HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Disability residential service failed to provide adequate standards of care to three consumers

1. This report is the opinion of Ms Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report discusses complaints about the care provided by Spectrum Care Limited (Spectrum) to three disability service consumers.

2. On 28 April 2021 the Health and Disability Commissioner (HDC) received a complaint from Mrs B about the care provided to Mr A by Spectrum. On 26 July 2021 HDC received an additional joint complaint from Mr and Mrs B, Mr and Mrs C (Mr D's parents), and Mr E about the care provided to Mr A, Mr D, and Mr F by Spectrum. The complaints raised concern about systemic organisational processes, including complaint processes and incident reporting systems, inadequate staffing levels/support, and Spectrum's ability to keep its consumers safe and well.

## Mr D

3. Mr D was in his twenties at the time of these events. He has an intellectual disability and was diagnosed with fetal alcohol spectrum disorder[1] (FASD). He has high and complex needs and needs specialised care. He has a history of repeated acts of violence, intimidatory and sexualised behaviour aimed at other residents of his Spectrum residence, and a history of self-harm and suicide attempts, which have resulted in multiple internal and external specialist interventions. Mr D can communicate his needs readily unless he is highly anxious, and he has stated his preference to advocate for himself. Mr and Mrs C do not hold a welfare guardian order for Mr D.

4. Mr C stated that he had concerns for the safety of all residents and staff members at the residential facility owing to Mr D's behaviours. Mr C was concerned that someone was going to get very badly hurt if Spectrum did not step in to safeguard all involved. In his view, despite complaints to Spectrum, the situation was not addressed adequately. Mr C raised concerns that Spectrum staff did not communicate adequately regarding incidents involving Mr D. For example, Mr C said that he was not informed when Mr D attempted to commit suicide three times.

## Mr A

5. At the time of the events, Mr A was in his sixties and resided at the facility. He had contracted measles as a child and had been diagnosed with developmental delay and an intellectual

[1] Babies exposed to alcohol before birth may develop FASD, which can cause problems including low birth weight, distinctive facial features, heart defects, behavioural problems, and intellectual disability.

disability. He is vulnerable as he is non-verbal, but he tries to verbalise words, and he uses sign language or visual aids.

6. Mr B (Mr A's brother) and Mrs B (Mr A's sister-in-law) raised concerns that the combination of different disabilities and ages of those living at the facility was inappropriate and unsafe, and that Mr D had been physically and sexually violent towards the residents at the facility, including Mr A. Mrs B is Mr A's welfare guardian.

7. Mrs B stated that previously they had asked Spectrum to control the situation and safeguard Mr A from Mr D's behaviours, which Spectrum had failed to do. Mr and Mrs B raised concerns that staff at the facility had not created incident reports for all incidents that occurred over the five months prior to the complaint (July 2021) and had failed to notify them that incidents had occurred. They were also concerned that no incident was considered urgent, including sexual assault. Mr and Mrs B feel that Spectrum responded to some of their concerns by addressing the minor issues in the complaints but continued to ignore the main concern of resident safety.

**Mr F**

8. Mr F was in his twenties at the time of these events. He has an intellectual disability and has been diagnosed with FASD[2] and oppositional defiant disorder (ODD).[3] Mr F appears to have very few social skills and has difficulty regulating his emotions. Mr E is Mr F's welfare guardian.

9. Mr E raised concerns that Mr F was not receiving the 24/7 care from Spectrum that he was entitled to, and that incidents occurred when the required level of care was not provided. Mr E stated that Spectrum's communication had been poor as he had not been informed of serious incidents in a timely matter, such as an incident that occurred when Mr F moved to another residence at Spectrum. Mr E said that he asked to meet with the staff who were providing care to Mr F regarding his needs and condition at the time of his complaint, but this did not occur.

**Breach by agreement proposal**

10. On 16 January 2025 I wrote to Spectrum outlining that the independent advice I had received from Dr Christine Howard-Brown[4] about the care provided to the three consumers highlighted several important shortcomings in Spectrum's care. Based on Dr Howard-Brown's advice, which Spectrum reviewed and accepted, I proposed to find Spectrum in breach of the Code of Health and Disability Services Consumers' Rights (the Code).

[2] See footnote 6.

[3] A disorder in a child marked by defiant and disobedient behaviour towards authority figures. Symptoms include irritable mood, argumentative and defiant behaviour, aggression, and vindictiveness that last longer than six months. Symptoms generally begin before a child is eight years old and cause significant problems at home or school.

[4] This was provided to Spectrum on 19 February 2024.

11. In a response dated 5 February 2025 Spectrum stated that it agreed with Dr Howard-Brown's findings and my proposed breaches of the Code.

**Responses to provisional opinion**

12. Spectrum, Mr and Mrs C, Mr and Mrs B, and Mr E were given the opportunity to respond to the provisional opinion.

13. Spectrum responded that it had considered the provisional opinion, and it accepted my proposed recommendations, including scheduling of follow-up meetings with the families.

14. Mr and Mrs C responded that they were disappointed in the complaints process. In addition, their statements have been incorporated into this report where relevant.

15. Mr and Mrs B responded that they never received an apology for the way Mr A was treated, and that some of the same issues are 'slowly slipping through the cracks again'.

16. Mr E responded that he accepts the findings and stated that the amendments to Spectrum's processes should lead to better communication and outcomes for consumers.

**Opinion: Care of Mr D — breach**

17. Dr Howard-Brown's advice to HDC on the standard of care provided to Mr D is attached as **Appendix A**. Dr Howard-Brown noted the following:

a) Given the age differences and breadth of support needs, it appears that Spectrum did not have an optimal mix of residents who were compatible as housemates at the facility.

b) The allegation of sexual abuse involving Mr D that occurred on 27 April 2021 was escalated to the Police by Mr D's and Mr A's families, but it was not reported to Mr D's family or the Ministry of Health.[5]

c) The incident of 27 April 2021 did not trigger a risk assessment of Mr D, which is a significant departure from accepted practice.

d) Following the incident of 27 April 2021, relocating residents to gain a better compatibility mix at the facility was not considered an initial priority.

e) Spectrum's incident register recorded 40 incidents involving Mr D between January and October 2021.

   — The three incidents noted as including inappropriate sexual behaviour did not have a corresponding investigation report.

   — Of the four reported self-harm events, three did not have a corresponding investigation report and no notifications were made to the Ministry of Health for these events.

[5] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents or a situation that puts (or could potentially put) the health and safety of people at risk, and any Police investigation into any aspects of the service.

— The incident of 12 August 2021, which involved Mr D punching another resident in retaliation, was not reported to the Ministry of Health.

f) The Spectrum complaints process was not communicated clearly to Mr D's family after the complaint was made to the Police, and there was complexity in Spectrum's complaints standard operating procedure, which split the responsibility for complaints acknowledgement in two areas.

*Placement of Mr D and incident reporting — breach*

18. I accept Dr Howard-Brown's advice and am critical that Spectrum did not have an optimal mix of residents at the facility. Following the serious incident on 27 April 2021, initially Spectrum did not consider relocation of residents a priority, which was a missed opportunity to resolve the concerns about resident safety. At the time, there was also the potential to increase staffing levels until such time as a solution had been found, which did not occur. I am also critical that the incident of 27 April 2021, including the Police investigation, was not reported to Mr D's family or the Ministry of Health, and that the incident did not trigger a risk assessment for Mr D.

19. Dr Howard-Brown also highlighted concerns about the absence of investigation reports following Mr D's inappropriate sexualised behaviours and self-harm, which I agree is of concern. I note that Mr and Mrs C did not have a welfare guardian order, and that Mr D was adamant that he wanted to advocate for himself and did not want Spectrum to share information with his family readily. This is a dilemma faced by many disability service providers, as they must weigh up the privacy of the consumer against the wishes of the family to receive important information, which may assist them in supporting their family member. I have made recommendations for how Spectrum could rectify similar issues in the future.[6]

20. Mr and Mrs C stated that they disagreed with the finding that Mr D 'can [r]epresent himself as he is an adult'. They said that 'he may be number wise but [is] not [able] to make sensible decisions'. I acknowledge Mr and Mrs C's concerns, but I remain of the view that Mr D has the right to advocate for himself.

21. In my view, taking into account Dr Howard-Brown's advice at a)–e) above, Spectrum breached Right 4(4) of the Code in respect of its care of Mr D.[7]

*Complaints processes — adverse comment*

22. I accept Dr Howard-Brown's advice at point f) above. I am critical that Spectrum's complaints process was not communicated to Mr D's family clearly after they made a complaint. In my view, the communication about what would happen following the incident that was escalated to the Police should have been clearer. While Spectrum's complaints management process is likely fit for purpose for straightforward complaints, Mr D's family was left feeling

[6] See proposed recommendations for further details.
[7] Right 4(4) states that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

that their serious concerns for resident safety were not being dealt with appropriately, and they were not informed about the outcome of the Police investigation.

**Opinion: Care of Mr A — breach**

23. Dr Howard-Brown's advice to HDC on the standard of care provided to Mr A is attached as **Appendix B**. Dr Howard-Brown advised:

a) While Mr A's placement at the facility may have been appropriate, it may not have been compatible with, or appropriate for, other residents, based on incident reports highlighting that at least two residents had behaviours that posed a high risk to others.

b) Mr A's November 2021 risk plan did not include a risk of Mr A being harmed by others given his level of intellectual disability, the mix of housemates, and prior incidents occurring, although it is noted that these risks are highlighted in the Interim Support Guidelines (a supplementary document).

c) The incident register included 28 incidents involving Mr A between January and September 2021. Of these, 15 related to outbursts or physical aggression, and two related to Mr A being the recipient of abusive sexualised behaviour.

   — Incidents were not reported to the Ministry of Health and investigated thoroughly when they related to assaults, sexualised behaviour, or other behaviour escalations.

   — There was inconsistency in applying Spectrum's policy of notifying Mr A's welfare guardian about incidents.

   — The incident reports suggest that Mr A's behaviour was being triggered by his living circumstances, and this suggests that a change in his living circumstances was indicated.

d) The low-level resolution approach utilised by Spectrum in respect of Mrs B's multiple complaints about Mr A's welfare likely contributed to an escalation of the complaints by the family. Following the initial complaint raised in April 2021, complaints should have been escalated internally with an immediate risk assessment at the facility undertaken. In addition, there was complexity in Spectrum's complaints standard operating procedure, which split the responsibility for complaints acknowledgement between two areas of management.

*Placement of Mr A and incident reporting — breach*

24. I accept Dr Howard-Brown's advice and am critical that Spectrum did not consider the compatibility of other residents at the facility once the incident reports reflected a pattern of conflicts between the residents. In my view, this put Mr A at risk. I am critical that Mr A's Risk Plan did not include risks of harm by others, and that not all applicable incidents involving Mr A, including assault and sexualised behaviour, were investigated thoroughly or reported to his welfare guardian, Mrs B, and the Ministry of Health. I note Dr Howard-Brown's advice that had the incidents been reported and investigated, this may have presented an opportunity to put in place preventative strategies to prevent further incidents occurring.

25. In my view, taking into account Dr Howard-Brown's advice at a)–c) above, Spectrum breached Right 4(4) of the Code.

*Complaints management — breach*

26. I accept Dr Howard-Brown's advice at point d) above, and I am critical that Spectrum's low-level approach to complaints was ill-suited for the complexity and quantity of concerns that were raised with Spectrum by Mr A's family. I agree with Dr Howard-Brown that the complaints should have been escalated internally, with an immediate risk assessment of the facility undertaken. I am particularly critical of Spectrum's low-level approach to multiple serious complaints, which could be seen as Spectrum minimising Mr A's family's concerns, with the effect of reducing the family's trust and confidence in Spectrum.

27. Accordingly, in my view, this supports a finding of a breach of Right 10(3) of the Code.[8]

**Opinion: Care of Mr F — breach**

28. Dr Howard-Brown's advice to HDC on the standard of care provided to Mr F is attached as **Appendix C**. Dr Howard-Brown advised:

a) In respect of the complaints made to Spectrum by Mr E, Mr F's welfare guardian, there was a level of informality in the complaints management process. The email approach and limited information provided by Spectrum to Mr E likely contributed to the level of dissatisfaction Mr E experienced.

b) When Mr F moved into Spectrum initially, staffing levels were very low, and it could have been anticipated that Mr F would need support to settle into a new environment. There were also low levels of staffing in May 2021, particularly for a resident being considered for Regional Intellectual Disability Support Accommodation Service (RIDSAS) support.

