Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 23HDC00878)

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 support provided to Ms A by support workers Ms B and Ms C, and Care Coordinator Ms E, at a disability service.

3. Ms D,[1] a former support worker at the disability service, raised concerns that Ms A was verbally abused by Ms B and Ms C. Ms D also raised concerns that her complaint about the verbal abuse was not managed and investigated appropriately when it was brought to the attention of Ms E.

4. Ms A does not wish to support the complaint, but the Deputy Commissioner decided to commence a Commissioner-initiated investigation pursuant to section 40(3)[2] of the Health and Disability Commissioner Act 1994 (the Act).

[1] Ms D told HDC that she left her employment with the disability service because of the manner in which Ms A was treated by the staff.
[2] The Commissioner may investigate an action under this section either on complaint or on the Commissioner's own initiative.

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

5. The following issues were identified for investigation:

- *Whether Ms B provided Ms A with an appropriate standard of care on 12 December 2022, including whether she treated her with respect and dignity.*
- *Whether Ms C provided Ms A with an appropriate standard of care on 12 December 2022, including whether she treated her with respect and dignity.*
- *Whether Ms E provided Ms A with an appropriate standard of care on 12–13 December 2022 (inclusive).*
- *Whether the disability service provided Ms A with an appropriate standard of care on 12–13 December 2022 (inclusive), including whether it treated her with respect and dignity.*

6. The parties directly involved in the investigation were:

Ms A	Consumer
Ms B	Support worker
Ms C	Support worker
Ms D	Complainant/support worker
Ms E	Care Coordinator
Disability service	Group provider

Background

Disability service

7. At the time of the events, Ms A resided at a group home. The service said that this group home specifically supports care recipients[3] who have committed an offence, and who have intellectual disabilities and high and complex needs. It is a secure environment where the activities of care recipients are supervised by staff.

8. The service said that care recipients are assigned a Care Coordinator (in this case Ms E), who assists with their care and rehabilitation, as well as a District Inspector, who ensures that their rights are upheld. At the time of the events, Ms B and Ms C reported to Ms E.

9. The disability service said that Ms E had a 'dual hybrid role' as both the Care Coordinator and the House Manager/House Coordinator. The disability service said that Ms E had oversight of the care recipients in the group home (as the Care Coordinator) as well as oversight of the group home's operations (as the House Manager/House Coordinator). the disability service said that this hybrid model allowed Care Coordinators to directly implement any changes they deemed necessary to a group home, without having to negotiate them through the House Coordinator.

10. The disability service stated that at the time of the events, Ms E reported to the Service Manager. Ms E provided the Service Manager a monthly written report around the care

[3] A person who is a special care recipient, or a care recipient no longer subject to the criminal justice system.

recipients under her supervision, and they communicated regularly by telephone and email about topical issues and incidents.

Ms A

11. Ms A (aged in her twenties at the time of the events) has a complex social and medical history.

12. Ms A's criminal history includes two criminal convictions.

13. Ms A entered the disability service in 2021, after she was found unfit to stand trial for criminal charges. The Care and Rehabilitation Plan (CARP) states:

> 'The common theme amongst these offences was [Ms A] not getting what she wanted, becoming frustrated and behaving in an antisocial manner in response.'

14. In 2021, the Family Court ordered Ms A to be supported as a care recipient. The Care Order requires Ms A to reside 24/7 in a Forensic Coordination Service — Intellectual Disability (FCS-ID) approved facility for a period of three years, until the expiry of the Care Order.

Support plans

15. The disability service said that it supports Ms A with verbal prompting around personal care tasks, medication administration, positive decision-making, community outings, ongoing communication with her whānau, and other recreational activities and hobbies.

16. The disability service said that due to the requirements of Ms A's Care Order and her complex presentation and behaviours, Ms A is supervised constantly by at least one staff member.

17. Ms A meets with a psychologist fortnightly, and several support plans are in place for the delivery of safe and appropriate care for Ms A. Ms A's support plans include a Behaviour Management Plan (BMP), CARP, Care Programme (CP), an assistance plan, and a Discharge and Crisis Plan (DCP). A summary of the relevant sections of Ms A's support plans is set out below.

<u>BMP</u>

18. The BMP was completed by a clinical psychologist and supervising behaviour specialist. The BMP states that its purpose is to address the challenging behaviours displayed by Ms A from a trauma-informed care and positive behaviour support perspective, where her need to connect with others and the need for reassurance is addressed, along with providing her with an environment where she feels safe and secure through consistency, routine, structure, and boundaries.

19. The BMP contains several reactive strategies for staff to follow when Ms A appears agitated, or when she displays verbal or physical aggression.

20. The reactive strategies for staff to follow when Ms A appears agitated include the importance of staff remaining calm, not taking anything personally, and not taking a punitive

stance. The reactive strategies for staff to follow when Ms A displays verbal aggression include reminding Ms A 'to go to her calm/safe place to calm down', suggesting strategies to calm down, such as breathing exercises and listening to music, and to refer to a handout prepared by the psychologist called '[Ms A's] Coping Skills'.

CARP

21. The CARP contains five core sections, namely 'understanding the person within their context', 'managing risks', 'addressing support needs', 'supporting cultural and spiritual needs', and 'developing a balanced and satisfied life without offending'.

