HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Standard of care provided to disabled man by vocational disability service

1. On 5 November 2021, the Health and Disability Commissioner (HDC) received a complaint from the Nationwide Health and Disability Advocacy Service regarding the care provided to Mr A by the Chris Ruth Centre (CRC),[1] a vocational day service provider.[2] Mr A's mother, Mrs B, contacted the Advocacy Service with concerns about the care her son received from CRC. This investigation focuses on the key issues Mrs B raised, which include the appropriateness of restraint[3] practices at CRC, the adequacy of CRC's intake process, CRC's formulation of care plans, and the incident reporting practices at CRC.

Information gathered

Background

2. Mr A, aged in his 20s at the time of events, has autism spectrum disorder[4] and Down syndrome,[5] is non-verbal, and has been known to display challenging behaviours. At the time, Mr A could mobilise short distances independently and used a self-propelled wheelchair for mobilising long distances. Mr A also used his wheelchair when travelling between locations in the transportation van. From 2015, Mr A lived in a home run by a residential disability service provider (residential provider) in Christchurch, and, between January 2017 and September 2020, he participated in vocational day services at CRC two and a half days a week. Mrs B is Mr A's welfare guardian.[6]

3. CRC supports disabled adults with complex physical and intellectual disabilities in a vocational setting. Activities at CRC focus on social and recreational opportunities, life skills development, community participation, work and vocational tasks tailored to individual strengths, and supporting disabled people to transition from school to its community day programme. CRC said it aimed to provide a 1:1 consumer-to-staff ratio to allow the people it supports to have an individual programme. It is not known whether Mr A received 1:1 support.

Intake process

4. There is concern around the adequacy of CRC's intake process after Mr A was referred to its service.

[1] Operated by the Chris Ruth Centre Charitable Trust.
[2] Services for disabled people who are not in school and are looking to build their community connections or move into employment.
[3] A device, method, or process that is used forcibly for the specific purpose of restricting a consumer's freedom of movement.
[4] Autism is a neurodevelopmental condition that affects cognitive, sensory, and social processing, changing the way people see the world and interact with others.
[5] This is a genetic disorder that may cause delays in learning and development.
[6] A welfare guardian is a person appointed by the Family Court to make personal and lifestyle decisions for a person who lacks the capacity to do so themselves.

5. CRC said it had a comprehensive and appropriate intake process. In 2017, the residential provider approached CRC to enrol Mr A into its service. At this stage, Mr A was attending school. CRC said its intake process involved making initial contact with the consumer's family and the school, then meeting with the consumer at their school environment to understand their needs and behaviours and to determine whether the CRC programme would be a suitable fit for them. Accordingly, CRC met with Mr A at his school and completed a transition plan with the school. This was followed by Mr A completing half-day visits to CRC with school staff and then full-day visits without school staff.

6. CRC said the school typically provided it with all the relevant information at the point of enrolment to its service. It said that Mr A's school had provided it with a 'Client Information' document. Information in this document included that 'Mr A does hit out at times', '[Mr A] likes his routine to be consistent' and that staff should explain what is happening to him at all times. The document did not identify any other specific behaviours of concern or outline other strategies to manage Mr A's behaviours.

7. CRC said an individual programme was put in place for Mr A in consultation with the residential provider and that it had planning meetings with the residential provider every year. The residential provider did not offer any existing behavioural support plans to CRC, and CRC was not aware it had developed such a plan. There is also no indication that CRC asked for this information as part of its intake process.

Care planning

8. As discussed above, Mr A has a history of challenging behaviours. Standard 4.4 of the New Zealand Home and Community Support Sector Standards (dated 2012) (NZHCSS) stipulates that consumers must have an individual service plan that describes their goals, support needs, and other requirements. In addition, CRC's Response to Challenging Behaviours policy (undated) states that a behaviour management plan must be developed and updated for consumers with challenging behaviours. However, CRC did not develop an individual service plan or a behaviour management plan for Mr A.

9. CRC acknowledged that it did not develop a formal behavioural management plan. However, it said that staff were regularly utilising effective behaviour management strategies to redirect any aggressive or challenging behaviours and to support Mr A to participate in his programme.

10. CRC acknowledged that Mr A presented with challenging behaviours very early on after enrolling. These are also evident in the incident forms that CRC staff completed in 2019 (discussed further below). CRC provided HDC with a copy of Mr A's Risk Management Plan (dated June 2020), which noted that Mr A was at risk for injuring others and had been known to display physical aggression. The plan notes that there was no behavioural management plan, and the only intervention documented was '[e]nsure others are removed from the area and alert a manager'. No other risk management strategies, including the use of restraint or enablers,[7] were documented in the plan. CRC said this plan was reviewed and

[7] Equipment, devices, or another method used to limit normal freedom of movement with the intention of promoting independence, comfort, and/or safety.

updated at every annual planning meeting. However, no evidence of any reviews or updates to the plan were provided to HDC.

Restraint practice

Wheelchair and lap belt

11. Mrs B told HDC that she observed Mr A being restrained in his wheelchair with a 'buckle' (lap belt[8]) on for long periods of time without any staff around him or anything to occupy him. Mrs B said the use of restraint was not one-off and was happening frequently. A support worker from the residential provider also said they observed Mr A being confined to a wheelchair while at CRC.