*Complaints management — breach*

29. I accept Dr Howard-Brown's advice and am critical that Spectrum had a low-level approach to a complaint that was by its very nature complex, as it related to allocated funding, staffing levels, and subsequent allocated support hours to which Mr F was entitled. The approach by email and the limited information provided to Mr E likely escalated and contributed to the dissatisfaction Mr E experienced. This was a missed opportunity for Spectrum leadership to intervene and provide a thorough follow-up and explanation for how the funding, staffing levels, needs assessment, and subsequent support for Mr F were calculated and put into practice.

30. Accordingly, in my view, this supports a finding of a breach of Right 10(3) of the Code.

*Staffing levels — breach*

31. I accept Dr Howard-Brown's advice that staffing levels were very low when Mr F initially entered Spectrum's residential facility. At the time, Mr F was being considered for RIDSAS

[8] Right 10(3) states that every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

care and support and was awaiting trial. This should have been considered in determining Mr F's staffing level needs. In addition, Mr F was settling into a new environment,[9] with new routines, other residents, and staff members surrounding him. Due to the low levels of staffing, Mr F had an incident on his first night at the facility. I also note that the staffing levels remained inappropriately low during May 2021.

32. Accordingly, in my view, this supports a finding of a breach of Right 4(1) of the Code.[10]

**Changes made since events**

*Incidents*

33. Spectrum stated that nowadays it would '[c]lassify each [incident of sexualised behaviour] as a serious incident and would therefore complete a serious incident investigation for each'.

34. Spectrum said that in July 2021 a new feedback system was implemented, and incidents have been logged and managed through a quality management system. In June 2021 a new incident management system was implemented, which requires investigation oversight by the Service Manager, and the completion of an investigation form, for any incident considered serious.

35. On 12 May 2023 Spectrum published and implemented SOP-041c, an Individual Risk Management Plan. Spectrum recognised that staff required more assistance, hence training modules were made available, and all coordinators and service managers have now completed these.

36. I note that Mr A and Mr D no longer reside together.

*Spectrum's Action Plan following family meeting 24 February 2022*

37. Following a meeting with the families of Mr A, Mr D, and Mr F on 24 February 2022, Spectrum and the families discussed their concerns and together developed an action plan of how to address the issues. The full action plan has been implemented, as set out in **Appendix D.** In addition, I have recommended follow-up of the Action Plan in the below paragraphs.

**Recommendations**

38. I recommend that Spectrum provide separate written apologies to Mr and Mrs B, Mr and Mrs C, and Mr E for the issues identified in this report. These should be provided to HDC, for forwarding to the families, within three weeks of the date of this decision.

39. I recommend that Spectrum develop a formal Family/Whānau Communication Strategy, including outlining where and when information and incidents are reported to the family, including but not limited to, steps to take and information to share. The implemented Family/Whānau Communication Strategy should be forwarded to HDC within six months of

[9] Having resided in a motel before moving to Spectrum's residential facility.
[10] Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill.

the date of this decision, with evidence that the strategy has been shared with all Spectrum employees.

40. I recommend that Spectrum develop a policy and procedure related to consumers who are independent and under no formal orders, who do not wish information to be shared with their family/whānau. The policy should include how and when the consumers are identified, a register, privacy considerations, involvement of a consumer advocate, and arrangement of a family/whānau hui, to disseminate and sometimes agree to what information will be shared, including Spectrum initially explaining the Privacy Act 2020. The implemented policy and procedure should be forwarded to HDC within six months of the date of this decision, with evidence that these have been shared with all Spectrum employees.

41. I recommend that Spectrum follow the first step as discussed in the previous paragraph, if not already completed, and thereafter arrange for a follow-up meeting with Mr and Mrs C, as outlined in the procedure in the above paragraph. Documentation of the family/whānau hui should be forwarded to HDC within six months of the date of this decision.

42. I recommend that Spectrum arrange for a follow-up meeting with Mr and Mrs B and Mr and Mrs C to discuss how the Action Plan has worked for the families and whether any issues are still outstanding following the plan. The meeting should be held within six months of the date of this decision, with minutes from the meeting sent to HDC.

**Follow-up actions**

43. A copy of this decision with details identifying the parties removed, except the advisor on this case, will be sent to the Ministry of Social Development, and it will be advised of Spectrum's name.

44. A copy of this decision with details identifying the parties removed, except Spectrum and the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

**Appendix A: In-house advice from Dr Christine Howard-Brown obtained on 5 March 2023**

'**Re: Complaint: 21HDC01898/Spectrum Care Trust/[Mr D]**

I agreed to provide an opinion to the Commissioner on case number **C21HDC01898**. 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 [Mr D] by Spectrum Care Trust was reasonable between the period January to October 2021 in the circumstances, and why. In particular, there were seven parts to the Commissioner's request.

Comment was requested in relation to the following items.

1. Whether [the residential facility] was an appropriate residential placement for [Mr D];
2. The actions taken when concerns about [Mr D's] behaviour and well-being were raised;
3. [Mr D's] ability to leave [the facility] at night.
4. The safety measures in place to protect [Mr D]. Please also discuss the general management of safety and risk for all clients at [the facility];
5. The adequacy of care, risk, safety, emergency, and support planning/management for [Mr D], including the standard of documentation;
6. Management of incidents, including communication with [Mr D's] family and the standard of documentation;
7. The reports of use of restraint at [the facility];
8. Management of [Mr and Mrs C's] complaints;
9. The adequacy of Spectrum Care's policies and SOPs;
10. Staffing levels at [the facility]; and
11. Any other matters in this case that you consider warrant comment.

The following documents were provided for review.

1. Letter of complaint to Spectrum Care dated 26 July 2021.
2. Email submission of complaint to HDC
3. Copy of Nationwide Health and Disability Advocacy Service report dated 16 September 2021.
4. Response letters from Spectrum Care Trust to the complainant dated
   a. 19 August 2021
   b. 28 September 2022
5. Emails between Spectrum Care Trust and the complainant September and October 2021

6. Response letters from Spectrum Care Trust to HDC dated
   a. 16 November 2021
   b. 28 September 2022
7. Clinical records (plans and incident reports) (excludes any progress notes or diaries) from 1 January 2021–November 2021
8. Fortnightly rosters for the periods 28/12/20–14/11/21
9. Standard operating procedures (SOPs) and policies from Spectrum Care Trust:
   a. Privacy and Confidentiality Policy (no date or letterhead)
   b. MS-11B Personal Information (Privacy) Policy
   c. POL-04 Rights Realisation
   d. MS-04A Restraint Minimisation and Safe Practice
   e. MS-04I Individual Risk Assessment and Plan
   f. MS-04M Behaviours of Concern
   g. SOP-04Ma Behaviour of Concern
   h. POL-07 Quality
   i. MS-07D Open Disclosure
   j. MS-07A Adverse Event Reporting
   k. SOP-07Aa Adverse Event Reporting
   l. SOP-07Ab Investigation of a Critical Incident or Serious Incident
   m. POL-09 Complaint or Negative Feedback
   n. MS-09A Complaint or Negative Feedback
   o. SOP-09Aa Complaint or Negative Feedback
   p. POL-16 Live Free From Abuse and Neglect
   q. MS-16A Live Free From Abuse and Neglect
   r. SOP-16Aa Live Free From Abuse and Neglect.
10. [Needs Assessment Service Coordination (NASC)] Report dated 12/05/2021
11. [NASC] Authorisation dated 09/02/2022

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

Contracts and service specifications, Disability Support Services, available at: Contracts and service specifications | Ministry of Health NZ (Note that the provider will have its own copies of the relevant specifications).

Section 31 notification process Notifying an incident under section 31 | Ministry of Health NZ

Ngā paerewa Health and disability services standard, available at: NZS 8134:2021:: 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)

Spectrum Care website, available at: Spectrum Care | Homepage

Serious adverse event review — Systems analysis of clinical incidents — London Protocol (2nd edition) toolkit, available at:

https://www.bing.com/ck/a?!&&p=594f14f41c130e0aJmltdHM9MTY2NzYwNjQwMCZpZ3VpZD0yZjZhMGYxYi1mMzhmLTZhOWQtMGNlNC0xZWRmZjc4ZjY0NzkmaW5zaWQ9NTQxMw&ptn=3&hsh=3&fclid=2f6a0f1b-f38f-6a9d-0ce4-1edff78f6479&psq=london+protocol+for+incident+review+systems&u=a1aHR0cHM6Ly93d3cuY2VjLmhlYWx0aC5uc3cuZ292LmF1L19fZGF0YS9hc3NldHMvcGRmX2ZpbGUvMDAxMS82MDY3NDYvTG9uZG9uLVByb3RvY29sLVRvb2xraXQucGRmIzp-OnRleHQ9VGhlJTIwU3lzdGVtcyUyMGFuYWx5c2lzJTIwb2YlMjBjbGluaWNhbCUyMEluY2lkZW50cyUyMC0lMjBMb25kb24saGVhbHRoY2FyZSUyMGNvbnRleHQlMjBieSUyMHBhdGllbnQlMjBzYWZldHklMjBleHBlcnQlMkMlMjBDaGFybGVzJTIwVmluY2VudC4&ntb=1

Whaikaha Ministry of Disabled People website links:
Assessments and funding | Whaikaha - Ministry of Disabled People
Housing and living options | Whaikaha - Ministry of Disabled People

Tier Two Service Specification Community Residential Support Services and Tier Three Service Specification Out of Family Residential Support Services for Children and Young People with a Disability Contracts and service specifications | Whaikaha - Ministry of Disabled People

RIDSAS Services information website link:
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 | Ministry of Health NZ

**Background**

[Mr and Mrs C] raise concerns about the placement of [Mr D] into [the facility] and the level of support provided to him. In addition, the management of incidents following [Mr D's] incidents of self-harm, suicide attempts, and escalation of behaviour has caused concern. [Mr and Mrs C] also express concerns about the use of restraint at [the facility]. [Mr D] has since relocated to another residence.

**Advice**

Comment is made in respect of questions raised by the Health and Disability Commissioner as below. As mentioned, the focus relates to the period January 2021–October 2021.

1. Whether [the facility] was an appropriate residential placement for [Mr D]

Spectrum Care Trust is certified under the Health and Disability Services (Safety) Act to provide residential disability support services and holds multiple contracts with government agencies including Whaikaha Ministry of Disabled People. To be certified under the Act, the service needs to be audited which includes observation of properties, and checking the service meets the needs of service users. This includes checking service users have been properly assessed for entry to services and that the environment and staffing is sufficient to meet the needs of service users.

The needs assessment (dated 12/05/2021) was completed by [the NASC] when [Mr D] was a resident at [the facility]. At the time of the reassessment, [Mr D] had been living at [the facility] for around 18 months. The report was initiated in response to a self-harm attempt.

The assessment report is stated as being a reassessment and provides a good narrative overview of [Mr D's] abilities and goals. The report indicates a high level of independence with anxiety management being an important aspect of maintaining a good level of wellness for [Mr D]. Past aggression and self-harm were noted in the assessment report and that there had been a recent incident where a misunderstanding between two residents had resulted in him hurting another person. [Mr D] had held down a job in the past and had a goal to obtain employment and improve his independence.

I note that the report appears to be partially incomplete as no tick boxes (beyond the final two pages) were selected or supervision needs identified. There were also no support for recreational and social activities identified. It appears that low level support is required to assist [Mr D] in managing his finances, anxiety and behaviour and to achieve three primary goals identified. As [Mr D] was well known to Spectrum Care Trust, peers would consider the incomplete areas of the report to be a minor omission. Whereas if this was an initial assessment or one being used for a new service provider, this would be considered to be a significant omission as the needs assessment is meant to guide the provider and is a critical process in determining whether needs can be adequately met by a provider. I also note that the needs assessment is contradictory in places. For example, "he likes a strict routine" but then says "he does not have any schedule for his week".