22. The CARP states that Ms A is at risk of damaging property, such as kicking doors and throwing items at windows. The CARP sets out management strategies to minimise the chances of damage to property, which include that Ms A is to reside in a '24/7 secure facility', that the level of supervision or observation within the facility is to be determined by the Care Coordinator, and that Ms A is to be monitored for early warning signs of these behaviours. The CARP states that de-escalation techniques are to be used, which include positive redirection to other activities, such as word puzzles, and calming techniques, such as breathing and relaxation, which the staff should do alongside Ms A.

23. The CARP states that the scenarios in which Ms A are likely to be the most vulnerable are 'inappropriate internet social media access e.g. they are vulnerable to being exploited online. Contacting people/inappropriate sites'. The CARP sets out the management strategies to minimise the risk of these vulnerabilities, which include that Ms A must be supervised when accessing any online technology to ensure that she is not 'cyber stalking/bullying people or victimised herself'.

24. The CARP contains a list of Ms A's early warning signs, which include:

> 'Not cooperating or being disruptive, stating "you are being mean to me" when known boundaries are put in place, fake smile and eyes look anxious, negative thoughts about self or others, speaking loudly/yelling, voicing intent to hurt self or others, threatening harm to others, inability to attend to task, constantly swapping activities, seeking staff reassurance, monotone speech, changes in behaviour and appearance.'

25. The de-escalation strategies listed in the CARP are:

> 'Listen to [Ms A's] concerns, ask clarifying questions, use [teamwork] approach, engage [Ms A] with meaningful activities, use visuals, repeat instructions if necessary, use relaxation and breathing exercises daily.'

CP

26. The CP contains three core sections, namely 'the objectives of the care proposed to be provided to the care recipient, and the approach or approaches to be followed in achieving those objectives', 'the general nature of the care proposed to be provided to the care recipient', and 'the degree of security required for the care of the care recipient and for the protection of others'.

27. The general nature of Ms A's support plan, as outlined in the CP, includes:

> '[Ms A] is supported in a 24/7 secure facility … The staff have a good understanding of all aspects of the CARP and other behavioural plans especially those that focus upon risk management, safety, de-escalation techniques and crisis management …'

Assistance plan

28. The assistance plan states that the staff are required to read the BMP/risk plan monthly to ensure that Ms A is supported and that risks are identified, where required.

29. The assistance plan also states that Ms A is to have a 'catch up' with staff at least once per shift, and that two staff members are to be present during a 'catch up' if it appears that Ms A is in a 'heightened mood'.

30. Regarding verbal aggression towards others, the assistance plan states that Ms A can become verbally aggressive towards others, and that staff are to disengage, and to refer to the BMP as needed.

DCP

31. The DCP states that when staff are 'finding it hard to cope', they are to be 'directed towards the proactive strategies developed by [the clinical psychologist]'. The DCP states that the following actions can also be taken:

- 'PRN medication[4] can be useful';
- 'utilise low stimulus environment';
- 'one to one time with staff';
- 'mindfulness exercises';
- 'using psychological tools — how is your engine running'; and
- 'engaging in meaningful activities'.

Specialist Assessor Review Report

32. A clinical psychologist and specialist assessor completed a Specialist Assessor Review Report dated 25 April 2023 (the Specialist Report).

33. The Specialist Report notes that Ms A's behaviour is often the most challenging towards female staff who provide her with 'authentic care and engaging activity'. The Specialist Report states that the staff support each other by exchanging responsibility for Ms A's care 'when she starts to antagonise them'.

34. The Specialist Report notes that Ms E and another staff member provide weekly sessions 'to talk through issues [Ms A] is having'. The Specialist Report also notes that the staff often use

[4] Medication that is taken as needed, or as the circumstance arises.

redirection techniques during escalating incidents, and that it is sometimes helpful for Ms A to telephone Ms E, as this can assist in de-escalating Ms A's behaviour.

35. The Specialist Report notes that there were 26 incident reports over the preceding six months, and that these incidents 'were characteristic of [Ms A's] ongoing challenging behaviour and included making false allegations, threatening to harm staff and absconding'.

36. The Specialist Report concluded:

> '[Ms A] has a complex history of varied and sustained trauma that has made relationships difficult for her, leading to maladaptive relational behaviour and difficulties regulating her emotions. She is difficult to support as challenging incidents are frequent, however she has established some good relationships with some of her support team and [the disability service has] worked hard to maintain her in a series of activities that provide plenty of opportunities for socialisation … [Ms A] was made a care recipient for a comparatively long period of time for relatively minor offending and her risk profile suggests she is most likely to assault her direct support team than members of the public … It seems reasonable to suggest that the care order has been useful in protecting [Ms A] from putting herself in vulnerable situations … There has been tangible improvement in [Ms A's] general behaviour, her compliance with care and in the quality of interactions with her father [and] this is attributable to the proactive support she receives …'

37. The recommendations outlined in the Specialist Report include for Ms A to remain a care recipient at the secure level for a further six-month period, and that Ms A would continue to benefit from a consistent approach from a direct support team that includes validation of her emotional state, positive reinforcement for coping with stress, and ongoing coaching around her social interactions. The Specialist Report also recommended that Ms A's support team explore opportunities for increased independence in the community in anticipation of her Care Order ending but acknowledged that this would 'require her provider to take positive risks and [would expose] them to the risk of reputational harm'.