12. As discussed above, Mr A only requires a wheelchair when walking long distances and when using the transportation van. Information provided by the residential provider indicates that Mr A did not use his wheelchair or lap belt inside his home. In addition, the residential provider said that Health New Zealand | Te Whatu Ora Canterbury (Health NZ) installed the lap belt on the wheelchair as a safety measure in 2013 to reduce the risk related to Mr A's behaviour when travelling in a van. CRC said the lap belt installed on Mr A's wheelchair in 2019 was one Mr A could operate himself and voluntarily remove. However, on 3 July 2020, Health NZ replaced the lap belt with a new type that Mr A could not operate himself.[9]

13. The Health and Disability Services (restraint minimisation and safe practice) Standards (2008) (HDRS) stipulates that restraint should only be used as a last resort and only after all less restrictive interventions have been attempted and found inadequate. This principle was also outlined in CRC's Restraint Minimisation and Safe Practice policy (undated but implemented in 2014, according to CRC).

14. CRC said that restraint is not a practice it condones and would only be applied if a person's safety was at risk. CRC emphasised that it is not CRC's normal practice to use a lap belt to restrain Mr A in a wheelchair as a strategy for managing aggressive behaviours. CRC said if Mr A had challenging and aggressive behaviours, it was CRC's strategy to direct him to another space to complete his activity or change the activity (redirection). CRC did not indicate what other interventions and strategies were used to support Mr A's behaviours.

15. The information CRC provided regarding the use of Mr A's wheelchair and lap belt was inconsistent. Their initial response indicated that these devices were used for restraint purposes. CRC said that there were times when it was 'necessary for [Mr A] to be in his wheelchair due to his behaviours and vulnerability to other persons we support', 'to maintain the health and safety of all others', and he was 'definitely given opportunities to not use [the wheelchair] throughout his day.' At this point, CRC also stated that 'there was a discussion about the buckle on the chair [with Mrs B] and it being a form of restraint' and that '[t]his was never dismissed as being the case'. Minutes from a meeting between Mrs B, CRC, and the residential provider staff on 6 December 2019 recorded that the use of the lap belt was a type of restraint that required consent and approval. In a further meeting on 12 December 2019, Mrs B raised concerns about Mr A being buckled into his wheelchair and left all day. In response, CRC told her that it had a responsibility to ensure the safety of other

[8] A belt worn across the lap.

[9] On 17 September 2021, on Mrs B's request, this lap belt was swapped with a non-restraint lap belt.

service users but that it would investigate options for Mr A to be supported without the use of his wheelchair. Lastly, three of the incident reports that CRC provided indicate that Mr A's wheelchair was being used for behaviour management purposes. One of these incident forms describe Mr A 'tipp[ing] his wheelchair out then wriggl[ing] out.'

16. In a further statement to HDC, CRC said that it considers the use of the wheelchair and lap belt to be an enabler rather than a restraint. CRC said these devices were used with the intent of protecting Mr A from harm because of his risk of falling.

17. Standard 1.1 of the HDRS states that the use of enablers must be voluntary. In addition, CRC's Restraint Minimisation and Safe Practice policy states that, as enablers can also limit normal freedom of movement, they can only be used if appropriate assessments have been undertaken and they have been approved by clients or their family. However, Mrs B said that CRC did not seek consent from her before using the wheelchair or lap belt, and CRC did not provide HDC with a copy of the enabler assessment or approval. Therefore, on balance, I consider the use of the wheelchair and lap belt to be a restraint.

18. Mrs B said that she found a letter in Mr A's file that stated she had been consulted regarding the use of a lap belt on his wheelchair, which she said was not the case. When she raised concerns with CRC about this letter and the use of the lap belt, she was told that Mr A would be exited from the day service if she did not sign a permission form. CRC deny that this happened.

19. HDC asked for an outline of each time the lap belt was applied on Mr A. CRC said it was unable to outline every instance where Mr A was restrained in his wheelchair but that he was given opportunities to not use it throughout his day. CRC's response also indicates that there was no restraint use planning. It said that the absence of restraint use planning for Mr A is because the wheelchair lap belt was not considered a method of restraint, and there were no other behaviour management strategies requiring restraint.

20. Standard 2.2 of the HDRS stipulates that an assessment must be undertaken prior to the use of restraints. The assessment must include input from the consumer and family, the identification of current and future risks when using restraints, the underlying causes of the relevant behaviour, and how future crises will be mitigated. The need to undertake a risk assessment is also stipulated in CRC's Restraint Minimisation and Safe Practice policy, although details of what a risk assessment should include are not discussed in the policy. There is no indication that CRC undertook this assessment.

21. Standard 2.4 of the HDRS stipulates that each episode of restraint must be evaluated and future options to avoid restraint use explored until the desired outcome is achieved. Although CRC's Restraint Minimisation and Safe Practice policy states that restraint episodes should be documented, it does not state what monitoring and evaluation is required. CRC did not document the frequency of the restraint use, evaluate the effectiveness of this intervention, or provide evidence of other options explored to minimise the use of restraint.

Use of personal restraint

22. CRC's Restraint Minimisation and Safe Practice policy defines personal restraint as 'the use of bodily force to limit or control the movement of a client.'

23. In 2020, Mrs B was advised that Mr A had been aggressive towards a staff member and that this aggression resulted in Mr A being manhandled by five male staff, suggesting that personal restraint had been used. Mrs B is concerned that Mr A was traumatised by this event and experienced behavioural change as a result. A staff member who witnessed the incident also advised Mrs B that they had approached management but were advised not to speak of it anymore. CRC said this was a staff member employed with the residential provider.