Peers would consider the level of need as described in the assessment and related service authorisation to be consistent with the type of service provided by Spectrum Care Trust. He would be considered to be one of the more highly functioning residents within the service given his ability to drive, manage public transport independently, read, write, use social media, email and manage his own shopping. He can readily communicate his needs unless highly anxious and had a stated preference to advocate for himself. I note from other information provided for review by HDC that [Mr D] has significant challenges in maintaining good mental health which includes self-harm. It is unknown whether [Mr D] is receiving mental health services. Please also see further comments at the end of my report.

Notwithstanding my comment about mental health, peers would likely conclude that the placement for [Mr D] with Spectrum Care Trust was appropriate based on his needs assessment. However, a key determinant to successful placements is assessing the compatibility of residents. If compatibility had not been considered by both [the NASC] and Spectrum Care Trust, then this would be a significant departure from accepted practice. Given the age differences and breadth of support needs, it appears that Spectrum Care Trust did not have an optimal mix of residents who were compatible as housemates at [the facility].

2. The actions taken when concerns about [Mr D's] behaviour and well-being were raised

Concerns about [Mr D's] behaviour and well-being were raised by another family in their complaint to Spectrum Care Trust in April 2021. In that complaint letter it also references that together with [Mr D's] guardian, they had also reported their concerns to the Police. There are also incident reports from staff that raises concerns about [Mr D's] behaviours and wellbeing.

There is no documented information provided for review that indicates an immediate risk assessment was done in respect to [Mr D] being named within the complaint. There may have been other actions taken but not documented. A reassessment report [the NASC] is dated 12 May 2021 and indicates this was in response to behaviours. It would be usual that a provider would ask for a reassessment when a resident's needs have changed. There is commentary within the Needs Assessment Report that indicates some of the events causing concern were being considered within the assessment.

There is also no evidence of reporting to the Ministry of Health under the requirements to report critical incidents. It appears that the Police were involved in speaking with staff and [Mr D] following the April complaint, but [Mr D's] family were not made aware of this. A conclusion was made by Spectrum Care Trust that the behaviour was not predatory. The outcome of the Police complaint was not included in documentation provided for review. However in the letter of complaint response to the family dated 19 August 2021, there is a statement that Spectrum Care Trust determined at the time of the allegation of sexual abuse on 27 April 2021 that it was not "*an immediate incident requiring reporting*" (to the family). Peers would usually consider any allegation of abuse requires reporting to family. This is acknowledged in the response from Spectrum Care Trust to the family (dated 19 August 2021).

There is a group complaint raised in July 2021. This includes a personal statement from [Mr D's] parents that sets out concerns and expectations. These are used as the basis for the complaint investigation then completed by Spectrum Care Trust which included a response letter dated 19 August. (See later in this report for further information about the management of this complaint.)

Peers would consider it appropriate to undertake a risk assessment by senior staff in response to the complaint made in April involving [Mr D]. This may have occurred within the context that there was also a Police complaint but this information was not shared for review by HDC. If a risk assessment had not been completed, this would be a significant departure from accepted practice. Allegations of the nature made, would usually be reported to the Ministry of Health. This would be considered a significant departure from a requirement set down by the Ministry of Health.

The request for a reassessment by the Needs Assessment Coordination Service … was appropriate. I note that Spectrum Care Trust has access to psychologists and [behaviour support specialists]. Peers would expect that both these avenues available to Spectrum Care Trust would have been used to support improvements and decision making in respect of [Mr D's] needs. There is a Behaviour Support Plan Review report (developed by [experts]) dated 11 June 2021 which indicates a review was requested by Spectrum Care Trust. It is not uncommon that there is a waiting time for reviews as [the experts are] well known as being in high demand for [their] services.

Given the incompatibility of residents, peers would consider immediate steps to relocate residents would be appropriate and potentially additional staffing put in place until alternative placements occurred if the risk assessment determined this as needed. From

correspondence reviewed, it appears that relocating residents to gain a better compatibility mix was not initially considered, as a priority.

3. [Mr D's] ability to leave [the facility] at night

I note [the NASC] needs assessment report did not state any supervision was required for [Mr D]. Furthermore the report states [Mr D] manages transport and outings independently and is able to get himself to safety in an emergency.

[Mr D's] Emergency Plan (developed by Spectrum Care Trust) includes being missing, self-harm and aggressive behaviour. In respect of managing [Mr D] being missing, there is a planned response by Spectrum Care Trust to try to contact [Mr D] by phone after 30 minutes and to call the Police and on-call Spectrum Care staff if it gets dark. The Emergency Plan doesn't link being independent in the community with self-harm or aggressive behaviour. Peers would expect that if a resident is highly anxious and has a history of self-harm and aggression which could be triggered in a community setting when he is out independently, that there should be strategies and tactics [Mr D] is taught in order to reduce risks to himself and others.

4. The safety measures in place to protect [Mr D]. Please also discuss the general management of safety and risk for all clients at [the facility];

Plans as provided to HDC were reviewed. These provide guidance to staff and represent the expectations for implementing safety measures to protect and support [Mr D]. See question 3 in respect of the Emergency Plan.

There is a Behaviour Support Plan Review report (developed by [experts]) dated 11 June 2021. The … review report references significant past big incidents of physical aggression and frequent self-harm episodes, anxiety and emotional dysregulation and a determination that [Mr D] was doing better than expected with fewer than expected events.

There is a … Safety Plan dated 18 December 2020. This plan addresses aggressive behaviours and self-harm. It is comprehensive and peers would consider this to be of an extremely high standard. The only thing it doesn't address is how staff should support [Mr D] to self-manage when he is independently in the community with no staff support. Given a key goal for [Mr D] was to become more independent including gaining employment and driving a vehicle, more strategies to support [Mr D] to regulate his behaviours to keep himself and others safe when alone or unsupported would be an important consideration. Peers would find this to be a moderate departure from accepted practice and that not having a plan and programme beyond what was written in respect of community engagement poses a risk to him. The actual level of risk would be difficult to determine without further assessment. However, I note one incident report where [Mr D] was in a public environment with staff which could have resulted in a retaliation based on his verbal insult, if circumstances had of been different (such as being alone in a similar situation).

In respect of general safety for all residents at [the facility], it is difficult to comment beyond the need to ensure compatibility of residents and ensuring plans are implemented to try to anticipate and avoid situations which pose risks to residents. Incident reports indicate that

there were many situations where incompatibility was the trigger for behavioural events which indicates the need to reconsider the mix of residents at the property and how staff are managing.

5. The adequacy of care, risk, safety, emergency, and support planning/management for [Mr D], including the standard of documentation

There is a Spectrum Care Trust health long and short term support needs assessment report. This is dated 9 November 2021 but includes three needs identified in 2020, all of which relate to physical health.

There is a Personal Goals Assessment report dated 11 October 2021. It outlines three primary goals and is completed to a standard that meets current accepted practice.

There is a Risk Plan (Individual Risk Plan) dated 2 September 2021. It identifies eight risks, with associated controls. I note that the risk of aggression to others; a previous history of stealing money; and self-harm does not consider how [Mr D] will manage when staff are not available to intervene (e.g. when he is out independently in the community). There is a further risk stated as inappropriate social boundaries/stranger danger but it has no detail or controls documented. The plan also states that oversight when in the community is "*not applicable"*.

There is a Spectrum Care Trust Support Needs Assessment dated 16 November 2021. It is based on activities of daily living and physical health. It is completed to a standard that meets current accepted practice.

Generally peers would consider the standard of documentation and adequacy of plans to be adequate with the exception of managing in the community when alone (and one incomplete part to the risk documentation). This would be a moderate departure from accepted practice.

Other clinical documentation provided for review included electronic incident reports which are commented on below.

6. Management of incidents, including communication with [Mr D's] family and the standard of documentation

An incident register was provided for review. It included 40 incidents reported between January and October 2021.

Of incident register reports provided for review, there were:

- 5 incidents related to outbursts or physical aggression, some which involved other residents
- 3 incidents related to inappropriate sexual behaviour
- 4 incidents related to self-harm (one report which included two self-harm episodes making 5 reported self-harm events in total)
- 3 incidents related to verbal insults (includes one in a public place)
- 25 related to medical concerns (e.g. pain, minor injury)

Because of the way the information was downloaded for review, some information is cut off (mostly incident notes of the actual event) so therefore an incomplete record was provided for review.

General observations from reviewing the records indicates:

- There were no reported incidents in February or September which goes against the trend for the rest of the year. Some incident dates were out of order which might indicate retrospective entry.
- None include notification to family. However, there is other correspondence that suggests [Mr D] wanted to limit family involvement and in the three investigation reports provided for review, there was family notification documented.
- Police were called for one self-harm event; an ambulance for another; accident and Emergency Services used for another; and no external agencies used for the other. There were not corresponding investigation reports for three self-harm events and no notifications to the Ministry of Health for these events (as per Critical Incident process[11]).
- There were no corresponding investigation reports related to incidents reporting inappropriate sexual behaviours.

Three investigation reports were provided for review:

Incident dated 4 May 2021. The report itself is not dated but first date signed is … on 31 May 2021 with a final signed date [of] … 30 July 2021. The incident was in relation to *suicidal ideation*. This states the family were notified by phone the day following the event. With the exception that this should have been notified to the Ministry of Health and included in the investigation report, the rest of the report has followed the Spectrum Care Trust investigation report template. There is also an associated action plan which appears to have been implemented.

Incident dated 12 August 2021. The report itself is not dated but first date signed … on 12 August 2021 with a final signed date [of] … 24 September 2021. The incident relates to *aggression* which was not initiated by [Mr D] but he retaliated by punching the other resident. The report states family were notified the same day of the event. There is no indication that the Ministry of Health were notified in respect of this event which would be considered a physical assault therefore meeting criteria for notification.

Incidents dated 26 August and 27 August 2021. The report itself is not dated but the date completed is recorded as 30 August 2021 and final sign-out … of 27 September 2021. The events related to *aggression, threatening harm to self and others and two self-harm events*. Action following the second of the two self-harm events had resulted in an emergency department assessment. It appears that the initial event was triggered by one resident asking others to be quiet. The report states family were notified on 29 August 2021. There is no recorded notification to the Ministry of Health. There is an associated action plan with dates of completion reported.

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8. The reports of use of restraint at [the facility]

There was no documentation that indicated restraints may be appropriate for [Mr D] or that any were used. It appears from the complaint documentation that there was action taken to redirect a resident during an altercation but that this had been appropriately managed and reviewed by the Spectrum Care Trust's Restraint Management Group, who considered the event to have been appropriately managed. Without further information, no additional comments can be made.

9. Management of [Mr and Mrs C's] complaints

A complaints register providing details of each complaint was not provided for review but such a register is referenced within the complaints policy. The policy notes a centralised process for managing complaints via a shared feedback inbox. The policy requires [that the coordination of the process be separate from the oversight of any investigation].

Timeframes for complaint communication with the complainant related to the group complaint (July 2021) is as per HDC Code of Rights (Right 10).

Reference to the prior complaint in April 2021 appears to be a miscommunication as:

- The complaint made directly to Spectrum Care Trust was a complaint made by another family which included naming [Mr D] as a resident of concern. [Mr D's family] had knowledge of this complaint and may have thought they were party to that complaint and expecting correspondence. However the letter is clearly from another family and would not be considered as a joint complaint. It would have been a reasonable expectation of [Mr D's family] to be contacted in respect of the April 2021 complaint;
- [Mr D's family] had in conjunction with another family made a complaint directly to the Police. They had expected that this would result in Spectrum Care Trust using its complaints process to manage that complaint and involve them, which did not occur.

Peers would usually treat a family making a complaint directly to the Police as being serious and would initiate an investigation. Peers would usually record this in their complaints registers as being an external agency complaint with related parties. Related parties, in this case the two families could have expected to receive a complaint acknowledgement letter simply stating that they were in receipt of their complaint made to the Police and were now working with the Police to investigate the matter. Generally, the outcome of the Police complaint would be communicated to the family by the Police. In this case, as a complaint was also made concurrently by one of the family members directly to Spectrum Care Trust, that family, who were the complainant (and not [Mr D's family]), would also receive information directly from Spectrum Care Trust via the complaints process. Communicating the process clearly to [Mr D's family] would have been helpful in setting expectations and them being aware that the matter was being taken seriously and Spectrum Care Trust had put the necessary resource into the investigation. Parallel investigation and complaints processes are complex and uncommon. Peers would expect this type of situation to be escalated within the organisation as a result.

