Service Manager, Ms E

Area Manager, Ms F

IDEA Services Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC01082)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a 23-year-old man (Mr C) by IDEA Services Limited (IDEA Services) and its staff. The man has an intellectual disability and autism, and during weekdays he attended a vocational service operated by IDEA Services.

2. While at the vocational service, another service user (Mr A) was found with his hand on Mr C's penis whilst he was accessing the toilet. In the same month, Mr A was found with his pants down, standing over Mr C while he was sitting on the toilet. IDEA Services' own internal review found 10 further documented events of inappropriate sexual behaviour by Mr A towards Mr C between 2015 and 2017 (inclusive).

Findings

3. The Deputy Commissioner, Rose Wall, found that IDEA Services, its Area Manager, and its Service Manager failed to keep the man safe by failing to minimise harm when many opportunities arose to do so.

4. IDEA Services and its staff were aware of the respective risks and vulnerabilities of Mr A and Mr C. The man's mother (who was also his welfare guardian) had repeatedly raised concerns, and there had been numerous documented serious events, yet little or no action was taken to respond appropriately to those incidents and concerns, and minimise the risk of future harm to the man.

5. Staff failed to follow policies and procedures or escalate events appropriately, and IDEA Services did not provide adequate training for staff. This resulted in a culture where the man's safety was not paramount and staff did not have a zero tolerance approach to abuse. The failures resulted in ongoing acts of sexually inappropriate behaviour by the other service user towards the man, culminating in the two preventable critical events in 2017.

6. The Deputy Commissioner found IDEA Services, the Area Manager, and the Service Manager all in breach of Rights 4(1),[1] 4(4),[2] and 6(1)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendations

7. The Deputy Commissioner recommended that IDEA Services, the Area Manager, and the Service Manager provide a formal written letter of apology to the man's mother.

8. The Deputy Commissioner made further recommendations in respect of IDEA Services, including:

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(4) states: "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."
[3] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

a) To obtain independent advice to consider further improvements that would ensure a positive organisational culture focussed on continuous improvement and a zero tolerance approach to abuse, and ensure that adequate team and incident review meetings take place, and that requests and concerns from service users are recorded, tracked, and actioned.

b) To audit vocational and residential services in the region for adherence to IDEA Services policies and procedures, and, where the results do not reflect 100% compliance, to advise HDC of the further improvements that could be made to ensure compliance.

c) To provide refresher training to relevant IDEA Services staff on the prevention and management of abuse, on incident reporting, and on leadership and promotion of a positive organisational culture.

d) To update HDC on the progress, effectiveness, and implementation of the recommendations from IDEA Services' National Quality and Safety Review carried out in 2018.

9. The Deputy Commissioner also recommended that the Ministry of Health and the Ministry of Social Development update her on the steps they have taken to ensure a zero tolerance approach to abuse within the disability support services they fund.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms D about the services provided to her son, Mr C, by IDEA Services Limited. The following issues were identified for investigation:

- *Whether Idea Services Limited provided Mr C with an appropriate standard of care between 2015 and 2017.*
- *Whether Ms F provided Mr C with an appropriate standard of care between 2015 and 2017.*
- *Whether Ms E provided Mr C with an appropriate standard of care between 2015 and 2017.*

11. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mr C	Consumer
Ms D	Complainant

Ms E	Provider/Service Manager
Ms F	Provider/Area Manager
IDEA Services Limited	Provider

13. Information was also reviewed from:

The Ministry of Health	
Ms G	Support worker
Ms H	Support worker
Ms I	General Manager

14. Also mentioned in this report:

Ms J	Support worker
Ms K	Support worker
Ms L	Support worker
Mr M	Support worker
Ms N	Senior support worker

15. Independent expert advice was obtained from a disability services advisor, Sandie Waddell (**Appendix C**).

Information gathered during investigation

Background

16. This report discusses the care provided to Mr C by IDEA Services[4] between 2015 and 2017 (inclusive). Prior to two critical events on 9 and 13 June 2017, IDEA Services' staff documented 10 events that were of an inappropriate nature by another service user (Mr A) towards Mr C. It was not until after the critical events that IDEA Services commenced an investigation into these incidents. In her complaint to HDC, Mr C's mother and welfare guardian, Ms D, told HDC:

> "My son was sexually violated twice while in the care of IDEA Services. My trust and confidence in the ability of IDEA Services to keep my son safe has been destroyed."

The parties

IDEA Services

17. IDEA Services is New Zealand's largest provider of services to people with intellectual disabilities and their families. It employs around 4,500 staff, who support approximately 4,000 people with intellectual disabilities around the country. IDEA Services' mission is to "advocate for the rights, inclusion and welfare of all people with intellectual disabilities

[4] IHC New Zealand Incorporated is the ultimate holding company of IDEA Services and owns 100% of its shares.

and support them to live satisfying lives in the community". Its services are primarily funded by the Ministry of Health and the Ministry of Social Development.

Ms F

18. Ms F was the Area Manager during 2015 to 2017.[5] Ms F's employment agreement outlines quality and risk management as part of her expected performance outcomes.

19. With respect to quality, Ms F was expected to ensure that complaints and incident reporting were managed and monitored in accordance with IDEA Services' organisational policies. With respect to risk management, Ms F was responsible for ensuring the following:

> "• All staff understand risk and systematically identifies the risk associated with the activities that they perform.
>
> • There is an appropriate system of control to prevent and manage risk and to respond to risk to minimise cost, damage and harm.
>
> • Monitoring system is in place to ensure risks are effectively managed.
>
> • Staff are provided with appropriate skills, knowledge and techniques to identify, assess, manage and monitor risk.
>
> • Risks are reported appropriately.
>
> • Incidents are effectively investigated."

Ms E

20. Ms E was the Community Service Manager for the day programme[6] at the time of the events.[7] Ms E's employment agreement outlined quality as part of her expected performance outcomes. With respect to this, Ms E was expected to ensure that complaints and incident reporting were managed and monitored in accordance with IDEA Services' organisational policies.

21. In addition, Ms E's job description set out a number of key result areas. Of relevance, Ms E was responsible for:

- Ensuring the delivery of quality services that met the needs of service users. This included identifying areas of risk and managing the risk, and creating systems and a culture that ensured continuous improvement in service delivery.
- Providing leadership and direction in services. This included managing performance and monitoring progress, building a team that was productive and supportive, and building relationships of trust and respect.

[5] Subsequently, Ms F resigned from IDEA Services.

[6] The day programme is a vocational programme operated by IDEA Services. The aim of the service is to achieve one or both of the following outcomes: to increase the participation of people with disabilities in employment; and/or to increase the participation of people with disabilities in their communities. This service is funded by the Ministry of Social Development.

[7] Subsequently, Ms E resigned from IDEA Services.

22. Specifically regarding vocational services, Ms E was expected to provide leadership in the provision of high quality vocational services, consistent with the organisation's philosophy and applicable national standards. This included ensuring:

- Services were safe for service users and staff.
- Services were regularly monitored and evaluated via internal and external review systems.
- Service users and their families were listened to and staff worked in partnership with them.
- Staff had the required values, knowledge, and competencies to meet service user goals.

Mr C

23. Mr C (23 years old at the time of the main events) has an intellectual disability and autism spectrum disorder. Mr C began attending the day programme in 2015. He attended the service from Monday to Friday between 8.30am and 3pm.

24. Mr C's risk assessment and management protocols (RAMP) detail that he is at risk of sexual exploitation owing to his inability to understand personal boundaries. To minimise this, Mr C's risk management plan outlines that there should be communication between residential and vocational staff, staff are to be aware of Mr C's whereabouts at all times, and personal boundaries should be reinforced.

Mr A

25. Mr A (37 years old at the time of the main events) has an intellectual disability and a mental health disorder. Mr A's support documentation shows that from at least July 2015, he has attended the day programme three days a week, and another vocational service for two days a week. However, sometimes Mr A attended the day programme more than three times a week because he would refuse to get out of the van that would take him to the other vocational service, and therefore he would be taken to the day programme instead.

26. As early as 2004, Mr A's support documentation has noted that he has engaged in sexually inappropriate activity. He has been reported to display little insight into the consequences of this behaviour, and does not recognise the risk of this behaviour. Mr A's RAMP documents that he is likely to display sexually inappropriate behaviours that may involve inappropriate touching and attempting to touch other support users' private parts. In order to minimise this, Mr A's risk management plan outlines that staff are to be aware of where Mr A is, and that should inappropriate touching occur, staff are to support the other service user, provide one-to-one support for Mr A, redirect Mr A, and complete incident reporting.

Critical events

27. This section of the report sets out a detailed description of the critical events that took place in June 2017.

9 June 2017

28. The staff working on this day were support workers Ms G, Ms H, Ms J, and Ms K.

29. On the afternoon of 9 June (a Friday), a service user (Mr B) alerted Ms G that Mr A had gone into the toilet that Mr C was using. Ms G found Mr C at the toilet with his trousers and underpants down and Mr A with his hand on Mr C's penis. Ms G was unable to get Mr A to leave the toilet area on verbal instruction, and therefore used her body as a shield between the two men. Ms G reported that Mr A was persistently trying to reach around her to touch Mr C, and that Mr A was fixated on Mr C.

30. It is disputed whether Ms H was informed by Ms G about the incident that had occurred. In a statement to IDEA Services, Ms G recollected that she spoke to Ms H immediately after the incident and told Ms H about what had happened. Specifically, Ms G told Ms H that Mr A and Mr C had been in the toilet together, and that Mr A had had his hand on Mr C's penis. Ms G stated that Ms H told her to complete an incident report and to use the office to do so, so that she could focus.

31. IDEA Services has provided HDC with two documented meetings with Ms H. One confirms that Ms G told Ms H about the incident, and states:

> "[Ms G] went [to] the toilet and [Mr A] was in there touching [Mr C] … I [Ms H] told her [Ms G] she needed to stop and write an incident report. Stay in the office so she wasn't distracted."

32. In another statement to IDEA Services, Ms H reported that although Ms G had told her that there had been an incident between Mr A and Mr C, she denied that Ms G told her what the incident was about.

33. It is unclear what steps were taken to ensure that the two men were separated for the rest of the day, or what support was offered to Mr C. Ms J and Ms K were not advised of the incident on this day. Ms G reported that the rest of the afternoon seemed normal, and she was not aware of any interactions between Mr A and Mr C. Ms H stated that Mr C was with her at a small table alcove. Ms H could not recall what Ms J was doing, but recalled that Ms K was with another service user (not Mr A).

34. Mr C's mother, Ms D, stated that it "horrifies and deeply saddens" her that Mr C had to spend hours in the presence of a person who had assaulted him, that staff members "did nothing to support or protect him after the sexual assault", and "denied [him] the care and support of those who love him". She also added that the staff members took no action to prevent further assaults.

35. The incident report completed by Ms G should have been taken upstairs to the office of the Service Manager, Ms E, at the end of the shift, so that Ms E could read it on Monday (12 June). However, this did not occur, and Ms E did not read the incident report until 13 June 2017.

36. On Monday 12 June 2017, both men attended the day programme. Ms G also worked on this day. She stated that she thought that it was odd that both Mr A and Mr C were still at the day programme together, and was "shocked" that Mr A was still present.

13 June 2017

37. The staff working on this day were support workers Ms H, Ms J, Ms L, and Mr M, and senior support worker Ms N.

38. Ms E reported that by approximately 8.30am she had read the incident report from 9 June 2017. Ms E coded the event as "Stereotyped behaviour" with medium impact, and set the report aside for the incident review meeting at 11.30am.

39. At 8.47am, both Mr C and Mr A arrived at the day programme. IDEA Services told HDC that Mr A had been scheduled to go to another vocational programme on this day, but that when the van arrived he refused to get out, and was taken to the day programme.

40. At approximately 9am, Mr M heard Mr C yelling for help from the accessible toilet. Mr M found Mr A with his pants down, standing over Mr C while he was sitting on the toilet. The two men were separated, and Mr A was removed from the toilet area.

41. Between 9am and 9.15am, Ms E received a call from Ms J advising her of the incident. Ms E left her office and proceeded downstairs to the day programme. Between 9.15am and 9.30am, Mr M and Ms J completed an incident report for Mr A. At 9.20am, Mr A was transported to the other vocational programme by Ms H. Mr M advised Ms J and Ms N about the incident; however, Ms L and Ms H were not advised of the events.

42. At 11.40am, Ms E informed the Area Manager, Ms F, of both incidents at the incident review meeting. Ms F informed Mr C's mother, Ms D, and the General Manager, Ms I, at approximately 12.30pm. Ms F also contacted the Police at approximately 1pm, and then later completed an internal critical incident report and notified the needs assessment service coordinator (NASC). Ms I notified the Ministry of Health and the Ministry of Social Development the following day.

Risks, incidents, and concerns prior to June 2017

43. Following the above critical events, IDEA Services carried out its own internal investigation. The investigation concluded that the events that occurred between Mr A and Mr C were preventable. The investigation also found 10 previous incidents[8] between Mr A and Mr C over a two-year period between 2015 and 2017, and considered that these events were also preventable. Attached at **Appendix A** is a list of incidents between Mr A and Mr C, for which incident reports were completed.

44. This section of the report sets out the risks, incidents, and concerns documented about Mr C and Mr A prior to the critical events on 9 and 13 June 2017.

[8] Nine incidents that occurred at the day programme and one incident that occurred during Mr C's residential living trial.

Mr A's and Mr C's risk management documents

45. IDEA Services reported that long-standing staff recall Mr A's sexually inappropriate behaviour beginning in the late 1990s. Mr A was referred to specialist behaviour support services in 2004, but the only record IDEA Services has of this assessment is a protocol that sets out the need for visual contact at all times. IDEA Services' internal investigation found that the need for constant visual sighting was not reflected in Mr A's risk management documentation at the time of the events.

46. Although Mr C's RAMP documentation identifies that he is at risk of sexual exploitation, this is not reflected in other key personal information documentation such as his Crisis and Alerts Response, Personal Support Information, and Risk Assessment Plan.

47. IDEA Services' internal investigation found that Mr C's Risk Management Plan did not adequately reflect his vulnerability for exploitation. The internal investigation reported that Mr C's vulnerability for possible exploitation had not been assessed sufficiently, and therefore his Risk Management Plan and other personal support information lacked key guidelines and focus in this regard.

Incident during residential living trial in 2015

48. The first incident reported between Mr A and Mr C occurred whilst Mr C trialled a residential living placement where Mr A resided in 2015.

49. On 25 March 2015, an incident form was completed that documented that Mr A had followed Mr C into his room and was found standing over Mr C "and attempted to get his penis out". No follow-up actions were noted on the incident report, but Mr C was removed from the residence shortly afterwards. Ms D told HDC that she was not informed of this incident. She reported that, instead, she was advised that as Mr C "could not set boundaries for himself, [Mr A] would see that as a 'green light' to assault him" and therefore the residential trial had to end.