Incident on 12 December 2022

38. At 7.30pm on 12 December 2022, Ms D created an audio recording of Ms A engaged in a verbal altercation with Ms B and Ms C. Ms D told HDC:

> 'I started [recording] when [Ms A] was beginning to elevate. The voices in this recording [are] myself who is trying to calm [Ms A] down [Ms B] who is abusing, threatening and slamming doors and [Ms A] who is standing up for herself. [Ms A] and I are sitting on the couch … The next morning I made a formal but verbal complaint to [Ms E]. She offered for me to make a formal complaint. However, I felt at the time [Ms E] would stand [Ms B] down. Another staff [Ms C] was also hurling insults at [Ms A] in the background.'

39. The disability service said that the verbal altercation between Ms A and the support staff occurred because Ms A wanted to keep her iPad and charger in her room, which was not allowed in the group home. The disability service explained:

> 'To support their rehabilitation, care recipients in [the group home] are expected to turn in their personal electronic devices at 9pm during weekdays and 10pm during weekends. [Ms A] was non-compliant and became verbally abusive. To our dismay, so too did those staff [Ms B and Ms C].'

40. HDC was provided with the audio recording, which is approximately 20 minutes long. In the audio recording, the slamming of doors can be heard. Ms B can be heard yelling and speaking to Ms A in a raised voice and calling Ms A offensive names. Ms B can also be heard saying 'I hate you too', 'I can't stand you', 'you're an ugly human being', 'you're mental enough', and 'no one is your friend, you don't have any' to Ms A.

41. In the audio recording, Ms C's raised voice can be heard in the background, but it is unclear from the audio recording what Ms C said to Ms A.

42. In the audio recording, Ms D can be heard saying 'let's try and calm down', 'help me to help you calm down', 'do you want to go for a walk outside?', 'I'm here to support you', 'come and sit down', and 'tell me what you're thinking' to Ms A.

Incident reporting

43. On 12 December 2022 (the day of the incident), Ms B completed an incident report, which was submitted to Ms E at 11pm on 12 December 2022. Ms B noted that the incident was behaviour-related and described the behaviour as follows:

> 'Verbal abuse (e.g. yelling, swearing, name calling), Behaviour causing fear (e.g. intimidation, stalking, threat to harm, bullying), Other behavioural concerns (e.g. causing disturbance to others, refusing to comply with support plans).'

44. Ms B included a detailed description of the incident, which included the following:

> '[Ms A] informed staff that she was keeping her new charger and her iPad in her room overnight, stated that a staff member from the morning shift told her that she could. [Ms A] was reminded about the [group home] rule that all devices were to be handed in at a certain time every night and was locked away, which [Ms A] is well aware of. She then said the rules had changed and didn't apply to her because "I am special". [Ms A] refused to listen and kept saying she was keeping everything in her room. Rang [House Coordinator] to reiterate to [Ms A] the [group home] rule about all devices but was unable to reach her at that time. [Ms A's] behaviour by this stage had escalated to name calling and threats to [two] staff members [Ms B and Ms C] who then disengaged and left the room. [Ms D] was trying to calm [Ms A] suggesting sensory items talking calmly to her but this was not working. [The House Coordinator] rang and said to tell [Ms A] that if she didn't stop her abusive behaviours towards staff and by then she was also targeting and threatening the other [two] [clients/service users], that she would lose the use of her iPad and suggested we offer some prn zopiclone, since [Ms A] had refused

> the offer earlier of another prn tablet … I relayed to [Ms A] what [Ms E] had said but it made no difference. She started demanding from [Ms D] who was supporting [Ms A] out in the courtyard to ring [Ms E]. By this stage the other [two] [clients/service users] were showing signs of stress and asked to be let outside so both were supported by [Ms B] and [Ms C] while [Ms D] continued to try and calm [Ms A]. [Ms A] eventually stopped the horrible name calling and foul language and agreed to taking the zopiclone at 8.40pm.'

45. Ms B documented that the incident was brought about because Ms A 'wanted things to go how she wanted them to and elevated as soon as she was told no because of the [group home] rules'.

46. Ms B did not include any reference to the verbal abuse by the staff members towards Ms A in the incident report.

Incident management

47. Ms D raised concerns about Ms E's management of the incident. Ms D said that she verbally informed Ms E of the incident and the audio recording on the following morning (13 December 2022), but Ms E did not listen to the audio recording and asked Ms D to delete it.

48. Ms E admits that she asked Ms D to delete the audio recording. Ms E said that she had done so as it was her understanding that the audio recording was illegal because it had been recorded without the consent of the parties involved. Ms E said that she directed Ms D to formalise her complaint by submitting it through the disability service's online complaints form, but Ms D did not do so.

49. Ms E said that she followed up on Ms D's concerns with the staff in question and took several actions in response to the incident.

