restrictions coming into effect about essential disability support services. Providers were required to assess on a case-by-case basis, what level of support was needed for kiritaki, including considering alternative ways of delivering essential services, such as virtual meetings, phone or post.

Information specific to residential disability providers was issued by the Ministry of Health late in Month4 YearG. This included advice to balance risks and take a cautious approach to any additional physical contact for the wellbeing of kaimahi and kiritaki.

Reducing social isolation as much as possible to support wellbeing was emphasised, along with continued use of personal protective equipment and social distancing.

The initial announcements effectively gave health and disability providers 48 hours to update their plans, policies and procedures such as major incident, risk management plan, management of hazardous waste plan, infection control programme and the infection outbreak management policy and procedure.[22] Although organisations certified under the Health and Disability Services (Safety) Act would have these documents, infection control documents were usually geared towards influenza and norovirus outbreaks and not public health restriction situations. Similarly, other major incident plans were geared towards natural disasters.

Peers would expect risk management plans to be in place for individual kiritaki, covering what level of support they may need in a natural disaster. This could then be used to determine the level of support needed during a time where usual supports were not readily available. Unlike a natural disaster plan that is based on a limited time period and/or the ability to move to an alternative environment, the restrictions did not provide this level of flexibility.

For Ms A, peers would expect the following factors to have been considered by IDEA Services in respect of restriction measures and risks this might pose for her:

— Reviewing risks in managing activities of daily living and usual support package. All documents reviewed (including historic incident reports) indicated that Ms A was independent but needed prompting. Ms A's support package was low, centring around a few hours per week to support household management, grocery shopping and meal preparation, budgeting and financial management, problem solving, reading and understanding mail and support booking or attending appointments. Therefore, she would be able to self-manage with remote support.

— Reviewing compatibility. Living in a flatting environment which although had been stable, was associated with the kiritaki having a lot of activities, including employment, outside of the flat, which meant this would represent a significant shift in the amount of time these flatmates would spend together. Reviewing compatibility would also include reviewing any incident reports that might point to risks to kiritaki safety and wellbeing. There had been one historic incident which could indicate increased risk to Ms A from another flatmate of physical aggression and controlling behaviour. A support needs assessment from yearB also notes that Ms A could be bossy towards others and at that time was undergoing a family planning course to learn about appropriate sexual behaviour as she was getting confused as to what was and was not appropriate which

[2] Or equivalent documents not necessarily named these.

included a reference to changing her mind when she had more time to reflect. This information suggested that Ms A may be vulnerable to physical, emotional or sexual abuse. The balance within the flat was also three males and one female. Together these factors would cause concern.

Peers would develop a safety plan in respect of these factors as together they represent current and new risks with the public health restrictions and requests by the Ministry of Health for remote contact where it was safe to do so. Relocating Ms A to a female friend's place may have been an option considered with more detailed planning. Alternatively, consideration of some face-to-face contact may have been included in a safety plan. IDEA Services did ensure that remote contact between kaimahi and kiritaki were with kaimahi known to the kiritaki which would be considered an important factor in moving to a remote contact model.

Progress notes and other documentation indicated that Ms A had 30 remote contacts between Month3 YearG and mid Month5 YearG. Notes indicated there was good contact between Ms A and her kaimahi during this period. There were no indications of any unusual concerns or risks to Ms A except for late Month3 and mid Month5 YearG. On the latter occasion, a flatmate had yelled at Ms A but subsequently there were no concerns in the following days. There were 28 records between this date and mid Month5 YearG that indicated Ms A was receiving adequate support by remote contact and that she was well and managing within the flatting environment. In mid Month5 YearG, kaimahi noted Ms A was distracted and not her usual self and that this related to another flatmate.

Having reviewed all correspondence, including Ministry of Health guidance, it is reasonable that peers would conclude that Ministry of Health guidance was followed and Ms A received adequate support from IDEA Services during the initial restriction period to mid Month5 YearG. From the level of information documented, it is difficult to know whether the response to the mid Month5 YearG remote contact was appropriately managed. Certainly this was the first indication of a change in the dynamics of the flat.

Peers would consider the flat compatibility and information known about each flatmate and Ms A's history as representing additional risks to the usual living situation in a restriction environment. Records provided for review did not include a detailed risk assessment for each kiritaki as part of determining whether full remote contact was appropriate. Given the rapidly moving situation of public health restrictions, it is understandable that this level of detailed assessment may have been overlooked in favour of the usual needs assessment and support needs documentation. As shown above, if only reviewing risks in managing activities of daily living and usual support package, then there were no concerns in remote working for Ms A. Peers would likely conclude that this was a moderate departure from accepted practice in that an inadequate risk assessment was completed in respect of compatibility of flatmates in a restriction situation.

