(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON OR THEIR MOTHER

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2022] NZHRRT 2**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 069/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**IDEA SERVICES LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms SJ Eyre, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms BL Klippel, Member

REPRESENTATION:
Ms C McCulloch for the Director of Proceedings
Mr R Jones, Chief Executive of IDEA Services Ltd

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **31 January 2022**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v IDEA Services Ltd* [2022] NZHRRT 2. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 8 December 2021.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make orders by consent. The parties have filed:

[2.1] A Consent Memorandum dated 3 December 2021; and

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked 'A'.

[3] In the Consent Memorandum dated 3 December 2021 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2. (a) A declaration pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of:
>
> (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;
>
> (ii) Right 4(4) by failing to provide services in a manner that minimised the potential harm to, and optimised the quality of life of, the aggrieved person; and
>
> (iii) Right 6(1) by failing to provide the aggrieved person with information that a reasonable consumer, in the aggrieved person's position, would expect to receive; and
>
> (b) A final order under s 107(3)(b) of the Human Rights Act 1993 prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mr B) and his mother (Ms D).

[4] Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] Having considered the submissions of counsel as to name suppression, and for the reasons set out below, the Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person (Mr B) and his mother (Ms D). It is also noted that the defendant supports the application for non-publication.

[6] The Tribunal may order non-publication of the name and identifying details in accordance with s 107(3)(b) of the Human Rights Act 1993, if the Tribunal is satisfied that it is desirable to do so.

[7] To determine this, the Tribunal must consider whether there is material before the Tribunal to show specific adverse consequences sufficient to justify an exception to the fundamental rule of open justice. The Tribunal must also consider whether an order is reasonably necessary to secure the "proper administration of justice" in proceedings before it and does no more than is necessary to achieve that (see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 at [66] (*Waxman*)).

[8] Open justice is an essential legal principle. It was described in *Waxman* at [56] where the Tribunal cited *Erceg v Erceg* [2016] NZSC 135, as follows:

> [2] The principle of open justice is fundamental to the common law system of civil and criminal justice. It is a principle of constitutional importance and has been described as "an almost priceless inheritance". The principle's underlying rationale is that transparency of court proceedings maintains public confidence in the administration of justice by guarding against arbitrariness or partiality, and suspicion of arbitrariness or partiality, on the part of courts. Open justice "imposes a certain self-discipline on all who are engaged in the adjudicatory process – parties, witnesses, counsel, Court officers and Judges". The principle means not only that judicial proceedings should be held in open court, accessible by the public, but also that media representatives should be free to provide fair and accurate reports of what occurs in court. Given the reality that few members of the public will be able to attend particular hearings, the media carry an important responsibility in this respect. The courts have confirmed these propositions on many occasions, often in stirring language. [Footnote citations omitted]

[9] This claim arises from inappropriate physical and sexual behaviour committed against Mr B on more than one occasion. Mr B has an intellectual disability and was a consumer attending a health service when this inappropriate physical and sexual behaviour occurred. The details of this claim therefore include reference to this behaviour as well as sensitive details about Mr B's private health information. All of this information is in the detailed Agreed Summary of Facts which will be published with this decision.

[10] Mr B has an intellectual disability and it is not possible or appropriate to seek his opinion regarding the suppression of his name and identifying details. However, it is submitted there is no public interest in Mr B's name being known or identified in connection with the circumstances of this claim. His mother, Ms D, who is also his welfare guardian supports the suppression of Mr B's name and also her own, as she shares his surname.

[11] IDEA Services Limited has accepted that it failed to provide services to Mr B in accordance with the Code and the details of those failures are in the Agreed Summary of Facts. There is no public interest in Mr B's identity being known or identified in connection with this claim.

[12] Furthermore, there is no public interest in knowing Ms D's name either, as it would identify Mr B. Given the nature of the behaviour inflicted upon Mr B, its repeated nature, his health and the process that has already been undertaken by Mr B's mother to seek resolution of this claim through the Health and Disability Commissioner and in this Tribunal, publication of either Mr B or his mother Ms D's name would result in specific adverse consequences to them both.

[13] It is also noted that given the nature of the behaviour Mr B was subjected to, it is appropriate and consistent with the Tribunal's previous approach to not publish Mr B's name or his mother's name or any other details which would lead to his identification.

[14] The Tribunal considers the principle of open justice can be maintained by the publication of the Tribunal's decision and the detailed Agreed Summary of Facts, with the names and identifying details of Mr B and Ms D redacted. Accordingly, the Tribunal is satisfied that it is desirable to prohibit publication of the names and identifying details of Mr B and his mother Ms D.

DECISION

[15] The decision of the Tribunal is that:

[15.1] A declaration is to be made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of:

[15.1.1] Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;

[15.1.2] Right 4(4) by failing to provide services in a manner that minimised the potential harm to, and optimised the quality of life of, the aggrieved person; and

[15.1.3] Right 6(1) by failing to provide the aggrieved person with information that a reasonable consumer, in the aggrieved person's position, would expect to receive.

[15.2] A final order is made prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mr B) and his mother (Ms D).

[15.3] There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms SJ Eyre	**Dr SJ Hickey MNZM**	**Ms BL Klippel**
Deputy Chairperson	**Member**	**Member**

'A'

This is the Agreed Summary of Facts marked with the letter 'A' and referred to in the annexed decision of the Tribunal delivered on 31 January 2022

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT /21

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **IDEA SERVICES LIMITED,** a limited liability company having its registered office at Level 2, 50 Customhouse Quay, Wellington

Defendant

REDACTED AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Courtney McCulloch – Counsel for Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by section 15 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" is the health and disability consumer, Mr B.

3. At all material times the defendant, IDEA Services Limited ("IDEA Services"),[1] was a limited liability company having its registered offices at Level 2, Customhouse Quay, Wellington.

4. At all material times the defendant was a disability services provider within the meaning of s 3 of the Act, and was providing disability services to the aggrieved person within the meaning of s 2 of the Act.

5. On 19 June 2017, the aggrieved person's mother, Ms D ("Ms D"), complained to the Health and Disability Commissioner about services provided by the defendant to her son. Ms D is the aggrieved person's welfare guardian.