The group complaint made on 26 July was acknowledged on 2 August 2021. A response letter was dated 19 August 2021. It covered seven elements of the multi-faceted complaint. There was also a follow-up email sent 23 September 2021 and again on 7 October enquiring whether the family were satisfied with the complaint outcome letter of 19 August 2021. A response from the family on 23 September 2021 was missed but received subsequent to the October follow-up. At that time, the family continued to express concerns in response to the 19 August 2021 letter.

The Complaints Standard Operating Procedure creates complexity by splitting complaints acknowledgement between [two areas of management] dependent on who received the complaint in the first instance. The actual investigation process for complaints is not documented or a template provided. This is not unusual amongst providers but there should be a process for investigation such as using the London Protocol or Human Factors methods.

9. The adequacy of Spectrum Care's policies and SOPs

Peers would consider policies and Standard Operating Procedures (SOPs) to be generally well written and provide adequate guidance to staff consistent with accepted practice. Opportunities to strengthen and streamline some policies and procedures have already been noted in this advice.

The devolved method in managing complaints is likely a major contributing factor in the overall timeframes, standard of investigations undertaken and communication in respect of complaints, concerns and requests.

10. Staffing levels at [the facility]

Rosters provided for review (28/12/20–14/11/21) indicates:

- A roster pattern where there are usually two staff on morning shift, one staff on a swing shift that straddles the morning and afternoon shift and an afternoon shift through to 10.00 pm. This pattern would be considered adequate by peers. The roster does not indicate whether there is sleepover staff or remote monitoring of the home.
- There were staff on long-term ACC, Sick Leave and Annual Leave during the period that resulted in many days of one staff member per shift (this includes two staff for the overlap period of the swing shift).
- There are multiple long shifts or extras being worked to cover the roster in places.

It should be noted that because staff names were not provided on the rosters, it is not possible to determine whether this was a standing roster or roster actually worked. It does look as if the rosters were actual rosters because there are entries for ACC and Sick Leave. There is also a line that looks to be bureau required compliment to ensure minimum staffing levels are achieved. It is unknown whether these shifts were covered. The second page of each roster period is blank. This is meant to total up actual hours against budgeted hours for all types of leave. It would be an improvement that would support cross referencing and monitoring if this was completed. Payroll records and bureau invoices would be needed to check whether all shifts were adequately covered.

Peers would consider staffing levels to be at a bare minimum where there is only one staff member on shifts due to the level of supervision and support required by residents. This would also limit the ability to support resident activities off-site unless there were other arrangements in place. Given the risks posed within the service between incompatible residents, it would be reasonable to increase staffing levels whilst looking for alternative placements. However, this is not always possible with workforce shortages across the sector. COVID-19 is likely to have been a factor where there was minimal staffing levels during this period. Staff working extra shifts and long shifts is unfortunately common with national and international health workforce shortages in the face of a pandemic.

11. Other comments

There is an unusual comment in the investigation report from 4 May 2021 that [Mr D] had tried to contact the duty staff member by text without success with an implication that it was the staff member's personal phone number. If this is the case, then this could be a professional boundaries concern.

I noted that [Mr D] has dual disability having both intellectual and mental health components. It may be worth considering whether he would be better served through a mental health service than an intellectual disability service or that Spectrum Care Trust should hold certification under the Health and Disability Services (Safety) Act for both disability support services and mental health services (if Spectrum Care Trust does not already hold certification for mental health services). To the best of my knowledge from a review of website, annual report and strategic plan, it does not appear that certification extends to mental health services.

Nāku noa, nā

Dr Christine Howard-Brown'

**Appendix B: Advice obtained from Dr Howard-Brown on 3 May 2023**

'**Re: Complaint: 21HDC00934/Spectrum Care Trust/[Mr A]**

I agreed to provide an opinion to the Commissioner on case number **C21HDC00934**. 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 [Mr A] … by Spectrum Care Trust was reasonable between the period January to November 2021 in the circumstances, and why. In particular, there were seven parts to the Commissioner's request.

Comment was requested in relation to the following items.

1. Whether [the facility] was an appropriate residential placement for [Mr A]
2. The safety measures in place to protect [Mr A]. Please also discuss the general management of safety and risk for all clients at [the facility];
3. Care, risk and support planning/management for [Mr A], including the standard of documentation;
4. Management of incidents, including communication with [Mr A's] family and the standard of documentation;
5. Management of [Mr and Mrs B's] complaints;
6. The adequacy of Spectrum Care's policies and SOPs;
7. Staffing levels at [the facility]; and
8. Any other matters that you consider warrant comments.

The following documents were provided for review.

1. Letter of complaint to Spectrum Care dated 26 July 2021.
2. Email submission of complaint to HDC & follow-on emails dated 29 April 2021; 17 August 2021; 24 August 2021; 24 November 2021 from the family of [Mr A]
3. Email submission of complaint to HDC dated 30 April 2021 from support worker and related phone call note dated 6 May 2021
4. Copy of Nationwide Health and Disability Advocacy Service report dated 16 September 2021.
5. Response letters from Spectrum Care Trust to the complainant dated
   a. 28 July 2021
   b. 12 August 2021
6. Response letters from Spectrum Care Trust to HDC dated
   a. 16 November 2021

   b. 10 August 2022
   c. 3 February 2022
   d. 26 April 2023
7. Incident reports involving another resident of Spectrum Care Trust where [Mr A] may have been involved
8. Clinical records (plans and incident reports) for [Mr A] (excludes any progress notes or diaries)
9. Email exchanges between Spectrum Care and [Mr A's] welfare guardian (as complainant)
10. Fortnightly rosters for the periods 28/12/20–14/11/21
11. Standard operating procedures (SOPs) and policies from Spectrum Care Trust:
    a. Privacy and Confidentiality Policy (no date or letterhead)
    b. MS-11B Personal Information (Privacy) Policy
    c. POL-04 Rights Realisation
    d. MS-04A Restraint Minimisation and Safe Practice
    e. MS-04I Individual Risk Assessment and Plan
    f. MS-04M Behaviours of Concern
    g. SOP-04Ma Behaviour of Concern
    h. POL-07 Quality
    i. MS-07D Open Disclosure
    j. MS-07A Adverse Event Reporting
    k. SOP-07Aa Adverse Event Reporting
    l. SOP-07Ab Investigation of a Critical Incident or Serious Incident
    m. POL-09 Complaint or Negative Feedback
    n. MS-09A Complaint or Negative Feedback
    o. SOP-09Aa Complaint or Negative Feedback
    p. POL-16 Live Free From Abuse and Neglect
    q. MS-16A Live Free From Abuse and Neglect
    r. SOP-16Aa Live Free From Abuse and Neglect
    s. SOP-07Ab Investigation of a Critical Incident or Serious Event
12. [NASC] Assessment Report dated 5/8/2019
13. [NASC] Service Authorisation dated 27/6/2022

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

Contracts and service specifications, Disability Support Services, available at: Contracts and service specifications | Ministry of Health NZ (Note that the provider will have its own copies of the relevant specifications).

Section 31 notification process Notifying an incident under section 31 | Ministry of Health NZ

Reporting of critical incidents and deaths Whaikaha Ministry of Disabled People Reporting of critical incidents and deaths | Whaikaha - Ministry of Disabled People

Critical Incident Categories and Definitions (Whaikaha Ministry of Disabled People) Critical-Incident-Categories-and-Definitions.docx (live.com)

Ngā paerewa Health and disability services standard, available at: NZS 8134:2021 :: 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)

Spectrum Care website, available at: Spectrum Care | Homepage

Serious adverse event review — Systems analysis of clinical incidents — London Protocol (2nd edition) toolkit, available at: https://www.bing.com/ck/a?!&&p=594f14f41c130e0aJmltdHM9MTY2NzYwNjQwMCZpZ3VpZD0yZjZhMGYxYi1mMzhmLTZhOWQtMGNlNC0xZWRmZjc4ZjY0NzkmaW5zaWQ9NTQxMw&ptn=3&hsh=3&fclid=2f6a0f1b-f38f-6a9d-0ce4-1edff78f6479&psq=london+protocol+for+incident+review+systems&u=a1aHR0cHM6Ly93d3cuY2VjLmhlYWx0aC5uc3cuZ292LmF1L19fZGF0YS9hc3NldHMvcGRmX2ZpbGUvMDAxMS82MDY3NDYvTG9uZG9uLVByb3RvY29sLVRvb2xraXQucGRmIzp-OnRleHQ9VGhlJTIwU3lzdGVtcyUyMGFuYWx5c2lzJTIwb2YlMjBjbGluaWNhbCUyMEluY2lkZW50cyUyMC0lMjBMb25kb24saGVhbHMrA2FyZSUyMGNvbnRleHQlMjBieSUyMHBhdGllbnQlMjBzYWZldHklMjBleHBlcnQlMkMlMjBDaGFybGVzJTIwVmluY2VudC4&ntb=1

Whaikaha Ministry of Disabled People website links:
Assessments and funding | Whaikaha - Ministry of Disabled People
Housing and living options | Whaikaha - Ministry of Disabled People

Tier Two Service Specification Community Residential Support Services and Tier Three Service Specification Out of Family Residential Support Services for Children and Young People with a Disability Contracts and service specifications | Whaikaha - Ministry of Disabled People

RIDSAS Services information website link:
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 | Ministry of Health NZ

**Background**

[Mr and Mrs B] are the legal welfare guardians of [Mr A]. [Mrs B] raised several concerns about the support provided, and management of incidents, for [Mr A] at [the facility]. [Mrs B] attempted to resolve her concerns directly with Spectrum Care Trust prior to expressing her concerns to HDC.

**Advice**

Comment is made in respect of questions raised by the Health and Disability Commissioner as below. As mentioned, the focus relates to the period January 2021–November 2021.

1. Whether [the facility] was an appropriate residential placement for [Mr A]

Spectrum Care Trust is certified under the Health and Disability Services (Safety) Act to provide residential disability support services and holds multiple contracts with government agencies including Whaikaha Ministry of Disabled People. To be certified under the Act, the service needs to be audited which includes observation of properties, and checking the service meets the needs of service users. This includes checking service users have been properly assessed for entry to services and that the environment and staffing is sufficient to meet the needs of service users.

The needs assessment (dated 2019) was completed by the Needs Assessment Coordination Service … when [Mr A] was a resident at [the facility]. The assessment report is stated as being a three yearly assessment and provides a comprehensive overview of [Mr A's] support needs. On the basis of it being a reassessment, [Mr A] would have previously been assessed at the same residence. Peers would consider the level of need as described in the assessment and related service authorisation to be consistent with the type of service provided by Spectrum Care Trust.

Peers would likely conclude that the placement for [Mr A] with Spectrum Care Trust was appropriate based on his needs assessment. However, a key determinant to successful placements is assessing the compatibility of residents. If compatibility had not been considered by both [the NASC] and Spectrum Care Trust, then this would be a significant departure from accepted practice. I note from a response to HDC by Spectrum Care Trust that there was a time when housemates were of a similar age to [Mr A] but when this changed, the family had a preference that [Mr A] would remain at the property as he had lived there for some sixteen years. This was not seen as ideal but was agreed by Spectrum Care Trust. However there is also conflicting correspondence from the family suggesting they were amenable to an alternative placement but that options had not been presented to them. Peers would accept that there is a balance to strike in this type of situation but not at the expense of [Mr A] being assaulted or abused by housemates who are much younger and have different support needs to himself. The absence of pursuing better living options for [Mr A] appears to have been hampered by a miscommunication as to the preferences of the family.

2. The safety measures in place to protect [Mr A]. Please also discuss the general management of safety and risk for all clients at [the facility];

Risk and Emergency Plans were provided for review. These are commented on in more detail in question 3. They do not address risks associated with harm caused by others but do cover general risks commonly found in plans for people with cognitive difficulties. The best information in respect of safety to protect [Mr A] from risk of others is found in the Interim Support Guidelines. This is a comprehensive document dated 28 September 2021. These guidelines note that there can be tension between housemates (who are mostly younger) and that [Mr A] can be a target. The guideline states that staff are excellent at recognising triggering situations and early warning signs enabling them to respond proactively. Behaviours of concern and strategies to manage them are outlined in this guideline. Peers

would consider the guidelines to be informative and enable staff to implement them as part of safety measures.

