Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC02152)

Introduction

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

2. The report discusses the care provided to Mr B by Enrich+ Trust (Enrich), a charitable organisation that provides support programmes for disabled people to help them develop their skills and abilities and enhance inclusion in the communities of their choice.

3. Mr B (aged in his thirties at the time of the events) is non-verbal and has limited vision and epilepsy.[1] Mr B receives residential support from a residential service. Since 2010, Mr B has attended Enrich regularly for disability support services. At the time of the events, Mr B attended Enrich for an activities programme six times per week.

4. On 25 July 2022, while at Enrich, a support worker restrained Mr B physically. The support worker pulled Mr B's sleeves over his hands and tied knots in them, so that Mr B was unable to use his hands or free himself from the restraint. A staff member from the residential

[1] A brain condition that causes recurring seizures.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

service was contacted to collect Mr B. When the staff member from the residential service arrived, Mr B was lying face down on a sofa bed, with the restraint continuing.

5. The following issues were identified for investigation:

- *Whether Enrich+ Trust provided Mr B with an appropriate standard of care in July and August 2022.*
- *Whether Ms C provided Mr B with an appropriate standard of care on 25 July 2022.*
- *Whether Mr D provided Mr B with an appropriate standard of care on 25 July 2022.*
- *Whether Ms E provided Mr B with an appropriate standard of care in July and August 2022.*

6. The following parties were directly involved in the investigation:

Mr B	Consumer
Ms A	Complainant/consumer's sister and welfare guardian
Enrich+ Trust	Provider
Ms C	Provider/support worker
Mr D	Provider/support worker
Ms E	Provider/Service Lead at Enrich
Ms F	Provider/support worker

7. Also mentioned in this report:

Ms G	Service Manager, residential service
Ms H	Behavioural Specialist

8. Further information was received from the residential service.

How matter arose

Behaviour support plan

9. Mr B's behaviour support plan was developed by Enrich in conjunction with the residential service. The plan was last reviewed on 1 September 2021. It notes that Mr B communicates by using his hands and body language, and that he understands 'basic commands in Māori and English'.

10. The plan identifies Mr B's risk behaviours as 'pinching', 'punching others', and 'kicking'. His anxiety behaviours are listed as 'vocal, grabbing, standing up', and his defensive behaviours as 'self harming, pinching'.

11. The plan lists the following strategies to be used by staff:

(i) 'Tension Reduction: Hands in his mouth, sleeping, quiet'

(ii) 'Supportive: Redirect, music, give him space'

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(iii) 'Directive: Redirect, Isolate'

(iv) 'Physical intervention: Isolate'

(v) 'Therapeutic Rapport: Reassure him, Offer a quiet place'

12. Under 'Other Support Considerations', the plan notes that some causes of Mr B's anxiety are: 'may need a [bowel movement]', 'working up to a seizure', and 'too loud'. The coping strategies are listed as 'redirect and isolate'. The plan also notes that during behaviours, Mr B's 'conflict can be with anyone'.

13. Enrich's Safe Practice Policy states that any behaviour support plan containing the use of restraint must be approved by the Safe Practice Team. Enrich's incident reporting system identifies 'Restraint' as an example of a 'physical intervention'. It is categorised as follows:

> 'Personal: support worker physically holding a client
>
> Physical: the use of equipment (mechanical restraints) and furniture
>
> Environmental: this form of restraint can range from a contained environment through to planned interventions that reduce the level of social contacts and/or environmental stimulation.'

14. Although Mr B's behaviour support plan refers to 'physical intervention: isolate', Enrich told HDC that Mr B did not have any approved restraints (in his behaviour support plan or otherwise).

Earlier incidents

15. Ms G, Service Manager at the residential service, told HDC that the residential service provided Enrich staff with the strategies used by Mr B's home staff to manage his challenging behaviour successfully. These strategies include saying 'E tu!' (a command to stand in te reo Māori), 'using directive/stern voice', and physical distancing. Ms G said that residential service staff 'have coached Enrich staff on multiple occasions, about what works, what it looks like i.e. elevation, pinching and the strategies to support each of these'.

16. Between 15 March 2022 and 18 July 2022 (inclusive), and prior to the incident on 25 July 2022, Enrich staff reported six other incidents[2] involving Mr B, all of which were rated three and above.

17. Enrich told HDC that incidents are rated on a scale from one to five, and that incidents rated three and above are shared with the primary contact, which in Mr B's case was the residential service. Enrich said that because all the six earlier incidents were rated three and above, the residential service was 'well aware' of the challenging behaviour that was occurring, and the challenges faced by Enrich staff.

18. Enrich told HDC that these incidents were considered serious and were concerning for Enrich's management team. Enrich said that it had ongoing discussions with residential

[2] On 15 March 2022, 19 April 2022, 20 April 2022, 30 May 2022, 27 June 2022, and 18 July 2022.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

service support staff and management about these concerns, seeking to identify whether further steps could be taken to keep both Mr B and the staff safe, and to ensure Mr B's ongoing wellbeing.

19. As noted in the incident summaries, the behaviour observed in Mr B during some of these incidents included 'hitting others, strikes object/property, kicking others, throwing items (not at people), pinching, scratching'. Some of these incidents resulted in injuries to Enrich staff, including 'scratched on right hand and forearm … pinched and hit … pinched on arm … pinched on both hands … hit in the stomach and pinched on the arms [and] hands … pinched and hit many times but no blood drawn …'

20. In response, as noted in the incident summaries, staff applied non-restrictive interventions, including 'redirect, allow time to vent, limit setting, sought assistance [from other staff] … block and move from strikes … low level disengagement, hold and [stabilise]'. The incident form on 20 April 2022 states:

> 'Staff tried, giving space and time outside, tactile objects and music in sensory room, toileting, food and drink, a warm blanket and lay down, laying on the Swiss ball/fake grass and taking him for a walk. A tally was taken for the day. Staff were pinched drawing blood 6 times, [Mr B] hit himself 6 times, and he hit staff and objects 10 times.'

21. Despite Mr B's behaviour support plan containing no approved restraints, the incident report from 25 July 2022 states that between March and July 2022, Mr B had 'three[3] approved personal restraints'. These are described in the incident report as 'approved CPI[4] low level holds and disengagement strategies'. The incident report does not include details as to how these restraints were 'approved'. As mentioned above, Mr B's behaviour support plan was last reviewed on 1 September 2021, some six to nine months prior to the exacerbation in incidents.

Safety plan and MAPA training

22. Enrich told HDC that in June 2022, the 'identified recent spike' in Mr B's behaviour was discussed at an internal Safe Practice Committee meeting, a bi-monthly health and safety risk management meeting. Enrich said that following this, Mr B was added to the internal waitlist for clinical psychologist review, with the aim of developing a safety plan. No referral was made to the clinical psychologist at this time.