50. On 13 December 2022 (the same day on which she was made aware of the incident), Ms E discussed the incident with Ms A and reminded her of the rules around devices and chargers. On the same day, Ms E also discussed the incident with both Ms B and Ms C.

Discussion with Ms B

51. Ms E documented her discussion with Ms B as follows:

> '… [Ms A's] behaviour escalated with verbal aggression [and] threatening behaviour towards [staff] [Ms B]. [Ms C] joined in this verbal elevated discussion that was going on between [Ms B] and [Ms A]. [The House Coordinator] is aware that [Ms B] had become elevated and used language towards [Ms A] that is inappropriate. It appears at the time [Ms B] was not able to control her own emotions which resulted in a verbal negative escalation between [Ms B], [Ms C], and [Ms A]. This now appears to [Ms A] that she has two staff on her case about her behaviour which only escalated verbal abuse that [Ms A] was presenting to both staff.
>
> As discussed on previous occasion to all staff there should be only one low calm voice supporting [service users] when they are becoming elevated. [The House Coordinator,

> Ms E] has discussed with [Ms B] on two previous occasions around staying calm where it appears that [service users] are elevating and becoming verbally aggressive. We discussed how important it is to tag out and not enter into arguments with [Ms A] as this only escalates her more. [Ms B] to be aware of her own emotions and triggers that cause her to also become elevated. [Ms B] to request to tag out as needed. Discussion with [Ms B] around alternative options that will be explored if required.'

Discussion with Ms C

52. Ms E documented her discussion with Ms C as follows:

> '… [The House Coordinator] is aware at the time [Ms C] was in the kitchen, while [Ms A] was sitting at the table with [Ms B] and another staff. [Ms A] had become definite, verbally aggressive and threatening towards [Ms B]. [Ms C] joined in on this elevated discussion that was going back and forth between [Ms A] and [Ms B]. Now it appears to [Ms A] that there are two [staff members] on her about her behaviour which only escalated her verbal aggression towards both [Ms C] and [Ms B].
>
> [The House Coordinator] is aware that [Ms C] also became [heightened] and verbally inappropriate towards [Ms A], during this time. [Ms C] acknowledges this and will be aware going forward that when supporting any [service users] that are displaying elevated behaviours, to remain calm and support her colleagues without becoming involved in any verbal altercation that [may be] occurring between staff and [service users]. [Ms C] to offer her support to her colleagues by requesting them to tag out where it appears this [is] needed.
>
> As discussed on previous occasions with all [staff] there should be only one calm low voice when supporting [service users] where they are becoming elevated. [The House Coordinator] reiterated this with [Ms C].
>
> [The House Coordinator] [believes] that it would be beneficial for [Ms C] to swap her out for her last two shifts to another [group home] …'

Recommendations and events following incident

53. Following the discussions, Ms E made recommendations for both Ms B and Ms C, which included being aware of any early warning signs of the disability service users they support, to read Ms A's CARP, DCP, and BMP regularly, to implement the de-escalation strategies and the calming techniques outlined in the support plans, to use only one voice in a low and calm manner to engage with service users when they are elevated, to tag out when becoming elevated, not to enter into any arguments with service users, to remain professional, to be aware of their own 'triggers', and to use their own calming techniques.

54. Both Ms B and Ms C were offered support through an employee assistance programme and agreed to meet with Ms E every fortnight from the beginning of 2023 to review matters.

55. Ms E said that she addressed the concerns directly with the staff involved and believed that no further escalation was required.

56. Ms E said that it was only after she had heard the audio recording that she appreciated the severity of the verbal abuse by Ms B and Ms C.

57. The disability service said that it is confident that the actions taken by Ms E, based on her understanding of the situation at the time, helped to prevent any similar incidents from occurring.

58. Upon receipt of Ms D's complaint, the disability service completed an investigation of the incident. The allegation against Ms B was substantiated and her employment was terminated.

59. The disability service said that the allegation that Ms C was 'hurling insults at [Ms A] in the background (of the recorded incident)' was unable to be substantiated to a level required by natural justice and employment law, but following the incident, Ms C was removed from the group home and had no further contact with Ms A. Ms C subsequently left her employment at the disability service.

Disability service's response

60. The disability service said that the behaviour of Ms B and Ms C in the audio recording provided by Ms D is 'categorically unacceptable', and it goes against the disability service's policies, procedures, Code of Conduct, and values.

61. The disability service said that both Ms B and Ms C were stood down following receipt of the complaint from HDC. The disability service stated:

> 'It is a risk that [staff] may respond emotionally to verbal abuse by [service users]. [Ms A's] Behaviour Management Plan specifically mentions that [staff] are not to take verbal abuse or threats personally … [Staff] are supported to do this with Management of Actual or Potential Aggression (MAPA) training, which outlines de-escalation techniques as well as the concept of "tagging in" and "tagging out". This is where [staff] are expected to actively intervene when they recognise a situation between another [staff member] and [a service user] is potentially escalating. At the time of recording, [Ms D] was working on shift and therefore should have intervened early to prevent escalation of the event. Throughout the duration of the recording, [Ms D] had several opportunities to follow this established practice, but instead chose to continue to record and resultantly prolong the incident. Based on our interviews with [staff] and all Care Recipients at [the group home], we understand this was an isolated event and have no reason to believe any other [staff] have behaved in such an unacceptable way with any Care Recipients residing in the [group home].'