6. On 13 November 2019, the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised her opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

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

THE PARTIES

The defendant

7. The defendant is New Zealand's largest provider of services to people with intellectual disabilities and their families and delivers various services including residential support, independent supported living, and vocational day services.

8. The defendant employs around 4,500 staff in order to support approximately 4,000 people with intellectual disabilities around New Zealand. The defendant's mission is to advocate for the rights, inclusion and welfare of all people with intellectual disabilities and support them to live satisfying lives in the community. Its services are primarily funded by the Ministry of Health and the Ministry of Social Development.

9. The aggrieved person attended the vocational day programme ("the day programme") run by the defendant. The defendant also provided the aggrieved person with residential support ("the residential service"). Both of these services are distinct from each other and have different managers and support staff delivering each service. Both services are overseen by the same Area Manager.

The day programme

10. The aim of the day programme is to increase the participation of people with disabilities in employment and/or in their communities. At the time in question, between 9 and 13 service users generally attended the day programme on a daily basis. The day programme is staffed by a core staff of support workers, supplemented by relief support workers, and overseen by a management team.

11. At all material times, the day programme was managed by the Community Service Manager ("the Service Manager").[2] The Service Manager managed five vocational facilities, including the day programme. The Service Manager was expected to provide leadership in the provision of high quality vocational services, consistent with the defendant's philosophy and applicable national standards, including ensuring: services were safe for service users and staff; services were regularly monitored and evaluated via internal and external review systems; that service users and their families were listened to and staff worked in partnership with them; and that staff had the required values, knowledge, and competencies to meet service user goals.

12. The Service Manager was expected to ensure that complaints and incident reporting were managed and monitored in accordance with the defendant's organisational policies. The Service Manager's review of an incident report included responsibility for coding incidents with respect to both the type of incident that had occurred and the impact on the service user involved. Incidents could be coded as "low impact" (a nuisance with minor or short distress / disruption to the person or others), "medium impact" (an event that will have or has had some consequence of harm / injury or significant disruption to the person or others), or "high impact" (an event with major or enduring consequences in terms of harm or potential harm). The Service Manager utilised an Incident Classification Code,[3] to identify the type of incident that had occurred.

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[2] Changes to this role have been made since the events of June 2017.

[3] Different types of incidents included: A. verbal aggression; B. physical aggression (including service user to other service user); C. service user health; D. medication; H. other; I. criminal behaviour (including inappropriate sexual behaviour); J. behaviour other (including nuisance behaviour and screaming/yelling); K. incident others; L. critical; and P. sensitive (including physical and sexual abuse).

13. In addition, the Service Manager was responsible for ensuring the delivery of quality services that met the needs of service users (including identifying areas of risk and managing the risk and creating systems and a culture that ensured continuous improvement of service delivery); and providing leadership and direction in services (including managing performance and monitoring progress, building a productive and supportive team, and building relationships of trust and respect).

14. The Service Manager was overseen by the Area Manager, who was responsible for leading and managing the delivery of support services in the area. The Area Manager's employment agreement outlined quality and risk management as part of the expected performance outcomes. During the material time period there were two Area Managers, the first holding the role until October 2015, and the second from October 2015 to July 2017.

15. Along with the Service Manager, the Area Manager was also expected to ensure that complaints and incident reporting were managed and monitored in accordance with the defendant's organisational policies. The Area Manager was responsible for reviewing and signing off incident reports coded as high or medium risk referred by the Service Manager.

16. In addition, the Area Manager was responsible for ensuring: staff understood risk and systematically identified risks associated with the activities they performed; there was an appropriate system of control to prevent and manage risk and to respond to risk to minimise cost, damage, and harm; monitoring systems were in place to ensure risks were effectively managed; staff were provided with appropriate skills, knowledge and techniques to identify, assess, manage, and monitor risk; risks were reported appropriately; and incidents were effectively investigated.

The aggrieved person

17. The aggrieved person (aged 23 at the time of the critical events) has an intellectual disability and autism spectrum disorder. In January 2015, the aggrieved person began attending the day programme Monday to Friday, between 8.30am and 3pm.

18. The aggrieved person's risk assessment and management protocols ("RAMP") set out that he was at risk of sexual exploitation because of his inability to understand personal boundaries. The aggrieved person's risk management plan outlined that, in order to minimise this risk: there should be communication between residential and vocational staff; staff should be aware of the aggrieved person's whereabouts at all times; and personal boundaries should be reinforced.

19. Although the aggrieved person's RAMP documentation identified his risk of sexual exploitation, this was not reflected in his other key personal information documentation, such as his Alerts and Crisis information or Risk Management Plan.

Mr A

20. Mr A (aged 37 years at the time of the critical events) was also a recipient of disability services from the defendant. At the time of the events set out below Mr A attended the day programme three days a week, and sometimes more than that when he refused to attend another vocational service and was instead taken to the day programme.

21. Mr A has an intellectual disability and a mental health disorder. It was well known to the defendant that Mr A had little sense of socially appropriate boundaries and was known to exhibit inappropriate sexual behaviours towards others. Mr A had a history of demonstrating sexually

inappropriate behaviour. In 2004, Mr A's support documentation recorded that he had engaged in sexually inappropriate activity. Mr A had been reported to display little insight into the consequences of his behaviour and did not recognise the risk of his behaviour.

22. An assessment with specialist behavioural support services in 2005 set out a protocol, held by the defendant, that recorded the need for visual contact with Mr A at all times and that the Service Manager be notified immediately of any inappropriate sexual behaviour when in the community.

23. Mr A's RAMP documented that he was likely to display sexually inappropriate behaviours that may involve inappropriate touching and attempting to touch other service user's private parts. The management plan set out that, in order to minimise that risk, staff should be aware of where Mr A was, and should inappropriate touching occur, staff should support the other service user, provide one-on-one support for Mr A, redirect Mr A, and complete incident reporting.

24. The defendant and its staff were aware of the respective risks and vulnerabilities of the aggrieved person and Mr A, and knew the support needs of both men, particularly the need to supervise at all times and that both men should not be left alone.