23. Enrich said that, in addition, refresher training on the management of actual and potential aggression (MAPA training) was provided to staff on 16 June 2022, specifically to address the concerns regarding Mr B's 'continued escalated aggressive behaviour'. Enrich said that at the MAPA training session, it was proposed that when Mr B became physically aggressive (pinching/punching), staff should keep their distance and guide Mr B to a safe place to calm himself.

[3] The three incidents where staff applied 'low level hold' restrictive interventions occurred on 19 April 2022, 20 April 2022, and 30 May 2022.
[4] Crisis Prevention Institute.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

24. Enrich stated:

> 'In hindsight, Enrich+ accepts that [Mr B's] case should have been managed as a priority and there should not have been more than a month's delay in the identified need for clinical psychologist review and input and related guidance for staff. If that review had occurred sooner, then a more appropriate safety plan would have been developed earlier, and it is likely that the incident in question would not have occurred.'

Incident on 25 July 2022

Events leading up to incident

25. Enrich told HDC that on 25 July 2022, upon Mr B's arrival at Enrich around 9.00am, staff noticed that he was 'already elevated in an agitated state'. At the handover with the residential service, Enrich staff were informed that Mr B had not had a bowel movement overnight and that he might be uncomfortable as a result. Mr B was due to take part in a music workshop that morning, which was being held in the dining room.

26. Enrich described Mr B as being 'very agitated — he was pushing, grabbing, and pinching and when walking or moving was leaning heavily on staff members'. Ms C, a support worker at Enrich, tried numerous methods that were known to calm Mr B. This included resting him on a yoga ball and leaning him against the wall. Ms C also tried sitting Mr B down on a chair in the lounge, but none of these methods were successful.

27. Enrich said that Ms E, the Service Lead at Enrich, then tried to take Mr B to the toilet for a bowel movement. However, Mr B started displaying challenging behaviours, including hitting his head against the wall, and Ms E escorted him back to the dining room.

28. Enrich explained that after Mr B had finished his morning tea, Ms C guided him to another room to see whether he wanted to spend time in a 'lazy boy' chair.[5] Enrich said that at this point, Mr B was still 'very vocal and pinchy', and the team felt he was clearly indicating that he was not comfortable at Enrich.

29. At 10.20am, Ms E telephoned the residential service to ask for Mr B to be taken home. As there was no answer, Enrich telephoned Ms G, the Service Manager at the residential service, on her mobile phone. Ms G told Ms E that she would organise someone to collect Mr B, but she was not sure how long this would take. Ms C continued to manage Mr B's agitated state while waiting for residential service staff to arrive.

30. Ms C told HDC:

> 'While trying out these different ways to calm him down Mr B was more agitated and was grabbing me throughout so I moved him away to [another room] to sit in a lazy boy chair. I reached out for his long sleeve [T-shirt], pulled down the long sleeves and covered his hands by tying a knot at both ends. I did this not in a negative sense but in a more positive sense for the safety of himself myself and anyone else …

[5] A reclining chair.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> [Mr B] sat on the lazy boy and I attempted to calm him. This did not last long as [he] began to get up and continued walking and attempting to hit himself and the wall. To ensure that he is safe, I approached him to ensure that he does not fall and prevent him from walking into the wall and hurting himself. But in doing so, he grabbed, struck and scratched me. This is when I tied both of [Mr B's] sleeves to a knot [so] that I could provide the close physical support to him and at the same time [minimising] his ability to scratch me …'

31. Mr D, a support worker at Enrich, also provided a statement in response to this investigation. Mr D recalled that Mr B was 'loud with an aggressive tone not a happy one which came from the [lounge room] area'. Mr D stated:

> 'He was being very pinchy and grabby as well as loud. I noticed that his sleeves were tied which I hadn't seen done before and at the time I saw it as a form of protection for us as it was not uncommon for him to draw blood and bruising from his pinches.'

32. Mr D said that after a short while, he suggested to Ms C that Mr B be taken to the sensory room to see if it would help him to settle. Mr D said that once Mr B was in the sensory room, he was still in an elevated state but he started to settle, provided no one came too close.

33. Enrich said that Mr B was given the opportunity either to sit or lie on the sofa bed, and he chose to lie face down. Enrich stated:

> 'This is a very common position for [Mr B] to be in. He chooses to lie this way as it appears it is a comfort to him and in the sensory room he can also feel the vibrations of the bubble column when it is turned on.'

34. Ms C left the sensory room to attend to other clients and supervise a new staff member, and Mr D remained in the sensory room with Mr B and two other clients.

Arrival of residential service staff

35. Ms F, a staff member at the residential service, arrived at Enrich to collect Mr B at some point after 10.30am.

36. Ms F, Ms C, and Ms E have different recollections of what happened.

Account from Ms F

37. In reporting the incident to her Line Manager (Ms G), Ms F stated that upon her arrival at Enrich, she entered the front door but there was no one around. She said that she could hear Mr B's voice coming from the sensory room and called out to him while walking down the hallway. In response to the provisional decision, Ms F said:

> 'I am concerned that [Ms E] claims she met me at [the] front door of Enrich build[ing]. This [is] incorrect and I stated no one met me at [the] front door or was around when I first entered [the] building. It was [Mr B's] voice/grunting that [led] me up the long hallway to the Sensory room. I was halfway up [the] hallway when I spotted [Ms E] was

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> standing in the doorway of [the] Sensory Room. When [Ms E] noticed me she took a step out into [the] hallway as she heard me calling reassurance to [Mr B].'

38. Ms F stated that Ms E (Service Lead at Enrich) exited the sensory room and 'seemed surprised' to see her. Ms F said that when she reached the doorway of the sensory room, Ms E stated to her: '[T]his may look like a restraint but [it's] not.'

39. In a statement provided to the New Zealand Police (see below at paragraphs 65–67), Ms F recalled that she arrived at Enrich between 10.30am and 10.40am. She described what she saw when she arrived at the sensory room:

> '[Mr B] lying on his stomach with his legs dangling off the sofa bed; [h]is long sleeve jersey-ends were tied in a knot and then tied around the nail; [h]is left arm was stretched upwards hooked on to a nail and his right arm was stretched downwards hooked [onto] a nail; [t]he jersey knot was tied around one singular nail on both ends; [h]e was struggling moving around on the sofa, he was very vocal grunting loudly.'

40. Ms F told HDC:

> 'On top of [Mr B's] jersey sleeves being tied closed, his arms were restrained on two separate nails, one on the wall above his head, which I untied before untying the jersey sleeves which were covering his hands. The other male [E]nrich staff at the same time was trying to free his other hand which was restrained and attached to another nail at the base of the sofa bed. He couldn't remove it from the nail and I had to remove it in the end.'

41. Ms F stated that the nail had left a hole in the sleeve of Mr B's jersey, and that this was sighted by the Police and given to her manager at the residential service. Ms F stated:

> 'The holes from the [nails] left in the wall and sofa bed also cannot have disappeared and therefore the only logical explanation is someone removed [nails] and repaired the holes and likely painted the area. While [Ms E] may recall events differently the physical evidence (nails) I saw in [Enrich's] Sensory Room has been removed. This concerns me that they are covering up their [actions] which totally breached [Enrich's] Duty of Care towards [Mr B]. He is a victim with no justice who cannot see or talk to give his own statement of the abuse he suffered.'