62. The disability service said that it remains committed to providing a service that upholds the rights of service users and enables them to live their best lives.

Relevant policies and procedures

63. The disability service said that all staff are oriented to its policies and procedures at induction, and all policies and procedures are available on the intranet.

Abuse and Neglect

64. The purpose of the disability service's Abuse and Neglect Policy is to ensure that service users are protected against all forms of abuse and neglect, including bullying, maltreatment, coercion, harassment, and/or exploitation.

65. The Abuse and Neglect Policy states that the disability service maintains a zero tolerance for any type of abuse, neglect, or harm against service users or staff. The policy applies to all staff, including agency staff contracted to provide support, volunteers, students, and vocational mentors.

66. The Abuse and Neglect Policy defines verbal abuse as:

> 'Swearing or using disrespectful, derogatory or demeaning language, either about or in conversation with [service users]; this language presents [service users] as less important, child-like or inferior.'

67. The Abuse and Neglect Policy states that the disability service will ensure that all staff are provided with the training and resources to ensure that they understand and identify possible indicators of abuse and neglect, both physical and behavioural.

68. The Abuse and Neglect Policy states that all staff have a responsibility to report any suspected or identified abuse and/or the maltreatment of any person using the disability service's services. The abuse and/or neglect could be reported as an incident or a complaint.

69. The Abuse and Neglect Policy states that the disability service takes every incident and/or complaint of any type of abuse seriously and a relevant line manager and/or a senior manager will conduct a review of all incidents/complaints involving allegations of abuse following the appropriate incident monitoring process and/or complaints resolution process. The outcome of the review process will include immediate remedial actions, which may include disciplinary and/or criminal proceedings against the staff involved, as well as suggested actions to prevent the reoccurrence of similar forms of abuse/neglect.

Code of Conduct

70. The disability service's Code of Conduct provides specific guidance as to the standard of personal and professional conduct and behaviour expected of everyone who works at the disability service, including contractors.

71. The Code of Conduct states that the disability service expects its staff to adhere to and conduct themselves in accordance with the disability service's values, to treat service users with courtesy and respect, and to maintain a zero-harm work environment free from harassment, threats, abuse, discrimination, bullying, and violence.

72. The Code of Conduct states that the safety of service users and staff is taken seriously, and that the disability service will not tolerate any form of abuse, including verbal abuse. The Code of Conduct states:

> 'We will not tolerate any form of harm, where the purpose or effect, even if unintended, has a detrimental effect on the individual(s) involved, or that a reasonable person would find offensive, humiliating, intimidating or embarrassing.'

73. The Code of Conduct also states:

> 'Your manager is the first person you should go to if you have questions about the Code of Conduct or if you experience behaviour or conduct that you think does not comply with the Code of Conduct.'

74. The Code of Conduct provides examples of breaches, which include:

- Use of inappropriate language, threatening or intimidating behaviour, verbal, or physical fighting (regardless of the instigator); and
- Harmful conduct such as harassment, discrimination, bullying, offensive behaviour, or unreasonable behaviour that creates workplace disharmony.

Complaints Management Policy and Complaints Resolution Process

75. The Complaints Management Policy and Complaints Resolution Process define a complaint as an expression of dissatisfaction (made verbally or in writing) regarding the quality of service provided to service users. The complaint may be made by a staff member on behalf of a service user.

76. The Complaints Management Policy states that all staff members are responsible for ensuring that any complaints received are recorded and reported, in line with the Complaints Resolution Process. The Complaints Management Policy states that the ultimate responsibility of resolving a complaint lies with the respective Service Manager for all complaints related to services within their area.

Incident Reporting and Monitoring

77. The policy on Incident Reporting and Monitoring (Incident Reporting Policy) deals with the reporting and monitoring of all service users and workplace-related incidents.

78. The Incident Reporting Policy defines an incident as any event that could have resulted, or did result, in an illness or harm (including emotional harm) to people and/or damage to property.

79. The Incident Reporting Policy states that all incidents are followed up by the relevant line manager/service manager/senior manager, as appropriate, with a view to identifying remedial actions and/or learnings for the future.

80. The Incident Reporting Policy states that staff involved in the incident must be part of any debrief or discussion that happens following the incident, and that all identified follow-up actions or learnings are to be implemented by the relevant line manager/service manager/senior manager in a timely manner to prevent or minimise similar incidents from reoccurring.

81. The Incident Reporting Policy states that learnings identified from the incidents must be shared with the other staff working at the group home during group home hui, or by way of other staff communication mechanisms.

Staff training

82. The disability service said that initially staff are provided with MAPA training (now called Crisis Prevention Institute (CPI) safety intervention training) during orientation, which covers the fundamental de-escalation strategies, and trains staff to 'tag in' and 'tag out' when they become aware that they, or any of their colleagues, are having difficulty managing a situation or incident.

83. The disability service said that all three of the staff members involved in the incident on 12 December 2022 (Ms B, Ms C, and Ms D) were competent and oriented to the disability service's Code of Conduct.