50. Subsequently, Ms D requested assurances from IDEA Services that there were plans in place to ensure the safety of Mr C given his attendance at the day programme with Mr A. Ms D told HDC that she was assured that a safety plan was in place at the day programme, and that staff levels enabled the two men to be supervised, kept occupied, and kept separate from each other.

51. Ms D recollected that although she was contacted by Ms E on a number of occasions and informed that Mr C had become angry or upset, at no time did Ms E advise that Mr A was involved in, or that there had been an incident of, inappropriate sexualised behaviour.

52. IDEA Services' internal investigation found that after this incident, there did not appear to be any record of consideration of the implications of Mr A's and Mr C's ongoing shared attendance at the day programme.

Earlier incidents at the day programme

53. In addition to the incident during the residential living trial and the events on 9 and 13 June 2017, a further nine incidents between Mr C and Mr A at the day programme were documented from 2015 to 2017. These earlier incidents include:

- Mr C with his hand over his private parts and stating that Mr A was "playing with his balls".
- Another service user reporting that he witnessed Mr A playing with Mr C's "zip on his jeans (private area)".
- Mr A found leaving the toilet that Mr C was also occupying.
- Mr A thrusting his pelvic area towards Mr C.
- Mr A approaching Mr C, jabbing and provoking him.
- Mr A blocking Mr C from coming out of the toilet and asking him if "he wants to fight".
- Mr A acting in a sexualised manner/suggestive manner, trying to touch Mr C.
- Mr A and Mr C punching each other and noted to be making a lot of sexual comments.
- Mr A standing over Mr C whilst Mr C was sitting on the toilet.

54. The internal investigation reported that there appeared to be a culture of acceptance of Mr A's challenging and inappropriate behaviour without sufficient consideration of the impact on others.

Concerns raised by Ms D

55. IDEA Services' "Service User Complaints Policy" (the Complaints Policy) provides that:

> "Service Users and those acting on their behalf (including staff, family members and advocates), must be provided with a safe environment to raise concerns or issues.
>
> Staff must actively listen to day-to-day concerns or issues raised by Service Users or those acting on their behalf and must respond to them.
>
> Staff must aim to resolve issues at the earliest possible point (i.e. when concerns or issues are first raised with staff)."

56. Through information provided to HDC from IDEA Services and Ms D, from 2015 to 2017 Ms D discussed Mr C's safety at the day programme with both the vocational and residential services a number of times (including in relation to his attendance with Mr A), and requested incident reports. Ms D's concerns are summarised in a table (**Appendix B**) and include:

- In 2015, Ms D sought assurances that a safety plan was in place at the day programme and staff levels enabled supervision and separation of Mr A and Mr C.
- In July 2016, Ms D became increasingly concerned that Mr C frequently stated that he was scared to go to the day programme.

- In January 2017, concerns were also raised about staffing, communication issues, and not being informed of incidents.
- In May 2017, Ms D raised concerns about Mr C being left unsupervised and with Mr A.

57. Ms D told HDC that staff at IDEA Services "minimised and ignored" the safety concerns she raised. Ms D stated that she did not receive any incident reports involving Mr C until 12 July 2017.

58. The Area Manager, Ms F, told HDC that she recalls "no concerns [being] raised regarding Mr C's vocational placement" initially. However, she stated that at a meeting in May 2017, Ms D raised concerns specifically relating to Mr A at the day programme, as there were a few recent incidents between the two men where it appeared that Mr A was targeting Mr C. Ms F reported that she was asked by Ms D to address this, and agreed that "[IDEA Services] needed to be more upfront about risks". Ms F acknowledged that she did not action Ms D's concerns, and she has "no explanation as to why", but noted that she was trying to find a way that would work for IDEA Services and all clients. Ms F told HDC that she does not believe that at this time she was aware of the extent or actual nature of the risk posed by Mr A.

59. The Service Manager, Ms E, stated that it was never relayed to her that Ms D had concerns about Mr A and Mr C attending the same vocational service, and that she "had very minimal contact with [Ms D] between 2015 and 2017". Ms E noted that Ms D had "regular contact with [Ms F]".

Supervision

60. As stated above, some of the issues raised by Ms D related to the concerns she had about the supervision of Mr C and Mr A. These concerns were not addressed. Consistent with this, IDEA Services' internal investigation found that the ongoing incidents that occurred between Mr A and Mr C demonstrated lapses in supervision, and there was no evidence that a robust process had occurred to address the lapses in staff supervision of the two men.

61. The investigation noted that the day programme is part of a large building that has a range of rooms. The layout of the building provides a poor line of sight, particularly of the toilet areas. The investigation identified that the organisation and management of the day programme did not provide sufficient surety as to who was responsible at all times to provide the requisite level of observation and support required for both men.

Abuse and incident reporting processes

62. At the time of the events, IDEA Services had a "Child Protection and Abuse Policy" (the Abuse Policy) and an "Incident Reporting and Response System Policy" (the Incident Reporting Policy). The Abuse Policy provided a framework for the protection of children and adults and for the investigation of alleged abuse. The Incident Reporting Policy sets out the requirements for reporting, responding to, and monitoring incidents.

63. This section of the report sets out IDEA Services' abuse and incident reporting processes that support staff, service managers, and area managers are to carry out when an incident or near miss has occurred.

Responding to incidents

Staff responsibilities

64. With respect to responding to incidents, the Incident Reporting Policy states: "[I]n the event of an incident or near miss, staff must take immediate action and respond to the situation." This includes the following:

- Assess the situation to "ensure the safety of yourself and others".
- "Call your Manager as soon as possible."
- "[A]t any time you require advice or support call [the] Manager."

65. The Abuse Policy states that when a person discloses abuse, or staff have grounds to believe that abuse has occurred, staff must take immediate action to "[m]ake sure the person is safe" and "avoid further risk to the person". The Abuse Policy also requires staff to report any cases where a person is being abused or neglected. It sets out the following procedures for reporting cases of abuse or neglect:

> "Inform their reporting manager … by way of incident report but supported by phone contact to raise urgency of response noting:
>
> - The incident reporting form is completed as soon as possible after each observation, communicating the name of the person reporting the abuse and their relationship to the person
> - Detail of anyone else who may have information
> - Signs and symptoms, and/or
> - Particular incidents with dates, times and place if possible
> - Action taken include any first aid attention
> - Signature of the person making the report
> - If any opinion included it must be identified as such e.g. urgency of response
>
> If a person is in imminent risk of abuse and staff believe their manager has not acted on information already reported then:
>
> - Recheck with the manager and suggest notifying Police on 111
> - Notify CYF/Police on 111 if not already notified
> - Document this in another incident reporting form"

66. IDEA Services' internal investigation found that on 9 June 2017, there was no common understanding amongst the staff as to what immediate actions should have been taken to

maintain separation and supervision of the two men, or what support was provided to them.

67. During the IDEA Services' internal investigation, the support worker who witnessed the critical event on 9 June 2017, Ms G, was interviewed. Ms G reported that although she expected a manager to be informed of the incident immediately and to discuss the incident with her, she did not consider contacting Ms E herself.

68. The table summarising incidents between Mr A and Mr C (see **Appendix A**) shows that for the majority of the incidents (nine out of the 11), the only immediate action taken by staff was to complete an incident report. On the other two occasions, the support workers documented "spoke to [Ms E]" and "contacted [Ms E]".

69. Ms E told HDC:

> "[The day programme], more than any [other vocational service was] pedantic about reporting any incidents. I would usually be rung before the [incident report] was written. The staff were very aware of the process [regarding] incidents … For this reason I still don't understand why the incident that occurred on the 9th June was not reported to me personally when it happened … It is so out of character for any of them."

70. IDEA Services' internal investigation found that there was "almost a culture and certainly a practice of poor communication within the team and between team and management and across the services". The investigation concluded that the failure of staff to notify management immediately of the incident on 9 June 2017 "significantly impacted" IDEA Services' ability to take remedial actions to prevent and minimise recurrence on 13 June 2017.

Service Manager responsibilities

71. In responding to notification of an incident of abuse, the Abuse Policy sets out the following responsibilities of the Service Manager:

> "
> - Check there is no contact between the alleged victim and the alleged abuser
> - Check staffing needs (if necessary, rearrange staff schedules — such as redeploying staff or changing routines)
> - Check that the person has received reassurance the allegation or disclosure will be acted on …
> - Check there is someone to support the alleged victim and someone different to support the alleged abuser …
> - Inform your Senior Manager"

72. With respect to the incident on 13 June 2017, the internal investigation also found that, in contravention with policy, Ms E did not immediately inform Ms F of the 9 June 2017 event after reading the incident report on the morning of 13 June 2017. Ms E also did not

immediately inform Ms F of the incident on 13 June 2017, electing to wait until the 11.30am incident review meeting to inform Ms F of both incidents.

73. Both Ms F and the General Manager, Ms I, told HDC that prior to 13 June 2017, they had not been informed of any incidents between Mr C and Mr A that were sexual in nature.

Notifying family

74. The Incident Reporting Policy also states that "the Service Manager will notify family … if the incident is serious or if there is agreement to call them after an incident". In all of the incident reports involving Mr A and Mr C from 2015 to 2017 (**Appendix A**), the section "COPIES FORWARDED TO" had "Vocational" and "Residential" services ticked, but not "Family".

75. Ms D told HDC that she "had made it clear from the outset" that she wanted to know what was happening with Mr C because if there were issues, she would be able to help because she knew him best. The table summarising the concerns raised by Ms D (**Appendix B**) sets out the number of times she requested incident reports from Ms E, Ms F, and other IDEA Services staff. Ms D stated:

> "[On 12 July 2017] I finally received the information that IDEA Services had … withheld from me. I spent [my son's] 24th birthday reading incident reports that document two and half years of sexual abuse, physical abuse and neglect of my son while in the care of IDEA Services."

76. Ms F confirmed that Ms D had requested copies of all incident reports involving Mr C, and acknowledged that this did not happen. Ms F stated that Ms E was tasked with this and was aware of the expectation. Ms E stated that although she was aware that Ms D had requested a copy of all incident reports involving Mr C, she had understood that these were to be forwarded by Ms F.

77. IDEA Services confirmed in its internal investigation that there is no evidence that Ms D was notified of all of the incidents throughout 2015 to 2017 despite her recorded request for this as far back as 2016. With respect to the 9 and 13 June 2017 critical events, IDEA Services' internal investigation noted that Ms D (Mr C's mother and welfare guardian) was not informed immediately.

Reporting and recording incidents

78. Following an incident or near miss, an incident is to be recorded on an incident report form. The Incident Reporting Policy sets out the following:

> "All accidents, incidents and near misses must be reported by staff within **24 hours** of the incident or near miss occurring.
>
> - All incidents and near misses must be recorded on an Incident Report Form …
> - Staff will be instructed by their Service Manager of any support a Service User may require following an incident or near miss or alerted to or informed by information in the Person's information."

79. The policy outlines that staff are also to "complete all boxes on the front of the form".

80. The incident reports provided to HDC (see **Appendix A**) show that not all staff were completing all the boxes on the front page of the incident report. In particular, the "STAFF/CLIENT COMMENT ON THIS INCIDENT (include your recommendations)" section was often left blank.

81. IDEA Services' internal investigation found that all the incident reports involving Mr C and Mr A had been filed only in Mr A's name, which "contributed to a loss of focus on the need to keep [Mr C] safe". Due to this, there is no evidence that the incidents were recorded in Mr C's Daily Information Diary/running records to alert oncoming staff and provide them with information about how to further support Mr C in these circumstances.

Critical events[9]

82. If an incident is a critical event, the Incident Reporting Policy states that the incident should be dealt with in the following way:

> "• Any critical event must be reported to the Services General Manager as soon as possible but no later than twelve (12) hours after the event has occurred using the Critical Event Incident Reporting Form.
>
> • Critical incidents are reported to the Ministry of Health, using the Ministry of Health Critical Event Incident Reporting Form, by the Services General Manager within twenty-four (24) hours of the incident occurring.
>
> • Only the Services General Manager will forward completed forms to the Ministry of Health.
>
> • The person delegated by the Services General Manager to undertake the investigations will complete and record the investigation using the Critical Event Investigations Checklist and the Senior Manager Investigation Report template."

83. When Ms E reviewed the 9 June 2017 incident report, she did not document the event as a critical event. When Ms F reviewed the incident report, she upgraded the incident to a critical event. Ms F also treated the event on 13 June 2017 as a critical event. For both incidents, she completed the steps outlined in the policy for reporting a critical event.

84. The table summarising the incidents between the two men (see **Appendix A**) shows that there were other incidents of a similar nature to the ones on 9 and 13 June 2017, but these were not treated as critical events.

Following up an incident

85. After an incident has occurred, the Service Manager is required to consider immediate follow-up actions such as those outlined in the Incident Reporting Policy:

[9] The policy deems critical events to include events being dangerous and putting the service user's safety at risk, a service user being involved in activity that has significant consequences (i.e., criminal activity), incidents/service issues having a serious impact on a service user's well-being, or any suspected abuse or neglect of a service user.

"Service Managers are responsible for the follow-up action required when they are informed of an incident or near miss …

…

Immediately assess the situation and provide support or advice that puts people's safety first. This may mean:

- Providing support, reassurance and advice by telephone.
- Going to the site of the incident and providing any support and reassurance needed.
- Allowing time for people involved to talk about and understand the incident and discuss any concerns they have.
- Discussing actions needed to help the person and others deal with what had happened.
- Arranging for replacement or additional staff cover if needed.
- Getting medical/other assistance.
- Reviewing RAMP and updating management strategies to eliminate or minimise risk.
- Reviewing and updating any hazard (update Hazard Register if required).
- Informing others as necessary (e.g. family …)
- Explaining what actions have been or will be taken to ensure similar incidents don't happen again.
- If there is an issue with the staff person and Service User then the manager needs to redirect the staff person to work elsewhere.
- Organising and holding a debrief for those involved in the incident."

86. For service users who have been exposed to violence or harm, the Incident Reporting Policy states that the Service Manager should consider the following:

"• Do they need to stay elsewhere (somewhere where they feel safe) until the situation has been managed?
- Does the person who caused the harm need to move to safety?
- If they stay where they are, how and by whom will they be supported?
- Making time with people involved to talk through what happened.
- Seeking advice from Senior Manager or Specialist Services staff."

87. For incidents where other types of harm have occurred, the policy states that the Service Manager should:

> "1. Go to the site of the incident.
> 2. Provide support immediately to any person who has been harmed
> 3. Provide reassurance and support needed."

88. As summarised in the table of incidents between the two men (**Appendix A**), many of the incidents involved Mr C being exposed to harm. Despite this, in all the incident reports from 2015 to 2017, Ms E left the "IMMEDIATE ACTIONS TO BE TAKEN" section blank. There is no evidence on the incident reports that Ms E carried out any of the immediate follow-up actions outlined above.