42. Ms F also told Ms G:

> 'It was obvious to me that the guy/staff and [Ms E] had been trying to undo the knots before I came into the room and had been surprised to hear my voice and not expected [residential service] staff to arrive at that point.'

43. Ms F said that it took approximately five minutes to untie the knots, and that once Mr B was released, it took approximately five to ten minutes to calm him down. She stated that Mr B appeared distressed and aggravated, and she 'couldn't reach him emotionally'.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Account from Ms E

44. Enrich told HDC that Ms E has a different recollection of events. Enrich said that during an incident investigation meeting on 4 August 2022, Ms E told Enrich's management team that she greeted Ms F at the front door and walked with her to the sensory room. Ms E recalled that Ms F was walking slowly, and that she (Ms E) was the first to arrive at the sensory room entrance.

45. Ms E further stated that she was aware of the restraint prior to Ms F's arrival and had asked Ms C 'to remove the knots immediately'. However, during an audit review by Whaikaha|Ministry of Disabled People (see paragraphs 75 to 85 below), Ms E stated that she became aware of the restraint only following Ms F's arrival.

46. Ms E told HDC that prior to this incident, she had never seen Ms C use this type of restraint with Mr B, or with anyone else. Ms E stated:

> 'I should have checked that the knots had been untied or untied them myself. I should have reprimanded the staff that did it straight away. I failed. I'm human and we sometimes make mistakes, but I can assure you that I live to protect the ones I serve.'

Account from Ms C

47. Enrich told HDC that that Ms C has no recollection of Ms E asking her to undo the knots.

48. Ms C told HDC:

> 'All I did was untied the knot and helped [Mr B] to stand up, walked him to his Carer who was waiting at the door. I told her everything, I owned up and [apologised] for tying those knots and her response was "oh, he [i]s in one of those moods".'

49. Ms C stated:

> 'There was never an intention of assaulting [Mr B], [Mr B] was in a way assaulting me, I'm there to support people and whatever assaulting [behaviour] he did we tried our very best to move away from it. I honestly thought that what I did for [Mr B] that day was keeping both of us safe including other clients.'

Account from Mr D

50. Mr D told HDC that when he became aware that Mr B was being collected, he sat him up and 'tried to undo his sleeves but they had become tight with him pushing against them'.

51. Enrich told HDC that Ms E and Mr D tried to untie the knots, but they were unable to do so. Ms E left the sensory room to call Ms C, who managed to untie both the knots.

52. Ms F and Mr B left Enrich at approximately 11.20am.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Incident reporting

Enrich

53. Ms E recorded the incident in Enrich's system on 25 July 2022. Ms C and Mr D did not contribute to the incident report, and there is no evidence that a debrief took place with any of the staff members involved. Ms E noted in the incident report that Mr B had been displaying verbally and physically defensive behaviours, as well as self-harming behaviours. However, she did not refer to the physical restraint that had taken place.

54. Ms E could not explain why she did not report the physical restraint and said that she 'stuffed up'. Ms E stated:

> 'I take full responsibility for not reporting appropriately, however, I had been crying out for help and no one seemed to be listening. I began the process months before this incident and had finally got our Specialist Supports involved, I wanted to protect and advocate for both individual and staff.'

55. On 3 August 2022, the CEO of the residential service notified the CEO of Enrich of the incident involving restraint.

Residential service

56. Ms F told her Line Manager, Ms G, that following the incident she felt 'conflicted and shocked'. Ms F stated that she wanted to discuss the incident with one of her colleagues, but he was away on annual leave.

57. Ms F did not report the incident to Ms G until 1 August 2022. Ms G told the General Manager at the residential service:

> 'From interviewing [Ms F], and also knowing her for a number of years, in my opinion she was so extremely shocked by what she witnessed seeing [Mr B] restrained that [she] experienced some kind of bystander paralysis and this resulted in her not following [the residential service's] Policy, actioning an Incident Report or contacting me (as her Line Manager) or anyone to alert them to what she had witnessed …
>
> [Ms F] is well aware of [the residential service's] Policy around Reporting Incidents. She's a reliable Staff person who in all other circumstance that I am aware of would follow our Policies and Procedures. As above I believe [Ms F] was so traumatised by what she witnessed and therefore was unable to emotionally or intellectually process what she witnessed. She recounts wanting to tell her colleague (a Level 4, service lead) but he was on [annual leave]. It was roughly a week later [that] she did finally talk to another core staff member. [Ms F] presented as very overwhelmed and could not process and articulate what she had witnessed. This seemed to be [a] Post-Traumatic response.'

58. Ms A, Mr B's sister and welfare guardian, was made aware of the incident by the residential service on 2 August 2022.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Events following incident

59. On 26 July 2022, Ms E discussed Mr B's behaviour with Ms H, a behavioural specialist at Enrich. Ms E did not inform Ms H about the restraint the previous day.

60. Ms H told Enrich that Mr B was referred to her officially for a behavioural assessment on 27 July 2022.

61. On 26 July 2022, Ms E also sent an email to the residential service requesting that Mr B not attend Enrich until further notice. The email stated:

> 'As you [may be] aware [Mr B] has been so elevated this week he had to leave service early on Monday and refused to get out of the car this morning. Can I please ask that [Mr B] remain home tomorrow Wednesday 27/07/2022 and perhaps until further notice! I would like to discuss some [behavioural] supports with our in-house psychologist (on Thursday) and then connect with you all around his support needs in the future.'

62. Ms E's email to the residential service contains no reference to the physical restraint on 25 July 2022.

63. Ms E told HDC that the staff at Enrich had tried 'all the usual things to appease Mr B on 25 July 2022, e.g. [f]ood, drink, toilet, music, space, comfort and finally sensory'. She said that Mr B communicates with his body and vocal noises, and that he was 'always elevated and hurting people'. She told HDC that she believed standing Mr B down for a short period of time would prevent this from reoccurring and provide Enrich with time to formulate an appropriate plan.

64. Mr B did not return to Enrich following the incident, as he was withdrawn from the service by his family after they learned of the 25 July 2022 incident.

Investigations/reviews following incident

Police investigation

65. On 9 August 2022, Ms A informed the New Zealand Police of the incident.

66. On 27 October 2022, the Police visited Enrich and met with its executive team. In its case summary report, the Police documented:

> 'Enrich Plus have admitted to being fully responsible for the staff in [question's] actions on that day and ongoing training/support has been/is being provided to prevent this happening in the future.
>
> In relation to the alleged offence of having [Mr B's] sleeve tied around a nail/screw, police could not see any item that would prove this.'

67. The Police concluded that no criminal offending was detected and decided to take no further action.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Enrich's review

68. Following the incident, Enrich conducted an internal review and completed an Incident Investigation Report dated 8 August 2022 (Enrich's Report).