As with any residential disability setting, if there are other residents who are incompatible then this can lead to the placement no longer being suitable for one or other resident. For this reason, providers usually work closely with Needs Assessment Coordination Services when there are vacancies in an attempt to ensure housemates are likely to get along and have similar support needs. Documentation suggests that Spectrum Care recognised that [Mr A's] housemates were not especially compatible to the extent that there were plans in place to prevent and respond to disagreements and escalations in behaviour. Peers would consider that [Mr A] was appropriate for the placement at [the facility] but other residents may not have been compatible or appropriate based on incident reports (in relation to at least two residents with behaviours which pose a high risk to others) and the plans in place for [Mr A] as per the Interim Support Guidelines.

I note that these guidelines are dated 28 September 2021 which is subsequent to the complaints of April and August 2021.

3. Care, risk and support planning/management for [Mr A], including the standard of documentation

See advice above in respect of Interim Support Guidelines and Needs Assessment. I note in the response by Spectrum Care to this complaint that clinical records of another resident (LB) were included in the response. This is a likely error by Spectrum Care, although one incident report also involves [Mr A].

There is an Emergency Plan dated 16 November 2021, Support Needs Plan dated 18 November 2020 and Behaviour Support Plan dated August 2016. There is a personal goals plan dated 19 February 2021 and 17 September 2021. There is a Risk Plan dated 16 November 2021 and prior plan dated 13 April 2021. They are straight forward plans which peers would consider typical and meet accepted practice with the exception of the Risk Plan. The 16 November 2021 Risk Plan is identical to the 13 April 2021 plan notwithstanding the dates and authors. The plan does not include a risk of [Mr A] being harmed by others given his level of intellectual disability; housemates and prior incidents occurring. Peers would likely consider this to be an omission in the Risk Plan. However the Interim Support Guidelines are useful in this respect. Taking this into consideration, peers would consider the Support Guidelines as being a supplementary document that takes full consideration of these risks.

There is also a useful supplementary document which outlines the usual morning routine for [Mr A]. This enables staff (including any casual or agency staff) to support [Mr A] in a way that is helpful and less likely to cause agitation. There is a further document that sets out [Mr A's] usual weekly activities across a monthly calendar. An historic behaviour plan dated August 2016 includes behaviours of concern. This provides details on prevention, triggers and effective strategies staff can use as part of behavioural management. It is thorough and would be a useful guide to staff. In Spectrum Care's response to HDC, it is stated that although written in 2016 it remained current to 2021. Peers would note that a documented

annual review of this plan to ensure currency even when needs are considered stable or unchanged would be accepted practice within disability services.

There is an assessment report from a clinical psychologist dated 6 July 2021 which was requested in response to alleged incidents of violence and sexual behaviour occurring at the service. The clinical psychologist's interview was in the company of a family member of [Mr A]. The report indicated that given [Mr A's] level of cognitive impairment any relevant information could not be elicited.

Other clinical documentation provided for review included a list of incidents the family had obtained from Spectrum Care and an incident report where [Mr A] was named as a second participant as provided by Spectrum Care to HDC. There is also a running record of complaint correspondence via email exchanges. These are commented on in following questions.

4. Management of incidents, including communication with [Mr A's] family and the standard of documentation;

An incident register together with one incident investigation report was provided for review. Some information appeared to be incomplete. This information together with complaint responses from Spectrum Care Trust suggests that there were at least 28 incidents reported January 2021–September 2021. No records were provided past 18 September 2021 beyond some email correspondence between staff and the family when the family had noticed a foot injury which was then explained by an aggressive outburst initiated by another resident.

Of incident information provided for review, there were:

- 15 incidents related to outbursts or physical aggression, some which involved other residents triggering the behaviour or [Mr A] being the recipient of the behaviour
- 2 incidents related to [Mr A] being a recipient of abusive sexualised behaviour
- 6 incidents related to medical concerns (e.g. fall, choking, pain)
- 5 incidents related to being unable to sleep.

General observations from reviewing the records indicates:

- Records of communication to family and the extent and timeliness of that communication was limited in documentation provided for review. Improving recording of communication with family in respect of incidents would be beneficial. The Spectrum Care policy requires the staff member reporting the incident to be responsible for ensuring family and other stakeholders are notified (yet this did not appear to be consistently implemented). It appears there was timely communication to notify of incidents in respect of:
  - One accident (not requiring hospitalisation was documented as the family having been notified) as part of the incident reporting (but was not communicated at the time but after medical assessment)
  - One incident of aggressive behaviour initiated by [Mr A] that resulted in him being struck by another resident which was recorded as the family having been emailed in respect of this (and an investigation report completed)

- There appears to be a high use of PRN medication in response to outbursts. It is difficult to know whether this is acceptable without more detailed review. It would be useful that Spectrum Care reviews the use of PRNs for management of behaviour as contemporary practice is to try to avoid use of PRN medication, particularly when the behaviour is triggered by predictable events (e.g. not going out when other residents are being taken out)
- The number of incidents, even when taking out those related to being unable to sleep appears to be high
- There were no corresponding investigation reports for the two incidents reported related to sexualised behaviour by another resident to which [Mr A] was the recipient — however it is possible that the incident report is associated with the other resident and not in [Mr A's] file.
- Notification to the funder using the Critical Incident process[12] may not have been followed. Peers would usually consider any assaults of a disabled person as meeting a threshold to report to the funder and escalate within the organisation to senior leadership and treat as critical incidents (noting critical incident examples provided by the Ministry of Health includes abuse or assault).

Peers would consider most of the incidents (other than being unable to sleep) should have been reported to family and an investigation of the circumstances of the events should have been investigated (even at a low level). Peers would consider given the seriousness of incidents reported, open disclosure of them to the family and notification to the Ministry of Health would have been appropriate. Immediate steps to avoid recurrences would usually be a priority for providers. From the incident reports, it appeared that [Mr A's] behaviour was being triggered by his living circumstances. This suggests that a change in living circumstances was indicated. Often when people with an intellectual disability are ageing, it becomes important to find a more appropriate environment.

Peers would consider it a significant departure from accepted practice that incidents were not reported and thoroughly investigated when they relate to assaults, sexualised behaviour and other escalations of behaviour. Peers would also consider not involving the Ministry of Health and family as an omission, not just for open disclosure but for the assistance that others can provide in joint problem solving.

I note that in one response letter to a complaint from [Mr A's] family that the sexualised behaviour events were investigated but were directly related to the resident who initiated the behaviour. As part of this investigation it appears that this had led to the clinical psychologist's appointment with [Mr A] related to the sexualised behaviour of another resident. Spectrum Care Trust stated in its complaint response that the matter had been taken seriously but it had not met the threshold for reporting as a critical incident to the Ministry of Health (presumably based on the outcome of the response). I note that Spectrum Care Trust has reiterated in a further letter to the HDC that sexualised behaviour incidents do not require escalation to the Ministry of Health or Needs Assessment Coordination Services as they do not meet the criteria for a critical incident (but that Spectrum Care would

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classify these as a serious incident requiring investigation under its current processes). The Ministry of Health expects notification at the time the event occurred (or becomes known) and not when an investigation has been completed. As the Ministry of Health Disability Supports Service recently transitioned to Whaikaha Ministry of Disabled People, the information about critical incidents is now available on this website. This includes a downloadable document which includes definitions and categories. This document states under the abuse and neglect category that sexual abuse or assault requires notification. This includes an allegation of sexual abuse (including grooming of a disabled person for sexual activity) in the context of provision of disability support. Therefore I remain of the view that peers would consider notification to be appropriate.

It is clear from documentation provided for review that compatibility was an issue that was associated with an increasing number of incidents involving [Mr A]. Miscommunications between family and Spectrum Care Trust appears to be a factor in not progressing other options for [Mr A]. Peers would likely increase the focus on finding alternatives to improve the mix of residents in the home in addition to reviewing risk management and behavioural plans.

There is also reference in documentation to a breakdown in communication between [Mr A's] family and staff at Spectrum Care Trust. This seemed to have been left unresolved for some time. Attempts were made to improve communication once complaints were escalated. However there was a significant period of time where communication appears to be sub-optimal. Peers would determine communication with the family was sub-optimal and represents a moderate departure from accepted practice. It is common that there is a key worker assigned to a family by the service to ensure good communication and regular sharing of diaries, finances, incidents and updating the family about activities and outings.

I also note that Spectrum Care Trust has in its complaint response stated staff are trained in de-escalation, all residents have risk management and behaviour guidelines or support plans; and that incidents are reported and monitored by managers. As part of monitoring incidents these are also discussed with the Needs Assessment Support Service, other health professionals of a specialist behavioural support provider. No such records or monitoring of incidents and onward actions were provided for review. There had been some retrospective reporting of incidents by a staff member which had also been a contributing factor to management of those incidents. This was communicated to [Mrs B] as part of one of the complaint investigations. There was also reference to incidents not meeting the threshold for escalation. This would warrant further investigation by Spectrum Care to determine why this situation occurred.

5. Management of [Mr and Mrs B's] complaints

A complaints register providing details of each complaint made by [Mr and Mrs B] was not provided for review but such a register is referenced within the complaints policy. The policy notes a centralised process for managing complaints via a shared feedback inbox. The policy requires [that the coordination of the process be separate from the oversight of any

investigation]. Timeframes for complaint communication with the complainant is as per HDC Code of Rights (Right 10) albeit a lot of extension notifications.

The Complaints Standard Operating Procedure creates complexity by splitting complaints acknowledgement between [two areas of management] dependent on who received the complaint in the first instance. The actual investigation process for complaints is not documented or a template provided. This is not unusual amongst providers but there should be a process for investigation such as using the London Protocol or Human Factors methods.

From January 2021–November 2021, documentation provided for review indicates there was a complaint raised by the family in April 2021 which was not adequately addressed to the complainant's satisfaction. This complaint included serious concerns as to the welfare of [Mr A] given the behaviours of other housemates. There were also several other concerns and complaints raised within email correspondence and partly related to the Spectrum Care Trust separating out elements of the complaint in April to manage them as separate complaints. This led on to further clarifications and additional related complaints.

A joint complaint with two other families was made in July as the families had some shared concerns. This complaint was subsequently taken to the Nationwide Health and Disability Advocacy Service and forwarded to HDC. HDC had further commentary provided by the family during the HDC investigation period. The complaint to HDC also had a corresponding complaint by a Spectrum Care Trust staff member choosing to remain anonymous who was concerned about [Mr A's] welfare in the group home.

Correspondence provided in relation to the initial complaint of April 2021 included reference to a verbal acknowledgement of the complaint with some verbal updates and a formal written response was grouped with the response to the July complaint issued on 12 August 2021. In between April and August there had been emailed correspondence to provide information requested in the complaint to receive incident reports, bank statements and regular communication.

The July complaint had a written acknowledgement of this complaint dated 28 July 2021. It included that … would lead an investigation. The response letter of 12 August addressed each element of the multi-faceted complaint. In summary, this included:

- an *apology in respect of open disclosure and associated delays;*
- *the position that lack of protection for [Mr A's] wellbeing and safety was not substantiated but the mix of residents was not ideal;*
- *an agreement that there had been a breach of privacy/staff professional boundaries which needed more focus by the organisation;*
- *noting the need to improve family communication;*
- *acknowledgement that the prior complaint of 29 April had not been adequately responded to;*
- *and notification of critical incident to the Ministry of Health should have been undertaken (and internal processes amended).*

Actual complaint investigation records were not provided for review. It is difficult to determine whether the full investigation process was followed to arrive at these determinations. There were also multiple emails from Spectrum Care Trust to extend and close out complaints which the family were not accepting as having been satisfactorily resolved.

Peers would be concerned at the escalating number of incident reports related to verbal, physical, behavioural events in respect of [Mr A]. There were also a plethora of emails between Spectrum Care and [Mrs B] outlining a number of concerns. These were themed as a lack of disclosure of incidents; privacy breach; breakdown or lack of communication with [Mrs B]; lack of commitment to [Mr A's] outcomes; and failing to protect [Mr A's] wellbeing. As mentioned, each were treated as separate complaints with running records of emails used to acknowledge complaints, provide updates and respond to the complaints.