89. On 9 June 2017, following the incident, no staff immediately reported the incident to Ms E, and therefore this part of the policy could not be complied with. On 13 June 2017, Ms E was informed of the incident by a support worker, Ms J. Ms E attended immediately and sent Mr A to the vocational programme he was meant to be at that day. Although Ms E reported that she ensured that Mr C was supported by ensuring that a support worker was with him after the incident, Ms F told HDC that "there was no real support" put in for Mr C until she contacted Ms D later in the day.

Investigating an incident

90. After an incident and after staff have completed the initial parts of the incident report form, the Incident Reporting Policy states that the Service Manager must investigate all incidents and near misses in the following way:

> "Check the Incident Report Form is complete and details are correct. If not, provide support to staff to correct or add to the information.
>
> 1. Follow-up with people involved in the incident to explore/investigate what happened …
> 2. Take detailed notes as you investigate the incident … Sign and date your notes.
> 3. Transfer key findings of investigations into section on back of the Incident Report Form.
>
> …
>
> 6. Complete the 'Follow-up actions taken' and 'Impact/or Potential Impact or Incident' sections on the back of Incident Report ensuring actions taken are aimed to prevent or minimise the incident occurring again."

91. As evidenced in the table summarising the incidents between Mr A and Mr C (**Appendix A**), support staff would not always complete all the boxes on the incident report form. There is no evidence on the incident report forms that Ms E went back to staff to ask them to add further information.

92. Ms E told HDC that after incidents occurred, she would catch up with staff to discuss any issues as much as possible. She stated that "all staff knew of the interactions between [Mr C] and [Mr A]" and "were aware that they were to be monitored while at the day programme at the same time" and were to be kept "away from each other".

93. For the incidents between Mr A and Mr C during 2015 to 2017, under the heading "KEY FINDINGS OF INVESTIGATION" Ms E would document findings such as:

- "[Mr A] has a history with [Mr C]. Seems to have an attraction towards him."
- "[Mr A] has had an increase in inappropriate sexual behaviour."
- "Changes in behaviour, concerns around [Mr A's] mental health."
- "Stereotyped behaviour for [Mr A]."
- "[Mr A] will do this."
- "[Mr A] and [Mr C] have in the past had issues around touching when they were [in a residential situation]."

94. The main strategies documented in the incident reports to address the above findings were that support/medical attention was to be provided to Mr A, and that the two men would be redirected or monitored. IDEA Services' internal review found that these interventions and strategies were not effective.

95. In all of the incident reports, under the section "FOLLOW UP ACTIONS TAKEN BY MANAGER (tick boxes)", Ms E ticked only that she "followed up with staff" or took "no further action". Other follow-up actions were available but not ticked, such as "caregiver/support user follow-up", "support/service plan amended", "behaviour support involvement", "family notified", "police contacted", and "debriefing session". Under the "REPORTED BACK TO" section, no parties (service user, staff, or family/guardian) were ticked by Ms E.

Coding of incidents

96. The Service Manager's review of an incident report includes responsibility for coding incidents for the type of incident that has occurred, and for the impact on the service user involved.

97. Incidents can be coded as a "Low", "Medium", or "High" impact. The Incident Reporting Policy states that incidents of violence towards others must be coded as "Medium"[10] or "High"[11] impact.

98. The policy also sets out the following Incident Classification Codes to be used by service managers when assessing the type of incident that has occurred:

A. Verbal aggression
B. Physical aggression (including service user to service user)
C. Service user health
D. Medication

[10] The policy defines a medium impact incident as one that will have or has had some consequence of harm/ injury or significant disruption to the person or others.
[11] The policy defines a high impact incident as one where there are major or enduring consequences in terms of harm or potential harm.

H. Other
I. Criminal behaviour (including inappropriate sexual behaviour)
J. Behaviour other (including nuisance behaviour and screaming/yelling)
K. Incident others
L. Critical
P. Sensitive (including physical and sexual abuse)

99. Ms E classified all the incidents at the day programme between Mr A and Mr C from 2015 to 2017 as either "Behaviour Other" or "Physical Aggression". Although there was a classification specifically for inappropriate sexual behaviour and critical incidents, these were never assessed as applicable by Ms E.

100. In addition, Ms E classified most incidents as "low impact", and where Mr A displayed inappropriate sexualised behaviour towards Mr C, Ms E coded this as "medium impact". It is noted that following Ms F's review of the incident report on 9 June 2017, she crossed out Ms E's "medium impact" rating and changed it to "high impact". No other incidents reported during 2015 to 2017 were documented as "high impact".

101. Ms E acknowledged that "sadly ongoing incidents between Mr C and [Mr A] may not have been treated with the seriousness they deserved". Support workers at the day programme told HDC that had Ms E considered these incidents serious, they would have acted on her advice. Ms F told HDC: "I do not put any of the incidents between the two [men] into the lower level category." Ms F considers that Ms E "seemed to have no comprehension of assessing the consequence of the incidents".

Monitoring and evaluating incidents

102. Following the investigation of an incident, the Incident Reporting Policy states that incidents are to be monitored and evaluated. The process is to be carried out at staff team meetings and incident review meetings.

Staff team meetings

103. All permanent staff in a relevant service (e.g., the day programme) attended a regular team meeting, usually once a fortnight. In relation to team meetings, the Incident Reporting Policy provides:

> "1. Incidents or near misses must be discussed at staff meetings and the effectiveness of any required changes monitored and evaluated …
>
> 2. Provide feedback to staff on changes needed (immediate/longer term) and discuss any learnings.
>
> 3. Complete feedback section on the Incident Report Register (Service) following feedback at staff meetings and feedback to individual staff members.
>
> 4. Monitor and evaluate the effectiveness of any changes required as an outcome of investigation."

Frequency of staff team meetings

104. The record of Team Meeting Minutes provided to HDC shows a decline in the number of team meetings from 2015 to 2017. In 2015, a total of 18 team meetings were held. In 2016, 11 team meetings were held, and prior to the June 2017 incidents, only two team meetings had been held.

105. Permanent staff at the day programme told HDC that often staff team meetings were cancelled by Ms E for various reasons, including a shortage of permanent staff (owing to sickness or injury). Ms E told HDC that team meetings "had been hard" in 2017. She noted that several staff had been off work because of injuries and illness, and there was a lack of relievers to cover permanent staff so that they could attend the meetings. Ms E stated that she also had a lot of time off for personal reasons.

106. Ms F told HDC:

> "[I]t is the responsibility of the [Service Manager] to hold regular [team] meetings, but it was my responsibility to ensure these were happening. I have no explanation as to why I did not address this."

107. Ms F was aware that Ms E managed five facilities, and that meetings were being held for the other four, and she has "no explanation as to why they were not regularly held at the day programme".

108. IDEA Services' internal investigation found that there were "insufficient" regular team meetings occurring at the day programme to provide effective management of incidents. IDEA Services considered that this had been "an ongoing issue for some time now and should have been identified and addressed well before the June 2017 incidents occurred".

Content of staff team meetings

109. On the Team Meeting Minutes form, there is a section titled "Individual Review/Planning", which provides for each service user to be discussed at least once over a one-month period. There is also a section titled "Health and Safety/Risk Management" for discussion of "Incident reporting trends and management feedback".

110. During 2015 to 2017, in the "Individual Review/Planning" section, Mr A was discussed five times and Mr C was discussed four times. Of these discussions, Mr A's inappropriate sexualised behaviour and the need for supervision was discussed three times, on the following dates:

- 2 June 2015: "Support and redirect [Mr A] in and around inappropriate physical contact."
- 27 January 2015: "Cannot be left alone, support at all times."
- 12 July 2016: "Inappropriate speech to others sexual behaviour e.g. exposing himself … CANNOT BE LEFT ALONE."

111. Mr C's need for supervision was also discussed on the following dates:

- 5 May 2015: "[Mr C] needs supervision, wanders off, cannot be left alone."
- 15 November 2016: "Supervision at all times."

112. Ms D noted that on 9 June 2017, it was another support user who alerted staff that Mr A and Mr C were in the toilet together. She added that on 13 June 2017, staff were unable to confirm how long Mr C was locked in the toilet with Mr A because the men were not being supervised.

113. IDEA Services' internal investigation found that on the morning of 13 June 2017, staff congregated in the office and were inattentive to the service users for approximately 30 minutes while they either engaged in some private conversation or were acquainting themselves with communication books and other administrative tasks.

114. The Team Meeting Minutes show that although there is some evidence that incident reports and trends were discussed, none of the incidents involving both Mr A and Mr C or related trends were discussed at the staff team meetings between 2015 and 2017.

Incident review meetings

115. Incident review meetings are where all managers in a particular area attend to review and sign off all incidents that are considered to be medium or high impact. These meetings usually occur twice a week. IDEA Services told HDC that the Area Manager is responsible for ensuring that incident review meetings are held regularly. The Incident Reporting Policy provides:

> "Management teams must hold Incident Review Meetings to … review High and Medium impact incidents.
>
> IDEA Services Review Meetings usually occur Monday or Tuesday and Thursday or Friday."

Sign-off of incident reports

116. The Incident Reporting Policy sets out the following process for signing off incident reports:

> "
> - Service Managers must sign-off all Incident Reports.
> - Senior Managers must co-sign all Medium and High Impact Incident Reports following discussing at Incident Review meetings.
>
> Before signing off incidents the Service Manager must:
>
> - Check that all sections of the Incident Report have been completed.
> - Ensure actions have been completed.

Before co-signing Medium and High impact reports the Senior Manager must:

- Ensure there is sufficient information to confidently sign off the report as completed.
- Ensure there is no further information required of the investigation manager prior to closing the incident investigation.
- Ensure actions are focused on prevention or minimising harm occurring again."

117. It is noted that irrespective of the impact category of the incident, all incident reports involving Mr A and Mr C were signed off by the Service Manager and co-signed by the Area Manager.

118. Ms F told HDC that she believed that what she was signing was what she had been advised verbally by Ms E and not that she had read it. Ms F added:

> "I am adamant that had I been made aware of these incidents as they were written, I would have addressed them … I cannot explain why [Ms E] would write one thing and say another."

119. In response, Ms E stated: "I'm unsure what [Ms F] is referring to when she said I wrote one thing but said another."

120. IDEA Services advised HDC that it considers that by signing the incident reports:

> "[Ms F] was acknowledging that she was aware of what was occurring, had reviewed the situation, and was recording that the risks of each incident were being adequately managed and meeting organisation requirements."

121. IDEA Services considered that Ms F should have read the incident reports before signing each one, as the Area Manager fulfils an important quality check of the incident reporting process.

Frequency and content of meetings

122. The minutes of incident review meetings provided to HDC are documented in the Area Manager's notebook. IDEA Services provided notes from incident review meetings on 21 July 2016, 26 July 2016, 26 August 2016, 11 May 2017, and 19 May 2017.

123. On 26 August 2016, it is noted: "[C]oncerns [with Mr C] taunting other [service users]. Fear is that [a service user] will assault [him]." On 19 May 2017, another note states: "[Mr C] hit by [Mr A]. [Mr C] foot stood on by [Mr A]. Accident?" The outcomes of these discussions and/or related action points are not documented.

124. Ms E told HDC that incident review meetings were not occurring twice a week. Ms F told HDC that the incident review meetings were "too short to properly share information and discuss incidents", and she does not recall having any concerns that directly related to Mr A or Mr C.

Trend analysis

125. The Incident Reporting Policy states that another purpose of team meetings and incident review meetings is trend analysis, which involves discussion of incidents and emerging trends.

126. Between 2015 and 2017, the staff team meeting notes specifically mention trends noticed about service users a total of three times. Neither Mr A nor Mr C was mentioned in relation to trends. In addition, the incident review meeting notes do not show any evidence of discussion around trends that were emerging from local registers or national database information, or whether trends needed to be discussed further at management meetings.

127. IDEA Services reported that, at the time, there was an electronic record system that reported on incidents and could have been used by service managers and area managers on a regular or episodic basis to identify trends. IDEA Services added that incident review meetings were an opportunity to identify that incidents between Mr A and Mr C were being reported only for Mr A. This should have prompted a request for analysis or a trend report of all incidents involving Mr C and Mr A, and should have initiated completion of separate incident reports. IDEA Services concluded that "none of the review mechanisms were carried out prior to the incidents of 9 and 13 June 2017 [and that the] processes were available but not applied".

128. IDEA Services' internal investigation found that there was insufficient attention to patterns/trends of incidents and near misses to inform a more systemic review.

Oversight, supervision, and training

129. IDEA Services reported that at an organisational level, it utilises multiple approaches to ensure the implementation of, and adherence to, policies and procedures. The approach includes staff orientation for new employees, ongoing staff training and familiarisation to specific policies and procedures, staff supervision, coaching and mentoring by peers and senior staff, discussion of policies and procedures at regular team meetings, ongoing refresher training programmes, and trend analysis of incidents/complaints.

Staff training

130. IDEA Services told HDC that it expects all staff to be aware of policies and procedures from the day on which they join the organisation and complete their orientation training.

131. IDEA Services' internal investigation reported that the core support team at the day programme are long-standing employees who have all completed IDEA Services' core learning and development programme. The investigation noted that all staff had completed training on abuse, but not all had received the specific training module on incident reporting.

132. The internal investigation found that despite having received training, some staff had very poor understanding of the organisation's reporting requirements for any alleged abuse, and the actions they needed to take.

133. IDEA Services provided HDC with records of learning for all staff at the day programme. These showed that staff received training on abuse in 2012, and again in 2016. However, some staff had not received incident reporting training, and those who had, had received it in 2006 or 2007, with the exception of one staff member, who was employed in 2016 and received all training at this time.

Service Manager supervision of support workers

134. IDEA Services' internal investigation found that Ms E's performance as a Service Manager was substandard in a number of areas. It noted that insufficient regular team meetings occurred at the day programme to provide effective management of programme delivery, incidents, and policies and procedures.

135. IDEA Services' internal investigation also found issues with team culture, cohesion, and communication. In particular, permanent core support staff were not cohesive, and communication amongst the team was not effective. The report also referenced some tension between members of core staff as to responsibilities when the senior support worker was absent. The report concluded that there was "almost a culture … of poor communication within the team and between team and management".

136. Ms F also noted that there was "staff disharmony" at the day programme, and that this "should have only been more reason to hold the meetings". Support workers submitted to HDC that difficulties with teamwork at the day programme dated back several years, and "no team meetings made communication difficult, resulting in an already dysfunctional team".

137. Ms E told HDC that as the Service Manager for the day programme she takes some responsibility, but she believes that the pressures of the job and the general lack of support and professionalism from Ms F were also contributing factors.