69. Enrich's Report confirms that on 25 July 2022, Mr B was subjected to an unapproved physical restraint, which involved having his sleeves pulled down over his hands, and having knots tied in the sleeves so that he was unable to use his hands or free himself from the restraint.

70. Enrich's Report states that the unapproved restraint was seen by Ms E, who immediately instructed Ms C to undo the restraint but did not follow up to ensure that her instructions had been complied with. Enrich's Report states:

> '[Mr B's] arms were restrained inside his sleeves during the time on the bed. He was able to move and sit up on his own, but he was unable to free his arms from his sleeves so remained restrained for an unspecified period. There is no evidence or staff reports of [Mr B] [being] attached to the wall by any device or nail. There are no holes in the wall or on the bed that [indicate] that a nail or device had been installed and then removed. Therefore it is concluded that [the residential service] member was mistaken in their report of the restraint by mechanical means.
>
> The complaint is upheld that [Mr B] was restrained using an unapproved physical restraint. Physical restraint must be reasonable and proportionate in the circumstances and staff must reasonably believe there is no other option available in the circumstances to prevent harm. There were other options available to the staff member involved, but she chose to knowingly restrain [Mr B] in a manner that prevented harm to herself and others but could reasonably be considered to cause distress to [Mr B].'

71. Enrich's Report states that unapproved physical restraint is a serious incident. It notes that both Ms C and Ms E were aware of Enrich's incident reporting system and the timeline for reporting incidents, but that the restraint was not included in the incident report on 25 July 2022. It also notes that Ms E failed to report the restraint to her service manager, and that 'all parties have failed to protect [Mr B] on this occasion'.

72. Following its investigation, Enrich made the following recommendations:

- For further investigation and disciplinary action to be taken in relation to Ms C and Ms E;
- To continue formulating a safety plan for Mr B, in line with the original plan structure; and
- For the staff to be provided with training on the restraint policies and procedures.

73. Enrich told HDC that on review, the following should have occurred:

- Earlier action should have been taken by staff to minimise the health and safety risks arising due to the repeated incidents and challenging behaviour escalation;
- Priority should have been given to seeking urgent input from the clinical psychologist and developing a better safety plan for immediate use by staff;

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ms C should not have restrained Mr B and instead, she should have redirected him, or sought assistance from a colleague;
- Ms E should have taken action earlier when she discovered the restraint in place, to ensure that it was removed; and
- Ms E should have completed an accurate incident report, including reference to the restraint, and taken follow-up action earlier, including reporting to the residential service and Mr B's family.

74. Enrich said that 'given the prior training and the policy guidance provided to staff previously', Ms C should have been aware that there were other available options to manage Mr B's behaviour. However, Enrich acknowledges and accepts that if earlier action had been taken to develop a safety plan and related guidance for staff, Ms C would not have been placed in that position. Enrich told HDC:

> 'Enrich+ is very disappointed that the restraint occurred, and that it appears it was covered up subsequently. As a result, management were not aware that this had occurred, and further action was not able to be taken until we subsequently became aware of the additional facts. We fully accept that it would have been expected that this incident was reported in full by the staff involved, and then both the residential service and the family could have been informed earlier too.'

Whaikaha's Report

75. Following the incident, Whaikaha commissioned an independent audit and completed a report dated 1 December 2022 (Whaikaha's Report).

76. Whaikaha's Report acknowledges that Enrich staff were experiencing increasing aggression and injuries, and that photographs document numerous occasions when 'blood was drawn because of [Mr B's] assaults'. Whaikaha's Report states that some of the staff 'shrugged it off, saying they expected to be injured when working with [Mr B]'.

77. Whaikaha's Report states that while Mr B's behaviour support plan advised the staff to redirect him and to 'stay at arm's length' when his behaviour became challenging, Mr B's poor vision and unsteady manner of walking required staff to maintain physical contact when redirecting him. Whaikaha's Report finds that this, together with the layout of the building, made it 'impossible for staff to avoid his assaults'.

78. Whaikaha's Report acknowledges that the residential service had provided Enrich staff with behaviour support strategies for Mr B but found that none of these strategies were effective in this environment.

79. Whaikaha's Report states that Enrich staff did not have a good understanding of what constitutes restraint, as neither of the support workers involved (Ms C and Mr D) recognised the action of tying Mr B's sleeves in a knot as a restraint. Rather, the support workers identified this as a way to keep themselves safe from further injuries.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

80. Whaikaha's Report found that Enrich management failed to protect its staff from 'almost daily assaults' and failed to provide adequate training in behaviour support and restraint. Whaikaha's Report states:

> 'The lack of knowledge about what constitutes a restraint, the lack of an effective management plan for [Mr B's] behaviour, the use of the unapproved restraint, the length of time it was in place and the failure of the [team leader] to reveal it in the incident report or to the interim psychologist were all unacceptable. It seems that the absence of effective strategies to avoid injury resulted in an acceptance of this restraint by the [Enrich] day support workers and their team leader.'

81. Whaikaha's Report identified the following areas for development:

- The service failed to provide sufficient training in restraint and has not complied with the requirements of providing annual refresher training in restraint minimisation and an annual review of restraint policies and procedures.
- A behaviour recording sheet was developed for Mr B that did not highlight the functional aspects of his behaviour, 'simply counting the incidents each day'. Training in positive behaviour support would help staff to understand behaviour as communication, and support the use of behaviour support plans.
- The use of an unapproved restraint was not included in the incident report of 25 July 2022 submitted by the team leader. The support worker who created the restraint (Ms C), and the support worker who witnessed the restraint (Mr D), did not contribute to the incident report and were not involved in any debriefing following the incident.
- The Abuse and Neglect policy and procedures are included in the Vulnerable Persons policy and procedures, and the Restraint policy and procedures are included in the Safe Practices policies. Enrich staff have little knowledge of these policies and procedures, suggesting that they are not easy to read, or easy to access.

82. The following requirements arose from Whaikaha's investigation:

- Enrich is to develop stand-alone policies and procedures on 'Abuse and Neglect' and 'Restraint Minimisation and Enablers' that are easy to read and access, and it is to provide staff with annual refresher training on these policies and procedures.
- Enrich is to provide staff with Positive Behaviour Support training alongside the Safe Interventions, or MAPA, training.
- Enrich is to develop a process to ensure that incidents are reported accurately.

83. Enrich accepted Whaikaha's findings and requirements and stated: '[Enrich] has accepted [the] report's findings and required actions, and we have commenced the related action plan.'

84. Whaikaha told HDC that it is monitoring Enrich, and that follow-up from Whaikaha's requirements are ongoing. Whaikaha stated:

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

'Whaikaha considers this matter to be serious and will continue to monitor the situation to ensure adequate changes are put in place to provide staff with thorough training around least restrictive practices.'

85. Whaikaha also told HDC that it is working with Mr B's whānau to ensure that suitable options and choices are available to Mr B during the day.