The complaint investigation and processes were further complicated by an historic complaint that came to light from providing historic incident records related to a prior resident who also had alleged sexualised behaviours and had included a Police investigation whilst [Mr A] was at the group home. This further reduced trust and confidence the family had in Spectrum Care Trust.

Peers would likely consider a level of informality in the complaints management process with the verbal and email update approach used together with a low level resolution approach to what were considered serious complaints. This likely contributed to an escalation of the complaints by the family as they did not consider they were being taken seriously enough. More immediate action to determine the safety of the resident would be a reasonable expectation of the family.

Peers would have likely escalated the initial complaint of April 2021 internally and done an immediate risk assessment at the property. The complaint management would usually have been managed by a senior person (such as a Quality Manager) given the nature of the complaint.

For larger organisations including Spectrum Care Trust, the style of complaints management would be seen as a moderate departure from accepted practice, albeit the approach used by Spectrum Care Trust is not necessarily wrong — it is based on low level resolution processes. This requires very skilled staff who are managing complaints of this complexity in this way. It is obvious in the emailed correspondence that the family had more questions than answers and were genuinely concerned for [Mr A's] welfare and were not feeling the complaints were being taken seriously or with enough urgency. Even if peers were aiming for low level resolution, the amount and nature of the email correspondence would result in escalation within the organisation.

6. The adequacy of Spectrum Care's policies and SOPs

Peers would consider policies and Standard Operating Procedures (SOPs) to be generally well written and provide adequate guidance to staff consistent with accepted practice.

Opportunities to strengthen and streamline some policies and procedures have already been noted in this advice.

In its latest correspondence to HDC, Spectrum Care provided an additional SOP for critical or serious incidents. This includes the steps for investigating and reporting events. I note that the links and references are to the Ministry of Health and it would be beneficial for Spectrum Care to download and use the Whaikaha Ministry of Disabled People definitions and categories document for critical incidents.

As mentioned, the devolved method in managing complaints is likely a major contributing factor in the overall timeframes, standard of investigations undertaken and communication in respect of complaints, concerns and requests. I note Spectrum Care has advised HDC that it is now ensuring oversight of serious incident investigations by the service manager verses the prior process of only doing this for critical incidents.

7. Staffing levels at [the facility]

Rosters provided for review (28/12/20–14/11/21) indicates:

- A roster pattern where there are usually two staff on morning shift, one staff on a swing shift that straddles the morning and afternoon shift and an afternoon shift through to 10.00 pm. This pattern would be considered adequate by peers. The roster does not indicate whether there is sleepover staff or remote monitoring of the home.
- There were staff on long-term ACC, Sick Leave and Annual Leave during the period that resulted in many days of one staff member per shift (this includes two staff for the overlap period of the swing shift).
- There are multiple long shifts or extras being worked to cover the roster in places.

It should be noted that because staff names were not provided on the rosters, it is not possible to determine whether this was a standing roster or roster actually worked. It does look as if the rosters were actual rosters because there are entries for ACC and Sick Leave. There is also a line that looks to be bureau required compliment to ensure minimum staffing levels are achieved. It is unknown whether these shifts were covered. The second page of each roster period is blank. This is meant to total up actual hours against budgeted hours for all types of leave. It would be an improvement that would support cross referencing and monitoring if this was completed. Payroll records and bureau invoices would be needed to check whether all shifts were adequately covered.

Peers would consider staffing levels to be at a bare minimum where there is only one staff member on shifts due to the level of supervision and support required by residents. This would also limit the ability to support resident activities off-site unless there were other arrangements in place. COVID-19 is likely to have been a factor where there was minimal staffing levels during this period. Staff working extra shifts and long shifts is unfortunately common with national and international health workforce shortages in the face of a pandemic.

8. Any other matters

I would recommend that Spectrum Care Trust review how it manages complaints to avoid using running email records and splitting out complaints into separate complaints. Although there may be many elements to a complaint, splitting them out may have been a contributory factor to the complaint not being escalated within the organisation to recognise the complexity of the complaint and that it was unlikely low level resolution processes would be successful.

Nāku noa, nā

Dr Christine Howard-Brown'

**Appendix C: Advice obtained from Dr Howard-Brown on 4 June 2023**

'Re**: Complaint: 21HDC01899/Spectrum Care Trust/[Mr F]**

I agreed to provide an opinion to the Commissioner on case number **C21HDC01899**. 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 [Mr F] by Spectrum Care Trust was reasonable between the period January to October 2021 in the circumstances, and why. In particular, there were seven parts to the Commissioner's request.

Comment was requested in relation to the following items.

1. Whether … was an appropriate residential placement for [Mr F].
2. The hours [Mr F] was entitled to, and communication surrounding expectations for entitlements with [Mr E], as his welfare guardian.
3. The adequacy of care, risk, safety, and support planning/management for [Mr F], including the standard of documentation.
4. Management of risk and incidents, including communication with [Mr F's] family, and the standard of documentation.
5. Management of [Mr E's] complaint.
6. The adequacy of Spectrum Care's policies and SOPs.
7. Staffing levels at [Mr F's] residence.
8. Any other matters in this case that you consider warrant comment.

The following documents were provided for review.

1. Letter of complaint dated 26 July 2021.
2. Copy of Nationwide Health and Disability Advocacy Service report dated 16 September 2021.
3. Response letter from Spectrum Care Trust dated 16 November 2021.
4. Response letter from Spectrum Care Trust dated 26 May 2023
5. [Mr F's] clinical records and associated documentation from Spectrum Care Trust covering the period 1 January 2021 to November 2021, as supplied to HDC. HDC requested: "*all clinical and service planning documentation … all incident reports, care plans and staffing rosters … for the period of 1 January 2021 onwards*". The following documents were provided for review: 2.
    a. emergency Plan
    b. explore — Safety Plan

c. incident reports summary
d. risk Plan (Individual Risk Plan)
e. staffing rosters (17 May 2021–14 November 2021)
f. support Needs
g. support Plan
h. investigation Report & Action Plan (inc_058) serious incident 23/08/2021
i. investigation Report & Action Plan (inc_059) serious incident 25/08/2021
j. investigation Report & Action Plan (inc_081) critical incident 13/10/2021 and associated Ministry of Health critical incident reporting form
k. Investigation Report & Action Plan (inc_107) critical incident 7/12/2021 and associated Ministry of Health critical incident reporting form (note outside timeframe for review requested by HDC)
l. Investigation Report & Action Plan (inc_141) critical incident 12/3/2022 (note outside timeframe for review requested by HDC)

6. Standard operating procedures (SOPs) and policies from Spectrum Care Trust:

a. POL-04 Rights Realisation
b. MS-04A Restraint Minimisation and Safe Practice
c. MS-04I Individual Risk Assessment and Plan
d. MS-04M Behaviours of Concern
e. SOP-04Ma Behaviour of Concern
f. POL-07 Quality
g. MS-07D Open Disclosure
h. MS-07A Adverse Event Reporting
i. SOP-07Aa Adverse Event Reporting
j. SOP-07Ab Investigation of a Critical Incident or Serious Incident (two versions, different dates)
k. POL-09 Complaint or Negative Feedback (two versions, different dates)
l. MS-09A Complaint or Negative Feedback
m. SOP-09Aa Complaint or Negative Feedback (two versions, different dates)
n. POL-16 Live Free From Abuse and Neglect
o. MS-16A Live Free From Abuse and Neglect
p. SOP-16Aa Live Free From Abuse and Neglect
q. SOP-04Hb Pre-entry and Entry to Service.

7. Investigation Report and Action Plan for [Mr F] from Spectrum Care Trust, dated 26 November 2021 [NASC] Service Authorisation (generated 10 October 2022 but assessment dated 12 February 2015) including Total Weekly Hours summary (dated 30 July 2015).

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

Contracts and service specifications, Disability Support Services, available at: Contracts and service specifications | Ministry of Health NZ (Note that the provider will have its own copies of the relevant specifications).

Section 31 notification process Notifying an incident under section 31 | Ministry of Health NZ

Ngā paerewa Health and disability services standard, available at: NZS 8134:2021 :: 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)

Spectrum Care website, available at: Spectrum Care | Homepage

Serious adverse event review — Systems analysis of clinical incidents — London Protocol (2nd edition) toolkit, available at: https://www.bing.com/ck/a?!&&p=594f14f41c130e0aJmltdHM9MTY2NzYwNjQwMCZpZ3VpZD0yZjZhMGYxYi1mMzhmLTZhOWQtMGNlNC0xZWRmZjc4ZjY0NzkmaW5zaWQ9NTQxMw&ptn=3&hsh=3&fclid=2f6a0f1b-f38f-6a9d-0ce4-1edff78f6479&psq=london+protocol+for+incident+review+systems&u=a1aHR0cHM6Ly93d3cuY2VjLmhlYWx0aC5uc3cuZ292LmF1L19fZGF0YS9hc3NldHMvcGRmX2ZpbGUvMDAxMS82M_DY3NDYvTG9uZG9uLVByb3RvY29sLVRvb2xraXQucGRmIzp-OnRleHQ9VGhlJTIwU3lzdGVtcyUyMGFuYWx5c2lzJTIwb2YlMjBjbGluaWNhbCUyMEluY2lkZW50cyUyMC0lMjBMb25kb24saGVhbHMrA2FyZSUyMGNvbnRleHQlMjBieSUyMHBhdGllbnQlMjBzYWZldHklMjBleHBlcnQlMkMlMjBDaGFybGVzJTIwVmluY2VudC4&ntb=1

Whaikaha Ministry of Disabled People website links:

Assessments and funding | Whaikaha - Ministry of Disabled People

Housing and living options | Whaikaha - Ministry of Disabled People

Tier Two Service Specification Community Residential Support Services and Tier Three Service Specification Out of Family Residential Support Services for Children and Young People with a Disability Contracts and service specifications | Whaikaha - Ministry of Disabled People

RIDSAS Services information website link:

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 | Ministry of Health NZ

**Background**

[Mr E], welfare guardian, raised concerns about the level of support provided to [Mr F] at … He expressed concern that the twenty-four hour care, that he was expecting [Mr F] to be entitled to, was not provided. In addition, [Mr E] is concerned about the management of his direct complaint to Spectrum Care Trust, and the standard of communication in regards to incidents involving [Mr F].

**Advice**

Comment is made in respect of questions raised by the Health and Disability Commissioner as below. As mentioned, the focus relates to the period January 2021–October 2021.

1. Whether … was an appropriate residential placement for [Mr F]

Spectrum Care Trust is certified under the Health and Disability Services (Safety) Act to provide residential disability support services and holds multiple contracts with government agencies including Whaikaha Ministry of Disabled People. To be certified under the Act, the service needs to be audited which includes observation of properties, and checking the service meets the needs of service users. This includes checking service users have been properly assessed for entry to services and that the environment and staffing is sufficient to meet the needs of service users.

Ahead of entry to services which are funded by Whaikaha Ministry of Disabled People, the Needs Assessment Coordination Service … determines that the needs of the service user (in this case [Mr F]) can be met by the provider (i.e. Spectrum Care Trust). On this basis, it is reasonable to determine that the placement was appropriate for [Mr F], at least at the time he was placed with the service. See also the answer to the next question as the actual needs assessment was completed in 2015 whilst [Mr F] was living at his family home. Peers would consider it unusual that this assessment had not been updated although the service authorisation by the [NASC] (authorising Spectrum Care Trust to provide services under contract) was recent. HDC asked Spectrum Care Trust for any information which demonstrated the process for assessment determining suitability and need between a family home environment and the supported living environment offered by Spectrum Care Trust given the purpose of the Needs Assessment being relied upon was not done for the purpose of moving [Mr F] to Spectrum Care Trust. Spectrum Care Trust was unable to locate paper-based documentation from 2015. However, Spectrum Care Trust did outline its usual process and process described in its 'pre-entry and entry to service' procedure (dated 10 January 2023). This procedure references a transition planning assessment, process for determining adding a client to a group home and appropriate needs assessments which determines needs and supports required.