Area Manager supervision of Service Manager

138. IDEA Services' internal investigation identified that Ms F's performance as an Area Manager was substandard in a number of areas. IDEA Services added that Ms F was aware that Ms E was not holding regular team meetings, but does not appear to have taken any action to remedy this or to provide additional support. IDEA Services stated: "[I]t is not known what supervision [Ms F] provided to [Ms E]."

139. Ms F told HDC that she had concerns about the operation of the day programme, and was aware that Ms E was not holding regular meetings. Ms F stated that she "relied on the assurances given by [Ms E]", and accepts that she should not have done this. Ms F also acknowledged that it was her responsibility to ensure that team meetings were occurring at the day programme, and she has "no explanation" as to why she did not address this with Ms E.

Senior management oversight

140. IDEA Services submitted that this case highlighted that senior management were not aware of performance issues arising in respect of Service Managers or Area Managers where the General Manager was not aware.

141. General Manager Ms I considered that Ms F had appropriate training and support. Ms I noted that Ms F's orientation included training on incident management processes and critical reporting.

142. Ms I is unable to comment on why Ms F did not take appropriate action on the apparently poor management of the day programme, but alleges that Ms F was not truthful in their monthly supervision. IDEA Services noted that Ms F did not convey to Ms I at her monthly supervision sessions that she had concerns about the performance of Ms E. IDEA Services told HDC that it has considered whether Ms I should have "dug deeper" or researched in more detail what Ms F was reporting to her. IDEA Services stated:

> "We do not believe that the General Manager could have known what … actions were not occurring as expected at Service Manager and Area Manager level and this was not an expectation of the General Manager at that time."

143. Ms F has indicated that she does not agree with all the information above. However, she confirmed that she had regular meetings with Ms I, "who was supportive, but extremely busy". IDEA Services added that it considered that Ms I met expectations in relation to oversight and monitoring requirements.

Further information — IDEA Services

144. IDEA Services' internal investigation identified a need for a further review for Mr A, and also a wider review to ensure the safety of other service users. IDEA Services reported that it will continue to engage with Mr A's family over plans for his ongoing support (including an updated assessment of his ongoing needs).

145. IDEA Services advised HDC that since the time of these events, it has introduced some key management changes and programmes of work that are designed to improve quality and safety.

146. IDEA Services reported that in early 2018 it completed a National Quality and Safety Review of Services and began implementing the review's recommendations. It also restructured its Service Manager role, which was led by a new Chief Operating Officer. The change in role sees service managers spending more time with service users and their families, to ensure that there is a clear focus on transparency and communications with all stakeholders.

147. IDEA Services has introduced a new training programme for its management team, with initial focus on service managers. The new programme is intended to provide an understanding of the concepts of leadership and management, as well as tools to use in the role of manager to improve workplace outcomes.

148. A new electronic system called Risk Manager was introduced as a pilot in September 2018. The system shows all incidents entered by support workers, enabling real-time reporting for managers. Full implementation of the system was scheduled for completion in June 2019. IDEA Services expects that the new system will provide opportunity for closer management oversight and monitoring of incidents at all levels.

149. A project to develop and revise Easy-Read documents for support workers and an operations manual for service managers was commenced in 2018. Advisory groups were put in place to ensure that documents are peer reviewed and understood by the intended audience. The aim of the project is to provide a simple online resource for support workers and managers that will increase their understanding of IDEA Services' comprehensive policies and procedures.

150. IDEA Services has expressed that it is "deeply sorry" for what happened to Mr C. It states that it is determined to learn from this complaint and to ensure that this does not occur again for any other service user in the future.

Responses to provisional decision

Ms D

151. Ms D was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where relevant, Ms D's response has been incorporated into this report.

Ms E

152. Ms E was given an opportunity to respond to the relevant sections of the provisional opinion, as it relates to her. She advised that she accepted the findings in the report. Ms E reiterated that she regrets the trauma that Mr C and his family have had to endure, and acknowledged that it was her responsibility, as the Service Manager, to keep Mr C safe.

Ms F

153. Ms F was given an opportunity to respond to the relevant sections of the provisional opinion, as it relates to her. She provided HDC with a formal written apology for forwarding to Ms D.

IDEA Services

154. IDEA Services was given an opportunity to respond to the provisional decision. Where relevant, IDEA Services' response has been incorporated into the report. IDEA Services advised that it accepted the referral to the Director of Proceedings and the recommendations.

Relevant standards

The Prevention and Management of Abuse Guide for services funded by Disability Support Services (Released 2016)

155. The Ministry of Health believes that people should have the support they need to lead a life free from exploitation, neglect, or abuse. The Guideline notes that abuse in support services reduces the confidence that disabled people and their families have in the services that the Ministry contracts and funds. The Ministry, along with providers, has a duty of care to ensure that any actions taken, or any failures to take action, do not injure

or harm the disabled people being supported. The Guideline recognises that providers play a vital role in fostering a positive organisational culture in which disabled people are respected and valued and have the same rights as other citizens. Such a culture significantly decreases opportunities for abuse to occur.

156. The "Purpose" section of the Guideline states:

> "Safeguarding the disabled people you support involves preventing abuse, creating a better understanding of signs that abuse is occurring and developing appropriate and responsive systems to deal with incidents of abuse. That is, as the service provider, you will:
>
> - Have strategies and safeguards in place to guide your organisation in the way you support disabled people
> - Give both staff and disabled people a good understanding of what abuse looks like
> - Ensure that where abuse occurs, the person who experiences it is supported appropriately and all incidents are reported
> - Have a process of debriefing and review when abuse does occur, to learn from the situation
> - Put strategies in place to prevent any further abuse."

157. Under the heading "Understanding abuse", the Guideline notes:

> "A range of individuals commit abuse acts in a variety of situations … Most commonly the abuse is by staff against people their service is supporting or by disabled people against other residents in the service."

158. Under the heading "Key principles in safeguarding individuals", the Guideline sets the following relevant principle:

> "3.1 People are individuals who have the inherent right to respect their human worth and dignity …
>
> The Ministry, providers and the disability community must all demonstrate zero tolerance to all forms of abuse. This includes abuse that support staff and disabled people carry out against other disabled people. The Ministry, and in particular DSS [Disability Support Services], expect that a DSS-funded provider will do everything it can to apply zero tolerance. You should demonstrate this approach through all levels of the organisation. Your systems and policies for and responses to abuse must reflect zero tolerance."

159. The "Expectations of providers — responses to alleged abuse" section states:

> "**6.1 Develop a feedback loop and a positive complaints culture**
>
> … [E]nsuring disabled people have a voice requires:
>
> Ensuring processes that capture complaints, incidents, and issues, do so in a way that:
>
> (i) keeps disabled people safe, and
>
> (ii) resolves the complaint or issue
>
> ...
>
> Safe feedback systems and a positive complaints culture can prevent abuse by prompting an intervention in response to the earliest indicators of a problem …
>
> **6.2 Have policies and quality systems in place**
>
> Organisations will have quality assurance processes in which incident debriefing and feedback lead to quality improvement. Service providers will have detailed quality systems that guide how they will manage serious incidents, including those of alleged abuse. Details should include strategies, based on learning from the event, to prevent further incidents. It is vital, however, that reviews and investigations of abuse also focus on service culture and values, rather than being limited to a procedural approach. In the policies developed to respond to abuse that has occurred, the provider will:
>
> - Treat the immediate safety of the individual as paramount
> - Immediately remove the alleged perpetrator from the location of the targeted service user
> - Inform the service user's family as soon as possible
> - Contact the police where alleged abuse — particularly sexual, physical or financial abuse — has occurred …
> - Support the service user to access any necessary follow-up support after the incident, such as advocacy services, medical assessment, counselling, buddy support
> - Notify the Ministry of the event and any follow-up
> - Review the situations of abuse to establish how similar events can be prevented in future."

The New Zealand Health and Disability Sector (Core) Standards (NZS8134.1:2008)

160. These standards enable consumers to be clear about their rights, and providers to be clear about their responsibilities for safe outcomes. The standards ensure that:

> "(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated and delivered in an appropriate manner.

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer."

161. Standard 1.3 states: "Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence." Criteria for this includes: "1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect."

162. Standard 1.8 states: "Consumers receive services of an appropriate standard." Various sections within the Standard deal with a consumer's right to receive services of an appropriate quality. This includes incident reporting systems that are linked to open disclosure and quality improvement processes.

163. Standard 2.2 states: "The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers."

164. Standard 2.3 states: "The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles." Criteria for this are:

"2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers …

2.3.6 Quality improvement data are collected, analysed, and evaluated and the result communicated to service providers and, where appropriate, consumers."

165. Standard 2.4 states: "All adverse, unplanned, or untoward events are systemically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner."

Opinion: Introduction

166. The Ministry of Health's *Prevention and Management of Abuse: Guide for services funded by Disability Support Services* (the Ministry's Abuse guidelines) state:

"Abuse in support services reduces the confidence that disabled people and their families have in the services that the Ministry contracts and funds. The Ministry, along

> with providers, has a duty of care to ensure that any actions taken, or any failures to take action, do not injure or harm disabled people that they support …
>
> Providers play a vital role in fostering a positive organisational culture in which disabled people are respected and valued and have the same rights as other citizens. Such a culture significantly decreases opportunities for abuse to occur."

167. On 9 June 2017, Mr C was found at the toilet with his trousers and underpants down, and Mr A with his hand on Mr C's penis. On 13 June 2017, Mr C and Mr A were allowed to attend the day programme together. Shortly after the men arrived at the day programme, a support worker heard Mr C calling for help from the accessible toilet. Mr A was found with his pants down, standing over Mr C, who was sitting on the toilet. These events were escalated to IDEA Services' management, and an internal investigation was commenced. The investigation identified 10 additional previous events of an inappropriate nature by Mr A towards Mr C, spanning across two years.

168. The key issue in this case is whether IDEA Services and its staff provided services to Mr C that ensured he was safe. For the reasons set out in this report, I consider that IDEA Services and its staff failed to keep Mr C safe by failing to minimise harm when many opportunities arose to do so.

169. IDEA Services and its staff were aware of the respective risks and vulnerabilities of Mr A and Mr C, and had been put on notice by the concerns raised by Ms D and by numerous documented serious events, yet little or no action was taken to minimise the risk of future harm to Mr C. This failure resulted in ongoing acts of sexually inappropriate behaviour towards Mr C, culminating in the two preventable critical events outlined above. Notwithstanding the significance of the two critical events and the magnitude of the failures to respond to them appropriately, I consider these events to be one aspect of greater, more systemic failures at play.

Opinion: Service Manager Ms E — breach

Introduction

170. As the Service Manager for IDEA Services' vocational day programme, Ms E was responsible for ensuring that she and her team provided a safe service to Mr C. For the reasons set out below, I consider that Ms E failed to minimise the risk of inappropriate physical and/or sexual behaviour and abuse towards Mr C.

171. On 9 June 2017, after the critical event described above, staff failed to:

- Contact Ms E immediately.
- Ensure that the incident report reached Ms E in a timely manner.
- Ensure Mr C's safety by removing Mr A from the day programme.

- Ensure that the event was communicated to all those working at the day programme.

172. On 13 June 2017, when Ms E reviewed the incident report for 9 June 2017, she did not consider it to be a critical event. Instead, she coded the event as "Stereotyped behaviour" with medium impact. She did not immediately raise the event with Ms F and/or Ms D, but rather set it aside for the incident review meeting later that day.

173. No mechanisms were put in place to ensure that Mr C and Mr A did not return to the same day programme after the first critical event. The two men were not being supervised prior to either critical event.

174. Staff and Ms E's inactions contravened IDEA Services' Incident Reporting Policy and Abuse Policy but, more significantly, their inactions failed to ensure Mr C's safety. My expert advisor, Sandie Waddell, confirmed that "correct procedures were not followed after the first incident on 9 June 2017". She added:

> "Staff also seemed unaware of the need to inform [Ms E] of incidents such as the one that occurred on 9 June as soon as possible. It is also unclear if staff were aware of the need to communicate incidents to all staff on duty at the day programme to ensure adequate supervision and support was provided. Communication generally about the incident report to [the Service Manager] was confused and the required processes in an incident of this nature were obviously not well understood."

175. I agree. I am critical of the way in which Ms E and her team responded to the critical events on 9 and 13 June 2017. I consider it wholly suboptimal that staff failed to ensure that Mr A and Mr C did not return to the same day programme following the first event. In my view, there was a complete lack of critical thinking and responsibility taken by staff at the day programme to avoid further harm to Mr C.

Harm minimisation

176. There were a number of significant opportunities for Ms E and her team to minimise harm to Mr C well before June 2017. These opportunities were missed owing to the inadequate supervision of Mr C and Mr A by Ms E and her team, and their poor response to incidents, lack of team meetings, and a team culture where Mr A and Mr C's interactions were minimised and normalised.

Supervision of Mr A and Mr C

177. Both Mr C's and Mr A's risk management documentation refer to the need for staff to supervise the two men. The need to monitor the two men was also documented a number of times on the incident reports. Despite this, there were many incidents between Mr A and Mr C that were unwitnessed, or the men were found unsupervised and/or staff were alerted to the incident by other service users.

178. IDEA Services' internal investigation found that the ongoing incidents that occurred between Mr A and Mr C demonstrated lapses in supervision, and there was no evidence

that a robust process had occurred to address the lapses in staff supervision of the two men.

179. Ms Waddell noted that not all casual staff appeared to be aware of the specific supervision requirements of Mr A and Mr C and the need to keep service users within eyesight at all times. I agree but add that the many lapses in supervision show that permanent staff were also unaware of, or did not adhere to, the supervision requirements for the two men. The lack of supervision that Mr A and Mr C received is concerning. It was Ms E's responsibility to ensure that her staff supervised Mr A and Mr C adequately at all times. I do not consider that she fulfilled her responsibility, and am critical of this. It is pertinent to note that had both men been supervised adequately, most of the reported incidents, including the two critical events in June 2017, could have been prevented.

Response to incidents

180. Prior to the events on 9 and 13 June 2017, there were 10 additional reported incidents between Mr A and Mr C, where Mr A demonstrated aggressive or inappropriate sexualised behaviour towards Mr C.

181. In dealing with these incidents, there was a consistent pattern of non-adherence to IDEA Services' Incident Reporting Policy, both by staff and Ms E. Staff consistently documented inappropriate behaviour displayed by Mr A towards Mr C, but failed to:

- Escalate the incident to the Service Manager via a telephone call.
- Take any immediate action after an incident, other than complete an incident report. Even when an incident report was completed, it was filed only in Mr A's name.
- Complete all sections of the incident report.