Policies and procedures

Enrich

86. Enrich told HDC that in this case, the staff did not follow its policies and procedures in respect of restraint and incident reporting. Enrich also said that the staff did not follow their MAPA training in relation to how best to manage Mr B's challenging behaviour.

Safe Practice Policy

87. Enrich's Safe Practice Policy[6] states that Enrich is committed to providing behaviour support in a positive manner and minimising or eliminating all forms of restraint. The Safe Practice Policy states that Enrich will provide positive, proactive, and person-centred behaviour support in the first instance where behaviours arise that make it difficult for a person to engage in their environment. It also states that Enrich requires its employees to be clear about their responsibilities in the management of behaviour and its reporting, in consultation with the people who access services, their whānau, employees, and other health and disability services, where appropriate.

88. The Safe Practice Policy states that the Service Managers and Service Leads must ensure that all employees understand the profile of every individual they are working with and are aware of and comprehend the procedures outlined within the behaviour support plan. It also states that any behaviour support plan containing the use of restraint must be approved by the Safe Practice Team.

89. The Safe Practice Policy states that Service Managers and Service Leads must provide support and guidance to employees after a crisis situation, including:

'— Notify the Executive Leader Services or in their absence the CEO as soon as possible.

— Inform all relevant parties associated with the individual who should be notified of such an event, this includes, but is not limited to, families, residential services, case manager at the appropriate external service, and the psychologist/behaviour support specialist if under the care of Explore.[7]

— Implement and provide debrief support to employees, the individual who was in crisis and others involved or witness to the incident, as required. This process may be supported by employees from other agencies/organisations, and/or others whom the individual identifies may be significant to them in this process.'

[6] Authorised on 30 July 2020.

[7] Explore Specialist Advice, national providers of behaviour support services.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

90. The Safe Practice Policy states that where restraint has been used, the Service Manager is to make a referral to the Safe Practice Team for investigation through the incident reporting system.

91. The Safe Practice Policy states that employees must follow behavioural support plans and the prescribed intervention strategies and use restraint as a last resort. The Safe Practice Policy states that using restraint is a specialised intervention and should be used only as a method of intervention when the use of restraint is clearly outlined in the individual's behaviour support plan.

92. The Safe Practice Policy states that a behaviour support plan should be reviewed 12 months after it has been created, unless behaviour change indicates that an earlier review is required.

93. At the time of the events, Enrich's Restraint Policy was included in its Safe Practice Policy. It is introduced to staff during induction training, and all staff are required to sign an acknowledgment that they understand the restraint protocols. The Restraint Policy is also available on Enrich's intranet.

94. As discussed above, Enrich's policies and procedures were reviewed by Whaikaha as part of its audit. Whaikaha's Report states that the Safe Practice Policy is 'quite comprehensive and detailed', and that '[r]eading through and understanding all of this material would be difficult without clear guidance'. Whaikaha's Report states that the Restraint Policy contained in the induction information package is 'rather brief'. The Restraint Policy states:

> 'Enrich+ believes in operating in totally non-aversive environments. Enrich+ does not use any practices that would be considered to be forms of restraint, neither physical, chemical or barriers unless as a last resort and in line with our Restraint Minimisation and Safe Practice Policy and Procedure.'

95. As discussed above, Whaikaha has required Enrich to develop stand-alone policies and procedures on 'Abuse and Neglect' and 'Restraint Minimisation and Enablers' that are easy to read and access. Whaikaha has also required that staff be provided with annual refresher training on these policies and procedures.

Incident Management Policy

Enrich

96. Enrich's Incident Management Policy[8] states that all employees shall ensure that all incidents are reported accurately as soon as possible after the event and within 24 hours.

Residential service

97. The residential service's policy on Accidents, Incidents and Hazards[9] (Incidents Policy) requires staff to accurately report and record all accidents, incidents and hazards that occur, or that are identified across the organisation. It states that staff have access to, and

[8] Issued in October 2020.
[9] Issued in October 2020.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

knowledge of, documented policies and procedures that provide good practice guidelines for the management of all accidents, incidents, and hazards across the residential service.

98. The Incident Policy requires all accidents and incidents that occur in the residential service to be reported as soon after the incident as possible, but no later than 24 hours after the event.

99. In accordance with the Incidents Policy, the Health and Safety Lead, Chief Executive, and relevant General Manager are to be advised of all notifiable events and serious harm injury events immediately, or as soon as practicable after the event.

100. The residential service's Standard Operating Procedure provides staff with information regarding the process to be followed when an incident or near miss occurs. It requires all incidents and near misses that occur as a result of work carried out by the residential service to be reported in the accident and incident reporting database, regardless of whether they involve staff, people supported, visitors or contractors. This must be done as soon as possible after the event, but no later than 24 hours following the event.

Further information

101. Enrich provided a formal written apology to Mr B's whānau on 20 June 2023.

102. Enrich told HDC:

> 'Enrich+ accepts that the restraint involving the sleeves being pulled down and knots being tied on each arm at the hands did occur. We do not accept that the sleeves were then further restrained via hooks on the wall or elsewhere.'

103. Enrich further stated:

> 'Enrich+ has learned a lot from this incident. Whilst in hindsight we may wish we could have taken earlier and different action, we also need to acknowledge that we are constrained due to the limited funding available for this service in terms of actions that we are able to take to address risks arising. We consider that we are limited by the framework that we are contracted within to provide safe and sufficient support to service users such as [Mr B].'

104. Enrich also told HDC that there is minimal guidance available to service providers on how to safely manage escalating challenging behaviour and related health and safety risks that arise. It said that it would be useful if there was more specific sector guidance provided by Whaikaha, or other relevant agencies.

105. Enrich told HDC:

> 'Enrich+ is very sorry for the events occurring in this complaint. Sadly [Mr B] was withdrawn by his family from our services soon after the 25 July 2022 incident.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> It is disappointing when we do not deliver the high level of service that we endeavour to provide to all of the people we support, and we wish to acknowledge and apologise to [Mr B] and his family that we let them down in these circumstances. We wish [Mr B] and his family well for the future, and we would welcome any opportunity in the future to support him again.
>
> Finally, we wish to assure the HDC and [Mr B] and his family that we are committed to learning from this, and have already taken action to make changes and provide related training to our staff so that we can ensure that this does not happen again.'

Responses to provisional opinion

Ms A

106. Ms A was given an opportunity to respond to the 'information gathered' sections of the provisional opinion. No comments were made by Ms A.

Enrich

107. Enrich was given an opportunity to respond to the provisional opinion.

108. Enrich advised that it accepts my provisional opinion and noted that it had already provided Mr B's whānau with a formal written apology on 20 June 2023.