84. The disability service said that Ms B holds a certificate in Health and Wellbeing (Level 3), and that both Ms B and Ms C received Code of Rights training facilitated by a local advocate. Both Ms B and Ms D received CPI safety intervention refresher training approximately six months prior to the incident, and Ms C received CPI safety intervention refresher training.

85. The disability service said that when staff are introduced to a group home, they are provided with orientation in relation to users' behaviour plans and processes specific to the group home. This training is reinforced periodically, as plans are updated and amended, or as circumstances warrant.

86. The disability service said that it holds monthly quizzes on policy and procedure, with monetary prizes for the winners, and the quizzes are 'hugely successful' in engaging with all staff and incentivises retaining and gaining awareness in relevant policy material. the disability service said that monthly group home hui and one-on-one meetings also provide a mechanism for the House Coordinator to upskill staff, and to address any concerns, or answer any queries around policies and procedures.

Whaikaha|Ministry of Disabled People

87. Whaikaha|Ministry of Disabled People (Whaikaha) told HDC that it has confirmed that a District Inspector was involved with, and provided support to, Ms A.

88. Whaikaha said that it considers that the concerns raised by Ms D have been addressed, and it continues to work closely with the disability service on safety and quality matters relating to the people it supports.

89. Whaikaha said that it has reviewed its quality register and there is no evidence of any staff abuse incidents in relation to Ms A or any other persons who previously resided or currently reside at the disability service's supported accommodation service.

90. Whaikaha's Quality Team commissioned an independent audit of the disability service's supported accommodation service, which took place in 2023, and the evaluation report was

completed in 2024. There were no recommendations or requirements arising from the evaluation report.

Further information

Disability service

91. In 2023, the disability service provided Ms A with a formal written apology. The letter of apology noted that Ms B and Ms C yelled at Ms A and that they used 'bad language', which they should not have done. The letter of apology advised that the disability service was 'doing things to make sure this does not happen again', and that the staff must talk to her 'nicely and with respect'.

92. The disability service told HDC that it extends its sincere apologies to Ms A for the actions of its staff on 12 December 2022. The disability service said that it is 'deeply disappointed' with the actions of its staff and that it is 'absolutely committed to supporting [Ms A] and her rehabilitation back into her community'.

Ms B

93. The disability service said that on being interviewed following the incident, Ms B expressed remorse to the disability service for her actions and apologised to Ms A in person.

Ms E

94. Ms E told HDC:

> 'I have worked in the disability sector for many years and will always put the needs of [service users] first and foremost, ensuring that they do have access to internal and external supports required for them to live their lives as valued members of their community.'

Responses to provisional opinion

Ms D

95. Ms D was given an opportunity to respond to the 'information gathered' section of my provisional opinion. Ms D did not provide any comment.

Ms B

96. Ms B was given an opportunity to respond to the sections of my provisional opinion that relate to the care she provided. Ms B did not provide any comment.

Ms C

97. Ms C was given an opportunity to respond to the sections of my provisional opinion that relate to the care she provided. Ms C did not provide any comment.

Ms E

98. Ms E was given an opportunity to respond to the sections of my provisional opinion that relate to the care she provided.

99. Ms E said that the usual practice is for staff to 'tag in' and 'tag out' with each other when it appears that a staff member is becoming frustrated and/or when a staff member is

'struggling to manage the situation', such as in Ms B's case. Ms E said that the staff support each other but she does not believe that Ms D supported her colleagues during this incident.

100. Ms E said that in hindsight, she should have listened to the audio recording. She said that she will ensure that she reflects on the manner in which she conducts reviews of complaints, and that in future she will escalate all allegations of abuse.

Disability service

101. The disability service was given an opportunity to respond to my provisional opinion. Their comments have been incorporated into this opinion where relevant and appropriate.

102. The disability service said that it agrees with the recommendations and follow-up actions.

Opinion: Ms B — breach

Verbal abuse

103. As a support worker, Ms B was required to provide services to Ms A in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). In particular, she was required to treat Ms A with respect, and to provide services in a manner that respected Ms A's dignity.

104. The disability service's Code of Conduct requires its staff members to adhere to and conduct themselves in accordance with the service's values, to treat service users with courtesy and respect, and to maintain a zero-harm work environment free from harassment, threats, abuse, discrimination, bullying, and violence.

105. It is clear from the audio recording that Ms B yelled at Ms A, called Ms A offensive names, and spoke to Ms A in a manner that was disrespectful. Ms B's yelling and the way she spoke to Ms A amount to verbal abuse and indicate a lack of respect. Under no circumstances is it acceptable for disability support service providers to verbally abuse anyone in their care. On two previous occasions, discussion had occurred with Ms B around the need to stay calm where it appears that service users are elevating and becoming verbally aggressive.

106. In addition to the verbal abuse, I am critical that Ms B did not follow the de-escalation strategies outlined in Ms A's support plans. The BMP states that it is important for staff to remain calm, not to take anything personally, and to suggest strategies to assist Ms A to calm down. The CARP directs staff to use a teamwork approach, and the assistance plan directs staff to disengage. Staff are also provided with training on 'tagging in' and 'tagging out' when they become aware that they, or any of their colleagues, are finding it challenging to manage a situation. This did not occur.