I also note there was regular reporting to the Ministry of Health on the status of kiritaki within IDEA Services during the restrictions, which included reference to any kiritaki where concerns had been identified needing additional support or risk assessment. This did not

include Ms A. Reference is also made to a welfare checklist used by kaimahi during the restrictions period but there was not a completed checklist evident in records provided for review.

2. The appropriateness of the response from IDEA Services to the concerns raised by Ms A and support workers about Mr C's behaviour in YearG.

Ms A raised concerns as to Mr C through contacts with kaimahi in addition to a written complaint made mid Month8 YearG via an advocate. Kaimahi also raised concerns by way of emails, progress records and incident reports. The actions of the kaimahi support workers would be considered as meeting accepted practice by peers; however, the actions beyond this of managers falls short of expectations.

There was ample evidence of escalation of inappropriate behaviour and increasing distress of Ms A in records provided for review. It was clear from reading the information provided that kaimahi support workers were getting increasingly concerned about Ms A's safety, to the extent that they further escalated concerns and found alternative accommodation for Ms A with her female friend.

The written complaint made in early Month8 YearG was responded to in writing in late Month8 YearG. There was no record of acknowledgement of the complaint within five working days. The letter of response was sent by the Regional Manager and included an apology but concluded that there was insufficient information held to have intervened beyond supporting the change in accommodation which had occurred. It is unclear whether the complaints investigation process had been followed. It appears that the complaint response letter and investigation of the complaint were not linked with the investigation completed by the Quality Manager in response to a request from the Regional Manager in Month6 (and with a corresponding report in Month7) following concerns raised by kaimahi support workers.

The Quality Manager investigation identified that incident reports were not acted on in a timely manner. Up until the Quality Manager investigation, increasing incidents were not seen as representing an escalating situation that needed intervention by managers. For example, there were no corrective actions in response to increasing arguments at the flat. There were three incident reports awaiting manager update at the time of the investigation by the Quality Manager that had occurred in Month5 YearG, and all from Month6 YearG were awaiting a manager update. The Quality Manager concluded that 11 of 14 incidents (occurring in Month5 and Month6) were awaiting manager update as at mid Month7 YearG. All but one completed incident report did not record outcomes from concerns raised.

Kaimahi support workers felt unsupported by managers. Where complaints had been raised within incident reports, there was no evidence the complaints process was followed. The Quality Manager concluded that incidents and complaints were not managed to policy expectations. Note that the standard of the investigation and report by the Quality Manager was consistent with accepted practice.

Peers would likely concur with the IDEA Services Quality Manager that there were shortfalls in expectations in the management of concerns, incidents and complaints that occurred in relation to Ms A. There were shortfalls in the completion of usual activities consistent with policies. The appropriateness of the complaint responses would be considered a major departure from accepted practice because the inaction in response to information available clearly demonstrated increasing risk to kiritaki safety.

3. The appropriateness of the response from Service Manager Ms B to the concerns raised by Ms A and support workers in YearG, about Mr C's behaviour, including whether or not you consider Ms B appropriately escalated those concerns.
As summarised in question 2, the Service Manager's response to concerns raised, including incident reports, progress notes and emails, would not be considered to meet accepted practice by peers. There were examples of long delays to respond, insufficient responses and no responses where kaimahi support workers were left to escalate to others. There was also an absence of escalation by the Service Manager to the Area Manager or Regional Manager when this would have been appropriate (e.g. deciding not to contact the Police when there was a reportable event).

The role description was provided for the Service Manager. This clearly outlines the requirements of the role and relationship with others. This role description is consistent with accepted practice.

A summary of training records was also provided for review. This showed full completion of complaints webinar series, facilitation skills, effective communication, risk management and incident reporting amongst other topics. There was also partial completion of abuse prevention, vulnerability to abuse and keeping safe.

It is noted that the Service Manager was on sick leave herself for a period of this time (early Month6 to late Month7 YearG in one statement in the records reviewed and a shorter period of six days in early Month6 and then late Month6 to early Month7 in another). However, it is usual practice that another nominated staff member would be delegated to perform duties when a Service Manager is on leave. Peers would consider the responses and responsiveness of the Service Manager to be inconsistent with the expectations of the role. There are likely many mitigating factors such as her own sick leave and management across other services which contributed to a lack of responsiveness to concerns in respect of Ms A. Irrespective, peers would likely consider the actions and inactions to be a moderate departure from accepted practice.

4. The appropriateness of the response from Area Manager Ms D to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms D appropriately escalated those concerns.
There was evidence that the Area Manager had been contacted by way of escalation by kaimahi support workers and also by the Regional Manager when kaimahi support workers had contacted the Regional Manager in respect to concerns. Escalations to the Area Manager appear to have occurred in Month6 YearG.

The role description was provided for the Area Manager. This clearly outlines the requirements of the role and relationship with others. Within the role description, expected outcomes include compliance with quality systems and standards. This role description is consistent with accepted practice.

A summary of training records was also provided for review. This showed full completion of complaints webinar series, abuse prevention for managers, incident reporting and vulnerability to abuse topics.