109. Enrich said that it has continued to work with and support the three employees involved in this investigation.

Ms C

110. Ms C was given an opportunity to respond to the provisional opinion.

111. Ms C did not wish to provide any comment.

Ms E

112. Ms E was given an opportunity to respond to the provisional opinion.

113. Ms E advised that she accepts my provisional opinion. Ms E did not wish to provide any further comment.

Mr D

114. Mr D was given an opportunity to respond to the provisional opinion.

115. Mr D did not wish to provide any comment.

Residential service

116. The residential service was given an opportunity to respond to the provisional opinion.

117. The residential service did not wish to provide any comment.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms F

118. Ms F was given an opportunity to respond to the provisional opinion. Her comments have been incorporated into this opinion where relevant and appropriate.

Opinion: Enrich+ Trust — breach

119. I acknowledge the distress that these events have caused Mr B and his whānau. I also acknowledge that Mr B's behaviour could be challenging, and that Enrich said that prior to the incident on 25 July 2022, it had had ongoing discussions with the residential service about what further steps could be taken to keep both Mr B and staff safe.

120. Whilst the residential service was aware of the concerns raised by Enrich about Mr B's behaviour, I nonetheless consider that Enrich bears primary responsibility for the events that occurred. Mr B is a vulnerable consumer who has Bardet-Biedl syndrome and is non-verbal and partially blind. Whilst in the care of Enrich, Enrich had a responsibility to keep Mr B safe, and ensure that he received services of an appropriate standard from suitably trained and supported staff.

121. I consider that a combination of inadequate care planning in relation to risk management, and inadequate staff training and guidance, placed Mr B in a position of vulnerability, and that the care provided to him by Enrich fell short of the accepted standard.

Support planning and risk management

122. Mr B's behaviour support plan identifies his risk behaviours as 'pinching', 'punching others', and 'kicking'. In accordance with the behaviour support plan, Mr B is to be redirected and isolated if his behaviour becomes challenging. The behaviour support plan refers to 'physical intervention: isolate' but does not include any approved restraints.

123. Mr B's behaviour support plan was last reviewed on 1 September 2021, approximately 10 months prior to the incident involving physical restraint on 25 July 2022.

124. It is clear that over the course of nearly four months, between 15 March 2022 and 18 July 2022, Mr B became increasingly unsettled in his behaviour and the staff at Enrich experienced injuries. Six incidents were reported over this timeframe, all of which were rated three and above. Staff applied the behaviour support strategies outlined in Mr B's behaviour support plan (to redirect and isolate). However, during three of the incidents (in April and May 2022), Enrich staff had to apply CPI low-level holds and disengagement strategies.

125. Despite the escalation in incidents and the increased risk posed to both Mr B and staff, Mr B's behaviour support plan was not reviewed and updated. Enrich's Safe Practice Policy states that behaviour support plans are to be reviewed within one year, 'unless behaviour changes indicate an earlier review is required'. In my view, Mr B's behaviour support plan should have been reviewed and updated in April or May 2022, when it became apparent that existing behaviour strategies were no longer effective, and staff were beginning to use low-level holds.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

126. In addition, although Mr B was placed on an internal waitlist for clinical psychologist review in June 2022, he was not referred to the intern psychologist until 27 July 2022, two days after the incident. In my view, specialist input should have been sought from the clinical psychologist on a more urgent basis, to put in place a more effective management plan for immediate use by staff. I consider that the decision by Enrich simply to place Mr B on an internal waitlist in June 2022 was inadequate in the circumstances.

127. I note that Enrich accepts that Mr B should have been managed as a priority and that there should not have been a delay of over one month in arranging a review with the clinical psychologist. Enrich accepts that if the review had occurred earlier, a more appropriate safety plan would have been developed earlier, and it is likely that the incident in question would not have occurred.

Staff training and guidance

128. As a facility responsible for supporting clients with a range of complex needs, it is vital for Enrich to provide its staff with adequate guidance, support, and training on how best to respond to inevitable incidents involving challenging behaviour. Enrich told HDC that the staff involved in the restraint on 25 July 2022 did not follow its internal policies in respect of restraint and incident reporting. Further, Enrich said that the staff involved failed to follow the strategies they had been provided with during their MAPA training on managing Mr B's behaviour.

129. I acknowledge that Enrich had policies in place on restraint, safe practice and incident management, and it provided its staff with some training on managing Mr B's behaviour. However, the extent of non-compliance by staff suggests that the policies were deficient, and that staff lacked understanding as to what was expected of them.

130. Enrich said that refresher MAPA training was provided to staff on 16 June 2022, due to the escalation in Mr B's behaviour. It was suggested that during incidents of physically challenging behaviour, staff should keep their distance from Mr B and guide him to a safe place to calm down.

131. Enrich told HDC that the staff involved in the restraint on 25 July 2022 (Ms C, who initiated the restraint, and Mr D, who was present while the restraint was continuing) failed to follow the MAPA training. However, as commented on by Whaikaha, the strategies suggested during the training (that staff should keep their distance and guide Mr B to a safe place) were ineffective in this environment. Mr B required staff to guide him physically when redirecting him to a safe place, because of his unsteady manner of walking and poor vision. This, combined with the small corridors, meant that staff could not safely keep their distance.

132. In addition, Enrich said that the staff failed to comply with its internal policies on restraint and incident reporting. I note that the Safe Practice Policy states that restraint should only ever be used as a last resort, and when it is approved in an individual's behaviour support plan. This was not the case here. At the time Ms C initiated the restraint, there were still

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

other options available to her, including seeking assistance from other staff member(s) and taking Mr B to the sensory room.

133. Further, following the incident, Ms C and Mr D failed to complete and/or contribute to an incident report and record the restraint, as required by the Incident Management Policy. From their own accounts, it seems that both Ms C and Mr D failed to appreciate the seriousness of the situation, and most significantly that Ms C's actions in knotting Mr B's sleeves was a form of physical restraint that placed him in an extremely unsafe position. I acknowledge that the Service Lead, Ms E, completed an incident report. However, by omitting reference to the physical restraint, and failing to report this to her manager, she also failed to comply with the Incident Management Policy.

134. As set out further below, I consider that individual staff members hold some degree of responsibility for their actions. However, the failure by multiple staff members to comply with Enrich's policies and procedures in relation to restraint and incident reporting suggests that staff did not understand these policies and procedures, and that the training provided was inadequate. Furthermore, I note that staff did not receive any training on positive behaviour support. As commented on by Whaikaha, this may have helped staff to understand Mr B's behaviour as a form of communication, and to respond appropriately, and I am critical that this did not happen.

135. Taking the above factors into account, I consider that the issues relating to training and guidance are service level failings, for which Enrich bears overall responsibility. As a result of these failings, I am of the view that Enrich failed to ensure the safety of both staff and Mr B.

Conclusion

136. For the following reasons, I consider that Enrich failed to provide services to Mr B with reasonable care and skill, and therefore breached Right 4(1)[10] of the Code of Health and Disability Services Consumers' Rights (the Code):

- There was an undue delay in reviewing and updating Mr B's behaviour support plan, given his changing behaviour, the escalation in incidents, and the risk this was posing to both Mr B and staff;
- There was an undue delay in arranging for specialist clinical psychologist review and, consequently, in putting in place an effective management plan for immediate use by staff; and
- The guidance, support and training provided to staff on positive behaviour support and restraint was inadequate.

