Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

# A Decision by the Deputy Health and Disability Commissioner

## (Case 24HDC00460)

Introduction ... 1
Background ... 2
HDC's investigation ... 3
Opinion: Mr B — breach ... 6
Opinion: Disability service — no breach ... 7
Recommendations ... 9
Follow-up action ... 9
Appendix A ... 10

## Introduction

1. This report is the opinion of Ms 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 Ms A by a disability service and support worker Mr B. The complaint raised concerns about verbal and physical treatment of a vulnerable consumer by a support worker.

3. The following issues were identified for investigation:

- *Whether the disability service provided Ms A with an appropriate standard of care in relation to the undated, recorded incident involving community support worker Mr B.*
- *Whether Mr B provided Ms A with an appropriate standard of care in relation to the undated, recorded incident.*

4. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms A | Consumer |
| Mr B | Community support worker |
| Group provider/disability support service | |

### Complaint

5. This Office received a complaint in 2023 about a female support worker who had taken photographs and videos of consumers in the disability service's care, without consent.

6. The bundle of videos submitted to HDC included three that exhibited verbal and physical interactions between Ms A and a male staff member, Mr B. Alongside the ongoing complaint about the female support worker, a Commissioner-initiated investigation was commenced to assess these interactions. This opinion is part of that investigation.

## Background

### Ms A

7. Ms A, who was in her twenties at the time of the events, lived in a disability service property for many years. Support workers assisted her with daily living and to gain her personal goals. Ms A has a dual disability diagnosis,[1] ie, mild intellectual disability and possibly autism spectrum disorder (autism[2]). In addition, Ms A has two mental health diagnoses of personality[3] and conduct disorder[4] (type B[5]). During her residency with the disability service, Ms A often displayed challenging behaviour and actions.

### Ms A's support needs

8. Because of her challenging behaviour and actions, Ms A had a Behaviour Support Plan. The plan, dated 29 June 2020, stated: '[I]ncidents of [Ms A's] aggression, property damage and self-harm have fluctuated over the past 6 months and remain a concern.' As a result of these incidents, a referral was sent[6] for specialist behaviour support advice, and in January 2020, the Regional Dual Disability Service[7] changed Ms A's medication. The plan outlined Ms A's behaviours of concern and primary strategies to reduce negative behaviours.

9. The referral in June 2019 was for assistance in managing and preventing Ms A's self-harming behaviour, verbal and physical outbursts towards others, and property damage. The assessment commenced in July 2020 and focused on reducing verbal and physical aggression that Ms A aimed at herself, property, and the team. A Safety Plan was created and provided to the team. The Review and Discharge Summary dated 21 January 2021 stated that Ms A had been discharged as there had been progress in minimising her negative behaviours. The Safety Plan stated that strategies put in place meant that '[Ms A] [was]

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[1] A dual disability diagnosis is given when a person has a developmental disability (significant limitations in cognitive functioning) and mental health disorder/s.

[2] Autism is a developmental disability caused by a difference in the brain. People with autism often have problems with social communication and interaction, and restricted or repetitive behaviours or interests and may also have different ways of learning, moving, or paying attention.

[3] A person with a personality disorder thinks, feels, behaves, or relates to others very differently from the average person. There are several different types of personality disorder.

[4] Conduct disorder is a mental health condition that affects children and teens. People with this condition persistently display severely antisocial and aggressive behaviours. They may bully others, be abusive to small animals, lie, steal, drink alcohol, use drugs, or skip school, often before their teenage years.

[5] A person with this type has difficulties regulating their emotions and behaviour. Others may consider their behaviour dramatic, emotional, or erratic. There are four cluster B disorders — antisocial, borderline, histrionic, and narcissistic personality disorders.

[6] The organisation provides specialised individual behaviour support advice/plans to organisations or whānau for consumers with autism and other challenging behaviours. Access occurs through Needs Assessment Service Coordination referral, and the service is funded by Whaikaha|Ministry of Disabled People.

[7] The Regional Dual Disability Mental Health Service provides support for people with intellectual disability who also have significant mental health concerns. The service is funded by Health New Zealand|Te Whatu Ora.