Ms D was a point of escalation for kaimahi support workers and the Service Manager. If Ms D was covering for the sick leave of her Service Manager, which may have spanned most of Month6 and Month7 YearG, peers would consider the responses and responsiveness to concerns raised to be inconsistent with the expectations of the role. It would also be considered usual by peers that any concerns about abuse to be escalated beyond the Area Manager. It is not apparent in documentation reviewed that there was consistent escalation from the Service Manager to the Area Manager and beyond which resulted in the right levels of decision making and support. This may be partly a symptom of the ineffective review of progress records, incident forms[3] and emailed concerns from kaimahi. A mitigating factor may be any confusion in sick leave and sick leave cover in relation to the Service Manager (which would be a separate issue in ensuring cover and communicating this if this was a factor).

There was one occasion where a kaimahi support worker took immediate action to call the Area Manager in relation to a concern. The Area Manager asked that this be documented in an incident report, but then that incident report was not actioned. In and of itself, the incident report only formed part of an emerging pattern, which if other incident reports were reviewed, may have assisted the Area Manager in determining whether the concerns were indicating there is a serious situation that needed leadership in managing and ensuring kiritaki safety.

It appeared that when the Police were involved (which was instigated by a Social Worker encouraging reporting), the Area Manager focused attention on the matter and escalated it to the Regional Manager. Correspondence in records reviewed indicated that the Area Manager had not been aware of the alleged abuse or extent to which it was considered serious despite some direct escalations by kaimahi in Month6.

Peers would likely consider the Area Manager did not respond swiftly enough to managing and escalating concerns raised with her. There was a lack of urgency, action and leadership which peers would expect from an Area Manager to manage risk and resolve concerns that were otherwise unresolved or needed support from an Area Manager in addition to a Service Manager. This would be considered a moderate departure from accepted practice by peers.

[3] I note that there are some incident reports that were not closed in relation to this case for many months and in one instance nearly one year. One incident that had an "extreme" risk noted, was closed 10 months after it was raised.

It would also be usual for a Service Manager to be providing a weekly report or meeting weekly with an Area Manager as another means of communicating about services. If this is something that isn't done, then this would be another line of defence in ensuring matters that need discussion and support in their management are uncovered. The frequency and topics of discussion for meetings between Service Managers and Area Managers may be something IDEA Services could review.

5. The appropriateness of the response from Regional Manager Ms E to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms E appropriately escalated those concerns.

The Regional Manager likely didn't have visibility of all concerns raised by kaimahi support workers up until the time where kaimahi support workers escalated beyond their line managers to the Area and/or Regional Manager. The Regional Manager was copied to an email early in Month6 YearG related to a concern. The Regional Manager then requested that the Area Manager acknowledge the concern and have the Service Manager review.[4] Based on this description of the email, the gravity of the situation was unlikely clear. The Regional Manager was again involved when a joint email was sent to her late Month6 YearG. The Regional Manager at that point requested additional support from the Quality Team to review the situation. Further reference is made to the Regional Manager in early Month7 YearG, with the Area Manager updating the Regional Manager in respect to Police involvement.

Peers would conclude that one of the difficulties that the Regional Manager most likely encountered related to insufficient information being provided to her and that if she was looking at anything escalated or copied to her in isolation, on face value, it would be difficult to determine that this was an unfolding serious situation. Improved communication would likely have meant the Regional Manager could have intervened earlier and taken different measures to act more quickly and more appropriately. The standard expected would be that there are established escalation processes in addition to regular reporting that the Regional Manager would receive and could then act on. Any departure by the Regional Manager based on information provided for review would be considered minor.

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

The kaimahi support workers appear to have been proactive in supporting kiritaki to the best of their abilities. Documentation demonstrates they tried to follow policies and procedures and were also confident in escalating to other leaders within IDEA Services to try to resolve concerns. It appears they also had a good relationship with kiritaki and others that support kiritaki within the community.

A variety of policies, procedures or excerpts from them were provided for review. These documents were well written and align with accepted practice. Some documentation would

[4] Note that the actual email was not provided for review but rather a summary of it with reference to the appendix with the email, but the email of early Month6 YearG was not included.

be considered good examples of plain English that assists in improving comprehension and implementation.

IDEA Services may like to review its processes for reviewing, investigating and closing out incident reports given the high number of reports made in this case that were not appropriately managed. Some information in emails was likely better recorded into the incident reporting system.

Nāku noa, nā

Dr Christine Howard-Brown'

Further advice from Dr Howard-Brown:

'Month10 YearJ **(updated Month4 YearK)**

[…]
Complaints Investigator
Health and Disability Commissioner
Private Bag
Auckland

Kia ora […]

Re: Complaint: 20HDC02164/IDEA Services Limited

I agreed to provide an opinion to the Commissioner on case number **20HDC02164**. I have read and followed the Commissioner's Guidelines for Independent Advisors and am not aware of any conflicts of interest in relation to this case.