RECORDED INCIDENTS OF INAPPROPRIATE (INCLUDING SEXUAL) BEHAVIOUR BY MR A TOWARDS THE AGGRIEVED PERSON

March 2015 to May 2017

25. Between March 2015 and May 2017, the defendant completed 10 incident reports detailing instances where Mr A exhibited inappropriate sexual behaviour, or aggressive behaviour, towards the aggrieved person.

26. On 16 March 2015, a staff member entered the foyer of the day programme and found Mr A with his hand on the aggrieved person's leg, while the aggrieved person had his hands covering his own genital area. The aggrieved person asked the staff member to take Mr A's hand away and reported that Mr A had been playing "with his balls". Mr A was taken to another room by a different staff member.

27. The first staff member recorded in an incident report that the aggrieved person was upset, and asked the staff member to text his mother, Ms D. The first staff member recorded in the incident report that while Mr A had not been witnessed playing with the aggrieved person's testicles, it was likely given the aggrieved person's reaction.

28. Ms D was not notified of this incident, or contacted by text as requested by the aggrieved person, who was upset.

29. The Service Manager was informed of the incident, and advised the staff member making the report that the incident should be discussed with the mental health team scheduled to visit Mr A that week. The Service Manager signed the incident report on the same day as the incident took place and coded the incident as low impact and "nuisance behaviour". The section relating to immediate actions taken by the Service Manager was left blank. The Area Manager signed off the report four days later, on 20 March 2015.

30. On 25 March 2015, while the aggrieved person was on a trial residential placement at the same residential facility as Mr A, Mr A followed the aggrieved person to his bedroom and was found standing over the aggrieved person (who was lying on his bed). Mr A was seen trying to take his own penis out of his trousers. Staff redirected Mr A and completed an incident report. No further actions were taken.

31. The Residential Services Manager recorded on the incident report: "[Mr A] displayed inappropriate sexual behaviour staff redirected him". The Residential Services Manager coded the incident as medium impact (having some consequence of harm), "inappropriate sexual behaviour", and signed off the report six days later, on 31 March 2015. The section relating to immediate action taken by the Residential Services Manager, was left blank. The Area Manager signed off the report on 2 April 2015. While no follow up actions were noted on the incident report, the aggrieved person was removed from the residential placement shortly afterwards.

32. While Ms D was informed that an incident had occurred, she was not given all of the details. Instead, Ms D was told by residential staff that the residential trial could not continue because the aggrieved person was unable to set boundaries for himself, which Mr A would see as a "green light".

33. The defendant's internal investigation[4] found that after this incident, which was of a sexual nature, there did not appear to be any record of consideration of the implications of Mr A's and the aggrieved person's ongoing shared attendance at the day programme (noting that this incident took place at the residential service during a trial period, not the day programme).

34. In April or May 2015, following cancellation of the trial residential placement, Ms D questioned the aggrieved person's safety in attending the day programme with Mr A and sought assurances that there were plans in place to ensure the aggrieved person's safety. Ms D was assured that a

[4] After the events detailed in this summary of facts (specifically the two critical incidents in June 2017) the defendant carried out its own internal investigation.

safety plan was in place, and that staffing levels at the day programme enabled supervision and separation of the aggrieved person and Mr A.

35. On 11 May 2015, another service user at the day programme reported to staff members that Mr A was playing with the zipper on the aggrieved person's jeans. The staff member who wrote the incident report commented: "[Mr A] – History – can act inappropriately with [the aggrieved person]". An incident report was completed by staff and subsequently reviewed by the Service Manager.

36. The Service Manager wrote on the incident report: "Incident was not seen by staff but this behaviour has happened before…", and coded the incident as low impact, "nuisance behaviour". The Service Manager also recorded that staff were to monitor Mr A when at the day programme. The Service Manager signed the incident report off on 11 May 2015, and the Area Manager signed the incident report off on 12 May 2015. The section relating to immediate actions taken by the Service Manager was left blank. Ms D was not advised of this incident.

37. At 10.45am on the morning of 4 April 2016, a staff member recorded in an incident report that when taking another service user to the disabled toilet at the day programme, she witnessed Mr A coming out of the toilet that the aggrieved person was using. The staff member recorded that other staff were unaware of the situation. The staff member completed an incident report. No further actions were taken.

38. The Service Manager recorded on the incident report that staff were to monitor Mr A when he was at the day programme. The Service Manager coded the incident as low impact, "nuisance behaviour". The Service Manager also recorded that Ms D was spoken to about the incident. The section of the incident report for immediate actions taken by the Service

Manager was left blank. The Service Manager signed off the report on 7 April 2016. The Area Manager signed the incident report on 8 April 2016.

39. Also on 4 April 2016, at 11.20am the aggrieved person was sitting with a staff member with his iPad in the front activity room when Mr A came into the room and went up to the aggrieved person and began thrusting his pelvic area toward the aggrieved person. Mr A was removed to another room at the day programme, and the staff member who was sitting with the aggrieved person spoke to other staff members and advised them to watch Mr A with the aggrieved person. An incident report was completed.

40. The Service Manager noted in the incident report that there had been an earlier incident where Mr A and the aggrieved person had been "in toilet together" and that this was "stereotyped behaviour for [Mr A]". The Service Manager also noted again that staff were to monitor Mr A while he was at the day programme. The Service Manager coded the incident as low impact, "screaming or yelling" and signed off the report on 7 April 2016. The section relating to immediate action taken by the Service Manager was left blank. The Area Manager signed off the incident report on 8 April 2016.

41. Ms D maintains the Service Manager did not give an accurate description of the first incident, in that the Service Manager did not tell Ms D the incident involved Mr A or that it occurred in the toilet. Ms D was not advised of this second incident.

42. In July 2016, Ms D says that she became increasingly concerned about the aggrieved person, and reports that he was frequently scared to go to the day programme. Ms D says she asked the Service Manager for copies of any incident reports concerning the aggrieved person. The defendant says there is no record of this request. IDEA Services believes that Ms D may have made this request to the Residential Services Manager. The defendant

notes that the Residential Service, and the Residential Service Manager, operate entirely separately to the day programme.

43. At 9.00am on 13 October 2016, Mr A approached the aggrieved person and began jabbing and provoking him. The staff member completing the incident report stated that staff intervened and redirected both Mr A and the aggrieved person.