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responding particularly well to clear calm communication, descriptive praise, being rewarded, and having clarity about when activities [were to] occur'. The Safety Plan also noted: 'During the past 2 months [Ms A's] feelings of frustration have not escalated into physically threatening behaviour.'

### Events leading up to complaint

*Video recordings*

10. A female support worker recorded videos of Ms A.[8] The video recordings show, among other things, Ms A verbally interacting with Mr B. Mr B's voice can be heard, but neither he nor his actions are visible in any of the video recordings.

11. In the first video recording, Ms A asks the female support worker for PRN[9] medication, and an argument ensues. The female support worker can be heard telling Ms A to go to her room. Mr B can be heard in the background saying: '[D]on't play up.' The video recording concludes by showing Ms A punching herself in the face. None of the support workers, including Mr B, intervene or try to stop Ms A hitting herself.

12. In the second video recording, the start of the video is inaudible. After that, Mr B can be heard saying something inaudible related to Ms A's mother's name. Ms A responds: '[T]hat's not her name, I love her, I love my family. Don't ever say anything about my family, mother fucker.' Mr B says: '[O]h that's your mum's name woo-hoo-hoo.' At this point, Ms A starts hitting herself, saying: '[D]on't say it.' Again, none of the support workers, including Mr B, intervene or try to stop Ms A hitting herself.

13. In the third video, Mr B says something inaudible relating to Ms A's father's name. Ms A responds: '[D]on't say it!' The video recording shows Ms A spitting at Mr B. Mr B cannot be seen in the video, but he can be heard spitting at Ms A in response. Mr B can be heard saying to Ms A: '[I]f you spit, I'll spit', '[Y]ou look like a devil', and '[Y]ou smell like a dead rat'.

14. These interactions were never reported to the house leader, service coordinator, or the disability service's leadership.

## HDC's investigation

### Mr B's background and response

*Background*

15. Mr B gained a Level 3 National Certificate in Community Support Services.[10] Mr B has worked as part of a team providing support to a group of people with disabilities living in, or supported by, one of the disability service's community homes, for more than 20 years.

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[8] According to the disability service, this incident occurred between the first COVID-19 lockdown at the end of March 2020, and 14 July 2022. According to Mr B, it occurred between late 2021 and early 2022.

[9] To be used when necessary.

[10] This qualification is designed to recognise the knowledge and skills required of residential-based support workers working in a health or disability setting. The compulsory section of the qualification includes skills and knowledge relating to handling people safely, infection control, supporting a person to take prescribed



HDC

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*Mr B's response*

16. Mr B stated that the videos were recorded between late 2021 and early 2022.

17. Mr B admitted that he had not provided Ms A with the appropriate standard of care. He stated: '[M]y actions were inappropriate towards [Ms A] and there was no need for me to speak such verbal things.' Mr B added: '[T]here is no excuse for my actions …'

18. Mr B said that at the time of events, he often worked overtime covering shifts for other disability service staff members. As a result, Mr B did not have much spare time for his family, and, when he did, he did not get enough sleep. Mr B said that his high blood pressure and diabetes were exaggerated when he encountered significant pressure at work.

19. Mr B stated that, in his opinion, management had '[p]oor management skills'. He outlined a number of incidents that were reported to the disability service regarding Ms A's past behaviours and actions, which, according to Mr B, created an unsafe work environment. The incidents included, but were not limited to, Ms A being aggressive, threatening lives, and being verbally and physically abusive. Mr B said that Ms A's behaviours and actions impacted on staff members and residents alike. Mr B also stated:

> '[N]o proper action has been taken against [Ms A] nor proper counse[l]ling service was given. I believe I have a right to be provided with a safe work environment. Even though I am a big … man I can't help but think if it were my other colleagues that are physically smaller than I.'

20. Mr B said that the last and only time he 'received proper full training' was when he started work at the service. He stated: '[I] have been working for 20+ years and the tactics and skills that I have been using are all from training received [when I started].'

21. Mr B told HDC that since receiving this complaint he has sought counselling, which has given him the courage to own up to his mistakes and learn from them.

**Disability service's response**

22. On the basis of statements from staff members, the disability service stated that the videos may have been filmed somewhere between the first COVID-19 lockdown at the end of March 2020 and 14 July 2022, when Ms A moved away.