My qualifications are a Bachelor of Nursing (Massey University); Master in Business Administration (merit) (Victoria University of Wellington) and Doctor of Philosophy in Medicine (University of Otago). I have extensive experience working in the health and disability sector in a variety of roles, including executive and senior leadership, quality audit, service design and service improvement.

I received instructions from the Commissioner to review documents and provide an opinion on whether the care provided to Ms A by IDEA Services in YearG was reasonable in the circumstances, and why. In particular, there were six parts to the Commissioner's request.

Comment was requested in relation to the following items.

1. Whether the care provided to Ms A by IDEA Services between late Month3 and mid Month5 YearG (including that Ms A only saw her support worker virtually) was appropriate in the circumstances, including whether it was in line with the Ministry of Health Guidelines regarding disability service provision.

2. The appropriateness of the response from IDEA Services to the concerns raised by Ms A and support workers about Mr C's behaviour in YearG.
3. The appropriateness of the response from Service Manager Ms B to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms B appropriately escalated those concerns.
4. The appropriateness of the response from Area Manager Ms D to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms D appropriately escalated those concerns.
5. The appropriateness of the response from Regional Manager Ms E to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms E appropriately escalated those concerns.
6. Any other matters in this case that you consider warrant comment.

The following documents were provided for review.

1. Letter of complaint dated late Month11, YearG.
2. Timeline of service provision by IDEA Services for Ms A.
3. Initial response from IDEA Services dated mid-Month1 YearH, and relevant attachments:
   - Needs Assessment (Month8 YearB)
   - Support Packages from Month10 YearB to Month9 YearC)
   - Referral for Supported Living (Month9 YearB)
   - Proposal Setup and Drafting Hours (Month8 YearB)
   - Formal Cease Notification (Month9 YearB)
   - Service Authorisation (Month9 YearB)
   - Property Brokers records (Month8 Year B, Month3 Year E)
   - Informed Consent Agreement (Month8 YearB)
   - Incident form (Month5 YearE)
   - Response to complaint letter (Month8 YearG)
   - Investigation report (Month7 YearG)
   - Investigation notes (Month7 YearG)
   - Risk and Control Information and Support Plan
4. Further information relating to public health restrictions (internal communications from YearG)
   - All incident reports for Ms A (beginning Month1 YearE–Month1 YearH)
   - Personal Support Information (Month1 YearC)
   - Personal Support Information (Month3 YearF)
   - MyPlan (Month12 YearG)
   - Funding details (YearA–YearH)
   - Internal correspondence regarding the closure of New Zealand Police investigation
   - Internal correspondence with Mana Whaikaha
   - Internal correspondence (Month6 YearG)
   - IDEA Services Supported Living Policy YearD

- Information on essential and non-essential services for disability support service providers Month4 YearG

5. Further response from IDEA Services dated Month6 YearI, and relevant attachments:
   - Daily notes for Ms A dated Month3–Month10 YearG
   - Support plan
   - Email correspondence
   - Health Note for Dr appointment following sexual abuse allegation
   - Updated incident report table
   - Incident reports
   - Statement from Ms F (Support worker)
   - Training records for Ms B (Former Service Manager)
   - Training records for Ms D (Former Area Manager)
   - Service manager Position description (YearF)
   - Service manager Position description (YearH)
   - Area manager Position description (YearF)
   - Area manager Position description (YearG)
   - Protection of Vulnerable Children and Adults Policy
   - Protection of Vulnerable Children and Adults Policy Quick Reference
   - Incident Reporting and Response System Policy
   - Incident Reporting and Response System Quick Reference
   - Service User Complaints Policy
   - Incident Management section in SM Ops Manual
   - Incident Reporting section in Support Worker Manual
   - Risk Assessment and Management Protocol section in SM Ops Manual
   - Preventing Abuse and Neglect section from Support Worker Manual
   - Ministry of Health DSS Supported Living Service Specification
   - Service Managers Response to Acting Area Manager Month9 YearG
   - Information relating to the complaint about the Area Manager
6. Information provided by IDEA staff member (previously employee of IDEA Services at the time of these events), including Formal complaint about IDEA Services Area Manager Ms D (sent to Regional Manager Ms E).
7. Response from Service Manager Ms B dated Month6 YearI.
8. Response from Ms D dated late Month8 YearI.
9. Official guidance from Whaikaha Ministry of Disabled People regarding disability service provision during public health restrictions.
10. **Further correspondence provided following the initial expert advice:**
    - **Supported Living Services Service Specification DSSL2620 (Ministry of Health)**
    - **Supported Living Operational Guide YearB (Ministry of Health)**
    - **Letter dated Month3 YearK from Ms D with attached email correspondence from Ms D and others (variously dated)**
    - **Letter dated Month3 YearK from IDEA Services**
    - **Email dated Month3 YearK from Ms B.**