24. The meeting notes dated 6 December 2019 identified that this incident had occurred on 12 November 2019. The meeting notes record that Mr A had been refusing to leave CRC at the end of the day, which resulted in four CRC staff (rather than five, as Mrs B alleged)[10] gently tipping the couch forward so that Mr A would get up and walk to the transportation van. However, this action was unsuccessful, so four staff lifted Mr A into his wheelchair and applied the lap belt. CRC said Mr A was not harmed, injured, or distressed about being transferred onto his wheelchair.

25. In contrast to the above, an incident form provided by the residential provider indicates that the above incident occurred on 23 October 2019. The incident form notes that, after the couch was tipped forward, Mr A fell onto the floor and was '[t]hrashing wildly' when he was lifted from the floor. This incident form also confirms that four staff, rather than five, had manhandled Mr A.

26. CRC acknowledged that the use of the lap belt on Mr A's wheelchair on this occasion amounted to a non-approved method of restraint. CRC said staff assessed the use of the lap belt as an enabler to aid Mr A to be safely transported home without any further delay. As Mr A did not resist or demonstrate agitation or aggression, staff did not consider the use of the lap belt to be against Mr A's wellbeing or disrespecting his dignity. CRC said this was a one-off error in judgement by staff.

27. An incident report was not completed for this event. CRC said this was because the staff did not consider the events to be a reportable incident.

Incident reporting

28. Standard 2.4 of the NZHCSS stipulates that all adverse and unplanned events must be systematically recorded and reported to identify opportunities to improve service delivery and to identify and manage risk.

29. As discussed, CRC did not complete incident reports for the event that occurred on 23 October 2019 or any of the occasions where Mr A had been restrained. Incident reports provided by CRC only record nine incidents occurring within its facilities between 2019 and 2020. However, incident reports provided by the residential provider show at least 18 adverse events that occurred at CRC between 2019 and 2020, many of which CRC did not record. All these incidents related to Mr A's challenging behaviours.

30. CRC acknowledged that there were many occasions where reports were not completed because of time constraints and the need to address Mr A's immediate behaviours. CRC

[10] CRC deny the involvement of five male staff and are unable to recall who was involved in the events.

acknowledges that, in hindsight, this was an error on its part and notes that incident reports were completed for the more intense and severe situations. Mrs B said these incidents could have been better handled if staff had the required information to deal with Mr A's needs.

31. CRC said the incident forms were completed as part of its process of investigating and reviewing incidents to understand the underlying causes of the incidents and to consider whether changes were required to manage the challenging behaviours. The forms record staff de-escalating Mr A and removing him from the situation. However, incident forms did not evaluate the behavioural changes. There is limited description in the incident forms around the triggers for Mr A's behavioural change, the events leading up to the incident, the contributing factors for the behaviours, what additional monitoring or assessment had occurred, what further strategies needed to be implemented or any trends analysis. On the incident form dated 6 November 2019, a staff member wrote that Mr A's 'behaviour may need to be reviewed by [a] health advisor or [he may need to] be referred to [the] behaviour support team'. It is not known whether this occurred.

32. CRC said that, at the time, there was less emphasis on industry best practice around incident reporting and that best practice for incident reporting has since changed. CRC's response also indicates that there was no incident management policy available to staff at the time.

Responses to provisional report

33. Mrs B was provided with the 'information gathered' section of the provisional report for comment. She disagreed with a lot of what CRC have told HDC, particularly their comments relating to the restraint practices. Mrs B maintained that Mr A should never have been restrained and that CRC did not follow its internal procedures. Mrs B said Mr A's behaviour has changed as a result of the care provided by CRC and this continues to impact him.

34. CRC was provided with a full copy of the provisional report for comment. CRC acknowledged that this case highlighted significant areas for improvement and accepted the findings. It said that it was committed to learning from this process. CRC also noted that its most recent audit (completed in 2025), which was conducted independently on-site, found no areas of concern within its service and confirmed that all standards were being met.

Decision – CRC – breach

35. The issues for me to determine are whether CRC's intake process, care planning, restraint practices, and incident reporting practices were acceptable. I have relied on independent clinical advice from a disability sector expert, Mr John Taylor (Appendix A), to guide my decision.

36. After reviewing all information, I consider that CRC breached Rights 4(1)[11] and 4(2)[12] of the Code of Health and Disability Consumers' Rights (the Code).

Intake process and care planning

37. It is reasonable to assume that, at the point of referral, a healthcare provider should undertake a thorough and accurate assessment to ensure that the consumer's needs are

[11] The right to have services provided with reasonable care and skill.
[12] The right to have services that comply with legal, professional, ethical, and other relevant standards.

appropriately met. However, Mr Taylor's advice indicates that CRC's intake process was inadequate.

38. Mr Taylor advised that the expected standard of care for someone who presents with a range of complex health and behavioural issues is to have a behaviour support and safety plan in place alongside the individual's support plan. However, neither a behavioural management plan nor an individual plan was developed in accordance with standard 4.4 of the NZHCSS.

39. CRC's response indicates that it worked with Mrs B, his school, and the residential provider to gather the necessary information to plan Mr A's care. The documents that CRC completed at the point of enrolment to its service did not identify Mr A's behavioural challenges or outline any strategies to manage Mr A's behaviours, despite CRC being aware of such challenges.

40. CRC acknowledged that Mr A presented with challenging behaviours very early on after enrolment, yet there is no indication that it consulted with the residential provider around a behavioural management plan.

41. CRC acknowledged that a formal behavioural management plan was not completed but note that a risk management plan had been developed that noted that Mr A was at risk of injuring others and had been known to display physical aggression. However, in my opinion, the risk management plan lacked sufficient details around the ways to manage Mr A's challenging behaviours, including the use of restraints and enablers (discussed further below).