44. An hour later, at 10.00am, Mr A blocked the aggrieved person when he was coming out of the toilet, pushed the aggrieved person and said "you want to fight?". Mr A was redirected by staff. The incident report noted that this was the second incident of the morning where Mr A had targeted the aggrieved person. Mr A was later taken home over concerns he might be unwell.

45. The Service Manager reviewed both incident reports the next day. With respect to the first incident, the Service Manager coded it as low impact/physical aggression, "service user to service user". With respect to the second incident the Service Manager coded it as low impact, "nuisance behaviour". On the first incident report, the Service Manager erroneously recorded that there were "not usually issues between [the aggrieved person] and [Mr A]". This was despite the incident report from 11 May 2015 confirming that Mr A can act "inappropriately" with the aggrieved person.

46. The Service Manager signed off both incident reports on 14 October 2016, and the Area Manager signed these on 18 October 2016.

47. Ms D was not advised of either incident.

48. On 17 October 2016 Mr A was observed acting in a "sexual manner" in that he was rubbing a ball against his crotch, dancing in a suggestive manner,

and trying to touch the aggrieved person. An incident report completed two days after the event (on 19 October 2016), noted that staff had concerns for Mr A's mental health, and that Mr A and the aggrieved person were kept apart.

49. The Service Manager coded the incident as low impact, "changes in usual pattern or response", and signed off the report on 21 October 2016, the same day the Area Manager signed off the report. Ms D was not advised of this incident.

50. In October 2016, Ms D attended a meeting with the Residential Service Manager and the Area Manager. Ms D recalls that she made a request for copies of all incident reports involving the aggrieved person. The defendant reports there is no record of this request (including in the related meeting minutes). That meeting was about the aggrieved person receiving residential support. Ms D recalls that she repeated this request in November 2016 when she spoke on the phone with the Residential Service Manager.

51. On 28 November 2016, staff recorded in an incident report that Mr A and the aggrieved person were punching each other. Mr A and the aggrieved person were separated. The report also noted that Mr A was making a lot of sexual comments.

52. The Service Manager coded the incident as medium impact (having some consequence of harm), "service user to service user", and noted that the aggrieved person had been winding everyone up, but also that Mr A had had an increase in inappropriate sexual behaviour. The Service Manager noted that she would discuss Mr A's medication with the Residential Service Manager. Both the Service Manager and the Area Manager signed

off the incident report on 29 November 2016. Ms D was not advised of this incident.

53. In January 2017, Ms D met with the Residential Service Manager and the Area Manager, and raised concerns about the Residential Service. Ms D asked for copies of all incident reports involving the aggrieved person, and in addition, for a copy of the aggrieved person's safety plans and support plans. It was agreed that the parties would meet again in one month to allow the Area Manager to look further into the concerns raised by Ms D.

54. In February 2017, Ms D and the Area Manager met for the planned follow up meeting. The defendant says the Area Manager became aware at that time that Ms D was also wanting incident report information related to the vocational service, although for what time period was not clear. The following day Ms D was incorrectly advised by the Area Manager that there was only one recent incident report and it related to an incident at the day programme where a blind was broken while the aggrieved person was operating it. Ms D was not provided with any incident reports relating to the aggrieved person and Mr A.

55. On 16 March 2017, a staff member went into the toilet to empty the bin and found Mr A standing over the aggrieved person while the aggrieved person was sitting on the toilet. Staff members were unaware that both men were in the toilet area. Mr A was redirected out of the toilet.

56. The Service Manager recorded in the subsequent incident report: "[Mr A] has a history with [the aggrieved person]. Seems to have an attraction towards him". The Service Manager coded the incident as low impact, "nuisance behaviour", and directed that staff were to monitor Mr A if they were aware the aggrieved person was in the toilet. Both the Service

Manager and Area Manager signed the incident report off on 17 March 2017. Ms D was not advised of this incident.

57. In May 2017, Ms D met with the Area Manager, to discuss her concerns that the aggrieved person was being left unsupervised and with Mr A. Ms D requested a copy of the aggrieved person's personal and safety plans. In response, the Area Manager assured Ms D the aggrieved person was safe. Following the meeting, Ms D received a copy of the aggrieved person's Personal Support Information and Alerts and Crisis documents. Information included in the documents was outdated. For example, the Personal Support Information sheet updated in January 2017 included a goal that the aggrieved person access respite care with his father, despite his father having died in May 2013.

58. The defendant's Incident Reporting and Response System Policy ("the Incident Reporting Policy") sets out that it was the Service Manager's responsibility to notify family members "… if the incident is serious or if there is agreement to call them after an incident". In all of the incident reports involving Mr A and the aggrieved person from 2015 to 2017 the section "COPIES FORWARDED TO" had "Vocational" and "Residential" services ticked, but not "Family".

59. Ms D had made it clear from the outset that she wanted to know what was happening with the aggrieved person because if there were issues she would be able to help because she knew him best.

60. Contrary to the Incident Reporting Policy, Ms D was notified of only one of the incidents that occurred between 2015 and 2017. With respect to the 9 and 13 June 2017 critical events (detailed below), Ms D was not informed immediately.

61. Ms D recalled that although she was contacted by the Service Manager on a number of occasions and informed that the aggrieved person had become angry or upset, at no time did the Service Manager advise that the aggrieved person was involved in, or that there had been an incident of, inappropriate sexual behaviour toward him.

62. The *New Zealand Health and Disability Sector (Core) Standards* (NZS8134.1:2008) ("NZHDS Core Standards") is a set of standards designed to "enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes".

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

64. The defendant's Service User Complaints Policy provides that:

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

65. The defendant's failure to provide Ms D with the incident reports and other documentation relating to the aggrieved person was contrary to the above national standard, and internal policies. Ms D felt as though her safety concerns with regard to the aggrieved person were being minimised and ignored.

66. Some of the issues raised by Ms D related to concerns she had about the supervision of the aggrieved person and Mr A. These concerns were not

addressed and despite the need to monitor Mr A and the aggrieved person being well documented, the required level of supervision and support was not always provided to both men. There were a number of incidents that were unwitnessed or where the aggrieved person and Mr A were found unsupervised and/or staff were alerted to the incident by another service user.