[10] Every consumer has the right to have services provided with reasonable care and skill.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Ms C — breach

137. On 25 July 2022, Mr B was physically restrained by a support worker, Ms C, who tied Mr B's sleeves in knots. The restraint was not authorised by Mr B's behaviour support plan, and it was inappropriate and caused Mr B considerable distress.

Length of time restraint was in place

138. It is not clear from the evidence available to me exactly how long the restraint was in place. However, I note that the first telephone call to the residential service was made at 10.20am, and the restraint was initiated by Ms C at some point after this, while Ms C and Mr B were in another room. Ms F recalled in her Police Statement that she arrived at Enrich between 10.30am and 10.40am, at which point Mr B had been moved to the sensory room, with the restraint continuing. Ms F and Mr B did not leave Enrich until approximately 11.20am, after the knots had been untied and Mr B had had time to calm down. This suggests that the restraint was in place for over half an hour, including a period when Mr B was lying face down.

Allegation that Mr B's sleeves were attached to a nail or hook

139. Ms F alleged that when she found Mr B in the sensory room, his sleeves were further restrained by way of nails or hooks on the wall. Enrich denies this allegation and told HDC: 'Enrich+ has found no evidence of any nail holes or otherwise in the wall or anywhere around the sofa in the sensory room.'

140. Enrich's internal review also found:

> 'There is no evidence or staff reports of Mr B [being] attached to the wall by any device or nail. There are no holes in the wall or on the bed that [indicate] that a nail or device had been installed and then removed. Therefore it is concluded that the [residential service] member was mistaken in their report of the restraint by mechanical means.'

141. The Police visited Enrich and could see no item that would prove that Mr B's sleeves were further restrained by way of nails or hooks on the wall.

142. While I acknowledge Ms F's stated position, that '[t]he holes from the [nails] left in the wall and sofa bed also cannot have disappeared and therefore the only logical explanation is someone removed [nails] and repaired the holes and likely painted the area', based on the evidence available to me, as set out above, I cannot be satisfied that Mr B's sleeves were further restrained by way of nails or hooks on the walls, or elsewhere. However, aside from this allegation, I accept that the restraint happened.

143. I am critical that Ms C used this physical restraint on Mr B on 25 July 2022. This was contrary to Enrich's Safe Practice Policy, which states that employees must follow an individual's behavioural support plan, and that restraint should be used as a method of intervention only when the use of restraint is clearly outlined in that plan.

144. In addition, the Safe Practice Policy states that restraint should only ever be used as a last resort. This was not the case here, as there were still other options available to Ms C,

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

including seeking assistance from other staff member(s) and taking Mr B to the sensory room. Acknowledging this, Enrich stated:

> 'Physical restraint must be reasonable and proportionate in the circumstances and staff must reasonably believe there is no other option available in the circumstances to prevent harm. There were other options available to the staff member involved, but she chose to knowingly restrain [Mr B] …'

145. I see no evidence that following the incident, Ms C completed, or was involved in completing, an incident report recording the restraint. This was contrary to Enrich's Incident Management Policy, which states that all employees shall ensure that incidents are reported accurately as soon as possible after the event and within 24 hours.

146. Ms C stated:

> 'There was never an intention of assaulting [Mr B], [Mr B] was in a way assaulting me … I honestly thought that what I did for [Mr B] that day was keeping both of us safe including other clients.'

147. I acknowledge that in the months preceding the incident, there had been an escalation in Mr B's challenging behaviour and staff had suffered physical injuries. Further, and as set out above, I consider that Enrich failed at a service level to ensure the safety of both staff and Mr B.

148. However, irrespective of this, the restraint that Ms C initiated on Mr B was unauthorised and inappropriate, and it should not have taken place. Restraining Mr B in such a manner placed him in an unsafe position, and from his reaction to the release of the knots, as described by Ms F in paragraph 43, it is fair to assume that he found the event profoundly distressing. Further, following the restraint it was imperative that Ms C report this accurately, but she did not do so. As such, I find that Ms C failed to provide services to Mr B with reasonable care and skill, in breach of Right 4(1) of the Code. I also find that Ms C failed to comply with the Safe Practice Policy, the Incident Management Policy, and other relevant standards, in breach of Right 4(2)[11] of the Code.

149. I have recommended that Ms C review and familiarise herself with Enrich's revised policies and procedures on restraint.

Opinion: Ms E, Service Lead at Enrich — breach

Unauthorised physical restraint

150. Enrich told HDC that during an incident investigation meeting on 4 August 2022, Ms E told Enrich's management team that she became aware of the restraint prior to Ms F arriving to collect Mr B. Further, Ms E said that she asked Ms C 'to remove the knots immediately'.

[11] Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

However, during the audit review by Whaikaha, Ms E stated that she became aware of the restraint only after Ms F had arrived.

151. I acknowledge the inconsistency in Ms E's evidence. However, based on the information available to me, I prefer the account that Ms E gave originally. In particular, I note that Enrich accepted this during its internal review. In addition, Enrich told HDC that 'it is [its] belief that the original account that [Ms E] gave to management on 4 August 2022 is the accurate account — which means that she became aware of the restraint earlier'. This is also consistent with Ms E's following statement to HDC: 'I should have checked that the knots had been untied or untied them myself. I should have reprimanded the staff that did it straight away.'

152. Whilst Ms E may have instructed Ms C to undo the knots immediately, she did not ensure that this had been done. From the evidence available to me, and as set out at paragraph 138 above, it appears that the restraint was in place for over half an hour. This included a period when Mr B was lying face down.

153. I am critical that Ms E did not take any further, and earlier, action to end the restraint, particularly given her senior position. In my view, this was inappropriate care and compromised Mr B's wellbeing for an even longer period.

Incident reporting

154. Following the incident on 25 July 2022, Ms E completed an incident report. However, she made no reference to the unauthorised physical restraint she had witnessed and did not report this to her manager.

155. Enrich's Incident Management Policy states that all employees shall ensure that incidents are reported accurately as soon as possible after the event and within 24 hours. Where a restraint has been used, the Safe Practice Policy also states that the Service Manager is to make a referral to the Safe Practice Team, for investigation of the incident through the incident reporting system. In addition, the Service Manager is to implement and provide debrief support to employees, the individual involved, and others who witnessed the incident.

156. Although Ms E completed an incident report within the 24-hour timeframe, I am critical that she did not comply with the Incident Management Policy, as she omitted reference to the physical restraint.

157. In addition, I am critical that Ms E failed to report the restraint to her manager. As a result, and contrary to the Safe Practice Policy, no referral was made to the Safe Practice Team and no debrief took place with the staff members involved or with Mr B.