42. As a service provider, CRC is responsible for collecting, reviewing, and updating all relevant information about an individual to deliver the best person-centred service possible. By failing to do so, CRC's ability to provide safe, appropriate, and individualised care to Mr A was compromised. Mr Taylor considered CRC's lack of a positive behaviour support plan to be contrary to its own policy and a moderate to severe departure from the expected standard of care. I agree with this view.

43. This meant that a shared understanding among staff around how to appropriately manage Mr A was lacking and resulted in a series of restraints being applied on Mr A on frequent occasions, which I discuss next.

Restraint practices

44. The HDRS and CRC's Restraint Minimisation and Safe Practice policy stipulate that restraint should only be used as a last resort and only after all less restrictive interventions have been attempted and found inadequate.

45. Mr Taylor advised that the wheelchair and lap belt were used as a restraint to confine Mr A. He also advised that long-term use of a wheelchair, with or without a lap belt, as a behaviour management strategy would not have been acceptable practice and constitutes restraint. As discussed earlier, CRC had an inconsistent view on the use of these devices, later stating that the wheelchair and lap belt were used as enablers rather than restraints.

46. Mr Taylor explained that an enabler supports autonomy and positive behaviour, whereas a restraint limits freedom of movement, access to the body, or the ability to engage in certain actions. However, from the information provided to me, it is evident that CRC routinely used a wheelchair and lap belt to restrict Mr A's movement and to manage his behaviours of concern. Incident reports provided by CRC describe occasions where Mr A 'tipped his wheelchair out then wriggled out,' indicating he was unable to simply unbuckle the lap belt without distress or physical struggle. In addition, at least four CRC staff used personal restraint to forcibly tip Mr A from his couch and move him to his wheelchair, which CRC acknowledged was an unapproved form of restraint.

47. For a restraint to be approved, the HDRS require a documented plan that outlines the reasons for the use of restraint, the specific circumstances in which it could be used, and how support would return to less restrictive measures as soon as possible. That plan needed to be developed and approved by an appropriate health professional. The HDRS also required continuous monitoring during restraint, a regular review of its necessity, and clear documentation each time the restraint is used. None of these requirements were evident in the information that CRC provided to HDC. The HDRS also required informed consent from Mrs B to be documented in Mr A's support plan before any restraint was used. However, it is clear that consent was not sought.

48. Mr Taylor considered the restraint practices by CRC to be a moderate to severe departure from accepted standards. I accept this advice. I also agree with Mr Taylor's view that CRC's new Restraint Free Practice Guideline is not fit for purpose.

Incident reporting

50. CRC acknowledged that, at the time of the events in 2019, it lacked guidance or policy in relation to incident reporting or reportable events, although an incident report template was available for staff to complete. It noted that reports were often not completed because of time constraints and the need to respond to Mr A's immediate behaviours. This was also evident in the number of incident reports completed by the residential provider.

51. It maintained that staff complied with the sector's reporting requirements as applicable in 2019. CRC acknowledged that no incident report was completed in relation to the incident on 23 October 2019 but asserted that this did not amount to a breach of the accepted standard of care. Their rationale was that industry best practice placed less emphasis on incident reporting at that time and that it was only in 2022 that reporting requirements were enhanced.

52. Mr Taylor advised that incident reporting requirements and accepted practice were established by the Health and Disability Services (Safety) Act 2001, associated legislation (such as the Health and Safety at Work Act 2015), and relevant industry standards. Mr Taylor advised that CRC's lack of, and inconsistent, incident reporting constituted a moderate departure from the accepted standard of care. I accept Mr Taylor's advice. The incident reporting requirements are also clearly stated in standard 2.4 of the NZHCSS.

53. In addition, I am of the view that the incident reports completed by CRC staff lacked sufficient detail on the behaviours of concern that were displayed, so CRC failed to analyse Mr A's reoccurring behaviours of concern critically. I acknowledge CRC's efforts in

developing new incident reporting guidelines and Response to Challenging Behaviours Guidelines but agree with Mr Taylor's view that these guidelines are not fit for purpose.

Conclusion

54. By accepting Mr A's referral, CRC had a responsibility to provide care that was consistent with his needs. In my opinion, the lack of a personalised behavioural support plan stemmed from CRC's failure to assess Mr A's needs adequately at the point of referral. This resulted in a delayed recognition of Mr A's complex needs and the inappropriate application of restraint. This forms the basis of my finding of a breach of Right 4(1).

55. In addition, I find that CRC did not adhere to the requirements set out in the standards set in the HDRS and NZHCSS and failed to follow its own Restraint Minimisation and Safe Practice policy and Response to Challenging Behaviours policy. For these reasons, I also find that CRC breached Right 4(2) of the Code.

Changes made

56. CRC apologised to Mr A and Mrs B for any undue stress. It stated that the following changes have been made since the time of the events:

- Developed three new guidelines: the Challenging Behaviour Management Guideline, Reportable Events Guideline, and Entry to Service Guideline. It also updated the Restraint Free Practice Guideline.
- It is now CRC's process to document and review all episodes of challenging behaviours for the purposes of effective behaviour management.
- Updated its record-keeping system.
- Completed Organisational Change training.