107. Ms A has a complex history and can exhibit challenging behaviours, but she has the right to be treated with dignity and respect.

108. In my view, by yelling at Ms A, Ms B failed to treat Ms A with respect, in breach of Right 1(1)[5] of the Code. In addition, by verbally abusing Ms A, Ms B failed to respect Ms A's dignity, in breach of Right 3[6] of the Code.

Non-compliance with professional standards

109. On 12 December 2022 (the day of the incident), Ms B completed an incident report. Ms B noted in the incident report that the incident was behaviour-related, and that the behaviour included verbal abuse (yelling, swearing, and name calling). However, she did not report the conduct of any staff members or specify that the staff members had displayed verbally abusive behaviour towards Ms A.

110. The Abuse and Neglect Policy states that all staff have a responsibility to report any suspected or identified abuse and/or the maltreatment of any person using the disability service's services, and that the abuse could be reported as an incident or a complaint.

111. Although Ms B completed an incident report in a timely manner, I am critical that she did not comply with the Abuse and Neglect Policy, as she omitted reference to the verbal abuse by staff members in the incident report.

112. I note that Ms B subsequently informed Ms E of the verbal abuse by the staff, which was documented in Ms E's record of her discussion with Ms B on 13 December 2022.

113. In addition to failing to comply with the Abuse and Neglect Policy, Ms B failed to follow Ms A's support plans, particularly in relation to the de-escalation strategies, and the Code of Conduct, which requires staff to adhere to, and conduct themselves in accordance with, the disability service's values, to treat service users with courtesy and respect, and to maintain a zero-harm work environment free from harassment, threats, abuse, discrimination, bullying, and violence. As Ms B failed to follow the Abuse and Neglect Policy (by failing to report the incident accurately in the incident report, including reference to the verbal abuse on the part of the staff members), and failed to follow the support plans and the Code of Conduct, I find that she failed to provide services to Ms A in accordance with professional standards, in breach of Right 4(2)[7] of the Code.

Opinion: Ms C — breach

114. On 12 December 2022, Ms C witnessed Ms A being verbally abused by another staff member. In the audio recording, Ms C's raised voice can be heard in the background, but it is unclear from the audio recording what Ms C said to Ms A. I am satisfied, on the balance of probabilities, that Ms C engaged in conduct that was contrary to one or more of the disability service's policies, notwithstanding the fact that, for the purposes of determining

[5] Every consumer has the right to be treated with respect.
[6] Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.
[7] Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

whether Ms C was in breach of the terms of her employment, that finding may not have been able to be substantiated.

115. Following the incident, Ms E discussed the matter with Ms C and documented that Ms C accepted that she also became 'heightened and verbally inappropriate' towards Ms A.

116. I am concerned that Ms C contributed to the verbal abuse and that she became involved in the verbal altercation between Ms A and another staff member.

117. Ms C did not take any action to end the verbal abuse, and she did not follow the de-escalation strategies outlined in Ms A's support plans. The BMP states that it is important for staff to remain calm, not to take anything personally, and to suggest strategies to assist Ms A to calm down. The CARP directs staff to use a teamwork approach, and the TOP directs staff to disengage. This did not occur.

118. Ms C's conduct was also in breach of the Code of Conduct, as she did not treat Ms A with courtesy and respect and did not maintain a zero-harm work environment free from harassment, threats, abuse, discrimination, bullying and violence.

119. In addition, Ms C did not report the verbal abuse incident by the staff member. On 12 December 2022 an incident report was completed by Ms B, but it made no reference to the verbal abuse by staff towards Ms A.

120. The Abuse and Neglect Policy states that all staff have a responsibility to report any suspected or identified abuse and/or the maltreatment of any person using the disability service's services, and that the abuse could be reported as an incident or a complaint.

121. I am critical that Ms C did not report the verbally abusive behaviour by a staff member. This was contrary to the Abuse and Neglect Policy.

122. By contributing to the verbal abuse, by failing to follow Ms A's support plans and the Code of Conduct, and by failing to report the verbally abusive behaviour by a staff member, I find that Ms C failed to provide services to Ms A in accordance with professional standards, in breach of Right 4(2) of the Code. In addition, while it is not clear from the audio recording what Ms C had said to Ms A, it is clear that Ms C had raised her voice towards Ms A. By doing so, I find that Ms C failed to treat Ms A with respect, in breach of Right 1(1) of the Code.

Opinion: Ms E — adverse comment

123. On 13 December 2022, the day following the incident, Ms D made a verbal complaint[8] to Ms E about the conduct of Ms B and Ms C, as required under the Code of Conduct,[9] and informed Ms E of the audio recording.

124. Ms E did not listen to the audio recording and asked Ms D to delete it, and to formalise her complaint by submitting it through the disability service's online complaints form. Although Ms D did not submit her complaint through the online system, Ms E took several actions in response to Ms D's complaint.

125. On the same day on which she was made aware of Ms D's complaint, Ms E formally discussed the incident with both Ms B and Ms C and made recommendations for them both. The recommendations included referring Ms B and Ms C to the de-escalation strategies and calming techniques outlined in Ms A's support plans, offering support through the employee assistance programme, and implementing additional supervision by scheduling regular meetings with Ms B and Ms C. Ms E also redeployed Ms C to another group home for several days.