182. Ms E also did not respond appropriately to incidents by consistently failing to:

- Take immediate action after her review of an incident, and seek further information from staff when incident report forms were incomplete.
- Categorise and code the incidents adequately. Ms E classified all incidents between Mr A and Mr C as either "Behaviour other" or "Physical Aggression" despite there being a classification specifically for inappropriate sexual behaviour.
- Identify when an incident was a critical event, and escalate this to the Area Manager, Ms F.
- Identify that a pattern of harm to Mr C was forming.
- Debrief with staff, and notify or report back to Mr C's family (Ms D) and staff about the incidents.

183. Ms Waddell advised that performance of all staff involved was compromised by inadequate supervision of direct reports, and non-adherence to organisational policies and procedures. I accept Ms Waddell's advice. Ms E played an important quality check of the incident reporting process. It was Ms E's responsibility to ensure that her direct reports

were responding to incidents appropriately. I am critical that in her review of the incidents, she did not identify her staff's deficiencies in reporting, and address them.

184. Ms Waddell further advised that "trends did emerge for both these service users and interactions reported with each other did show a pattern". I agree. There was clear evidence of a pattern of harm to Mr C, and I am critical that Ms E failed to identify that pattern. After completing her review of incidents, there were also missed opportunities to debrief with and/or report back to staff and Ms D about the incidents, so that the service could learn from the incidents and continuously improve on strategies to keep Mr C safe.

185. Ms Waddell also noted that Ms E did not appear to have a good understanding of the required coding for incident reporting, nor the level at which incidents became serious enough to be escalated. As the Service Manager of the day programme, Ms E was responsible for ensuring that she was well informed about the Incident Reporting Policy and Abuse Policy, and I am critical of her failure to apply the policies correctly.

186. I consider the above failures to respond appropriately to incidents to be significant, as they eroded key processes that were meant to safeguard Mr C from harm.

Culture

187. The way in which the incidents were reported by staff and then reviewed by Ms E clearly demonstrated a poor culture at the day programme.

188. As stated above, staff would identify incidents relating to Mr A being physically aggressive towards Mr C, inappropriately touching Mr C, or being in the same toilet as Mr C, yet they did not consider the events serious enough to escalate to Ms E immediately. Similarly, in Ms E's reviews of the incidents, the code assigned showed a lack of appreciation that the incidents were serious and required escalation to Ms F. Further, Ms E's assessment that the incidents had only a "low impact" showed a concerning lack of insight into the significance of such incidents and the harm they may have been causing Mr C.

189. In the incident reports, when asked to state a possible cause or key findings of the events, staff and Ms E normalised the interactions between the two men as something historical or expected. For example, staff and Ms E wrote that Mr A's behaviour was "stereotypical", a similar incident had "happened before", the two men had "a history", or that they "have in the past had issues around touching". This approach suggests that staff accepted that these interactions would occur rather than considering them unacceptable and requiring continuous improvement strategies to prevent the incidents from occurring again.

190. Furthermore, the same strategies such as redirection and monitoring were being documented to address the incident, but the strategies were not re-evaluated or reviewed when incidents continued to occur. I note that IDEA Services' internal investigation found that these interventions were not effective. This also suggests a lack of critical thinking, and a degree of acceptance that incidents between Mr C and Mr A would occur.

191. In my view, the inadequate responses to incidents between Mr A and Mr C were not only in violation of organisational policies and procedures but, more importantly, demonstrated

that a culture had formed at the day programme where staff, including Ms E, minimised and normalised traumatic events that were occurring to Mr C. I note that IDEA Services' internal investigation also supports this view. I am critical that not only did Ms E fail to identify and address the unsafe culture within her team, she also contributed to it.

Team meetings

192. Over the period of 2015 to 2017, team meetings at the day programme were declining. Prior to the events in June 2017, only two team meetings had been held. The team meeting minutes showed that in 2015 and 2016 staff had been reminded of the need to supervise Mr A and Mr C, but these discussions did not include any analysis of the incident reports or trends relating to the two men's interactions.

193. Ms Waddell advised that the lack of effective leadership, communication, and supervision of staff at the day programme by Ms E was demonstrated by the lack of regular team meetings, especially during the period leading up to the critical events. Ms Waddell commented:

> "Good communication is essential in ensuring all staff are aware of all necessary supervision requirements for service users. All incidents that have occurred and any trends noted need to be clearly communicated and understood. All staff roles and responsibilities … need to be clearly understood. It is accepted practice that team meetings are a time where any concerns are discussed, any new processes are introduced and ways of working together positively and cohesively are embedded."

194. Ms Waddell added that team meetings were also a time "where service users' needs/risks/management plans were all discussed and updated". She considered that the lack of team meetings meant that staff did not receive the relevant information required to support Mr C and supervise and care for him appropriately.

195. I accept Ms Waddell's advice. It was Ms E's responsibility to ensure that she was holding regular team meetings, and that the meetings canvassed the necessary information required to support Mr C and keep him safe. I am critical that despite the mounting evidence of inappropriate behaviour that Mr A was displaying towards Mr C over a sustained period of time, the trend was not identified and discussed at any team meeting. I am also critical that in the period of time leading up to the events of June 2017, only two team meetings had occurred. This would not have been sufficient to communicate and remind staff of the need to supervise the two men, or to discuss incidents in a meaningful way.

Conclusion

196. Ms Waddell concluded that the lack of adequate team supervision and leadership, poor communication practices, and a lack of knowledge by the team at the day programme on the appropriate procedures and reporting requirements following incidents "should all have been addressed by Ms E in her role as manager of the day programme and would be expected as reflecting good management practice … in these positions across this sector".

Ms Waddell concluded that "the departure from accepted practice [was] significant in this case and contributed to an inadequate level of safe care for [Mr C]".

197. I agree. I also note in Ms E's job description that she was responsible for ensuring the delivery of quality services, which included identifying areas of risk and managing them, as well as creating systems and a culture that ensured continuous improvement in service delivery. Specific to vocational services, Ms E was expected to provide leadership in the provision of high quality services, which included ensuring that the service was safe. I do not consider that she fulfilled these responsibilities.

198. In summary, Ms E failed to:

- Respond adequately to the critical events on 9 and 13 June 2017.
- Ensure that her team was supervising Mr A and Mr C adequately at all times.
- Ensure that harm to Mr C was minimised through responding appropriately to the incidents between Mr A and Mr C.
- Identify and address the unsafe culture at the day programme, as well as create a culture focused on harm minimisation and continuous improvement.
- Hold regular team meetings to ensure effective communication to staff about the support Mr C needed to keep him safe.

199. I reiterate that these failures are significant, as they contributed to Mr C being repeatedly exposed to physically and sexually inappropriate behaviour and abuse. For the reasons set out above, I consider that Ms E did not provide services to Mr C with reasonable care and skill, and breached Right 4(1) of the Code. I also find that Ms E did not provide services to Mr C in a manner that minimised potential harm to him, and accordingly that she breached Right 4(4) of the Code.

Open disclosure — breach

200. IDEA Services' Incident Reporting Policy outlines that it is the Service Manager's responsibility to notify the family if an incident is serious or if there is an agreement to call the family after an incident. Ms D — Mr C's welfare guardian — had made it clear from the outset that she wanted to know what was happening with Mr C.

201. Ms D told HDC that as far back as 2016, she asked Ms E for copies of any incident reports concerning Mr C. Ms F was also aware that Ms D had requested a copy of all incident reports in 2017, and that Ms E was tasked with this and was aware of the expectation to notify family following an incident. Ms E stated that she was aware that Ms D had requested a copy of all incident reports involving Mr C, but said that her understanding was that these were to be forward by Ms F.

202. Right 6 of the Code gives all consumers the right to be fully informed — in other words, to receive the information that a reasonable consumer in his or her situation would expect to receive. Consumers have a right to know what has happened to them. In this case, in order

to uphold this right, Mr C's welfare guardian and mother, Ms D, should have been informed of the incidents relating to Mr C.

203. Given that the Incident Reporting Policy states that it is the Service Manager's responsibility to notify the family following an incident, and that Ms E was aware of Ms D's request for all incident reports relating to Mr C, it is highly concerning that none of the nine incidents reported about Mr A and Mr C at the day programme (all involving a form of inappropriate aggressive or sexualised behaviour) caused her to disclose the incidents to Ms D. In my view, Ms E's failure to provide Ms D with incident reports meant that Ms D was not fully informed about the serious and harmful events occurring to Mr C at the day programme. Accordingly, I find that Ms E breached Right 6(1) of the Code.

Opinion: Area Manager Ms F — breach

Introduction

204. As an Area Manager for IDEA Services, Ms F was responsible for ensuring that the services within her designated catchment, including the day programme, were providing a safe service to Mr C. For the reasons set out below, I consider that Ms F failed to minimise the risk of sexual and/or physical abuse for Mr C.

Harm minimisation

205. There were critical failures on the part of Ms F to respond to the concerns raised by Ms D, and to oversee incidents and address Ms E's performance issues appropriately. Ms F's inaction meant that opportunities were missed to minimise harm to Mr C well before the critical events in June 2017.

Response to Ms D's concerns

206. IDEA Services' Complaints Policy required staff to respond to concerns or issues raised by service users or their families at the earliest point. Throughout Ms F's time as the Area Manager, Ms D raised specific concerns about the safety plan in place in relation to Mr A's and Mr C's joint attendance at the day programme. She also raised concerns about not being informed about incidents and inadequate supervision of the two men. Ms D consistently requested incident reports from IDEA Services, and did not receive all of the reports until July 2017. Ms F accepts that she did not action Ms D's concerns, and has "no explanation as to why".

207. My expert advisor, Ms Waddell, stated:

> "Given the history of incidents between the two men, it is surprising there is no evidence of a review of the appropriateness of both men attending the same vocational service. In my view, this would have been expected and in line with the relevant organisational policies and quality measures. This is especially concerning

> after the meetings held with [Ms D] … and the discussions about the number of incidents where both men had been involved."

208. I accept Ms Waddell's advice. It was Ms F's responsibility to ensure that the concerns being raised with her were being addressed adequately. In my view, the failures to respond to Ms D's concerns and to action her requests were missed opportunities to safeguard Mr C from harm. This necessitated effective communication by Ms F to Ms E that incident reports were to be forwarded to Ms D, that the two men were to be supervised adequately, and that there was to be a safety and risk management plan in place and known to staff. Furthermore, as Ms Waddell has highlighted, and as IDEA Services' internal investigation found, there should have been a review of the two men attending the same service. I am very critical of Ms F's failure to give effect to the valid concerns raised by Ms D, which was also inconsistent with IDEA Services' Complaints Policy. I support Ms D in her view that the safety concerns she raised were minimised and ignored.

Oversight of incidents

209. In contravention of the Incident Reporting Policy, Ms F signed off incident reports for the day programme but did not read them. She believed she was signing off only on what she had been advised verbally by Ms E.

210. IDEA Services considered that Ms F should have read the incident reports before signing each one, as the Area Manager fulfils an important quality check on the incident reporting process. IDEA Services told HDC that it considers that by signing the incident reports:

> "[Ms F] was acknowledging that she was aware of what was occurring, has reviewed the situation, and was recording that the risks of each incident were being adequately managed and meeting organisational requirements."

211. Furthermore, incident review meetings were not occurring twice a week, and did not identify or discuss any trends evolving from the reported incidents between Mr A and Mr C. Ms Waddell advised:

> "At [incident review meetings] there were opportunities to initiate reviews that should … have been conducted as trends did emerge for both these service users and interactions reported with each other did show a pattern. This did not occur. The adherence to policy requirements regarding trend analysis and reviews was not apparent to provide sufficient support to [Ms E]."

212. I agree that Ms F played an important quality check on the incident reporting process. Ms F's failure to sign off incident reports appropriately also meant that there were missed opportunities to identify Ms E's poor understanding of the coding and classification of incidents and to correct this.

213. I also accept Ms Waddell's advice that trends did emerge from the incidents involving Mr A and Mr C, and I am critical that these were not explored or acted on at incident review meetings. I am also critical that incident review meetings were not occurring as regularly

as they should have been. In my opinion, Ms F significantly misapplied the requirements set out in the Incident Reporting Policy relating to the sign-off of incidents and incident review meetings. As a result, many opportunities were missed to minimise future harm to Mr C.

Staff performance

214. Ms F had concerns about the operation of the day programme, and was aware of staff disharmony and difficulties with team work at the day programme. She was also aware that regular team meetings were not being held at the day programme, and accepts that it was her responsibility to ensure that they were occurring.

215. Ms Waddell advised that Ms F ought to have followed up with Ms E about the lack of team meetings to determine whether there were any problems with the team, and to work with Ms E to address any problems that were identified. Ms Waddell noted that Ms F also did not share any of her concerns about the day programme during her regular supervision with the General Manager, Ms I. Ms Waddell advised:

> "As the senior manager, [Ms F] needed to take responsibility to address any concerns she had [about] the performance of [Ms E] in her role. Her supervision was not as comprehensive as would be expected when issues with performance presented themselves."

216. I agree. One of Ms E's primary responsibilities as a Service Manager was to ensure the quality of IDEA Services' support services, including identifying risks and managing them, and creating systems and a culture that ensured continuous improvement in service delivery. Therefore, as Ms E's direct line manager, it was Ms F's responsibility to ensure that Ms E was performing her roles and responsibilities adequately. Given the concern that Ms F had about the operation of the day programme, the team work, and the lack of team meetings, I am very concerned that Ms F did not address Ms E's performance issues and take a more proactive approach in addressing the issues at the day programme.

Conclusion

217. Ms Waddell concluded that the deficiencies that occurred in the management of Ms E, and therefore of the day programme, would be considered a significant departure from accepted practice and a contributing factor to the lack of adequate care provided to Mr C. I agree. I also note that Ms F's job description required her to ensure that complaints and incident reporting were managed in accordance with IDEA Services' organisational policies, and to ensure that risks were managed effectively. I do not consider that she fulfilled these responsibilities.

218. In summary, Ms F failed to:

- Address the concerns raised by Ms D and ensure that she received incident reports.
- Sign off incident reports appropriately and hold regular incident review meetings in order to identify trends and take action on them.

- Address the concerns she had about the performance of her direct report, Ms E, and the operation of the day programme.

219. I reiterate that these failures are significant, as they contributed to Mr C being repeatedly exposed to physically and sexually inappropriate behaviour and abuse. For the reasons set out above, I consider that Ms F did not provide services to Mr C with reasonable care and skill, and breached Right 4(1) of the Code. All of the above failures also meant that Ms F did not provide services to Mr C in a manner that minimised the potential harm to him, and therefore I find that Ms F also breached Right 4(4) of the Code.

Open disclosure — breach

220. IDEA Services' Incident Report Policy outlines that it is the Service Manager's responsibility to notify the family if an incident is serious or if there is agreement to call the family after an incident. Ms D is Mr C's welfare guardian, and had made it clear from the outset that she wanted to know what was happening with Mr C.