23. The disability service said that once it was notified of the incident by HDC, it '[c]ommenced a formal investigation' into Mr B's conduct. The disability service stated:

> 'At a meeting on 18 July 2023, [the disability service] provided [Mr B] with its preliminary decision, which was that the actions of [Mr B] toward [Ms A] amounted to serious misconduct warranting dismissal.
>
> …

medication, supporting a person's personal care needs, the ageing process, observing and recording changes, responding to loss and grief, and supporting people with dementia.



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> [Mr B] was placed on suspension pending a final outcome. No feedback was received from [Mr B]. However, prior to the follow-up meeting, on the 27th of July [Mr B] resigned with immediate effect.'

24. The disability service said that apart from the initial orientation, Mr B had completed a wide range of training courses suitable for his role during the tenure of his employment. The training courses included Maybo training,[11] Non-Violent Crisis-Intervention training,[12] First Aid training and a National Certificate, and Level 3 in Community Support Services.[13] The disability service provided records showing Mr B's completed training.[14]

**Relevant management standards, policies, and procedures**

25. The disability service had comprehensive policies and standard operating procedures in place at the time of the events, which are discussed below.

*Code of Conduct*

26. The disability service's Code of Conduct[15] states that behaviour and conduct are critical aspects of providing safe and appropriate care. The Code of Conduct outlines minimum requirements that must be observed by all employees of the disability service. It states that any breach of the Code of Conduct may result in disciplinary action, and cases of serious breach of the Code of Conduct may result in instant dismissal. All employees are required to ensure that they are aware of, understand, and comply with, the disability service's policies and procedures.

*Code of Ethics*

27. The disability service's Code of Ethics for employees[16] states that its purpose is to provide principles to underpin support work, professional and management practice, and decision-making. It states that employees are responsible for understanding and following management standards and related procedures.

28. The Code of Ethics states that employees should acknowledge and respect the trust placed in them by disabled persons, their families, other professional organisations, and the disability service. Furthermore, it notes:

> '[S]upport staff acknowledge that the way they behave directly influences the quality of life of a person they support and the reputation of the disability service. They are committed to conducting themselves in ways that demonstrate respect for every disabled person and those with whom they work.'

[11] Assists organisations to reduce the risk of behaviours of concern and workplace violence through the provision of engaging, outcome-focused training programmes.
[12] Assists staff to gain the skills to recognise, respond to, and de-escalate challenging behaviours.
[13] See Appendix A.
[14] See Appendix A.
[15] Approved on 1 April 2021.
[16] Approved on 1 April 2021 and last amended on 3 August 2022.

### Responses to provisional opinion

29. The disability service, Ms A's father, and Mr B were given the opportunity to respond to relevant sections of the provisional opinion. The disability service informed HDC that it agreed with the provisional opinion and had no further comment. Ms A's father did not submit any comments to HDC. Mr B apologised for his actions and stated that his behaviour was unacceptable and he has learnt from his mistakes, and he assured HDC that this will not occur again.

## Opinion: Mr B — breach

### Introduction

30. I consider that this complaint is significant, as it raises concerns about a longstanding support worker's verbal maltreatment of a vulnerable consumer with dual disabilities and challenging behaviour, in residential care. The complaint may never have been brought to the attention of this Office had it not come to light in another complaint investigation.

31. As a support worker, Mr B had a duty to provide vulnerable consumers with an appropriate standard of care. This included complying with the Code of Conduct and Code of Ethics, and the Code of Health and Disability Services Consumers' Rights (the Code).

32. Right 1(1) of the Code states that '[e]very consumer has the right to be treated with respect'. In particular, Mr B was required to treat Ms A with respect and provide services in a manner that respected her dignity. Right 3 of the Code states that '[e]very consumer has the right to have services provided in a manner that respects the dignity and independence of that individual'.

33. In two of the videos, Mr B talked about Ms A's mother and father, which on both occasions triggered a negative response from Ms A. Mr B continued to provoke her and said, '[O]h that's your mum's name woo-hoo-hoo,' when she reacted negatively. In one of the videos, Ms A spat at Mr B and he retaliated by spitting at Ms A and uttering: '[I]f you spit, I spit.' Mr B also said to Ms A: '[Y]ou look like a devil' and '[Y]ou smell like a dead rat'. In all three videos, Ms A is seen self-harming with no intervention from Mr B.