To support the opinions I have expressed, I have relied on the following:

Health and Disability Services Standards — Health and Disability Services (core) Standards NZS8134:2008 NZS 8134.1:2008 :: Standards New Zealand[5]

Health and Disability Services (Infection Prevention and Control) Standards NZS8134:2008, available at: NZS 8134.3:2008 :: Standards New Zealand

The Code of Health and Disability Services Consumers' Rights, available at: Code of Health and Disability Services Consumers' Rights - Health and Disability Commissioner (hdc.org.nz)

Supported Living Services Service Specification DSSL2620 (Ministry of Health) and its compendium Supported Living Operational Guide 2012 (Ministry of Health)

Background

Ms A (aged 51 years at the time of these events) has an intellectual disability and has been supported by IDEA Services under supported living since YearB. Prior to this, she had been in IDEA Services' residential care. At the time of the agreement since events, Ms A lived with three male flatmates who were also being supported by IDEA Services. IDEA Services told HDC that Ms A chose her own flatmates in YearB.

During the public health restrictions in YearG, from Month3 to mid Month5, Ms A told HDC that she was sexually and verbally abused by one of her flatmates (Mr C, 55 years old, who she had been living with since YearB). She alleges that this flatmate had previously sexually assaulted her two years prior and that IDEA Services were aware of that incident. IDEA Services told HDC that while they were aware of a physical altercation (Mr C yelled at Ms A and hit her on the shoulder with a closed fist) between Ms A and Mr C in Month3 YearE, this was the first they had heard about any sexual activity (consensual or otherwise) between the two consumers.

Over the restrictions period, Ms A had less support from IDEA Services than usual, and only met with her support worker virtually. She would usually have been seen face-to-face, five days a week. She told HDC that she was unable to express her concerns during these calls as her flatmate was always nearby.

IDEA Services explained that it was following the Ministry of Health Guidelines and was restricted in sending staff to visit service users who were independent and receiving limited support, referring to Month4 YearG guidance and a teleconference with MOH at the end of Month3 YearG. It noted at least 36 phone or video calls with Ms A during the restrictions, and the first time they became aware of more significant (non-sexual) abuse concerns was in May, and the sexual abuse disclosure was made after she moved out.

Ms A was moved out of the flat and, as of later Month3 YearH, no longer receives services from IDEA Services.

Advice

[5] Note now superseded by NZS8134:2021 but NZS8134:2008 was current at the time

Comment is made in respect of questions raised by the Health and Disability Commissioner as below.

1. **Whether the care provided to Ms A by IDEA Services between Month3 and mid Month5 YearG (including that Ms A only saw her support worker virtually) was appropriate in the circumstances, including whether it was in line with the Ministry of Health Guidelines regarding disability service provision.**

During the first New Zealand public health restrictions, the government issued a range of orders and guidance that impacted health and disability providers. Disability Support Services, which was at that time part of the Ministry of Health, provided regular communications to providers to assist in navigating through what was a rapidly changing environment.

There was little time for health and disability providers to prepare for restrictions, where it was required that all non-essential businesses were to close.

The Ministry of Health was clear in its guidance to disability support providers, issuing more detailed correspondence the day prior to the restrictions about essential disability support services. Providers were required to assess on a case-by-case basis, what level of support was needed for kiritaki, including considering alternative ways of delivering essential services, such as virtual meetings, phone or post.

Information specific to residential disability providers was issued by the Ministry of Health in Month4 YearG. This included advice to balance risks and take a cautious approach to any additional physical contact for the wellbeing of kaimahi and kiritaki. Reducing social isolation as much as possible to support wellbeing was emphasised, along with continued use of personal protective equipment and social distancing.

The initial announcements effectively gave health and disability providers 48 hours to update their plans, policies and procedures such as major incident, risk management plan, management of hazardous waste plan, infection control programme and the infection outbreak management policy and procedure.[6] Although organisations certified under the Health and Disability Services (Safety) Act would have these documents, infection control documents were usually geared towards influenza and norovirus outbreaks and not a public health restriction situation. Similarly, other major incident plans were geared towards natural disasters.

Peers would expect risk management plans to be in place for individual kiritaki covering what level of support they may need in a natural disaster. This could then be used to determine the level of support needed during a time where usual supports were not readily available. Unlike a natural disaster plan that is based on a limited time period and/or the ability to move to an alternative environment, the restrictions did not provide this level of flexibility.

For Ms A, peers would expect the following factors to have been considered by IDEA Services

[6] Or equivalent documents not necessarily named these.

in respect of restriction measures and risks this might pose for her:

— Reviewing risks in managing activities of daily living and usual support package. All documents reviewed (including historic incident reports) indicated that Ms A was independent but needed prompting. Ms A's support package was low, centring around a few hours per week to support household management, grocery shopping and meal preparation, budgeting and financial management, problem solving, reading and understanding mail and support booking or attending appointments. Therefore, she would be able to self-manage with remote support.