Recommendations and follow-up actions

57. In response to these findings, I recommend that CRC:

a) Provide a written apology to Mr A and his family for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report for forwarding to Mrs B;

b) Provide HDC with evidence of a review of the Entry to Service Guidelines, including templates that demonstrate how specific information will be gathered to ensure CRC can provide optimal care tailored to each individual. Evidence of the review, along with any corrective actions to be implemented, is to be provided to HDC within six months of the date of this report;

c) Provide HDC with evidence of a review and revision of the following guidelines to ensure they are accessible and usable by staff at all levels. This is to be provided within six months of the date of this report:

i. Behaviour Management and Response to Challenging Behaviour Guideline

ii. Challenging Behaviour Management Guideline

iii. Reportable Events Guideline

iv. Restraint Free Practice Guideline

d) Provide HDC with evidence that all staff have completed restraint training. This is to be provided to HDC within six months of the date of this report.

e) Undertake an audit of the last 10 incident reports completed by staff to determine whether the quality of the reporting meets accepted standards. Evidence of the review, along with any corrective actions to be implemented, is to be provided to HDC within 12 months of the date of this report.

58. CRC has confirmed it will comply with the above recommendations.

59. An anonymised copy of this decision (naming only the Chris Ruth Centre and my expert advisor) will be sent to the Disability Support Services team at the Ministry of Social Development and published on the HDC website (www.hdc.org.nz) for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from disability sector expert, Mr John Taylor:

> ‘‘Re: [Mr A] - C21HDC02747
>
> I have been asked to provide an opinion on case number C21HDC02747 that relates to the care provided by the Chris Ruth Centre (CRC) and [the residential provider] to [Mr A] between 2020 and 2021. I have read and agree to abide by the Commissioner’s Guidelines for Independent Advisors.
>
> I have the following qualifications and experience to fulfil this request.
>
> Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh.
>
> Experience: over 37 years of working within the disability sector, including the following roles: direct support worker, agency management (over 15 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH’s New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles, and I have helped set up a number of support agencies and disability-related businesses.
>
> I have been asked to provide my opinion to the Deputy Health and Disability Commissioner as to whether I consider the care provided by Chris Ruth Centre and [the residential provider] was reasonable in the circumstances, and why.
>
> The specific areas I have been asked to comment on are as follows.
>
> Chris Ruth Centre:
>
> - Whether appropriate planning occurred to manage [Mr A]’s behaviour, and how/when restraint would be used;
> - Whether restraint was used reasonably/lawfully by staff in response to [Mr A]’s behaviour, in particular the use of [Mr A]’s wheelchair belt;
> - Whether the documentation in relation to restraint use, including incident reporting, was appropriate;
> - Whether concerns raised by [Mrs B] were managed appropriately; and
> - Any other comments you wish to make.
>
> I have based my opinion on the information I have been provided, which is listed below:
>
> - Referral of complaint from the Nationwide Health and Disability Advocacy Service dated 5 November 2021.
> - The response from the Chris Ruth Centre and appendices.
> - The response from [the residential provider] and appendices.

Introductory comments

By way of context, it is important to remember that this complaint relates to things that happened during the two years when COVID-19 was severely impacting the country. COVID-19 put an enormous strain on support organisations, and while this does not excuse maltreatment, in my opinion it can help to explain why some things were not done as well as they might normally be done.

It is also clear to me from the responses from both the Chris Ruth Centre and [the residential provider] that there was a lot of goodwill in the support of Mr [A] and that people were providing the best support they knew to provide. Nevertheless, there were deficiencies in that support, and some of them were significant, albeit probably resulting from lack of knowledge rather than lack of intent.

Finally, I note that both organisations, in their responses, apologised to Mr [A]'s mother and guardian – Mrs [B]– for any hurt or failure to meet her expectations in the support they offered. I hope this has been passed back to the complainant, and I think it speaks well of the two organisations and their approach.

1. **Did CRC undertake appropriate planning to manage [Mr A]'s behaviour, and how/when restraint would be used?**

Before I answer this question, it is important to consider the difference between a 'restraint' and an 'enabler'. This is important because the Chris Ruth Centre appears to consider the wheelchair lap belt to be an enabler and not a restraint ('restraining the persons we support is not a practice we condone').

An enabler is a person, tool, strategy, or environmental modification that promotes positive behaviour and helps individuals with challenging behaviour achieve better outcomes. Enablers empower individuals by providing the necessary support to enhance their autonomy and well-being.

A restraint is any method, device, or action used to limit an individual's freedom of movement, access to their body, or ability to engage in certain behaviours.

In their response to the HDC questions about the use of the lap belt, the CRC commented:

> '[Mr A]'s behaviour was very unpredictable with a number of challenging and aggressive behaviours. There were also times it was necessary for him to be in his wheelchair due to his behaviours and vulnerability to other persons we support.'
>
> 'it was necessary from time to time for [Mr A] to be in his wheelchair for him to complete aspects of his programme and to maintain the health and safety of all others within the centre.'
>
> 'There was also discussion about the need for [Mr A] to utilise his wheelchair to keep others safe.'
>
> 'We have a duty of care and responsibility to ensure others were kept safe from [Mr A] when he was being aggressive or there was the potential for this to happen. If [Mr A] wasn't able to utilise his wheelchair then there would

> more than likely have been many near misses or incidents where this may have happened as his behaviour was often unreadable and unpredictable.'

I think it is clear from these comments that the lap belt was used as a restraint even if it was not thought of that way.

Given that, the expected standard of care for someone who presents with a range of complex health and behavioural issues is to have a behaviour support and safety plan in place alongside the individual's support plan. If there is to be a restraint applied, then it is required by the appropriate Sector Standard (NZS 8134.2:2008[1]) to have a documented plan that outlines the reasons, specific circumstances, and how support will return to less restrictive measures as soon as possible. This latter plan should be developed and/or signed off by an appropriate health professional.