67. The defendant's internal investigation found that the ongoing incidents that occurred demonstrated lapses in supervision, and there was no evidence that a robust process had occurred to address the lapses in staff supervision of the two men.

68. The defendant's internal investigation further found that the concerns of Ms D and her request to be informed of incidents as far back as July 2016 had not been fully met, and if provided at the time, would likely have led to significant change to the service provided to ensure the aggrieved person's safety at a much earlier stage.

CRITICAL EVENTS

9 June 2017

69. On 9 June 2017, both the aggrieved person and Mr A attended the day programme. There were four support workers working at the day programme in the afternoon on 9 June 2017.

70. At approximately 1.15pm, a service user alerted one of the support workers that Mr A had gone into the toilet the aggrieved person was using.

71. The support worker found the aggrieved person at the toilet with his trousers and underpants down, and Mr A with his hand on the aggrieved person's penis.

72. The support worker recorded in the incident report: "I tried to call [Mr A] back but he was fixated + wouldn't move…". Unable to get Mr A to leave the toilet on verbal instruction, the support worker put herself between the aggrieved person and Mr A to shield the aggrieved person while he finished using the toilet. Mr A was fixated on the aggrieved person and persisted in trying to reach around the support worker to touch the aggrieved person.

73. After the incident, the support worker informed a second support worker of what had occurred, and completed an incident report. Contrary to the Incident Reporting Policy, set out below, the incident report was not reported to management as soon as possible (as required). As a result the Service Manager did not read the incident report until Tuesday 13 June 2017 when it was delivered through internal mail.

74. Mr A remained at the day programme with the aggrieved person. It is unclear what steps were taken (if any) to ensure that the two men were separated for the rest of the day, or what support was offered to the aggrieved person. Although four support workers were working at the day programme that afternoon, only two support workers were aware of the critical incident. Without that knowledge, the remaining two support workers were unable to take any actions to ensure ongoing separation of the aggrieved person and Mr A for the remainder of the day or offer more effective support to the aggrieved person in response to the incident.

75. The defendant's internal investigation found that on 9 June 2017 there was no common understanding amongst the staff as to what immediate actions should have been taken to maintain separation and supervision of the aggrieved person and Mr A, or what support was provided to them. In addition, the failure of staff to notify management immediately of the

incident significantly impacted on the defendant's ability to take remedial actions to prevent or minimise a recurrence of similar events.

76. Ms D was not informed that the aggrieved person had been involved in a critical event involving serious sexual behaviour against him until 13 June 2017. Upon later learning of this event, Ms D was deeply saddened that the aggrieved person was denied the care and support of those who love him and had to instead spend hours in the presence of Mr A.

12 June 2017

77. No mechanisms were put in place to ensure that Mr A and the aggrieved person did not return to the same day programme after the critical event on 9 June 2017.

78. On Monday 12 June 2017 Mr A attended the day programme from midday onwards. The aggrieved person also attended the day programme.

79. There is no evidence that any steps were taken to ensure the aggrieved person and Mr A were adequately supervised and kept separated while attending the day programme together on Monday 12 June 2017.

13 June 2017

80. The staff working at the day programme on 13 June 2017 included four support workers and one senior support worker.

81. At approximately 9:00am, the Service Manager read the incident report from 9 June 2017. The Service Manager coded the incident as "behaviour other – stereotyped behaviour" with medium impact (having some consequence of harm). The Service Manager also recorded on the incident report: "No other staff to assist so [the support worker] remained in toilet

area until she was able to get both out. Staff to closely monitor both men when at the base. Discussed with [Residential Services Manager]".

82. The Service Manager then put the report aside for discussion at an incident review meeting scheduled for 11.30am that day. In contravention of internal policy, the Service Manager did not immediately inform the Area Manager of what had occurred on 9 June 2017.

83. At 8.47am, Mr A and the aggrieved person arrived at the day programme. Mr A was scheduled to attend a different vocational programme that day but had refused to do so and so was taken to the day programme.

84. At approximately 9.00am, a support worker heard the aggrieved person yelling for help from the accessible toilet. The support worker discovered the toilet door was locked. When the support worker unlocked the door and entered the toilet, he found Mr A with his pants and underpants pulled down, standing over the aggrieved person, who was sitting on the toilet. The support worker separated the two men and removed Mr A from the toilet.

85. The support worker advised a second support worker of what had occurred (one other support worker was also informed but the remainder of the staff were not informed of the incident which meant messages of key safety could not be reaffirmed with the staff). At some time between 9.00am and 9.15am, the second support worker telephoned the Service Manager and advised her of the incident. The Service Manager came to the day programme, but did not immediately inform the Area Manager of what had occurred, electing to wait until the 11.30am incident review meeting to inform the Area Manager of both critical incidents.

86. Between 9.15am and 9.30am, the two support workers completed an incident report.

87. At 9.20am, Mr A was transported to the vocational programme he was originally scheduled to attend.

88. At 11.40am, at the incident review meeting, the Service Manager informed the Area Manager of both the 9 June and 13 June incidents.

89. The Area Manager re-coded the 9 June 2017 incident as "high impact" (an event with major or enduring consequences in terms of harm or potential harm) and labelled it a critical event, "other".

90. The Area Manager coded the 13 June 2017 incident as "high impact" and labelled it a high/critical event, "major near miss", and recorded on the incident report: "Second event of similar nature within short period of time. Earlier event not reported [to the Area Manager]. Requires high level investigation. Critical event notification".

91. At 12.30pm, the Area Manager informed Ms D and the General Manager of both incidents. This was the first time Ms D was made aware of the incident from 9 June 2017.

92. At approximately 1.00pm, the Area Manager reported both incidents to Police.

93. Later that day, the Area Manager completed an internal critical incident report (covering both events) and notified the needs assessment service coordinator ("NASC").

94. On 14 June 2017, the General Manager notified the Ministry of Health and Ministry of Social Development of both incidents.

DEFENDANT'S INTERNAL POLICIES, AND NATIONAL STANDARDS

95. At the time of the events set out above, the defendant had a "Child Protection and Abuse Policy" ("the Abuse Policy") in place, which provided a framework for the protection of children and adults, and for the investigation of alleged abuse. The defendant also had the Incident Reporting Policy in place, which set out the requirements for reporting, responding to, and monitoring incidents and near misses.