158. On 26 July 2022 (the day following the incident) Ms E sent an email to the residential service asking that Mr B remain home and not attend Enrich until further notice. However, she failed to inform the residential service of the restraint.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

159. That same day, Ms E also discussed Mr B's behaviour with Ms H, the Behavioural Specialist at Enrich. However, Ms E did not inform Ms H of the physical restraint. I consider that this information would have been highly relevant to Ms H in formulating a management plan for Mr B going forwards.

160. Although Mr B did not return to the facility after 25 July 2022, as he was withdrawn by his family, I am critical that Ms E withheld information about the restraint from the residential service, Ms H, and Mr B's whānau.

Conclusion

161. For the following reasons, I consider that Ms E failed to provide services to Mr B with reasonable care and skill, in breach of Right 4(1) of the Code:

- She failed to take further action to stop the inappropriate and unauthorised physical restraint;
- She failed to report the incident accurately in the incident report, including reference to the physical restraint; and
- She failed to report the unauthorised physical restraint to her manager, the interim psychologist, the residential service, and Mr B's whānau.

162. I also find that Ms E failed to comply with the Incident Management Policy and other relevant standards, in breach of Right 4(2) of the Code.

Opinion: Mr D — breach

163. The physical restraint was witnessed by another support worker, Mr D, who did not direct Ms C to end the restraint or take any other action. Mr D stayed with Mr B in the sensory room while the restraint was continuing, and Mr D did not take any action to release Mr B from the restraint until he became aware that Mr B was being collected by a staff member from the residential service.

164. Mr B is a vulnerable consumer who is reliant on others to protect him and to keep him safe. Mr D should have advocated for Mr B and should have taken immediate action to release Mr B from the restraint.

165. I am critical that Mr D did not take immediate action to end the restraint once he became aware of it. In my view, this was inappropriate care.

166. I acknowledge that Mr D did not initiate the restraint. However, irrespective of this, as a fellow Enrich staff member, he should have recognised that the restraint was unauthorised and inappropriate, and he should have taken action to end the restraint. As such, I find that Mr D failed to provide services to Mr B with reasonable care and skill, in breach of Right 4(1) of the Code.

167. I have recommended that Mr D review and familiarise himself with Enrich's revised policies and procedures on restraint.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Ms F — adverse comment

168. On 25 July 2022, Ms F witnessed Mr B being physically restrained, but she did not report the incident to her Line Manager until 1 August 2022. This was contrary to the residential service's Incidents Policy, which requires all incidents to be reported as soon as possible after the incident and no later than 24 hours.

169. I am concerned that Ms F did not follow the residential service's policy in relation to reporting the incident. This was a serious incident, and it was important for Ms F to follow the processes and procedures in place. I acknowledge, however, that Ms F reports that she was distressed by these events and says that this contributed to the delay in reporting the incident. I am also prepared to acknowledge that Ms F was observing the actions of an independent service provider and as such may not have felt as empowered to intervene immediately.

170. Once the incident was reported by Ms F, the staff members at the residential service took the appropriate actions by immediately informing both Mr B's whānau and the CEO of Enrich of the incident.

171. I have recommended that Ms F review and familiarise herself with the residential service's policies and procedures on incident reporting.

Changes made since events

172. Enrich said that work is underway to ensure that the actions required by Whaikaha are completed as soon as possible, including the engagement of external specialist assistance. Enrich said that in the meantime, the following actions have been taken:

- In November 2022, staff completed a two-day Safety Interventions[12] course highlighting the guiding philosophies of care, welfare, safety, and security.
- The two staff members involved in the incident (Ms C and Ms E) underwent an employment disciplinary process, and both indicated that they learnt a lot from the incident.
- The Restraint Minimisation policy and the Abuse and Neglect policy were revised and updated to ensure that they are easy to read and easy to access. Enrich said that these policies were sent to all teams to discuss in team meetings and were posted on Enrich's internal hub.
- The recommendations to discontinue the use of restrictive interventions as a 'general practice', to maintain the option for use of restrictive interventions if it is approved in an individual behaviour support plan, and to maintain the use of verbal and non-restrictive interventions for general practice were adopted.
- The following training recommendations were put in place:

[12] The new name for the former MAPA training within the health and disability sector.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

a) All support staff are to undergo the Safety Interventions course, including training on the theory component. Training on the physical component of restrictive interventions is to be excluded;[13]

b) All staff are to receive annual refresher training on the Safety Interventions course, and refresher training for 'smaller' courses on a more regular basis; and

c) Where restrictive interventions are approved in a behaviour support plan, the relevant service staff are to undergo specific training for the appropriate use in the given circumstances. Staff are also to undergo six-monthly refresher training on restrictive interventions (ie, a three-hour training session with a Safety Interventions Instructor).

173. Enrich stated that currently positive behaviour support courses are being researched and a timetable established to enable it to deliver this training to all Enrich staff.

174. Enrich said that it believes that these changes will ensure that improved, appropriate, and robust frameworks and guidance are in place for staff, going forward.

Recommendations

175. Considering the formal written apology provided to Mr B's whānau on 20 June 2023, the changes made by Enrich since the events, and the changes required by Whaikaha, I recommend that Enrich:

a) Report to HDC with an update on the completion of the actions required by Whaikaha, within six months of the date of this report.

b) Use this case as a basis for developing education/training on restraint and incident reporting for staff. Evidence confirming the content of the education/training and the attendance records are to be provided to HDC within six months of the date of this report.

176. I recommend that Ms C:

a) Provide a formal written apology to Mr B and his whānau for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Mr B and his whānau, within three weeks of the date of this report.

b) Review and familiarise herself with Enrich's Safe Practice Policy, its revised policy on Restraint Minimisation, and its Incident Management Policy. Evidence of this is to be provided to HDC within three months of the date of this report.

[13] I understand that this is because the service intends to discontinue the use of restrictive interventions as a general practice.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

177. I recommend that Ms E:

a) Provide a formal written apology to Mr B and his whānau for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Mr B and his whānau, within three weeks of the date of this report.

b) Review and familiarise herself with Enrich's Safe Practice Policy, its revised policy on Restraint Minimisation, and its Incident Management Policy. Evidence of this is to be provided to HDC within three months of the date of this report.

178. I recommend that Mr D:

a) Provide a formal written apology to Mr B and his whānau for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Mr B and his whānau, within three weeks of the date of this report.

b) Review and familiarise himself with Enrich's Safe Practice Policy, its revised policy on Restraint Minimisation, and its Incident Management Policy. Evidence of this is to be provided to HDC within three months of the date of this report.

179. I recommend that Ms F review and familiarise herself with the residential service's policies and procedures on incident reporting. Evidence of this is to be provided to HDC within three months of the date of this report.

Follow-up actions

180. A copy of this report with details identifying the parties removed, except Enrich+ Trust, will be sent to Whaikaha|Ministry of Disabled People and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes. I will specifically draw Whaikaha's attention to paragraph 103, in which Enrich states that it is constrained by limited funding in terms of the actions it is able to take to address risks arising. I will leave Whaikaha to determine how it will respond to this feedback and whether follow-up action on its part is warranted.

Names have been removed (except Enrich+ Trust) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.