The Chris Ruth Centre did not have those plans or documents in place ('a formal Behaviour Management Plan was not put in place. In hindsight this should have been'), and they stated they did not have copies of any documents that instigated the use of the lap belt restraint.

The lack of positive behaviour support and restraint usage planning by CRC is both contrary to their own policy statements and a severe departure from the expected standard of care.

2. Was the restraint used reasonably/lawfully by staff in response to [Mr A]'s behaviour, in particular the use of [Mr A]'s wheelchair belt?

If a restraint is used without complying with the appropriate standard, and it results in harm to an individual, the service provider could be held legally liable.

As mentioned above, the relevant standard in this case, at the time, was the New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008), which outlined the specific requirements and guidelines regarding the use of restraints within health and disability services. It required the following:

> Minimising Restraints. Restraints should be used only as a last resort when all other alternatives have been considered and found ineffective.
>
> Assessment and Approval: Before a restraint is applied, a thorough assessment must be conducted to determine its necessity, and approval must be obtained from a qualified health professional. This assessment should consider the individual's physical and psychological needs, the environment, and the potential risks associated with the restraint.
>
> Informed Consent: Whenever possible, informed consent should be obtained from the individual or their legal representative.

[1] Now superseded by NZS 8134:2021

> Training and Competency: Staff involved in the application of restraints must be appropriately trained and demonstrate competency in restraint techniques, including the use of de-escalation strategies and alternative interventions.
>
> Monitoring and Review: Continuous monitoring of the individual is required during the period of restraint to ensure their safety and wellbeing. The use of restraint should be regularly reviewed to determine if it remains necessary and to identify opportunities for reducing or eliminating its use.
>
> Documentation and Reporting: Detailed records must be maintained regarding the use of restraints, including the rationale for their use, the type of restraint applied, the duration, and any incidents or adverse effects. This documentation should be reviewed periodically to ensure compliance with the standards and to improve restraint practices.

None of these requirements were evident in the CRC response. On that basis, I would consider that their use of restraint was a severe departure from the expected standard and potentially unlawful.

3. Was the documentation in relation to restraint use, including incident reporting, appropriate?

As mentioned in the previous section, the documentation in relation to the restraint applied to Mr [A] was severely deficient.

By CRC's own admission, their recording of incidents was inconsistent and incomplete.

> 'Also please note that there were many occasions where reports were not completed due to time restraints and the need to address [Mr A]'s immediate behaviours. In hindsight we acknowledge this was an error on our part and we have altered our processes to address this.'

The expected standard is to complete an incident report for every occasion where one is applicable. CRC's inconsistent use of incident reports is a moderate departure from that expectation and, hopefully, one that they have now remedied.

4. Were the concerns raised by [Mrs B] managed appropriately?

The short answer is, I don't know. From reading the material, it appears there was a slightly difficult relationship between CRC and [Mrs B].

CRC were clearly doing the best job they knew to do for Mr [A] even though, as I have said above, it fell short of particular sector standards. It also appears that CRC received, or at least interpreted, some mixed messages from [Mrs B]. I think there is evidence that CRC could have handled some parts of the relationship differently, but that is likely to be 20:20 hindsight.

5. Any other comments.

1. The information that CRC supplied is that their policies on Abuse and Neglect, Managing Challenging Behaviour, Restraint Free Practice, etc. were lengthy and provided some outdated information with little helpful guidance. In particular, these documents lack current best practice for positive behaviour

support and are confused about the difference between a restraint and an enabler.

2. Given that [the residential provider] had the necessary Behaviour Support Plans in place at the time CRC commenced work with Mr [A], it suggests that their intake process may have been inadequate. These documents should have been requested and supplied as part of the intake.

…

Yours faithfully

John Taylor ONZM'

Further independent advice obtained from Mr John Taylor:

Complaint:	[Mr A] - The Chris Ruth Centre
Our ref:	21HDC02747
Independent advisor:	John Taylor

I have been asked to provide additional clinical advice to HDC on case number 21HDC02747. (My original advice was submitted on 24 July 2024.) I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I have the following qualifications and experience to fulfil this request. Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh. Experience: over 37 years of working within the disability sector, including the following roles: direct support worker, agency management (over 15 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles, and I have helped set up a number of support agencies and disability-related businesses.
Documents provided by HDC:	The Chris Ruth Centre's letter dated 3 March 2025 and appendices.

Referral instructions from HDC:	The Chris Ruth Centre (CRC) Whether there was appropriate planning to manage [Mr A]'s behaviour. Whether the restraint used by CRC Trust staff in response to [Mr A]'s behaviour was reasonable/appropriate, in particular, a wheelchair belt being used to keep [Mr A] in his wheelchair for lengthy periods of time. Whether the documentation in relation to restraint use, including incident reporting, was appropriate. Any other comments you wish to make.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	The complaint was made by [Mr A]'s mother and welfare guardian ([Mrs B]) in relation to his care from two agencies. In regards to the CRC, the complaint was that a disclosure was made at a meeting that [Mr A] had been manhandled by five male staff members at the centre. This had been witnessed by a staff member of another agency. Subsequently, [Mrs B] was told that [Mr A] did not want to get into his wheelchair after a good day at work placement and was 'manhandled' into it instead of following protocols that had already been put in place between CRC and herself. [Mrs B] stated that 'at no time did I give my approval. My son should never be buckled into his chair' and that 'I was then threatened by Chris Ruth that if I did not sign an authority for the buckle, that [Mr A] would be removed from the premises.' CRC say that this incident could not have happened as described as they did not have five male staff at the centre that [Mr A] attended at that time. (Although, from their notes of the meeting mentioned above, it appears that [Mr A] was lifted into his wheelchair by four people on 12/11/2019 at 3pm.) They have no recollection of anyone threatening to remove [Mr A] for not signing a permission form.