The response from Spectrum Care Trust to HDC includes commentary that the choice of [residence] was based on finding the right balance between a supervised environment, space to support [Mr F's] independence and separation from others (as part of preventing challenging behaviours). I also note that [Mr F] was living in a motel prior to his move to [the residence] where most of the time spent there was unsupervised. This suggests a level of independence that did not require 24 hour 1:1 supervision.

Correspondence provided for review indicates that there was a separate legal process underway that may have resulted in an alternative placement for a higher level of support through a Regional Intellectual Disability Supported Accommodation Service (RIDSAS) occurring. A RIDSAS is for people who have been directed by the courts, under the Intellectual Disability (Compulsory Care and Rehabilitation) Act, to be supported by a provider holding a RIDSAS contract, for a specified period of time. This information indicates that [Mr F] was

being considered for a different level of support (i.e. higher and more secure) to which he was receiving by Spectrum Care Trust. As per information available from the Ministry of Health, Spectrum Care Trust does not hold a RIDSAS contract.

Note that staffing levels are addressed in a separate question below, as staffing levels are another determinant of suitability for placement to a service. Peers would likely consider [the residence] as being a suitable placement at least in the short term whilst waiting for a court decision as to whether a RIDSAS service was required. This may have impacted on the type and level of staffing required.

2. The hours [Mr F] was entitled to, and communication surrounding expectations for entitlements with [Mr E], as his welfare guardian

In respect of entitlement, [the NASC] … needs assessment information indicates the level of support required which includes a summary of hours per week under categories of support. The summary of hours report for [Mr F] indicates 56 sleep over hours per week and 112 hours of support. Under the behaviour emotional support category, 87.50 hours are allocated with a specific comment that 1:1 staffing is required for the safety of everyone. It is important to note that the assessed support needs when allocated to total weekly hours creates an indication of how the time should be attributed and is not literal (e.g. the report allocates 3.67 hours per week for household activities and 1.5 hours per week for nutrition and hydration).

The assessment was completed in July 2015 when [Mr F] was not residing at Spectrum Care Trust. Importantly, the assessment did not indicate the need for 24 hour supervision but for daily prompts and some supervision for safety (see page 10 of the assessment report where 24 hour supervision check box was not checked but daily prompts and some supervision for safety was).

The Service Authorisation form (copy provided dated 10 October 2022) is for High Level needs support with Spectrum Care under the YP ID Community Residential Service contract at a standard daily rate. The rate payable does not indicate 1:1 staffing as 1:1 staffing costs incurred alone would be higher than the daily rate of the contract. However, if [Mr F] was receiving support from Work and Income, then the amount paid under the contract may be exclusive of a contribution by [Mr F]. This means that [Mr F] would be expected to also contribute costs of residential support which effectively tops up the funding from Disability Supports. It is unclear whether this is the case as this level of information was not provided for review. Irrespective if a client contribution is being made, it is reasonable to estimate that the additional funding would still fall short of the amount required to meet 1:1 staffing, accommodation and living costs.

In correspondence from Spectrum Care to HDC, it is stated that it was clarified with [the NASC] in July 2021 that the amount of support [Mr F] was entitled to equated to approximately eight hours per day and that funding is premised on a group home model. Peers would consider it appropriate to check back with [the NASC] if there were any concerns as to the interpretation of needs and associated funding.

The Service Specification requires suitably qualified staff providing supervision that meets the needs of the person receiving residential support. Specific requirements for 1:1 supervision would usually be found in an individualised contract (as opposed to the standard Service Specification) and/or the NASC assessment report and weekly summary of hours needed.

There is commentary that in response to some more serious incidents occurring in late August 2021, that additional staff was provided and that routine staffing was based around mealtimes and outings. Peers would consider this appropriate that staffing levels are increased in response to need.

With the number of hours allocated and comments made within the report, peers would consider some 1:1 staffing was required likely approximating 87.50 hours per week (as this was specified as 1:1 in the needs assessment) unless otherwise agreed with the NASC. With … being co-located with another property, additional support by way of oversight would likely be considered appropriate by peers to meet some of [Mr F's] support needs.

Peers would consider current workforce shortages have increased the need for consistent risk assessments to determine where staffing resources should be best placed. Use of bureau staff was also indicated in the rosters on occasions but it is also well known by peers that bureaus have had difficulty in supplying staff. It is therefore not as simple as requesting staff from a bureau to meet staffing shortfalls. Where staffing falls short of meeting minimum requirements, peers would expect that this is raised with the Ministry of Health (or Whaikaha Ministry of Disabled People) as part of joint problem solving to achieve safe levels of staffing.

It is likely that [Mr E], as [Mr F's] welfare guardian would need an explanation as to how the needs assessments are undertaken and weekly hours summaries are considered within a residential disability home setting as a literal interpretation of the assessment may have led [Mr E] to believe the entitlement was for 1:1 support 24 hours per day. The fact the needs assessment was likely not up to date being dated 2015 when [Mr F] was living at his family home is another confounding factor. [The NASC] could have provided this advice independently of Spectrum Care Trust, to explain assessed levels for funding and supervision.

Communication to [Mr E] in respect of entitlements included some email correspondence and attempts to meet to discuss which did not occur due to COVID-19 restrictions. Peers would likely consider that initial concerns raised by [Mr E] as to staffing levels were not sufficiently explained until July 2021 and then this was not to [Mr E's] satisfaction, although this may not have been immediately apparent to Spectrum Care Trust. See notes further in this advice as to complaints management by Spectrum Care Trust.

3. The adequacy of care, risk, safety, and support planning/management for [Mr F], including the standard of documentation

There is a Safety Plan dated 22 December 2020. It is well written and includes behaviours you might see, triggers, what each look like for [Mr F] and what actions staff should take. It

is practical and would be considered good guidance for staff. I note however, it did not include a trigger for challenging behaviour as including alcohol consumption.

There is an assessment support plan dated 17 August 2021. There is another section of the plan dated 27 August 2021. This plan assesses [Mr F] as being independent of personal cares, notes no support needed to support his sleep routine, but support needed to engage in activities and administer medicines. A section of the report covers behaviours and the best way to communicate with [Mr F].

Progress notes or diary entries were not provided for review. Incident reports are commented on below. The level of staffing (such as a need for 1:1) is not included in the plan because the assessment determines a high level of independence and strategies for support are limited to prompting and communication approaches. The plan does not include instructions on the right level of communication with [Mr E]. For example, it would strengthen the plan if this was documented so all staff were aware as to who was communicating what and when. The plan also does not include that [Mr E] would like to meet with new staff ahead of them providing supports for [Mr F]. The plan could also be strengthened with additional activities or strategies to reduce boredom and manage frustrations.

There is an emergency plan dated 16 November 2021 and an individual risk assessment plan also dated 16 November 2021. Both are outside of the focus dates for the HDC Review.

Peers would consider the assessments and plans to be of a very good standard. The absence of additional information about risks related to alcohol consumption and communication with
[Mr E] are things that suggest the documentation could have been updated when these matters became apparent. This might be considered a minor variation to good practice. Irrespective of areas where the plans could be strengthened, peers would consider these assessments and plans to meet accepted practice (or even be of a higher standard given the involvement of [the behaviour support specialists]).

4. Management of risk and incidents, including communication with [Mr F's] family, and the standard of documentation (January–October 2021)

An incident register together with incident investigation and action plan reports were provided for review. There were 19 incident reports between January 2021– October 2021 of which some related to the same or sequence of events. There were three investigation reports completed in respect of these incidents which included consideration of onward actions as summarised below.

| Month | Number of incident reports | Number of events | Nature of Incidents | Further investigation | Documented as notified or known to [Mr E] |
|---|---|---|---|---|---|
| January 2021 | 3 | 2 | Aggressive behaviour (one incl. Police involvement)<br><br>1 — anxiety related | No | 1/2 |
| May 2021 | 8 | 8 | Aggressive or agitated behaviour<br><br>3 — unsettled in new environment<br>1 — paranoid thoughts<br>4 — anxiety related | No | 1/8 |
| June 2021 | 1 | 1 | Agitated<br><br>1 — anxiety related | No | 1/1 |
| August 2021 | 4 | 2 | 2 — anxiety related | Yes x2 to cover both events | 2/2<br><br>(within 24 hours) |
| October 2021 | 3 | 2 | Aggressive behaviour (incl. Police involvement) | Yes x1 covering both events | 2/2<br><br>(noted in report) |

The standard of the incident reporting would be considered as adequate by peers. The standard of investigation reporting where escalated for investigation would also be considered to meet current accepted practice. However, there are some opportunities for improvement noted:

- Categorisation of incidents as per Spectrum Care Incident Reporting policy was not clearly documented within incident report documentation as links to website information was used. This then makes it difficult to know what needs to be treated as a reportable, serious or critical incident.
- Notification to the funder using the Critical Incident process[13] may not have been followed for all critical events as per Ministry of Health policy. One notification in the time period for the events of 13 and 14 October 2021 was provided for review. Peers would usually consider Police involvement (i.e. as per January 2021 and October 2021) as meeting a threshold to report to the funder and escalate within the organisation to

[13] Reporting of critical incidents and death in service | Ministry of Health NZ

senior leadership and treat as critical incidents (noting critical incident examples provided by the Ministry of Health includes a client involved in criminal activity).

Records of communication to family and the extent and timeliness of that communication was limited in documentation provided for review. Improving recording of communication with family in respect of incidents would be beneficial. The Spectrum Care policy requires the staff member reporting the incident to be responsible for ensuring family and other stakeholders are notified (yet this did not appear to be consistently implemented which may be the source of delays and confusion). There is also documentation that a weekly communication process had been initiated with [Mr E] which could have caused confusion for staff as to who was notifying whom for what. It is clear that [Mr E] was expecting more timely communication in respect of any incidents and follow-up on outcomes from any investigations which did not appear to have been well communicated.

Records reviewed notes that invitations were extended to [Mr E] on at least three occasions to meet but COVID-19 restrictions delayed progressing these meetings. Peers would accept that COVID-19 has been a significant factor in trying to achieve any face to face visits during lockdown periods.

5. Management of [Mr E's] complaint

A complaints register providing details of each complaint made by [Mr E] was not provided for review but such a register is referenced within the complaints policy. The policy notes a centralised process for managing complaints via a shared feedback inbox. The policy requires [that the coordination of the process be separate from the oversight of any investigation]. Timeframes for complaint communication with the complainant is as per HDC Code of Rights (Right 10).

The Complaints Standard Operating Procedure creates complexity by splitting complaints acknowledgement between [two areas of management] dependent on who received the complaint in the first instance. The actual investigation process for complaints is not documented or a template provided. This is not unusual amongst providers but there should be a process for investigation such as using the London Protocol or Human Factors methods.

The Standard Operating Procedure references standard acknowledgement letters and a final complaint letter but it appears that email correspondence with information to the body of an email was mostly used in preference to an attached letter to respond to [Mr E's] complaints.

The use of emails trying to link them as a running record for a specific complaint was difficult to achieve as separate emails were not initiated and existing ones tracked to achieve this. Therefore there were multiple emails unrelated to subject headings in exchanges between [Mr E] and Spectrum Care Trust.

There was also splitting of topics within a complaint to create complaint reference numbers which sometimes also cross reference to already notified complaints meaning some letters of complaint put forward by [Mr E] were being cross referenced in some way. The splitting

of information within complaints (although helpful for investigation) makes it complicated for a complainant to follow and difficult for the provider to ensure any nuanced issues have an appropriate investigation and response. This is a likely contributing factor to concerns held by [Mr E] that communication was insufficient and complaints were not resolved to his satisfaction.