221. Throughout 2016 and 2017, Ms D asked Ms F for copies of incident reports involving Mr C. Ms F was aware of these requests and advised that Ms E was tasked with this and was aware of the expectation. Ms E confirmed that she was aware of Ms D's request for the incident reports, but said that she understood that these were to be forwarded on by Ms F.

222. Right 6 of the Code gives all consumers the right to be fully informed — in other words, to receive the information that a reasonable consumer in his or her situation would expect to receive. Consumers have a right to know what has happened to them. In this case, in order to uphold this right, Mr C's welfare guardian and mother, Ms D, should have been informed of incidents relating to Mr C.

223. In accordance with organisational policy, I accept that it was Ms E's responsibility to notify Ms D of incidents involving Mr C. However, the repeated requests from Ms D to Ms F for the incident reports clearly meant that she was not receiving them. In these circumstances, it was Ms F's responsibility to action Ms D's request by either providing the incident reports to Ms D herself or ensuring that Ms E was doing this. Ms F's failure to take these steps meant that Ms D was not fully informed about the serious and harmful events occurring to Mr C at the day programme. Accordingly, I find that Ms F breached Right 6(1) of the Code.

Opinion: IDEA Services — breach

Introduction

224. As a provider of disability support services, IDEA Services is responsible for delivering services to its clients in accordance with Ministry of Health guidelines, Health and Disability Sector (Core) Standards, and the Code.

225. The Ministry's Abuse guidelines make it clear that the Ministry and disability support services have a duty of care to ensure that any actions taken, or any failures to take action, do not injure or harm the disabled people they support. The guidelines state that the Ministry, providers, and the disability community must all demonstrate zero tolerance to all forms of abuse. The Ministry expects that disability support services, such as IDEA Services, will do everything it can to apply zero tolerance, and that this approach will be demonstrated through all levels of the organisation.

226. The Health and Disability Sector (Core) Standards (the Sector Standards) clearly set out IDEA Services' responsibility to ensure that consumers receive safe services, and that services are managed in a safe manner and in a safe environment that is appropriate for the needs of the consumer.

227. For the reasons set out below, I consider that IDEA Services did not adhere to the Ministry's Abuse guidelines and the Sector Standards. More importantly, IDEA Services failed its duty of care to Mr C to keep him safe from harm, including physical and/or sexual abuse. I have also found that a number of IDEA Services' staff breached the Code, and ultimately I hold IDEA Services responsible for this.

Harm minimisation

Responses to incidents and concerns

228. There are many instances where the treatment of incidents of abuse of Mr C and concerns raised by Ms D did not reflect "a zero tolerance" approach to abuse, as expected in the Ministry's Abuse guidelines.

229. Between 2015 and 2017, IDEA Services as an organisation recorded and held information that indicated that Mr A was a risk to Mr C, but did not action this information adequately. To summarise:

- Mr A's risk documentation showed that he has a long-standing history of sexually inappropriate behaviour and requires visual contact at all times. Mr C's risk documentation clearly identifies that he is at risk of sexual exploitation. Neither of these risks were reflected adequately in the men's personal or safety plans.
- Mr C began attending the day programme in January 2015. By March 2015, the first known incident between Mr A and Mr C occurred whilst Mr C trialled a residential placement in the same home as Mr A. Mr A was found in Mr C's room attempting to get out his penis. An incident report was completed by staff, but Ms D was not informed about the incident.
- For the two years that followed, Mr A continued to act inappropriately and harmfully towards Mr C. Staff documented this in a further nine incident reports before the critical events occurred, and IDEA Services commenced an investigation.
- Also during this time, Ms D repeatedly raised concerns about Mr C's safety and, at times, specifically in relation to Mr A. These were recorded in meeting minutes but not addressed.

- Team meeting and incident review meeting minutes showed a decline in the frequency of meetings, and a lack of feedback about incidents and discussions about incident trends, but this was not addressed by IDEA Services' Service Manager or Area Manager.

230. The Ministry expects IDEA Services to ensure that its processes for the capture of complaints, incidents, and issues do so in a way that keeps disabled people safe and resolves the complaint or issue. I am critical that, for Mr C, IDEA Services' processes did neither, and he was harmed on numerous occasions.

Policies and procedures

231. Across support worker, Service Manager, and Area Manager levels, there was widespread non-adherence and/or misapplication of the Complaints Policy, Incident Reporting Policy, and Abuse Policy, and therefore the organisation's system for preventing harm and abuse. There was also a widespread lack of understanding about what constituted abuse and inappropriate behaviour.

232. This meant that although IDEA Services had in place a system (its policies and procedures) within which incidents were reported, these incidents did not translate into meaningful learning for staff, nor did they lead to quality improvement of the service being provided to Mr C. To summarise, the missed opportunities to learn and improve quality were:

- Support workers consistently failing to escalate serious incidents to Ms E and complete all necessary parts of the incident report. Incidents were also completed and filed only in Mr A's name, creating a gap in risk management information held about Mr C.
- IDEA Services' internal investigation also found that staff at the day programme showed very poor understanding of organisational reporting requirements for any alleged abuse, and the actions they needed to take.
- Ms E's review of the incident reports and coding and categorisation of the incidents were consistently inappropriate and inadequate. She did not address the issue of staff completing incident reports for Mr A only, nor did she debrief or report back on the incidents to staff or Ms D.
- Ms E failed to hold regular team meetings where incident trends were to be discussed and analysed.
- Ms F consistently failed to read incident reports when signing them off. She also did not hold incident review meetings regularly, and no trends emerging between Mr A and Mr C were identified or discussed.
- Ms F consistently failed to address Ms D's concerns about Mr C's safety, and did not ensure that incident reports were being forwarded on to Ms D despite being asked on numerous occasions.

233. The Ministry's Abuse guidelines expect that IDEA Services will have quality assurance processes in which incident debriefing and feedback lead to quality improvement. This

should include strategies, based on learning from the event, to prevent further incidents. As set out above, IDEA Services' policies and procedures were not being applied in a way that led to learning and quality improvement to the ways in which the day programme could keep Mr C safe. As a result, the same or similar incidents between Mr A and Mr C kept occurring.

234. Furthermore, the widespread non-adherence to these policies suggests that they were not well understood, or implemented and embedded into day-to-day operations effectively. This is not in accordance with Standards 2.2 and 2.3.1 of the Sector Standards. The disconnect between how IDEA Services intended its policies to be applied and what was occurring in practice meant that the same approach to abuse was not reflected across all levels of the organisation, which also contravenes the Ministry's Abuse guidelines.

235. Ms Waddell advised that IDEA Services' policies were "appropriate and comprehensive". However, she identified staff training as an area that should be reviewed. She advised that the management and reporting of incidents indicated that there may be areas where some improvements would be advantageous and provide additional support and guidance to staff.

236. In my opinion, IDEA Services did not train staff adequately on what constituted abuse, inappropriate behaviour, or a critical event. This lack of understanding can be seen in the widespread failure to escalate serious incidents. I am also critical that IDEA Services failed to give effect to the Sector Standards and the Ministry's Abuse guidelines in a number of ways. The significance of these failures is that they allowed the continuation of inappropriate and harmful events occurring to Mr C for a period of two years, culminating in the critical events in June 2017.

Culture

237. The inadequate responses to incidents and concerns, as well as the extensive non-adherence to incident reporting practices by IDEA Services' staff (set out in the above two headings) are also indicative of a concerning culture within the service providing care to Mr C. Further evidence of this poor culture can be seen by the following:

- At the support worker and Service Manager level, instances of inappropriate behaviour and abuse targeted at Mr C were normalised. This is seen in the inadequate responses to the incidents. Staff accepted rather than challenged the incidents that occurred between the two men, and minimised the impact that it could have on Mr C. I have elaborated on this in my opinion about Ms E above.
- At the Area Manager level, there was repetitive inaction to address the concerns Ms D raised about Mr C's safety, and a failure to act on repeated requests for incident reports involving Mr C.

238. IDEA Services told HDC that it did not expect senior management to be aware of the inactions of its Area Manager and Service Manager at the time of the events.

239. The Ministry's Abuse guidelines state that providers such as IDEA Services play a vital role in fostering a positive organisational culture in which disabled people are respected and valued. Such a culture significantly decreases opportunities for abuse to occur. Standard 1.3 of the Sector Standards states that consumers are to be treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. Standard 1.3.7 adds to this by stating that consumers are to be kept safe and not subject to, or at risk of, abuse.

240. In my view, a culture had formed at the day programme where Mr C's safety was not treated as paramount, and all staff did not have a zero tolerance approach to abuse. I do not accept that senior management were not expected to know about the failings at the Service Manager and Area Manager levels. These failings are indicative of staff culture and values, and the Ministry's Abuse guidelines and the Sector Standards clearly state that this is an organisational responsibility. For these reasons, I hold IDEA Services and its senior management team accountable for the poor and unsafe culture identified across support worker, Service Manager, and Area Manager levels.

Conclusion

241. Whilst receiving support from IDEA Services, Mr C was repeatedly subjected to harm, including physical and sexual abuse. Given the systemic level of the deficiencies identified across a number of staff and levels of management, ultimately I hold IDEA Services responsible for these failings and, in particular, the critical events in June 2017.

242. In summary, I also consider that IDEA Services failed to ensure that:

- Its processes that captured complaints, incidents, and issues did so in a way that kept Mr C safe and resolved the concerns being raised.
- Its policies and procedures were applied in a way that led to learning and quality improvement to the ways in which the day programme could keep Mr C safe and prevent the same or similar incidents between Mr A and Mr C reoccurring.
- Its policies and procedures were well understood, and implemented and embedded into day-to-day operations effectively.
- There was no disconnect between how IDEA Services intended its policies to be applied and what was occurring in practice, so that the same approach to abuse was reflected across all levels of the organisation.
- It had a positive organisational culture that treated Mr C's safety as paramount, and that all staff took a zero tolerance approach to abuse. This would have significantly decreased opportunities for abuse to occur.

243. As stated, all of the above failures also contravene the Ministry's Abuse guidelines and the Sector Standards. I also reiterate that these failures are significant, as they contributed to Mr C being repeatedly exposed to physically and sexually inappropriate behaviour and abuse.

244. For the reasons set out above, I consider that IDEA Services did not provide services to Mr C with reasonable care and skill and breached Right 4(1) of the Code. I also find that IDEA Services did not provide services to Mr C in a manner that minimised the potential harm to him, and accordingly that IDEA Services also breached Right 4(4) of the Code.

Open disclosure — breach

245. During Mr C's residential living trial in 2015, Mr A was found in Mr C's room attempting to get out his penis. Ms D was not informed of the incident. Instead, she was told that Mr C could not set boundaries for himself, so Mr A would see that as a "green light" and therefore the trial had to end.

246. From 2015 onwards, Ms D repeatedly requested incident reports from numerous staff at IDEA Services. Ms D is Mr C's welfare guardian, and had made it clear from the outset that she wanted to know what was happening with Mr C. A number of staff, including Ms E and Ms F, were aware of Ms D's requests but failed to action them.

247. IDEA Services Incident Report Policy outlines that it is the Service Manager's responsibility to notify the family if an incident is serious or if there is agreement to call the family after an incident. Ms E consistently failed to adhere to this policy. Furthermore, Ms F also consistently failed to action this request or follow up with Ms E, despite repeated requests from Ms D.

248. Right 6 of the Code gives all consumers the right to be fully informed — in other words, to receive the information that a reasonable consumer in his or her situation would expect to receive. Consumers have a right to know what has happened to them. In this case, in order to uphold this right, Mr C's welfare guardian and mother, Ms D, should have been informed of incidents relating to Mr C.

249. I am very critical that Ms D was not fully informed about the incident that occurred during Mr C's residential trial in 2015. The information that Ms D recollects was provided to her following this event was wholly inadequate, and framed Mr C as the problem rather than the victim. If this was the information provided to Ms D in 2015, this is very concerning.

250. Furthermore, in light of the sustained failures of IDEA Services staff over a significant period of time to provide Ms D with incident reports when she requested them, ultimately I hold IDEA Services responsible for these failures. I note that the failures contravene Standard 2.4 of the Sector Standards, which state that all adverse, unplanned, or untoward events are to be reported to affected consumers and their family in an open manner.

251. In my view, IDEA Services' failure to provide Ms D with incident reports meant that Ms D was not fully informed about serious and harmful events that occurred to Mr C from 2015 to 2017. Accordingly, I find that IDEA Services breached Right 6(1) of the Code.

Recommendations

252. I recommend that Ms E provide Ms D with a formal written letter of apology for the failings and breaches of the Code identified in this report. The apology should include a personal reflection on the events, and the improvements she has implemented in her current role if it is in the health and disability sector. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms D.

253. In response to my provisional decision, Ms F provided HDC with a formal written letter of apology. As such, I have no further recommendations with respect to Ms F.

254. I recommend that IDEA Services Limited:

a) Provide Ms D with a formal written letter of apology for the failings identified and its breaches of the Code. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms D.

b) Provide HDC with a detailed update on the progress and effectiveness of its quality and safety improvement initiatives, as well as the work programmes flowing from the recommendations of the National Quality and Safety Review carried out in 2018, within three weeks of the date of this report.

c) Report back to HDC, within three weeks of the date of this report, on the implementation of its electronic incident reporting system, and advise how the system addresses the failures identified in this report — in particular, whether the system:

(i) ensures that incidents are reported for all service users involved;

(ii) can identify trends for individuals as well as between individuals; and

(iii) can be accessed by all levels of management.

Where the incident reporting system is unable to address any of the above, IDEA Services is to advise HDC of how it is ensuring that these issues are being addressed.

d) Obtain independent advice to consider what current processes are in place and what further improvements can be implemented to ensure that the content and frequency of team meetings and incident review meetings are adequate. IDEA Services should report back to HDC on this within four months of the date of this report.

e) Obtain independent advice to consider what current processes are in place and what further improvements can be implemented to ensure that requests and concerns from a service user or the service user's family are recorded, tracked, and actioned. IDEA Services should report back to HDC on this within four months of the date of this report.

f) Obtain independent advice to consider what current processes are in place and what further improvements can be implemented to foster a positive organisational culture

focussed on continuous improvement and a zero tolerance approach to abuse. IDEA Services should report back to HDC on this within four months of the date of this report.

g) Randomly audit, over a period of three months, 50% or 100 incident reports (whichever is less) from vocational and residential services in the region for adherence to IDEA Services' Complaints Policy, Incident Reporting Policy, and Abuse Policy at support worker, Service Manager, and Area Manager levels. The audit should also consider the Ministry of Health's *Prevention and Management of Abuse* guidelines and, in particular, the focus on service culture and values. IDEA Services should provide HDC with the outcome of this audit within six months of the date of this report. Where the results do not reflect 100% compliance, IDEA Services should consider and advise HDC on what further improvements could be made to ensure compliance.

h) Provide refresher training on the prevention and management of abuse, as well as on incident reporting, for all IDEA Services staff (including managers) who have not received this training in the past two years. IDEA Services should provide HDC with evidence that this training has been completed within six months of the date of this report. This investigation should be used as an anonymous case study during the training sessions.

i) Provide refresher training to all IDEA Services' managers on leadership and promoting positive organisational culture, within six months of the date of this report.