Chris Ruth Centre	
Question 1: Whether there was appropriate planning to manage [Mr A]'s behaviour.	
List any sources of information reviewed other than the	NZS 8134.2.2008 – Restraint Minimisation and Safe Practice Standard

documents provided by HDC:	Ngā Paerewa Health and Disability Services Standard NZS8134:2021
Advisor's opinion:	My original opinion was that the CRC did not have the appropriate plans in place, specifically a restraint plan and a behaviour management plan. There is nothing in the current response from CRC to change my original opinion in that regard. CRC has disputed my response above on the basis that the lap belt and wheelchair were used as enablers and not restraints and, if it was used as a restraint during the particular incident, it was a one-off occurrence. CRC claim that the lap belt was only used to ensure [Mr A] did not fall out of his wheelchair when being transported in it. I accept this but it doesn't really change the key issue about restraint; it merely moves the restraint device from the lap belt to the wheelchair. In my opinion, CRC remains confused between intent and practice. Their argument is that because they used the wheelchair and lap belt with the intent to assist [Mr A] take part in activities it is an enabler. The problem is that, even if something enables access, under NZS 8134.2.2008, it's still a restraint if: • It's not initiated by the person. • It restricts their movement. • It's primarily done to control risk to others. From my reading of the evidence supplied by CRC, including the quotes I used in my original advice, all of these conditions were met. There is no evidence provided that [Mr A] or [Mrs B] approved the use of the wheelchair and lap belt in the way it was used. To the contrary, the complaint from [Mrs B] indicates she was not happy about it. CRC states the wheelchair was used 'to maintain the health and safety of others.' Therefore, the use of the wheelchair, with or without the lap belt, constituted a restraint, albeit a well-intentioned one. It would be expected that CRC acknowledge this, given that, in their most recent version of 'Restraint Free Practice Guidelines' v02, they state that: 'Restraint: The use of any intervention by a service provider that limits a person's normal freedom of

	movement. **Where restraint is consented to by a third party, it is always restraint**.' (My emphasis) It is important to acknowledge that the use of the wheelchair and lap belt were consented by people other than [Mr A] and his guardian, that is, by 'a third party' so, according to the Standard and to CRC's own policy, its use was a restraint. I previously commented that CRC's intake process may be inadequate given that they did not ask for plans already in existence ([the residential provider] had a well-written safety plan and behaviour support plan that could have assisted CRC in its support of [Mr A]). CRC, in their current response, disputes my view. However, their response offers contradictory statements on this. They state that: a: 'Overall, this intake and transition process allows CRC to gain a full understanding of a person's behaviours and needs.' b: 'We note that these [transition planning] documents did not disclose to CRC specific information about [Mr A]'s challenging behaviours.' It is evident that the CRC intake process was not adequate to get the relevant information they required. I also note that the CRC's updated 'Entry to Service Guidelines' still doesn't offer any information about what questions are asked now to ensure the necessary information is collected. Best practice would be that the following areas are canvassed as part of the 'Entry to Service' process: • Goals • Staffing compatibility • Legal information (such as welfare guardianship) • Safety planning • Support plan • About the person (communication, likes/ dislikes, etc.) • Decision-making: how, who is involved, how is it recorded, and who needs to know • Health • Medication plan

	• Other information required to provide safe, effective transition, including any: o Mental Health support plan o Medication plan o Behaviour support plan Many of these areas were not covered off in [Mr A]'s transition planning, and a more comprehensive process may well have avoided the issues that are central to the complaint.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	If there is to be a restraint applied, then it is required by the appropriate Sector Standard (NZS 8134.2:2008) to have a documented plan that outlines the reasons, specific circumstances, and how support will return to less restrictive measures as soon as possible. This latter plan should be developed and/or signed off by an appropriate health professional. There is no similar standard for transition planning, but accepted practice is to gain sufficient information to safely support the individual, and that it is the responsibility of the service provider to ensure they have at least asked the right questions to get that information. (Obviously they are not responsible if they have been deceived or deliberately misled.)
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	In my original advice, I stated there was a severe departure from the expected standard of care in relation to the planning around and the use of restraints. On reflection, I still consider this a significant departure from the expected standard of care as set out in the relevant Standard and in terms of accepted practice for similar enterprises, even if it was driven by misunderstanding rather than negligence. Also, I have observed that in some, maybe many, schools around the country, using this style of restraint was not such an unusual thing. That doesn't make it right, but it does mean that, in the context of a transition from school, it was probably similar to usual practice. I would therefore modify my opinion and rate this as a moderate to severe departure from the expected standard of care. In relation to appropriate planning to manage [Mr A]'s behaviour, I consider this to be a moderate to severe

	departure from the expected standard of care for the same reasons as for the restraints.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Working with people whose behaviour challenges is a fraught subject as there are many interpretations of what good practice should look like. These range from the full use of punishments and restraints through to best practice in non-aversive Positive Behaviour Support. Where people sit depends on their education in the area. I say this as a preface to commenting on the views of our peers. Some would see the actions of CRC as mild departures and others would align with my view. I think the difference will come down to the weight that is given to the person's rights versus the pragmatics of the support situation.