The Abuse Policy

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

> Inform their reporting manager of the disclosed or suspected abuse by way of incident report but supported by phone contact to raise urgency of response noting:
>
> - The incident reporting form is completed as soon as possible after each observation, communicating the name of the person reporting the abuse and their relationship to the person
> - Detail of anyone else who may have information
> - Signs and symptoms …
> - Particular incidents with dates, times and place if possible
> - Action taken including any first aid attention
> - Signature of the person making the report
> - If any opinion included it must be identified as such e.g. urgency of response

If a person is in imminent risk of abuse and staff believe their manager has not acted on information already reported then:

- Recheck with the manager and suggest notifying Police on 111
- Notify CYF/Police on 111 if not already notified
- Document this in another incident reporting form.

97. In responding to notification of an incident of abuse, the Abuse Policy confirms it is the manager's responsibility to act on alleged abuse or neglect. The Abuse Policy sets out the following responsibilities of the Service Manager:

- Check there is no contact between the alleged victim and the alleged abuser
- Check staffing needs (if necessary, rearrange staff schedules — such as redeploying staff or changing routines)
- Check that the person has received reassurance the allegation or disclosure will be acted on and the alleged victim doesn't feel they have caused trouble
- Check there is someone to support the alleged victim and someone different to support the alleged abuser (if known)

...

- Consult with your Senior Manager throughout the process

…

- Inform your Senior Manager – forward this record to them urgently for further action which may include phone contact or face-to-face.

98. The incident reports completed by staff show that for the majority of the incidents the only immediate action taken by staff was completion of an incident report. On two occasions, support workers documented that the Service Manager had been spoken to. On the other occasions, incident reports were forwarded to the Service Manager who signed and coded them often several days after the incident occurred.

99. As above, the defendant's internal investigation found that on 9 June 2017 there was no common understanding amongst the staff as to what actions should have been taken to maintain separation and supervision of the two men. Expert advice provided to the Commissioner noted that support by

the Service Manager to her team to manage the incidents was not available, and there was a general lack of understanding amongst them on what to do, how to report effectively in a timely way and what responses were appropriate with this type of incident. The expert advised that this support was compromised by a lack of sound management processes being in place at the time.

The Incident Reporting Policy

100. This policy sets out the defendant's requirements for reporting and responding to incidents and near misses, with an aim to make sure all such events are: responded to quickly and appropriately; reported; recorded; and that external authorities are notified where required.

101. With respect to responding to incidents and near misses, and reporting and recording incidents and near misses, the policy states:

> **1. RESPONDING TO INCIDENTS AND NEAR MISSES**
>
> **1.1 Immediate Action to Take Following an Incident or Near miss**
>
> In the event of an incident or near miss, staff must take immediate action and respond to the situation using the following procedure.
>
> **Staff**
>
> 1. Assess the situation to ensure the safety of yourself and others.
>
> …
>
> 3. Call your Manager as soon as possible …
> 4. At any time you require advice or support call your Service Manager ...
>
> …
>
> **Service Manager**
>
> The Service Manager will notify family/advocate if the incident is serious or if there is agreement to call them after an incident.
>
> …

2 REPORTING AND RECORDING INCIDENTS AND NEAR MISSES

2.1 How to Report and Record an Incident or Near Miss

All accidents, incidents and near misses must be reported by staff within **24 hours** of the incident or near miss occurring.

All incidents and near misses must be recorded on an Incident Report Form …

Staff will be instructed by their Service Manager of any support a Service User may require following an incident or near miss or alerted to or informed by information in the Person's information.

Staff

1 Record an incident has occurred in the Service User's "Daily Information Diary" …

2 Complete an Incident Report Form before the end of your work period, or within 24 hours of the incident.

3 Complete all boxes on the front of the form…

…

9 Fax or scan or email serious incidents to your Manager and then forward original to Manager.

…

2.4 Reporting and Investigating Critical Events[5]

Any critical incident must be reported to the Services General Manager as soon as possible but no later than twelve (12) hours after the event has occurred using the Critical Event Incident Reporting Form.

Critical incidents are reported to the Ministry of Health, using the Ministry of Health Critical Event Incident Reporting Form, by the Services General Manager within twenty-four (24) hours of the incident occurring.

Only the Services General Manager will forward completed forms to the Ministry of Health.

The person delegated by the Services General Manager to undertake the investigations will complete and record the investigation using the Critical Event Investigation Checklist and the Senior Manager Investigation Report template. Some investigations may be conducted by an independent person or teams.

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

102. The incident reports in relation to the inappropriate sexual and other behaviour from Mr A towards the aggrieved person were filed only in Mr A's name. In addition, there is no evidence that the incidents were recorded in the aggrieved person's daily information diary/running records to alert oncoming staff and provide them with information about how to further support the aggrieved person. The defendant's internal investigation found an incident report should have been completed for each man and noted in their daily information books, and that the failure to do so contributed to a loss of focus on the need to keep the aggrieved person safe.

103. When the Service Manager reviewed the incident report in relation to the 9 June 2017 incident she failed to record the incident as a critical event. This error was corrected by the Area Manager when she reviewed the incident reports for both the 9 and 13 June 2017 events. The Area Manager then followed the steps outlined in the policy for reporting a critical event.

104. The first recorded incident on 16 March 2015, the incident at the residential placement on 25 March 2015, and the incident that occurred on 16 March 2017 met the definition of a critical incident, but were not coded or treated as such.

105. With respect to follow-up action required after an incident or near miss the Incident Reporting Policy states:

> **3 FOLLOW-UP AFTER AN INCIDENT OR NEAR MISS**
>
> Service Managers are responsible for the follow-up action required when they are informed of an incident or near miss.
>
> For incidents where harm has occurred the Service Manager / On-call Manager must attend the site of the incident.
>
> Service Managers must assess the situation to determine whether those involved require a debrief session.

Service Managers must check that the front of the Incident Report Form records all relevant and necessary information.

All reported incidents and near misses must be investigated.

Service Managers must complete the Incident Investigation and Follow-up Actions sections on the back of the Incident Report Form when the investigation into the incident or near miss is complete.

Feedback must be provided to staff, Service Users and others involved in an incident or near miss. This includes the Service User's family/advocate.