— Reviewing compatibility. Living in a flatting environment which although had been stable, was associated with the kiritaki having a lot of activities, including employment outside of the flat, which meant this would represent a significant shift in the amount of time these flatmates would spend together. Reviewing compatibility would also include reviewing any incident reports that might point to risks to kiritaki safety and wellbeing. There had been one historic incident which could indicate increased risk to Ms A from another flatmate of physical aggression and controlling behaviour. A support needs assessment from YearB also notes that Ms A could be bossy towards others and at that time was undergoing a family planning course to learn about appropriate sexual behaviour as she was getting confused as to what was and was not appropriate which included a reference to changing her mind when she had more time to reflect. This information suggested that Ms A may be vulnerable to physical, emotional or sexual abuse. The balance within the flat was also three males and one female. Together these factors would cause concern. **However, as the IDEA Services contract with the Ministry of Health (now Whaikaha) was for Supported Living and flatmates would be considered natural supports, and the flatmates were longstanding with no known concerns held by IDEA Services, it would be unlikely that IDEA Services would have considered spending more time within the flatting arrangement would represent a new risk. IDEA Services would have to determine that the restrictions represented an increase in vulnerability where intentional safeguards would be required.**

Peers would develop a safety plan in respect of these factors as together they represent current and new risks with the restrictions and requests by the Ministry of Health for remote contact where it was safe to do so. IDEA Services did ensure that remote contact between kaimahi and kiritaki were with kaimahi known to the kiritaki which would be considered an important factor in moving to a remote contact model.

Progress notes and other documentation indicated that Ms A had 30 remote contacts between Month3 YearG and mid Month5 YearG. Notes indicated there was good contact between Ms A and her kaimahi during this period. There were no indications of any unusual concerns or risks to Ms A except for Month3 and Month5 YearG. In Month3 YearG, a flatmate had yelled at Ms A but subsequently there were no concerns in the following days. There were 28 records between this date and mid Month5 YearG that indicated Ms A was receiving adequate support by remote contact and that she was well and managing within the flatting environment. In mid Month5 YearG, kaimahi noted Ms A was distracted and not her usual self and that this related to another flatmate.

Having reviewed all correspondence, including Ministry of Health guidance, it is reasonable that peers would conclude that Ministry of Health guidance was followed and Ms A received adequate support from IDEA Services during the initial restrictions period to mid Month5 YearG. From the level of information documented, it is difficult to know whether the response to the mid Month5 YearG remote contact was appropriately managed. Certainly this was the first indication of a change in the dynamics of the flat.

Peers would consider the flat compatibility and information known about each flatmate and Ms A's history as representing additional risks to the usual living situation in a restriction environment. **As IDEA Services's role related to supported living services, it is reasonable that IDEA Services considered the longstanding and usual dynamics of the living situation between flatmates was stable (and therefore did not consider new or additional risks of restrictions).** Records provided for review did not include a detailed risk assessment for each kiritaki as part of determining whether full remote contact was appropriate. Given the rapidly moving situation of restrictions, it is understandable that this level of detailed assessment may have been overlooked **or not considered relevant given the** needs assessment and support needs documentation **(from YearB)**. As shown above, if only reviewing risks in managing activities of daily living and usual support package, then there were no concerns in remote working for Ms A. Peers would likely conclude that this **process met** accepted practice **for the provision of supported living services as the restrictions associated with the public health situation was new territory. Given the experiences of the impacts of restrictions on vulnerable people, future policies and processes would benefit from more detailed determination of the risks posed and potential changes in living circumstances that would fall into the safety provision expectations of the supported living service**.

I also note there was regular reporting to the Ministry of Health on the status of kiritaki within IDEA Services during the restrictions which included reference to any kiritaki where concerns had been identified needing additional support or risk assessment. This did not include Ms A. Reference is also made to a welfare checklist used by kaimahi during the restrictions but there was not a completed checklist evident in records provided for review. **This would be considered a moderate departure from practice by peers but one that the Ministry of Health would have followed up on in usual circumstances.**

2. The appropriateness of the response from IDEA Services to the concerns raised by Ms A and support workers about Mr C's behaviour in YearG.

Ms A raised concerns as to Mr C through contacts with kaimahi in addition to a written complaint made Month8 YearG via an advocate. Kaimahi also raised concerns by way of emails, progress records and incident reports. The actions of the kaimahi support workers would be considered as meeting accepted practice by peers; however, the actions beyond this of managers falls short of expectations.

There was ample evidence of escalation of inappropriate behaviour and increasing distress of Ms A in records provided for review. It was clear from reading the information provided that kaimahi support workers were getting increasingly concerned about Ms A's safety, to

the extent that they further escalated concerns and found alternative accommodation for Ms A with her female friend.

