Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Disability service provider breaches Code for physically restraining a man
22HDC02152

A charitable organisation that provides support programmes for disabled people, and several of its employees, breached the Code of Health and Disability Services Consumers' Rights (the Code) after a man was physically restrained.

The man, aged in his thirties, has limited vision and epilepsy, and is non-verbal. He lives in a residential service and regularly attended an Enrich+ Trust (Enrich) day activity programme.

In 2022 a staff member from the residential service was contacted to collect the man from Enrich. When she arrived, she discovered an Enrich support worker had physically restrained the man by pulling the sleeves of his jersey up over his hands and tying knots in them.

The man's behaviour support plan, developed by Enrich and the residential service, refers to 'physical intervention: isolate', but does not include any approved restraints.

Deputy Health and Disability Commissioner Rose Wall acknowledged the psychological distress these events caused the man and his whānau. She also acknowledged the restraint was unsafe and put the man at risk of personal injury.

"Enrich had a responsibility to keep the man safe and ensure that he received services of an appropriate standard from suitably trained and supported staff," Ms Wall said.

"I consider a combination of inadequate care planning in relation to risk management and responding to challenging behaviours, and inadequate staff training and guidance, placed the man in a position of vulnerability, and the care provided to him by Enrich fell short of the accepted standard," she said.

Ms Wall found Enrich breached Right 4(1) of the Code which gives every consumer the right to have services provided with reasonable care and skill.

She also found the Enrich support worker who used physical restraint breached Right 4(1). In addition, the support worker breached Right 4(2), which gives every consumer the right to have services provided that comply with legal, professional, ethical, and other relevant standards. This breach was for failing to comply with the Safe Practice Policy, the Incident Management Policy, and other relevant standards.

A service lead and another support worker at Enrich who witnessed the physical restraint also breached Right 4(1).

Since the event, Enrich said work is underway to ensure the actions required by the funder of their service, Whaikaha, are completed as soon as possible, including the engagement of external specialist assistance. Enrich's Restraint Minimisation policy and the Abuse and Neglect policy have also been revised and updated and all support staff now have to undergo the Safety Interventions course. Two staff members have faced disciplinary action.

Ms Wall recommended the support workers and service lead write letters of apology to the man and his whānau. She recommended Enrich report to HDC with an update on the completion of the actions required by Whaikaha, and use this case as a basis for developing education/training on restraint and incident reporting for staff.

11 December 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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