From January 2021–October 2021, documentation provided for review indicates there were six sets of concerns/complaints raised by [Mr E] as summarised in the table below. Peers would consider a succession of complaints that have some inter related components to be complex.

| **Date** | **Nature of complaint** | **Acknowledged within 5 days and includes reference to independent advocacy support** | **Final response date** | **Comment** |
|---|---|---|---|---|
| 26/4/21 | Written complaint<br>— letter (Ref …)<br>— Actions of a staff member<br>— boundaries,<br>— professionalism,<br>— risk to [Mr F's] safety<br>— request no further support from that staff member.<br><br>Includes request to meet staff supporting [Mr F] prior to their involvement | No<br><br>19/5/21 | 14/6/21 | Outcome: Email 14/6/21<br>Complaint partially upheld<br><br>Did not agree that boundaries were breached or safety risk to [Mr F] from the outing and shared transport.<br><br>*Did not address request specific to meeting new staff as not treated as a complaint.* |
| 5/5/21 | Written complaint — letter (ref: …)<br><br>— Actions of a staff member<br>— boundaries<br>— professionalism | Yes<br><br>7/5/21 and update 21/5/21 | 23/6/21 | Outcome:<br>Complaint upheld with an apology<br><br>*As a human resources issue, full consequences and onward actions were not provided in the final complaint* |

| | | | | |
|---|---|---|---|---|
| 18/5/21 | Written complaint — letter (Reference numbers …)<br><br>Actions of a staff member as reported to [Mr E] by [Mr F] & links to 26 April and 5 May complaint (Ref …) | Yes<br>19/5/21<br><br>Updates: 1/6/21 (Ref … — requiring more time) | 14/6/21 (Ref …)<br><br>14/6/21 (Ref …)<br><br>19/8/21 (Ref …) | Outcome: Separate Email 14/6/21 for … — Partially upheld<br><br>Outcome: Separate Email 14/6/21 for … (first raised 26/4/21 with additional |
| | — boundaries<br>— professionalism<br>— privacy breach<br><br>Request specific staff member not work with [Mr F] (Ref …)<br><br>Lack of 24/7 staffing support (Ref …) | 14/6/21 (Ref … — requiring more time & actively recruiting) | | information 18/5/21)<br>— Apology re miscommunication resulting in continued scheduling of staff member to support [Mr F]<br><br>Outcome: … — Letter dated 19/8/21 from CEO with clarification in interpretation on funding |
| 20/7/21 | Written email<br><br>Staffing/roster insufficient to meet needs as funded (Cross referenced to prior complaint Ref: …) | Yes<br><br>20/7/21 | 23/7/21 email explanation of staffing support<br><br>19/8/21 | Outcome: … — Letter from CEO with clarification in interpretation on funding |

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| 26/7/21 | Group letter of complaint by three sets of complainants (welfare guardians) in respect of three residents (Ref fee_ …) mirrors complaint made to HDC.<br><br>General concerns about processes, communication, staff actions/boundaries.<br><br>Complaint specific to [Mr F] summarised as repeated request for 24/7 support despite funding and communication issues | Yes<br><br>2/8/2021 | 19/8/21 (Ref_ …) | Letter from CEO with clarification in interpretation on funding |
| 26/10/21 | Written letter summarising 5 complaints considered unresolved by complainant<br>1. Not updated on the move to … May 2021 (states letter sent to Spectrum Care Trust)<br>2. Request to meet all support workers ahead of working with [Mr F] …<br>3. Insufficient staffing to provide 1:1 (July 2021) until recently<br>4. Staff allocations (2 part complaint) …<br>5. Staff complaint … | | ? 2/11/21 | *Records reviewed references an attached letter of response 2/11/21 (but not provided for review and outside of the review period for this advice)* |

Notes to the above table:

— Reference by Spectrum Care Trust to a letter dated 12 August 2021 has been clarified by Spectrum Care Trust that this reference was in fact the letter dated 19 August 2021.

— Potentially there are emails or letters not treated as complaints in respect of the initial placement of [Mr F] to … and insufficient communication around this
— There may have been a request that support workers meet with [Mr E] ahead of providing services in other correspondence than complaint reference … (and this could have been added to [Mr F's] support plan).
— There was also a written letter dated 31/5/21 stating concern by [Mr E] in respect of a staff member failing to report they were assaulted by [Mr F] to Police (which could be considered a complaint). There is no response to this letter in the documents provided for review.

Peers would likely consider a level of informality in the complaints management process with the email approach used and limited information provided as to the investigation process. This would be considered a variation in style by many disability providers but none-the-less it is a likely contributing factor as to the level of dissatisfaction experienced by [Mr E]. For larger organisations including Spectrum Care Trust, the style of complaints management would be seen as a moderate departure from accepted practice, albeit the approach used by Spectrum Care Trust is not necessarily wrong — it is based on low level resolution processes. This requires very skilled staff who are managing complaints in this way. I note that in documents provided in May 2023 that Spectrum Care Trust has updated its procedures in respect of complaint management.

6. The adequacy of Spectrum Care's policies and SOPs

Peers would consider policies and Standard Operating Procedures (SOPs) to be generally well written and provide adequate guidance to staff consistent with accepted practice. Opportunities to strengthen and streamline some policies and procedures have already been noted in this advice. Note that SOP-07Ab Investigation of a Critical Incident or Serious Event was updated in May 2023 which is up-to-date with critical incident reporting whereas the prior version of this procedure dated May 2021 was not as it made reference to how Spectrum Care Trust interprets Ministry of Health requirements.

As mentioned, the devolved method in managing complaints is likely a major contributing factor in the overall timeframes, standard of investigations undertaken and communication in respect of complaints, concerns and requests. I note that in procedures provided for review in May 2023 that the role of … in the complaints process has been strengthened. The process of replying to the original emails of the complainant to try to create a running record remains which I consider has been a contributory factor to tracking, managing and being responsive to the complainant in a way that is not confusing, particularly where there are multiple concerns raised.

7. Staffing levels at [Mr F's] residence

Rosters provided for review (17 May 2021–14 Nov 2021) and other correspondence reviewed within the information provided indicates:

— Low levels of staffing throughout May and June (range of 35–112 in any one week) but a significant improvement from 28 June

- A steady increase in staffing levels in July (range of 104–149 in any one week of which sleepover hours were mostly allocated)
- Consistent staffing since 30 August of 168 hours per week (of which 56 hours are generally sleep over hours).

Levels of daytime support have some association with incidents along with other contributing factors where triggers for incidents were identified (such as anxiety related to upcoming court proceedings or correspondence with his solicitor).

Peers would likely consider staffing levels were very low initially and particularly when it could be anticipated that [Mr F] would need support to settle into a new environment. The low levels of staffing throughout May in particular would be considered to be a moderate departure from accepted practice, particularly for a resident being considered for RIDSAS support.

As mentioned, earlier in this advice, peers would consider the increase in staffing in response to incidents to be appropriate. Mitigating factors provided by Spectrum Care Trust included COVID-19 and workforce shortages which are genuine factors.

Working more closely with [Mr E] and [the NASC] would be helpful in establishing a usual pattern of staffing support for [Mr F]. Peers are increasingly using video monitoring and other technologies to reduce staffing levels in response to workforce shortages which are often very successful, particularly to avoid sleepover or 24 hour 1:1 support. Taking this type of approach could be helpful in balancing support needs with workforce shortages and the promotion of independence for someone who does not have a short term need.

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

Additional points have been made within the advice. These relate to:

- Centralising complaints management (beyond the centralised email system and register) when there are a series of complaints creating complexity. I note that there has been some change since 2021 in respect of this observation.
- Acknowledging and reporting back on complaints with letters attached to emails rather than information within the body of an email

Nāku noa, nā

Dr Christine Howard-Brown'

**Appendix D: [The facility's] Action Plan following family meeting 24 February 2022**

| Theme | Action required | Responsible for leading this action | Actual completion date | Notes |
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| Documentation | Share complaints and communication process for Spectrum Care and how this is operationalised at a house level. This could include sending a list of people in order of who should be communicated through and include feedback email address e.g. HL, SC, SM, COO etc. (with meeting action plan draft) | service manager | 21/02/2022 | Attached to email sent with updated action plan |
| Accommodation | Reinforce to management the importance of following our consultation process when considering both temporary and permanent moves within homes. | Chief Operating Officer | 2/03/2022 | Discussed at … meeting and ensured adherence will be monitored for all internal movements and new referrals |
| Documentation | Book online meeting regarding goal plan for [Mr A] | service coordinator | 14/03/2022 | Completed by email |
| Activities | Share [Mr A's] programme during the day, seek further input if required and ensure diary entries comment on programme activity for the day | service coordinator | 16/03/2022 | Service coordinator visited the house and spoke with the staff around the importance of detailed progress notes |
| Accommodation | Discuss and seek input from family and [Mr D] about a temporary move until … becomes available | Chief Operating Officer | 21/03/2022 | Service coordinator called and emailed [Mr and Mrs C] about [Mr D] moving to … |
| Suggestion | Review the need for a house mobile phone (as per welfare guardian's request) | service manager | 21/03/2022 | No longer needed as person has moved out of our service |

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| Staff training | Reinforce to staff the importance of not talking about other people supported in the home when their house mates are around | service manager | 21/03/2022 | Email sent to all staff from service manager |
| staff training | Share orientation schedule provided to staff as well as L&D learning catalogue of what training is available to staff and possibly families if required. | service manager | 21/03/2022 | Attached to email sent with updated action plan |
| Accommodation | Engage … to consider disposal option of [the facility] | Chief Operating Officer | 22/03/2022 | [Mr D] engaged with … around intentions of disposing [of the facility] and buying a fit for purpose house |
| Accommodation | Find a 2 bedroom rental for [Mr D] to move into for six months while awaiting court case. | service manager | 25/03/2022 | [Mr D] moved out of [the facility] and into a new property |
| Accommodation | Send enquiry to [the NASC] about funding implications of [Mr D] moving into a rental | Chief Operating Officer | 25/03/2022 | Meeting with [the NASC] funding team, indicating steps taken to date, and requested consideration for alternative options. [Mr D] to meet with [NASC representative] to progress discussions. |
| Documentation | Update the annual house agreement between family and [the facility] and then a copy to be sent to family | service coordinator | 26/03/2022 | Agreement signed |
| Staff training | Provide training to community support workers (CSWs) about appropriate communication with families | service coordinator | 21/04/2022 | Completed with all staff |
| Staff training | Provide training to CSWs about effective handovers — especially for appointments etc … | service coordinator | 21/04/2022 | Completed with all staff |

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| Staff training | Provide training to CSWs about writing clear accurate notes in eCase including incident reports and progress notes | service coordinator | 21/04/2022 | Completed with all staff |

| **Theme** | **Action required** | **Responsible for leading this action** | **Actual completion date** | **Notes** |
|---|---|---|---|---|
| Suggestion | Review the need for a SOP for appropriate alcohol use by adults (as per welfare guardian's request) in Spectrum Care homes. | Quality and Risk Manager | 10/06/2022 | *SOP-04Cam Alcohol, Tobacco and Vaping for an Adult in Supported Accommodation* — published |
| Finances | Need to validate the transfer of funds issue raised by welfare guardian for [Mr F] | Chief Operating Officer | 23/06/2022 | Phone call from lawyer confirming money transfer |
| Suggestion | Review the consent process followed for … and refresh awareness of transfer engagement and consenting of all whānau, … and people in the home to choose who they live with | Quality and Risk Manager | 7/07/2022 | *SOP-04Hc Transfer — Move within One Service* — published |
| Accommodation | Review staff mix & determine if they are the right fit for the people at [the facility] at the moment. | service coordinator | 17/11/2022 | The house leader has stepped down to casual and does minimal shifts and have been replaced with a new staff member, family have been involved in this process and feel that the new staff member is a better fit for the people living at [the facility]. |

2024 01 24 — [The facility's] Action Plan following family meeting 24 February 2022 — complete

| Theme | Action required | Responsible for leading this action | Actual completion date | Notes |
|---|---|---|---|---|
| Suggestion | Include family's input into whānau input into wider communication initiatives — which might be newsletter. Family forums to be completed first to understand how best to meet whānau communication requirements. | Service Delivery Senior Project Manager | 29/08/2023 | The Quality Plan for 2023 includes an initiative to ensure that whānau have a better sense of partnership through better consultation, communication, and responsiveness with a number of initiatives to progress this work. In addition Spectrum Care's Strategic Plan for 2023–2026 includes a pou entitled embedding voice and choice with the intention that the voices of disabled people and whānau lead our decision making. Both of these action plans are regularly reported upon to Executive Team and Spectrum Care Board.<br><br>Shorter focused customer surveys are also underway with people and whānau. |
| Accommodation | Consider alternative living options for [Mr A] and possible more compatible house mates. What does good look like for [Mr A]. | service manager | 4/01/2024 | A house was purchased and renovated and [Mr A] moved into his new home … |