Question 2: Whether the restraint used by CRC Trust staff in response to [Mr A]'s behaviour was reasonable/appropriate, in particular, a wheelchair belt being used to keep [Mr A] in his wheelchair for lengthy periods of time.	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	Much of this is answered in question 1 above, so I will focus briefly on the 'reasonable/appropriate' aspect here. CRC maintains that the lap belt was to prevent [Mr A] falling out of his wheelchair in transit. However, it seems clear to me that both the chair and the belt were used to confine [Mr A] to some extent. There may have been occasions when this was either reasonable or appropriate but, without a plan in place and an appropriately qualified health professional's opinion, it is difficult to know for sure. In general though, my opinion is that a long-term restraint is never a good support option as it does not react to the underlying issue that is causing the apparent need for the restraint, nor does it assist the person to learn other ways to act. Neither the relevant standard nor the accepted practice of the time would have indicated that long-term use of a

	wheelchair as a mechanism to control behaviour, with or without the lap belt, would have been acceptable.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	In terms of the relevant standard (NZS 8134.2:2008), this requires that restraint only be used when absolutely necessary to prevent serious harm and that it must be the least restrictive option, used for the shortest possible time, and fully documented. In addition, consent must be sought wherever possible, and regular review is required. At that time, Positive Behaviour Support informed accepted practice, and a core PBS principle is: Restraint should never be used to punish or control — only to prevent imminent harm, and only when no less restrictive option is available.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	The use of the wheelchair as a restraint is, in my opinion, completely outside the expectation of the standard of care indicated by NZS 8134.2:2008 and contrary to the effective use of Positive Behavioural Support. However, again acknowledging the practice in, at least, some schools around the country, this was not such an unusual thing. In my opinion, the use of a wheelchair, with or without the lap belt, as a form of restraint was a moderate to severe departure from the expected standard of care.
Question 3: Whether the documentation in relation to restraint use, including incident reporting, was appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	Again, much of this is answered in question 1 above, so I will focus briefly on the 'incident reporting' aspect here. In their response of 3 March 2025, CRC wants to reduce the severity of any breach. They argue: 'At the time of the events in 2019, there was less emphasis in industry best practice around incident reporting. CRC acknowledges that best practice for incident reporting has since changed. However, the appropriateness of CRC's approach to incident reporting must be assessed against the relevant standard of care in 2019, and not retrospectively in comparison to current standards, which have significantly improved and with which CRC is now compliant.'

	I am not sure where they get this view from. The updated NZ Standard for Restraint (NZS 8134: 2021) does provide clearer guidance on how to use incident reporting, but the requirements and the accepted practice were already established by the Health and Disability Services (Safety) Act 2001 and implicit in the HDC code and the previous restraint standard: NZS 8134.2.2008[2] as well as associated legislation such as the Health and Safety at Work Act 2015. To my knowledge, there has been no significant change in the expectations for incident reporting between 2019 and now, with the exception of a very recent change in critical incident reporting to the DSS [Disability Support Services] and HQSC [Health Quality & Safety Commission], neither of which apply here. CRC also comment that: 'CRC acknowledges that a formal incident report was not created at the time. This was due to the events not being considered a reportable incident by staff.' Previously CRC have said their incident reporting was inconsistent. In this case though, it seems to me, from the above comment, that the issue may not be so much about CRC's incident process as with staff training on what counts as a restraint and is therefore reportable. I find it problematic that the staff involved in the particular event where [Mr A] was tipped out of the chair he was sitting in and then four staff were required to put him into his wheelchair because it was against his will, did not see this as a reportable incident. I find the defence of this event by CRC in its original response to HDC and in its most recent response to be even more problematic.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The accepted practice was and is to complete an incident report for every occasion where one is applicable.

[2] Although 'incident reporting' isn't named directly, the standard addresses the monitoring and quality review of restraint, which would encompass tracking and evaluating events associated with its use, most commonly achieved through incident reporting.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	CRC's inconsistent use of incident reports is a moderate departure from that expectation and, hopefully, one that they have now remedied.
Question 4: Any other comments you wish to make.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I would make a few comments on the new policies CRC provided to HDC as evidence of progress. The first thing I would say is that, overall, what was provided is wordy and hard to read. If the primary audience for these are direct support staff so that they know how to do their jobs, then I think the documents are not really fit for the use of the average support person. They are long, dense in structure, poorly laid out, and it was difficult to find the useful advice in many of them. Below are a few specific comments on some of these. 1. Entry to Service Guidelines: this still doesn't offer any information about what questions are asked to ensure the necessary information is collected. 2. Restraint Free Practice Guidelines: the latest version is a significant improvement on the old one and the 2023 version, albeit still way more complex than I think useful for direct support staff. 3. Challenging Behaviour Management Guidelines: These are still poorly developed. There is no obvious link to the principles of Positive Behaviour Support and its underlying values. They continue with the rather strange definition of: 'Challenging Behaviour: Behaviour that interferes with an individual or **support worker's** daily life.' (My emphasis)

	Challenging behaviour is not a diagnosis — it is a signal that the person's environment, communication, or support may need to be adjusted. Defining it as something that is inconvenient to support staff seems to me to pathologise it and to diminish its communicative value. The more usual definition is: 'Behaviour of such intensity, frequency, or duration that it significantly interferes with a person's own quality of life, or the safety and wellbeing of themselves or others.' This keeps the focus on the person and not on the reactions of staff. 4. Response to Challenging Behaviours: As above, this completely misses the 'why' behind the behaviour; instead looks to just ameliorate issues that arise from the behaviour. The reason I have commented on these particular documents is that they inform how the staff at CRC operate. With the exception of the Restraint Free Practice Guidelines, I see nothing here that would change the situation [Mr A] found himself in.

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Name: Mr John Taylor
Date of Advice: 30 April 2025