255. I recommend that the Ministry of Health and the Ministry of Social Development update me on the steps they have taken to ensure a zero tolerance approach to abuse within the disability support services they fund, and, in particular, in response to the two critical events relating to this investigation, as reported to the Ministries by IDEA Services on 14 June 2017. I will also write to the Ministry of Social Development to ask that it endorse the application of the Ministry of Health's *Prevention and Management of Abuse* guidelines in vocational services it funds for people with disabilities.

Follow-up actions

256. IDEA Services will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

257. A copy of this report with details identifying the parties removed, except the expert who advised on this case and IDEA Services, will be sent to the Ministry of Health, the Ministry of Social Development, the Office for Disability Issues, People First New Zealand, and the relevant district health board. The district health board will be advised of the names of Ms F and Ms E.

258. A copy of this report with details identifying the parties removed, except the expert who advised on this case and IDEA Services, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Summary of incident reports (IR)

Date	Incident	Immediate actions taken (by staff)	Comment on cause (by staff)	Immediate actions taken (by SM[12])	Impact/ Incident code (by SM)	Key findings (by SM approved by AM[13])	IR completed for
25/3/15[14]	[Mr C] was "led on his bed and [Mr A] followed [Mr C] to his room and appeared to stand over [Mr C] and attempted to get his penis out".	Completed incident report.	"Don't know."	Section left blank.	Medium/Criminal behaviour "Inappropriate sexual behaviour".	"[Mr A] displayed inappropriate sexual behaviour. Staff redirected him."	[Mr A] only.
16/03/15	[Mr C] with his hand over his private parts. [Mr A] with his hand on [Mr C's] leg. [Mr C] stated that [Mr A] was "playing with his balls".	Spoke to [Ms E] and completed Incident Report	"Not witnessed but likely given [Mr C's] reaction."	Section left blank.	Low/Behaviour other "Nuisance behaviour".	"Staff to discuss incident at [Mr A's] next mental health team visit on 18 March."	[Mr A] only.
11/05/15	[Mr A] was reported by another service user to be "playing with [Mr C's] zip on his jeans (private areas)".	Completed incident report.	"[Mr A] has a history with [Mr C] — can act inappropriately with [Mr C]".	Section left blank.	Low/Behaviour other "Nuisance behaviour".	"Incident was not seen by staff by this behaviour has happened before …" "Staff to monitor [Mr A] when at the day programme."	[Mr A] only.
04/04/16 10.45am	[Mr A] found leaving the toilet that [Mr C] was also occupying.	Completed incident report.	"Unsure what was going on … other staff	Section left blank.	Low/Behaviour other "Nuisance behaviour".	"Staff are to monitor when [Mr A] at [the day programme]. Spoke to [Mr	[Mr A] only.

[12] Service Manager.
[13] Area Manager.
[14] This incident occurred during Mr C's residential living trial (not the day programme) and involved a different staff member and Service Manager to those at the day programme.

			unaware of situation at the time."			C's] mum … Unsure if any incident took place."	
04/04/16 11.20am	[Mr A] approached [Mr C] and began thrusting his pelvic area towards [Mr C].	Completed incident report.	Section left blank.	Section left blank.	Low/ Behaviour other "Screaming or yelling".	Earlier incident noted. "Stereotyped behaviour" for [Mr A]. Staff to monitor when [Mr A] is at [the day programme].	[Mr A] only.
13/10/16 9am	[Mr A] approached [Mr C] and began jabbing and provoking [Mr C].	Completed incident report.	Section left blank.	Section left blank.	Low/Physical Aggression "Service user to service user"	"[Mr A] seemed unwell … taken home as a precaution … Not usually issues between [Mr C] and [Mr A]."	[Mr A] only.
13/10/16 10am	[Mr A] blocked [Mr C] from coming out of the toilet. He pushed [Mr C] and said "you want to fight?"	Completed incident report.	"[Mr A] been targeting [Mr C] today."	Section left blank.	Low/Behaviour other "Nuisance behaviour".	Earlier incident noted.	[Mr A] only.
17/10/16	[Mr A] acting in a sexualised manner — rubbing a ball against his crotch, dancing in a suggestive manner and trying to touch [Mr C].	Completed incident report.	Section left blank.	Section left blank.	Low/Behaviour other "Changes in usual pattern or Response".	"Changes in behaviour. Concern around his mental health."	[Mr A] only.
28/11/16	[Mr A] and [Mr C] were punching each other. [Mr A] noted to be making a lot of sexual comments.	Completed incident report.	Section left blank.	Section left blank.	Medium/Physical Aggression "Service user to service user".	[Mr C] "has been winding everyone up" and [Mr A] "also heightened in last 2 weeks". "Redirected by staff. [Mr A] has had an increase in inappropriate sexual	[Mr A] only.

						behaviour. Discuss with [residential] SM re PRN[15] for [Mr A]."	
16/03/17	[Mr A] standing over [Mr C] whilst [Mr C] was sitting on the toilet. Other staff were unaware and busy.	Completed incident report.	Section left blank.	Section left blank.	Low/Behaviour other "Nuisance behaviour".	[Mr A] "has a history with [Mr C]. Seems to have an attraction towards him. Staff to monitor [Mr A] if they are aware that [Mr C] in toilet."	[Mr A] only.
09/06/17	[Mr A] had walked into toilet that [Mr C] was already occupying. [Mr C] found with his pants down about to pass urine and [Mr A] was touching [Mr C's] penis.	Completed incident report.	"Do not know."	Critical event/ Notification of parents, policy and investigator.	Initially, Medium/ Behaviour other "Stereotyped behaviour" but crossed out and replaced with High/Critical event "Other".	[Mr A] and [Mr C] "have in the past had issues around touching when they were both at [residential service] … No other staff to assist … Staff to closely monitor both men … Discussed with [Residential Service Manager]."	[Mr A] only and critical incident report form completed for [Mr C].
13/06/17	[Mr C] heard yelling for help from bathroom. [Mr A] discovered standing over [Mr C] whilst he was sitting on the toilet. [Mr A] had his pants down.	Contact [Ms E].	"Unknown."	Section left blank.	High/Critical event "Major near miss (High impact)".	Second event of similar nature within short period of time. Requires high level investigation and critical event notification.	[Mr A] and critical incident report form completed for [Mr C].

[15] Pro re nata — as needed.

Appendix B: Summary of concerns raised by [Ms D]

Date	[Ms D's] request/concern	IDEA Services' response
April/May 2015	Following the incident [during the residential trial] on 25 March 2015 between [Mr A] and [Mr C], [Ms D] questioned [Mr C's] safety at the day programme with [Mr A].	[Ms D] was assured that a safety plan was in place at the day programme and staffing levels enabled supervision and separation of the two men.
July 2016	[Ms D] became increasingly concerned about [Mr C] as he frequently stated he was scared to go to the day programme. [Ms D] asked [Ms E] for copies of any incident reports concerning [Mr C].	[Ms D] reported that she did not receive any incident report. In IDEA Services' internal investigation it found that [Ms D's] requests had "not been fully met".
October 2016	[Ms D] attended a meeting with [Ms F] and [the residential service manager]. [Ms D] told HDC that she asked for copies of incident reports involving [Mr C].	[Ms D] advised that she did not receive any incident reports.
November 2016	[Ms D] spoke on the phone with [the residential service manager] and requested a copy of all incident forms held by IDEA Services involving [Mr C].	[Ms D] advised that she did not receive any incident reports.
January 2017	[Ms D] had another meeting with [Ms F] and [the residential service manager] where she raised concerns about staffing, communication issues, and being informed of incident reports. She asked for copies of incident reports involving [Mr C]. She also asked for [Mr C's] safety plans and support plans.	It was agreed that [Ms D] and [Ms F] would meet again in a month's time to allow [Ms F] time to look further into these matters.
February 2017	Follow-up meeting with [Ms F]. [Ms D] requested incident reports involving [Mr C].	The following day, [Ms D] received one incident report involving a broken blind at the day programme.
May 2017	[Ms D] met with [Ms F] and raised concerns about [Mr C] being left unsupervised with [Mr A]. [Ms D] requested copies of [Mr C's] personal and safety plans.	[Ms F] assured [Ms D] that [Mr C] was safe. [Ms D] received [Mr C's] Personal Support Information and Alerts and Crisis documents a few days later; however, [Ms D] noted that some of this information was outdated.

Appendix C: Independent advice to the Commissioner

The following expert advice was obtained from Sandie Waddell:

"**REPORT PREPARED FOR THE HEALTH AND DISABILITY COMMISSIONER**:

REF: C17HDC01082
Report prepared by:
Sandie Waddell MNZM.
PG Dip.HSM,
NZOQ Cert QS

I have been asked to provide an opinion to the Commissioner on case number C17HDC01082.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and Experience Relevant to the Review:

I have a Post Graduate Diploma in Health Service Management and a Certificate in Quality Systems and Auditing Principles. I have worked in the Health and Disability sector for 30 years and have held senior management roles in community organisations, the Ministry of Health and ACC. I was the CEO of the New Zealand Disability Support Provider Network and am currently working as a lead auditor of Health and Disability Services nationwide. This includes auditing the development and implementation of policies, procedures and guidelines for compliance with the New Zealand Health and Disability Services Standards NZS 8134:2008 (the Standards).

Also a part of the audit process I am also involved in reviewing organisational policies and procedures, service planning, assessment and delivery and the evaluation of effectiveness of outcomes for clients.

I also conduct assessments of business and community organisations' responsiveness to accessibility and the needs of people with impairment and provide advice on how this can be improved. In addition I facilitate workshops with staff on working with people with diverse needs.

The Commissioner has asked that I:

Provide independent expert advice on care provided to [Mr C] by the following parties: [Ms E], [Ms F] and IDEA Services Limited and if this was reasonable in the circumstances, and why.

Background:

[Mr C], 23 years old at the time of the two incidents, attended [the day programme] five times a week. [Mr C] has an intellectual disability and Autism Spectrum Disorder. He has been assessed as vulnerable and may succumb to persuasion.

[Mr A], 37 years old at the time of these events, attended the day programme three times a week. He has an intellectual disability and a mental health disorder. He has been identified as making inappropriate sexual behaviours toward others. Both men require supervision at all times and should not be left alone.

On 20 June 2017, this Office received a complaint from [Ms D] about the management of two incidents of alleged sexual assault on [Mr C] and [Mr A] at [the day programme] on 9 June 2017 and 13 June 2017.

However a review of this case showed that, as far back as 2015, [Mr A's] records documented numerous other incidents where he has appeared to focus on [Mr C] in an inappropriate way. However, none of these incidents led to any pathways of escalation or a systematic review of the two men attending the same vocational service.

The following Documents were provided to inform the review:

1. Letter of complaint, including a letter from HDC outlining the scope of the investigation.
2. [Mr C's] personal profile including safety plans.
3. IDEA Services Limited's response dated 25 July 2017.
4. IDEA Services Limited's further response dated 16 August 2017 including an internal investigation report dated 31 July 2017.
5. [Ms E's] response … including her resignation …
6. [Ms F's] response … including her resignation …
7. Separate response from IDEA Services Limited support workers received 8 November 2017.
8. IDEA Services Limited's further response dated 10 November 2017.
9. [Mr C's] Incident reports covering the period of 2015 to 2017.
10. Team, Incident Management Review and Area Management meeting notes.
11. IDEA Services Limited's policies and procedures.
12. Relevant Job Descriptions

Also used for reference purposes:
NZS8134:2008 Health and Disability Services Core Standards

QUESTION 1:

The appropriateness of the care provided by [Ms E] to [Mr C], including the adequacy of steps taken by [Ms E] following the reporting of incidents between [Mr C] and [Mr A].

[Ms E] was employed as the service manager at [the vocational service, day programme] where the incidents took place.

The Service Manager (SM) role has clear key result areas (KRAs) defined in the relevant position description. Most relevant in considering the appropriateness of care in this case, are concerning the provision of leadership in the delivery of vocational services that are consistent with the organisational philosophy and applicable national standards. In addition to this is also that areas of risk are identified and managed, people receive safe and reasonable services with a minimisation of any harm and that the services provided are safe.

A number of issues have been identified in the documentation reviewed referring to the handling of these incidents by IDEA Services in their internal investigation, [day programme] staff responses to the initial investigation report and both the area manager's and [Ms E's] responses.

An underlying concern that is apparent across all the information made available around the complaint, is the apparent dysfunctional relationships between the core staff at [the day programme] and casual staff employed to fill in when core staff are absent and between the staff and [Ms E] in her role as service manager. Also the relationship between [Ms E] and the area manager (AM) to whom she reported could not be considered to be one that should be expected in a well-functioning team.

The resulting performance of all those immediately involved was compromised, in my view, by the lack of clear and regular communication, inadequate supervision of direct reports, and non-adherence to organisational policy and procedure.

The specific issues that, in my opinion, contributed to the lack of appropriate care both in the previous incidents reported involving [Mr C] and [Mr A], and in the incidents occurring on 9 and 13 June 2017 are:

1. Issues and tensions occurring both between core staff and also with casual staff themselves. These would certainly be distracting influence from consistent team performance by all staff at the day programme.

2. Information available on the files of both service users that was not used to guide staff in providing safe care. Clear alerts on file for [Mr C] updated in March 2017 indicated he needed constant supervision. On 16/03/17 an entry on his notes stated 'Monitor [Mr A] if [Mr C] goes to toilet'. Also in 2016 it was identified he was at risk of exploitation [...] It appears that casual relief staff were not all aware of the specific supervision requirements for these men and of the need to keep both service users within eyesight at all times.

3. Correct procedures were not followed after the first incident on 9 June 2017. The SM was not aware of the first incident until the morning of the second incident due to the fact staff had not sent the courier bag containing the incident report on the day of the first incident as was required. Staff had not phoned the SM to report the incident, as is also required as per the organisational incident reporting and response policy and procedures. Other

staff, including those working at the day programme at the time and both men's residential houses were also not made aware of the incident.

4. Once [Ms E] received the first report, it was put aside for a meeting later in the morning. No notification to either the AM or the family was made at this point. This was despite a previous agreement made with [Ms D] around the reporting of any incidents.

5. It appears the first incident report has had a number of changes made to upgrade its urgency and its actual classification which suggests staff were not clear and experienced some confusion about the meaning of the different classifications and subsequent impact levels of an incident of this type. In this case this is a significant contributing factor to the subsequent lack of an appropriate immediate response, in my view, as it could be argued that if the incident had been reported with regard given to previous history of events first by [Mr A] and also between the two men, it would have triggered a more urgent response.