126. The Abuse and Neglect Policy states that a relevant line manager and/or a senior manager will conduct a review of all incidents/complaints involving allegations of abuse following the appropriate incident monitoring process and/or complaints resolution process, and that the outcome of the review process will include immediate remedial actions, which may include disciplinary and/or criminal proceedings against the staff involved, as well as suggested actions to prevent the reoccurrence of similar forms of abuse/neglect.

127. The Incident Reporting Policy states that staff involved in the incident must be part of any debrief or discussion that happens following the incident, and that all identified follow-up actions or learnings are to be implemented by the relevant line manager/service manager/senior manager in a timely manner to prevent or minimise similar incidents from reoccurring.

128. I acknowledge that Ms E addressed the complaint directly with the staff members involved and implemented the follow-up actions in a timely manner. As set out in the Complaints Management Policy, ultimately the responsibility for resolving the complaint rested with Ms E.

129. I note the disability service's comments that the actions taken by Ms E were based on her understanding of the situation at the time. However, in my view, one of the most important aspects of Ms D's complaint was the content of the audio recording, which Ms E did not listen to. It would have been preferable for Ms E to have listened to the audio recording

[8] The Complaints Management Policy and Complaints Resolution Process define a complaint as an expression of dissatisfaction, made verbally or in writing, regarding the quality of service provided to service users.
[9] The Code of Conduct states: 'Your manager is the first person you should go to if you have any questions about the Code of Conduct or if you experience behaviour or conduct that you think does not comply with the Code of Conduct.'

before asking Ms D to delete it, or to raise it with management if she was unsure or had any concerns.

130. Ms D's complaint raised sufficiently serious issues that warranted the involvement of management. I am critical that Ms E did not treat Ms D's complaint sufficiently seriously, and that she did not escalate the matter.

131. I invite the disability service to reflect on my adverse comments about Ms E's management of Ms D's complaint in the context of their own assessment of this situation.

132. I note the changes made by Ms E since the events and that she will now escalate any similar incidents, which is appropriate. I suggest that Ms E reflect on the manner in which she conducts reviews of complaints, and that in future she escalate all allegations of abuse.

Opinion: Disability service — no breach

133. As a disability support service provider, the disability service is responsible for providing services in accordance with the Code. At the time of the events, the disability service had comprehensive policies and procedures in place. The disability service's expectations of staff behaviour is clearly set out in these documents.

134. The disability service said that all staff are oriented to its policies and procedures at induction, and all policies and procedures are available to staff on the intranet. The disability service also said that during orientation, staff are provided with CPI safety intervention training, and that all the staff members involved in the incident had received CPI safety intervention refresher training.

135. In a review conducted by Whaikaha, no evidence was found of any staff abuse incidents in relation to Ms A or any other persons who previously resided or currently reside at the supported accommodation service.

136. In this case, I consider that the failures were individual failures on the part of Ms B and Ms C, rather than deficient guidance or training, and therefore not indicative of broader systems or organisational issues at the disability service. Accordingly, I find that the disability service did not breach the Code.

Changes made since events

137. Ms B and Ms C are no longer employed by the disability service.

138. Ms E told HDC that she will now escalate any similar incidents to ensure that they are dealt with appropriately.

139. The disability service said that while it is confident that this was an isolated incident, it has taken the complaint seriously and has taken the opportunity to ensure that the group home staff and its wider team are supported to meet the disability service's expectations regarding the quality of service it provides.

140. The disability service told HDC that it has taken the following actions to address the concerns raised in the complaint:

- Provided a formal written apology to Ms A for the incident;
- Sought feedback from the care recipients at the group home to ensure that they are happy with the disability service being provided, feel that they are treated with respect, and know how to make a complaint;
- Reminded the care recipients at the group home of their rights under the Code and provided them with the disability service's internal complaints pack;
- Organised Code of Rights refresher training through the local Nationwide Health and Disability Advocacy Service; and
- It is in the process of organising CPI safety intervention training, complaints training, Code of Conduct training, re-orientation to BMPs, and staff resilience training to all staff in the group home.

141. The disability service told HDC that it has also completed a restructure of its operations. The disability service said that, at the time of the events, the House Manager or House Coordinator worked offsite. The disability service explained that while there was a House Leader who worked in the group home, the House Leader was not a line manager and had limited authority to address any concerns that arose. The disability service said that the new structure now provides for a House Coordinator to be based in the group home full time. The disability service said that while this change was not made as a result of Ms D's complaint, it strongly believes that it will help to improve direct oversight and accountability in the group home and prevent similar events from occurring in the future.

Recommendations

142. Considering the formal written apology provided to Ms A by the disability service, and the changes made since the events, I recommend that the disability service use this case as a basis for developing education/training on verbal abuse, incident reporting, and incident management 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.

143. I recommend that Ms C provide a formal written apology to Ms A for the deficiencies in care outlined in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

144. Considering the formal written apology provided to Ms A by Ms B, and as Ms B is no longer employed by the disability service, I consider that no other recommendations in respect of Ms B are necessary.

Follow-up actions

145. A copy of this report with details identifying the parties removed 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.