Service Manager

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

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

For Service Users Who Have Been Exposed to Violence or Harm

Consider:

- Do they need to stay elsewhere (somewhere where they feel safe) until the situation has been managed?
- Does the person who caused the harm need to move to safety?
- If they stay where they are, how and by whom will they be supported?

- Making time with people involved to talk through what happened.
- Seeking advice from Senior Manager or Specialist Services staff.

…

For Incidents Where Other Types of Harm have Occurred

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

106. In all of the incident reports from 2015 to 2017, the Service Manager left the "IMMEDIATE ACTIONS TO BE TAKEN" section blank. There is no evidence that the Service Manager carried out any of the immediate follow up actions required by the Incident Reporting Policy.

107. The Service Manager was not immediately informed of the 9 June 2017 incident, but when advised of the 13 June 2017 incident, attended the day programme, and sent Mr A to the vocational programme he was supposed to be at that day. There are different accounts from the Service Manager and the Area Manager as to what support was offered to the aggrieved person after the incident on 13 June.

108. The Incident Reporting Policy sets out a process for investigating incidents and near misses and confirms it is the responsibility of the Service Manager to do so. The relevant section of the policy states:

4 INVESTIGATING INCIDENTS AND NEAR MISSES

4.1 How to Investigate an Incident or Near Miss

Service Managers must investigate all incidents and near misses and take action to prevent or minimise it happening again.

…

Service Manager

1. Check the Incident Report Form is complete and details are correct. If not, provide support to staff to correct or add to the information.
2. Follow-up with people involved in the incident to explore/investigate what happened …

> 3. Take detailed notes as you investigate the incident … Sign and date your notes.
> 4. Transfer key findings of investigations into section on back of the Incident Report Form.
>
> …
>
> 6. Complete the "Follow-up actions taken" and "Impact/ or Potential Impact of Incident" sections on the back of the Incident Report ensuring actions taken are aimed to prevent or minimise the incident occurring again.

109. The incident reports prepared by staff would not always be complete with some of the boxes on the incident report form left blank. There is no evidence that the Service Manager sought further information from staff in relation to the reports.

110. Under the heading "KEY FINDINGS OF INVESTIGATION" the Service Manager variously recorded that Mr A had a history with the aggrieved person, seeming to have an attraction towards him; that this was stereotypical behaviour for Mr A; and that Mr A had had an increase in inappropriate sexual behaviour, with concerns around his mental health. The main strategies documented in the incident reports to address these findings were that support/medical attention was to be provided to Mr A, and that the two men would be redirected or monitored. The defendant's internal review found that these interventions and strategies were not effective, as demonstrated by the recurrence of the inappropriate sexual behaviour from Mr A toward the aggrieved person. No alternative strategies were recorded as having been considered or attempted.

111. The only follow up action recorded as having been taken by the Service Manager on each of the incident reports was that she had followed up with staff, or had taken no further action. Other follow up action available included "caregiver/support user follow-up", "support/service plan amended", and "family notified".

112. The guidance provided on the "Coding of incidents or near misses" in the Incident Reporting Policy, included that the Service Manager must code incidents or near misses on an incident report form and that incidents of violence towards other (staff and/or Service Users) must be coded "Medium" or "High" (impact).

113. Despite a classification specifically for inappropriate sexual behaviour and critical incidents, the Service Manager classified all incidents at the day programme between Mr A and the aggrieved person as either "Behaviour other (including nuisance behaviour and screaming/yelling)" or "Physical Aggression". In addition, the Service Manager predominantly coded the incidents as having only a "low impact". The Service Manager has acknowledged that the ongoing incidents may not have been treated with the seriousness they deserved.

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

> **4.3 Signing Off Incident Reports**
>
> Service Managers must sign off all Incident Reports.
>
> Senior Managers must co-sign all Medium and High Impact Incident Reports following discussion at Incident Review meetings.
>
> **Service Manager**
>
> Before signing off incidents the Service Manager must:
>
> - Check that all sections of Incident Report have been completed.
> - Ensure actions have been completed.
>
> **Senior Manager**
>
> Before co-signing Medium and High impact reports the Senior Manager must:
>
> - Ensure there is sufficient information to confidently sign off the report as completed.
> - Ensure there is no further information required of the investigating manager prior to closing the incident investigation.

- Ensure actions are focused on preventing or minimising harm occurring again.

115. It is noted that irrespective of the impact category of the incident, all incident reports involving Mr A and the aggrieved person were signed off by the Service Manager and the Area Manager.

116. The Area Manager has indicated that rather than reading the incident reports, she relied upon a verbal report from the Service Manager, with a suggestion that what was verbally conveyed was different to what was recorded. This is disputed by the Service Manager.

117. The defendant has accepted that the Area Manager should have read the incident reports before signing each one, as the Area Manager fulfils an important quality check of the incident reporting process.

118. The Incident Reporting Policy includes a section on the monitoring and evaluating of incidents and near misses including identifying trends that require discussion at management and/or staff meetings. The policy states:

> **5 MONITORING AND EVALUATING INCIDENTS AND NEAR MISSES**
>
> **5.1 Staff Team Meetings**
>
> Incidents or near misses must be discussed at staff meetings and the effectiveness of any required changes monitored and evaluated.
>
> 1. Discuss incidents and trends at staff meetings.
> 2. Provide feedback to staff on changes needed (immediate / longer term) and discuss any learnings
> 3. Compete feedback section on the Incident Report Register (Service) following feedback at staff meetings and feedback to individual staff members.
> 4. Monitor and evaluate the effectiveness of any changes required as an outcome of investigation.
>
> **5.2 Incident Review Meetings**
>
> Management team must hold Incident Review Meetings to:

- Review High and Medium impact incidents.
- Identify and discuss any trends emerging from local registers and/or national database information.
- Identify the trends that need to be discussed further at management and/or staff meetings.

IDEA Services Review Meeting usually occur Monday or Tuesday and Thursday or Friday …

…

119. Staff team meetings were supposed to occur at the day programme on a fortnightly basis. In 2015, a total of 18 team meetings were held, and in 2016, only 11 team meetings were held. Prior to the June 2017 critical events only 2 team meetings had been held.

