Care provided by disability support service
20HDC02200, 18 September 2023

This case concerns the care provided to a man during a transfer in a vehicle in 2020. The man has intellectual disabilities (including autism spectrum disorder and attention deficit hyperactivity disorder) and limited verbal communication. At the time of events, he resided at a house run by Brackenridge Services Limited.

The man was being taken to visit a different community house and was travelling in a vehicle with two staff members (a new team leader and an agency member of staff) when he opened the door and fell out. As a result of the incident, he sustained serious injuries and spent two months in hospital and has diminished capability.

Findings
Brackenridge has an organisational responsibility to provide a reasonable standard of care to its consumers. Deputy Health and Disability Commissioner Rose Wall noted several failures in the care provided, including the following:

- Inadequate action had been taken in response to previous incidents of a similar nature.
- Prior to the man's transfer, the accompanying staff were changed at the last minute.
- The staff who accompanied the man lacked experience.
- The man was unfamiliar with the agency staff member.
- The vehicle had locking defects.
- Another resident's harness was used.

The Deputy Commissioner accepted her independent advisor's advice that the transfer should have been rescheduled to allow for better planning and safety. The Deputy Commissioner criticised the lack of detail in the man's individual service plan (ISP) regarding information on behavioural management and sensory modulation. Such information may have assisted staff in their decision-making on the day.

The Deputy Commissioner found that Brackenridge failed to provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Since the incident Brackenridge has remedied the equipment failures.

Recommendations
Ms Wall recommended that Brackenridge provide a written apology to the man and his whānau and update the man's ISP to include details of potential triggers, early warning signs, a management plan, and a sensory plan. It was also recommended that Brackenridge report to HDC on what similar changes have been made to a sample of its other residents' ISPs and provide HDC with a copy of its new risk assessment and response matrix.