34. When Mr B commenced employment with the disability service, he completed the Orientation and Positive Practice training. Mr B told HDC that this was the only '[p]roper full training' he received. He stated that due to the lack of training provided by the disability service, he had to rely on the tactics and skills he acquired during his orientation training.

35. As discussed below, in my view it is more likely than not that Mr B did receive adequate training, which should have equipped him with strategies and tools to utilise when working with Ms A. In any case, I do not consider that a lack of training excuses or mitigates Mr B's behaviour towards Ms A.

36. Mr B also stated that Ms A was aggressive, threatened lives, and frequently was verbally and physically abusive towards staff members and other consumers. According to Mr B, many of these incidents were recorded and reported to the disability service, to no avail.



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37. I accept that Ms A's behaviour was challenging. However, as detailed in paragraph 50 below, I consider that the disability service had responded to Ms A's challenging behaviours adequately, having implemented plans and referred her for specialised behaviour support advice. In any case, in my view, Ms A's behaviour does not excuse or mitigate Mr B's behaviour towards her.

**Findings**

38. From reviewing the videos, it is apparent that Mr B provoked and insulted Ms A in a way that amounted to verbal abuse and a serious lack of respect. Mr B spat at Ms A and failed to attempt to intervene when she was self-harming. There were many options available to Mr B to intervene, including talking to Ms A, employing de-escalation techniques he had learned in Non-Violent Crisis-Intervention training, and/or calling for assistance. He did not attempt any of those actions or any other type of intervention.

39. I am critical and appalled when watching and listening to the videos, and I consider that Mr B behaved entirely inappropriately towards Ms A.

40. Under no circumstances is it acceptable for a community support worker to behave in this way. Mr B's statements about lack of training and unreported incidents do not, in my view, mitigate his actions.

41. In my opinion, by verbally abusing both Ms A and her family, provoking and calling Ms A disrespectful names, spitting at Ms A, and failing to intervene when she self-harmed, Mr B failed to treat Ms A with respect, in breach of Right 1(1)[17] of the Code, and failed to respect Ms A's dignity, in breach of Right 3[18] of the Code.

## Opinion: Disability service — no breach

### Introduction

42. The disability service has a legal and contractual duty of care to ensure the protection of the vulnerable disability services consumers in its care. In addition, the disability service is responsible for providing services of an appropriate standard and in accordance with the Code. At the time of the events, the disability service safeguarded this duty of care by having in place comprehensive policies and standard operating procedures, which set out expectations of staff behaviour and actions.

43. The Code of Conduct outlines minimum requirements that must be observed by all employees of the disability service. It states that any breach of the Code of Conduct may result in disciplinary action, and cases of serious breach of the Code of Conduct may result in instant dismissal. All employees are required to ensure that they are aware of, understand, and comply with, the disability service's policies and procedures. The Code of Ethics states:

[17] Every consumer has the right to be treated with respect.

[18] Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.



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> '[S]upport staff acknowledge that the way they behave directly influences the quality of life of a person they support and the reputation of the disability service. They are committed to conducting themselves in ways that demonstrate respect for every disabled person and those with whom they work.'

44. It is incumbent on the support workers to carry out their duties in accordance with legal and contractual obligations whilst adhering to the disability service's standards, policies, and the Code.

**Training provided to Mr B**

45. Mr B claimed that when dealing with Ms A he was forced to rely on the tactics and skills he acquired during his orientation training, as he received no further '[p]roper full training'. In response, the disability service submitted excerpts from Mr B's personal file. The records demonstrate that Mr B completed a wide range of training modules during his tenure with the disability service, including Maybo training, Non-Violent Crisis-Intervention training, and a National Certificate, Level 3 in Community Support Services.

46. In my view, the information provided by the disability service is a reliable source of evidence of the training Mr B received. Accordingly, I accept the disability service's statement that Mr B completed a range of training modules during his tenure, which were aimed at enhancing Mr B's skill levels relevant to his support worker role.