The written complaint made in early Month8 YearG was responded to in writing in late Month8 YearG. There was no record of acknowledgement of the complaint within five working days. The letter of response was sent by the Regional Manager and included an apology but concluded that there was insufficient information held to have intervened beyond supporting the change in accommodation which had occurred. It is unclear whether the complaints investigation process had been followed. It appears that the complaint response letter and investigation of the complaint were not linked with the investigation completed by the Quality Manager in response to a request from the Regional Manager in Month6 (and with a corresponding report in Month7) following concerns raised by kaimahi support workers.

The Quality Manager investigation identified that incident reports were not acted on in a timely manner. Up until the Quality Manager investigation, increasing incidents were not seen as representing an escalating situation that needed intervention by managers. For example, there were no corrective actions in response to increasing arguments at the flat. There were three incident reports awaiting manager update at the time of the investigation by the Quality Manager that had occurred in Month5 YearG, and all from Month6 YearG were awaiting a manager update. The Quality Manager concluded that 11 of 14 incidents (occurring in Month5 and Month6) were awaiting manager update as at mid Month7 YearG. All but one completed incident report did not record outcomes from concerns raised. Kaimahi support workers felt unsupported by managers. Where complaints had been raised within incident reports there was no evidence the complaints process was followed. The Quality Manager concluded that incidents and complaints were not managed to policy expectations. Note that the standard of the investigation and report by the Quality Manager was consistent with accepted practice.

Peers would likely concur with the IDEA Services Quality Manager that there were shortfalls in expectations in the management of concerns, incidents and complaints that occurred in relation to Ms A. There were shortfalls in the completion of usual activities consistent with policies. The appropriateness of the complaint responses would be considered a major departure from accepted practice because the inaction in response to information available clearly demonstrated increasing risk to kiritaki safety **(and a change in their needs or circumstances which posed risks and the use of intentional safeguards)**.

3. The appropriateness of the response from Service Manager Ms B to the concerns raised by Ms A and support workers in 2020 about Mr C's behaviour, including whether or not you consider Ms B appropriately escalated those concerns.

As summarised in question 2, the Service Manager's response to concerns raised, including incident reports, progress notes and emails, would not be considered to meet accepted practice by peers. There were examples of long delays to respond, insufficient responses and no responses where kaimahi support workers were left to escalate to others. There was also an absence of escalation by the Service Manager to the Area Manager or Regional

Manager when this would have been appropriate (e.g. deciding not to contact the Police when there was a reportable event).

The role description was provided for the Service Manager. This clearly outlines the requirements of the role and relationship with others. This role description is consistent with accepted practice.

A summary of training records was also provided for review. This showed full completion of complaints webinar series, facilitation skills, effective communication, risk management and incident reporting amongst other topics. There was also partial completion of abuse prevention, vulnerability to abuse and keeping safe.

It is noted that the Service Manager was on sick leave herself for a period of this time (early Month6 to late Month7 YearG in one statement in the records reviewed and a shorter period of six days in early Month6 and then late Month6 to late Month7 in another). It is usual practice that another nominated staff member is delegated to perform duties when a Service Manager is on leave. **There was confusion as to notification of leave periods by the Service Manager and whether the Service Manager was partially or fully working during throughout some of the initial leave period.**

Peers would consider the responses and responsiveness of the Service Manager to be inconsistent with the expectations of the role. There are likely many mitigating factors such as her own sick leave and management across other services which contributed to a lack of responsiveness to concerns in respect of Ms A. Irrespective, peers would likely consider the actions and inactions **of the Service Manager** to be a moderate departure from accepted practice.

4. The appropriateness of the response from Area Manager Ms D to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms D appropriately escalated those concerns.

There was evidence that the Area Manager had been contacted by way of escalation by kaimahi support workers and also by the Regional Manager when kaimahi support workers had contacted the Regional Manager in respect to concerns. Escalations to the Area Manager appear to have occurred in Month6 YearG.

The role description was provided for the Area Manager. This clearly outlines the requirements of the role and relationship with others. Within the role description expected outcomes include compliance with quality systems and standards. This role description is consistent with accepted practice.

A summary of training records was also provided for review. This showed full completion of complaints webinar series, abuse prevention for managers, incident reporting and vulnerability to abuse topics.