6. An immediate notification was not made by the SM to the AM which could also be seen as not making an appropriate judgement as to the seriousness of such an incident. It is noted [Ms E] did go to [the day programme] immediately following notification of 2nd incident and implemented safety procedures for the service users, so this demonstrated she was aware of process around reporting of incidents where there has been reports of abuse.

It is my opinion that all these issues compromised an appropriate level of the care provided by [Ms E] to [Mr C], both prior to this incident and subsequently following the first incident. The responses by [Ms E] and her team did not reflect the standard that would be considered acceptable in the sector. This resulted from a lack of adequate team supervision and leadership, poor communication practices and an apparent lack of knowledge by the team involved at [the day programme] on the appropriate procedures and reporting requirements following an incident of this nature. These should all have been addressed by [Ms E] in her role as manager of [the day programme] and would be expected as reflecting good management practice by managers in these positions across this sector. She did acknowledge this and takes some responsibility for her actions at the time in her statement to the Commission.

The departure from accepted practice, in my view and I believe would also be that of my peers, is significant in this case and contributed to an inadequate level of safe care for [Mr C].

QUESTION 2:

The appropriateness of the care provided by [Ms F] to [Mr C], including the adequacy of steps taken by [Ms F] following the reporting of incidents between [Mr C] and [Mr A].

[Ms F] was in the role of Area Manager at the time of the incidents and had been in the sector in management roles for four years.

Her job description required that she maintain good employer practices and provide leadership and direction with a KRA to lead, manage and develop staff.

There are a number of issues that contributed to [Ms F's] responses prior to and following her learning of the incidents.

1. The relationship between [Ms F] and [Ms E] is reported by both parties in the documentation reviewed, as not an easy one. Both had concerns about a range of issues that, in my view, were not addressed well by either party. However as the senior manager [Ms F] needed to take responsibility to address any concerns she had concerning the performance of [Ms E] in her role. Her supervision was not as comprehensive as would be expected when issues with the performance presented themselves as she has reported. It does appear from the documentation provided, that [Ms E] was not at all times totally honest and open with [Ms F] and this did contribute to the lack of understanding by [Ms F] of the ongoing issues with the two men.

2. [Ms F] had a number of meetings with [Mr C's] mother, [Ms D], in 2017 prior to the incidents referred to in the complaint. At a meeting in early 2017, the issue of incident reports and family notifications was discussed and a request was made that all incidents be notified to the family. This was passed onto the relevant SM for action. This was not followed up with [Ms E] and her team to ensure this indeed occurred.

3. Another documented meeting with [Ms D] held on 19/5/17, records a number of concerns expressed by [Ms D] with a request to develop a 'list' of risk management strategies in [the day programme] to support [Mr C's] safety. This was particularly pertinent because of previous issues between [Mr C] and [Mr A] while he was attending the vocational programme. [Ms F] gave assurances that there was a risk management and safety plan in place for both service users. A number of incidents were discussed including one with [Mr C] being 'hit' by [Mr A]. [Ms D] was given assurance they would not be left together alone. This assurance does also not appear to have been acted upon by [Ms F].

4. Given the history of incidents between the two men, it is surprising there is no evidence of a review of the appropriateness of both men attending the same vocational service. In my view this would have been expected and in line with the relevant organizational policies and quality measures. This is especially concerning after the meetings held with [Ms D] during that year and the discussions about the number of incidents where both men had been involved. The weekly incident reporting meetings held with the managers did not identify a specific need for this as required in procedural process where a trend has been identified. There appeared to be enough information recorded over time for this to have become a concern. Again this was not actioned.

5. [Ms F] was aware of the lack of meetings being held as scheduled at [the day programme] with the SM and her staff. No appropriate follow up occurred to

determine if there were indeed any problems within the team and to work with the SM to address these if any were subsequently identified. She also did not share any of her concerns during her regular supervision with her own General Manager.

6. Once [Ms F] learnt of the incidents of 9 and 13 June 2017 involving [Mr C], her responses were immediate and appropriate.

7. One of the concerns raised by [Ms F] in her response to the Deputy Commissioner, which has relevance here, is that the current practice in the organisation is that any incident is only recorded against one of the people involved rather than both if two people are involved. It could be argued, in my view that this did contribute to [Ms F] not getting a clear picture of all the incidents involving both the two men.

It is my opinion that the communication processes and relationship difficulties between [Ms F] and [Ms E] contributed to a lack of appropriate care to [Mr C], which [Ms F] had the responsibility to address as the senior manager. This did not reflect sufficient adherence to acceptable management practice for a senior role such as this.

However the response from [Ms F] as soon as she was made aware of the incidents was swift and followed proper process. She did acknowledge her shortfalls throughout the process in her statements following the incidents. Therefore the view I believe that would be taken by my peers in the sector, would be that the deficiencies occurring in the management of [Ms E] would be a significant departure from accepted practice and a contributing factor to the lack of adequate care provided to [Mr C]. The subsequent actions from [Ms F] following the receipt of the incident notifications was appropriate and in line with the expected response from a senior manager.

Recommendations for improvement to policies and procedures for the organisation to consider to support managers in these roles will be addressed in question 6.

QUESTION 3:

The appropriateness of the support [Ms E] as Service Manager, provided her staff to manage the incidents between [Mr C] and [Mr A].

From the documentation reviewed and referred to in the previous questions, it is clear that the lack of effective leadership, communication and supervision of staff at [the day programme] by [Ms E] as the SM prior to the incidents, was a crucial factor in the lack of appropriate responses in the management of the incidents.

This is demonstrated by:

1. The lack of regular team meetings, especially during the period leading up to the incidents. Good communication is essential in ensuring all staff are aware of all the necessary supervision requirements for service users. All incidents that have occurred and any trends noted need to be clearly communicated and understood. All staff roles and responsibilities, including coding and

processes around the reporting of incidents, need also to be clearly understood. It is accepted practice that team meetings are a time where any concerns are discussed, any new processes are introduced and ways of working together positively and cohesively are embedded.

2. It is noted in the responses from the team members to the initial internal investigation that team meetings were not regular and this was becoming a real issue for the team. The minutes reviewed showed this had been concerning for the team over the previous year but had got worse in the early stages of 2017. A meeting held in early April was the last one recorded as occurring until 27 June 2017. A number had been scheduled but a handwritten note recorded on, what appeared to be meeting notes, read 'did not occur'. According to an IDEA Services' response to that internal investigation, these were required as regular fortnightly meetings. This was the time to be allocated where service users' needs/risks/management plans were all discussed and updated. That these did not occur compromised the support needed by the team members to have the relevant information required to provide appropriate supervision and care for the service users.

3. [Ms E] did not appear to have a good understanding of the required coding for incident reporting nor the levels at which incidents become serious enough to be escalated. This is demonstrated in the changes made to the first incident report from the June 9 incident. Subsequently actions by her team also reflected this lack of knowledge.

4. The minutes from a L 4 meeting on 25 May 2017 did note a discussion around a 'lack of follow up on incident reports' in the Health and Safety section. The fact that procedures following incidents had been identified in previous group meetings, indicated this was an issue that appears not to have been addressed prior to the June incidents. This is further evidenced by the subsequent responses to the incidents.

5. The staff roles, responsibilities and workloads in the team were reported by staff as being unclear. This is further confirmed when not all staff were informed at [the day programme] or at [Mr C's] residential home about the initial incident on June 9. It was also not noted in his diary.

6. There was no apparent specific instructions and support given to the team from [Ms E] prior to, and on the days of, the incidents regarding the staff roles and the ongoing need for adequate supervision of individuals attending the service as per risk plans and identified issues.

7. Staff also seemed unaware of the need to inform her of incidents such as the one that occurred on 9 June as soon as possible. It is also unclear if staff were aware of the need to communicate incidents to all staff on duty at [the day programme] to ensure adequate supervision and support was provided. Communication generally about the incident report to SM was confused and the required processes in an incident of this nature were obviously not well understood.

Support by [Ms E] to her team to manage the incidents, was not available to the team at the time. This was, in my opinion, due to a general lack of understanding amongst them on what to do, how to report effectively in a timely way and what responses were appropriate with this type of incident. This support was again compromised, in my view, by lack of sound management processes being in place at the time. I would consider this opinion would be shared by my colleagues who are working in similar organisations with similar service users.

Once the incident was identified as a critical one, the response was appropriate and followed the required organisational procedure.

QUESTION 4:

The appropriateness of the support [Ms F] as Area Manager, provided to [Ms E] to manage the incidents between [Mr C] and [Mr A].

A number of issues raised in Question 2 are also relevant here.

The support able to be provided by [Ms F] to [Ms E] to manage the incidents was affected by the fact that [Ms F] was not informed of either of the incidents until later on the morning of the second incident. Once she had been informed she immediately took over the process and informed the family, her General Manager and the Police.

However, regarding the incidents that had occurred in the past, on her own acknowledgement, there had been a lack of meaningful communication around those historical incidents. At Area Incident Management team meetings, there were opportunities to initiate reviews that should, in my view, have been conducted as trends did emerge for both these service users and interactions reported with each other did show a pattern. This did not occur. The adherence to policy requirements regarding trend analysis and reviews was not apparent to provide sufficient support to [Ms E]. In addition there was also no appropriate follow up on issues that had been noted in the L4 meetings around general incident follow up. [Ms F] did not follow up documentation that was overdue and all these actions will have been a contributory factor in the lack of cohesive approaches from all staff in the reporting process for the incidents under investigation.

On reflection of the issues, [Ms F] stated she did rely on assurances from the SM that there were no ongoing issues at [the day programme]. This could certainly be viewed as usual informal practice where a relationship between management and direct reports is one of mutual respect and professional regard. In this case this was not the reality.

This would generally be viewed across the sector as inadequate supervision and management practice. This would be considered, in my opinion, a moderate departure from an acceptable level of practice. I believe this view would be supported by health professionals and other service providers in management roles supporting similar groups of clients.

QUESTION 5:
The adequacy of IDEA Services Limited's policies, procedures and systems to manage incidents of this nature, including how well they support staff to provide appropriate care to [Mr C].

Please specifically discuss the adequacy of IDEA Services Limited's incident reporting system.

The Health and Disability Services Core Standards (2008) require:

1.1.3.7 Consumers are kept safe and are not subjected to, or at risk, of, abuse and/or neglect.

1.2.4.3 The service provider documents adverse, unplanned or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

The Health and Disability Services Standards also require regular review of all policies and procedures to ensure they are aligned with current good practice and service delivery.

A number of IDEA Services Limited policy and procedural documents were able to be reviewed in the documentation provided.

The incident reporting policy and procedures cover all the requirements of the legislation. The processes are clearly documented and roles and actions defined for the relevant staff and management.

The systems in place, would in my view, be seen as adequate and address the needs for both the clients and staff. It states it is compulsory for staff to immediately inform their senior manager of any suspected or reports of abuse and a process is outlined that is required to be followed. A procedural flow chart is included.

In addition the requirement is that all incidents are discussed at staff meetings and management team meetings will include any high and medium impact incidents and relevant trends are required to be identified.

The policy needs to be considered alongside the Protection and Vulnerable Adults policy to further inform the managers and staff. Also relevant is the Relationships and Sexuality policy and the Abuse policy which details risk management plans to be put in place for service users who may have challenging sexual behaviours and/or are at risk of abuse.

These documents are all aligned to those accepted in the sector as appropriate and comprehensive. The policies are all current and are reviewed regularly by senior staff.

In my view the current policies, procedures and systems are adequate to manage incidents of this nature and do provide sufficient guidance for staff. I believe my peers in the sector in general would support this view that the relevant set of policy documents provided are appropriate for organisations delivering the type of services

IDEA Services Limited are involved in.

The management of these incidents has indicated there may be areas where some improvements would be advantageous to providing additional support and guidance for staff.

These are:

1. The AM suggested in her response to the Commissioner that she felt the reporting system was 'clumsy'. A review of that in light of the incidents would be prudent.

2. Another comment noted that the incident reporting system has no set process to put in an incident report for both service users — only against the main perpetrator. This was reported by IDEA Services as being 'expected' but it is not clearly documented nor understood.

3. There is also an apparent confusion and a lack of clarity about the coding and classification system among staff at [the day programme]. This may be an isolated concern at this site which needs to be addressed. However it may also be reflective of an issue across the organisation and may need reviewing in the context of the training programmes.

QUESTION 6:

The adequacy of IDEA Services' internal investigation and the appropriateness of the conclusions reached in that report.

The internal investigation was carried out by an experienced senior staff member.

As is usual practice the review included organisational documentation, interviews with the complainant, key staff and other relevant staff.

The report looked at relevant policies and procedures, staff practice, support both for service users and relevant staff. A draft report was shared with relevant parties to review and provide feedback which was then considered and included as appropriate before the report was finalised.

It is my view the investigation did not avoid addressing or reporting any activity that occurred that may have been outside the organisational requirements or any issues surrounding staff management or behaviour that may have impacted negatively on the outcomes. It certainly appeared as a 'warts and all' report that reported all the details of the case discovered in a comprehensive and balanced way.

The organisation has uncovered some shortcomings and made no effort to conceal the fact that they believed the incidents were avoidable and were completely a fault of the organisation. They are clear they would be using the investigation as an opportunity to improve the quality of their service delivery to their service users. It is noted they also plan to implement a number of changes across the board to try and ensure that this sort of incident was not able to happen again.

I note in the IDEA Services' response of 10 November 2017 to the Deputy Commissioner, a number of strategies have already been put in place for additional managerial oversight at [the day programme], management training tools and a number of management forums alongside an independent review of some of the regional services including [this one]. Other changes in response to these incidents are also planned.

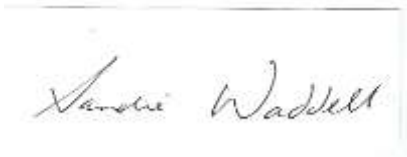
In my opinion the investigation and the conclusions was comprehensive, open and appropriate for the situation. I also consider the recommendations made were a fair reflection of the findings. I believe this opinion would be shared by my colleagues in the wider sector.

QUESTION 7:

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

Staff training: In the staff responses to the investigation report, it is noted that staff were unsure if they had had any recent training on sexuality, abuse and indeed on the incident reporting process. I would recommend that the training programme for the staff at [the day programme] be reviewed to ensure attendance at all training provided has been regular. It may also be appropriate to look across the wider organisation to ensure all staff have attended regular training to further embed the understanding and procedural requirements around incident reporting, abuse and protection issues for this vulnerable group of service users as well as all other core training requirements for staff working to the Health and Disability Services Standards.

I consider all other relevant matters have been addressed.



Sandie Waddell"