47. I consider that Mr B received adequate training that could have been utilised when dealing with Ms A. Accordingly, I am not critical of this aspect of the care provided by the disability service to Ms A.

**Incidents**

48. Mr B told HDC that the disability service did not investigate reports of Ms A's challenging behaviour adequately. I accept that her behaviour was challenging, and this is evident in the videos. The disability service provides residential and support services for people with disabilities, and, as such, some of the residents have traits as described by Mr B. Ms A had additional disabilities, which presented further challenges.

49. Whilst I acknowledge that Ms A exhibited difficult behaviours, I do not consider that the disability service's responses to previous incidents have any bearing on Mr B's recorded conduct towards Ms A. I do not consider it necessary to make a determination on the adequacy of the disability service's management of previous incidents, as it is not relevant to the issues of this investigation.

50. I also note that due to Ms A's dual disabilities and challenging behaviour, she had a comprehensive Behaviour Support Plan, which outlined her behaviour in full, as well as strategies to reduce or minimise her actions and behaviours. In addition, the disability service referred Ms A for specialist behaviour support advice on at least two occasions. The review and discharge of Ms A recorded that her behaviour had improved. In my view, the disability service's management of Ms A was reasonable, and there is no evidence to suggest that this had any bearing on the matters at hand.



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### Disability service investigation

51. When HDC notified the disability service of the complaint regarding the videos of the interactions between Ms A, the female support worker, and Mr B, the disability service acted appropriately by investigating Mr B's conduct. At an investigation outcome/disciplinary meeting on 18 July 2023 with Mr B, the disability service's preliminary decision was that Mr B had committed serious misconduct, and he was suspended pending the final decision. Mr B resigned before the final disciplinary meeting on 27 July 2023. The disability service advised that it followed relevant internal investigation and disciplinary processes.

### Findings

52. I am satisfied that the disability service had trained Mr B adequately and had in place appropriate guidance for working with Ms A. There is no evidence to suggest that the disability service is at fault in respect of the incidents between Mr B and Ms A. I consider that the disability service was entitled to rely on Mr B, as an experienced support worker, to adhere to the disability service's Code of Conduct and Code of Ethics. Accordingly, I find that the disability service did not breach the Code in respect of its care of Ms A.

## Recommendations

53. In the provisional opinion, I recommended that Mr B provide a formal written apology to Ms A for the deficiencies outlined in this report. The apology has already been sent to HDC, and will be forwarded to Ms A's father (who will relay the apology to Ms A) with this report.

54. I recommend that Mr B refamiliarise himself with the Code by reviewing it on the HDC website.[19] In particular, he should review Right 1(1) and Right 3, which relate to consumers being treated with respect and dignity. Confirmation that he has done so should be provided to HDC within three months of the date of this report.

55. In the event that Mr B finds employment as a support worker, I recommend he approach his employer for support to undertake rights-based training targeting 'treating consumers with respect and dignity', and 'relationship management/communicating with consumers who present with challenging behaviours'. Confirmation of the completion of this training and the learnings taken from it should be provided to HDC.

## Follow-up action

56. A copy of this report with details identifying the parties removed will be sent to Whaikaha| Ministry of Disabled People, Ministry of Social Development and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[19] See: www.hdc.org.nz

# Appendix A

**Mr B's training records**

| | Course |
|---|---|
| | • Induction training<br>• Positive Practices training |
| | • CPI Non-violent Crisis Intervention training |
| | • Dual Diagnosis training<br>• SAFE sexuality training<br>• CPI Non-violent Crisis Intervention training |
| | • CPI Non-violent Crisis Intervention training |
| | • SPELL autism training<br>• SAFE sexuality training<br>• CPI Non-violent Crisis Intervention training |
| | Gap in records due to the move to a new system |
| | • CPI Refresher now called MAPA on de-escalation<br>• Active Support training<br>• Community Integration training<br>• Relationship training |
| | • Dual Diagnosis training (intellectual disability and mental illness)<br>• Maybo training on de-escalation<br>• Positive Behaviour Support Practitioner programme |
| | • Maybo refresher training in 2021<br>• Autism training in 2021<br>• Level 3 National Certificate in Community Support Services from Careerforce (similar to this) completed |



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