Ms D was a point of escalation for kaimahi support workers and the Service Manager. It would also be considered usual by peers that any concerns about abuse to be escalated

beyond the Area Manager. It is not apparent in documentation reviewed that there was consistent escalation from the Service Manager to the Area Manager and beyond which resulted in the right levels of decision making and support. This may be partly a symptom of the ineffective review of progress records, incident forms[7] and emailed concerns from kaimahi. A mitigating factor **was** confusion in sick leave **taken**. **Documentation provided supports the position by IDEA Services that it was unaware the Service Manager was on sick leave Month6 as a medical certificate was provided late Month6 for leave taken from early Month6. There is also documentation indicating at least some work was occurring by the Service Manager during the period that was later notified as sick leave. Therefore, IDEA Services was unaware that the Service Manager was on leave and there was no need to provide cover.**

There was one occasion where a kaimahi support worker took immediate action to **contact** the Area Manager **(early Month6, YearK)** in relation to a concern **that related to the behaviour of another flatmate impacting Ms A (with daily notes provided stating the Service Manager was known to be on leave by the Support Worker staff)**. The Area Manager asked that this be documented in an incident report **(report 81374),** but then that incident report was not **recorded as** actioned. In and of itself the incident report only formed part of an emerging pattern which if other incident reports were reviewed may have assisted the Area Manager in determining whether the concerns were indicating there is a serious situation that needed leadership in managing and ensuring kiritaki safety.

When the Area Manager was contacted late Month6 YearG in respect of allegations by Ms A of sexual abuse, documentation shows the Area Manager took appropriate steps to contact the NASC in late Month6 YearG via email (consistent with requirements of the Service Specification for Supported Living). It is noted in the correspondence that the NASC response was to provide a connector (as per its processes) but did not provide additional advice. The Area Manager states that they also contacted the Police at this time. It is difficult to piece together all elements of events as a corresponding incident report of the notification late Month6 of alleged sexual abuse was not provided for review. There also does not appear to be a daily progress report on that day.

It appeared that when the Police were involved (**with** a Social Worker encouraging reporting), the Area Manager focused attention on the matter and escalated it to the Regional Manager. Correspondence in records reviewed indicated that the Area Manager had not been aware of the alleged abuse or extent to which it was considered serious despite some direct escalations by kaimahi **early** in Month6 **of behaviours indicating concern**.

Peers would likely consider the Area Manager did not respond swiftly enough to managing and escalating concerns raised with her early in Month6 **but did act appropriately to concerns raised late in Month6.** Peers would expect an Area Manager to manage risk and

[7] I note that there are some incident reports that were not closed in relation to this case for many months and in one instance nearly one year. One incident that had an "extreme" risk noted was closed 10 months after it was raised.

resolve concerns that were otherwise unresolved or needed support of an Area Manager in addition to a Service Manager. This would be considered a moderate departure from accepted practice by peers **as to events early in Month6. Slippages in incident reporting processes may be a mitigating factor**.

It would also be usual for a Service Manager to be providing a weekly report or meeting weekly with an Area Manager as another means of communicating about services. If this is something that isn't done, then this would be another line of defence in ensuring matters that need discussion and support in their management are uncovered. The frequency and topics of discussion for meetings between Service Managers and Area Managers may be something IDEA Services could review.

5. The appropriateness of the response from Regional Manager Ms E to the concerns raised by Ms A and support workers in YearG about Mr C's behaviour, including whether or not you consider Ms E appropriately escalated those concerns.

The Regional Manager likely didn't have visibility of all concerns raised by kaimahi support workers up until the time where kaimahi support workers escalated beyond their line managers to the Area and/or Regional Manager. The Regional Manager was copied to an email early in Month6 YearG related to a concern. The Regional Manager then requested that the Area Manager acknowledge the concern and have the Service Manager review[8]. Based on this description of the email, the gravity of the situation was unlikely clear. The Regional Manager was again involved when a joint email was sent to her late Month6 YearG. The Regional Manager at that point requested additional support from the Quality Team to review the situation. Further reference is made to the Regional Manager in early Month7 YearG, with the Area Manager updating the Regional Manager in respect to Police involvement.

Peers would conclude that one of the difficulties that the Regional Manager most likely encountered related to insufficient information being provided to them and that if they were looking at anything escalated or copied to them in isolation, on face value, it would be difficult to determine that this was an unfolding serious situation. Improved communication would likely have meant the Regional Manager could have intervened earlier and taken different measures to act more quickly and more appropriately. The standard expected would be that there are established escalation processes in addition to regular reporting that the Regional Manager would receive and could then act on. Any departure by the Regional Manager based on information provided for review would be considered minor.

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

The kaimahi support workers appear to have been proactive in supporting kiritaki to the best of their abilities. Documentation demonstrates they tried to follow policies and procedures and were also confident in escalating to other leaders within IDEA Services to

[8] Note that the actual email was not provided for review but rather a summary of it with reference to the appendix with the email but the email of early Month6, YearG was not included.

try to resolve concerns. It appears they also had a good relationship with kiritaki and others that support kiritaki within the community.

A variety of policies, procedures or excerpts from them were provided for review. These documents were well written and align with accepted practice. Some documentation would be considered good examples of plain English that assists in improving comprehension and implementation.

IDEA Services may like to review its processes for reviewing, investigating and closing out incident reports given the high number of reports made in this case that were not appropriately managed. Some information in emails was likely better recorded into the incident reporting system.

Nāku noa, nā

Dr Christine Howard-Brown'