120. The defendant's internal investigation found that there were insufficient regular team meetings occurring at the day programme to provide effective management of incidents and that this had been an ongoing issue for some time which should have been identified and addressed well before the June 2017 incidents occurred.

121. On the Team Meeting Minutes form there is a section which provides for each service user to be discussed at least once over a one-month period. During 2015 to 2017 Mr A was discussed five times (3 times in relation to his inappropriate sexualised behaviour) and the aggrieved person was discussed four times. On 12 July 2016, when Mr A's behaviour was discussed, the notes record, "Inappropriate speech to others sexual behaviour e.g. exposing himself … CANNOT BE LEFT ALONE". On 15 November 2016 when the aggrieved person was discussed, the notes record, "Supervision at all times". None of the incidents involving both Mr A and the aggrieved person or related trends were discussed at the staff team meetings between 2015 and 2017.

122. Minutes from the Incident Review Meetings established that there were concerns with the aggrieved person's safety but the outcomes of the discussions and/or related action points were not documented. The incident review meetings were not occurring twice a week, were reported to be too short to share information and discuss incidents, and did not identify or discuss any trends evolving from the reported incidents of inappropriate sexual and other behaviour towards the aggrieved person by Mr A.

123. Between 2015 and 2017 staff team meeting notes specifically mention trends noticed about service users a total of three times. Neither Mr A nor the aggrieved person are mentioned in relation to trends. The defendant states that at the time there was an electronic record system that reported on incidents and could have been used by service managers and area managers on a regular or episodic basis to identify trends. In addition, the incident review meetings were an opportunity to identify that incidents between Mr A and the aggrieved person were being reported only for Mr A, which should have prompted a request for analysis or a trend report of all incidents involving the aggrieved person and Mr A.

124. There was a clear pattern of exposure to harm to the aggrieved person which the Service Manager failed to identify and to report on so that staff at the day programme could learn from the incidents and improve on strategies to keep the aggrieved person safe. Expert advice to the Deputy Commissioner was that trends did emerge for both the aggrieved person and Mr A and interactions reported with each other did show a pattern. The defendant's internal investigation concluded that there was insufficient attention to patterns/trends of incidents and near misses to inform a more systematic review.

125. In addition, the defendant was also subject to the NZHDS Core Standards, which enable consumers to be clear about their rights, and providers to be clear about their responsibilities for safe outcomes. The standards ensure that consumers receive safe services of an appropriate standard that complies with consumer rights legislation, and that services are managed in a safe, efficient, and effective manner.

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

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

128. Standard 2.3 states: "The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles". Criteria for this includes the organisation having a quality and risk management system which is understood and implemented by service providers.

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

130. In its care of the aggrieved person the defendant did not adhere to the NZHDS Core Standards by ensuring the aggrieved person received services in a safe manner and safe environment appropriate to his needs.

INTERNAL INVESTIGATION BY DEFENDANT

131. Following the critical events in June 2017, the defendant carried out an internal investigation. The investigation found:

a. The incidents that occurred between Mr A and the aggrieved person between 2015 and 2017 (including the two June 2017 critical incidents) were preventable.

b. Since 2015 there had been several incidents where Mr A had appeared to focus on the aggrieved person in an aggressive or inappropriate way but those incidents had not led to a systematic review of the two men attending the same service. Such review could have been triggered through team meetings, incident management team meetings, annual review and as a result of concerns raised by Ms D.

c. Due to the prior incidents and knowledge that staff and management had about Mr A's behaviour and the support that both the aggrieved person and Mr A required, both June 2017 incidents could have been prevented if appropriate steps had been taken to provide the support as assessed.

d. There appeared to be complacency in regards to the management of family concerns regarding safety of their family member within the Area management team and a loss of focus on the aggrieved person's need for safety, contributed to by the failure to complete separate incident reports for both Mr A and the aggrieved person.

e. There appeared to be a culture of acceptance of Mr A's sexually inappropriate or challenging behaviour without appropriate consideration of the impact on, or risk towards, others (including the

aggrieved person) that had established over time within some members of the support staff and within the management team.

f. There appeared to be almost a culture and certainly a practice of poor communication within the team, and between team and management, and across the services, as well as a tension between some core staff members as to responsibilities when senior members were absent. This likely contributed to the events investigated.

g. While support information and Alerts and Crisis information set out the need for constant supervision, i.e. never to leave either man alone, the ongoing incidents at the day programme were showing lapses in supervision. There is no evidence that a robust process had occurred to address the lapses in staff supervision and non-adherence to policy regarding both men when at the day programme on those notified occasions throughout 2015-2017. More timely systematic review of the placement of the aggrieved person and Mr A at the same vocational service was warranted, as was the need to ensure that appropriate risk management was in place in regards to the known risks. The lack of robust organisation and co-ordination of the day programme compromised the supervision requirements for Mr A and the aggrieved person.

h. The organisation, coordination, and management of the day programme, including assignment of workload amongst staff, did not provide sufficient surety as to who was responsible at all times to provide the requisite level of observation and support required of the aggrieved person and Mr A. The day programme did not appear to operate a clear process to allocate responsibilities for individual or specific activities on a daily basis, and who does what each day

appears to be loosely defined. The lack of clear coordination of staff and activities on the day appears to be a significant factor in both incidents occurring (9 and 13 June).

i. There was a failure to follow key organisational policy requirements, including incident management, reporting of abuse, health and safety (risk management) and complaint management. In addition, there was insufficient attention to patterns/trends of incidents and near misses to inform more systematic review.

j. There were insufficient regular team meetings occurring in the day programme to provide effective management of such aspects as review of programme delivery for each person on a regular basis, incidents and other organisational policies, and other quality information. It appeared this had been an ongoing issue for some time and should have been identified and addressed well before the June 2017 incidents occurred.

k. There were 22 incidents (inclusive of those involving the aggrieved person) reported in the period 16 March 2015 to 13 June 2017 in which Mr A exhibited either challenging or inappropriate behaviours. This showed a pattern that current support strategies and interventions were not being effective and required urgent review.

l. The concerns of Ms D and her request to be informed of incidents since July 2016 had not been fully met and if provided at the time would likely have led to significant change to the service provided to ensure the aggrieved person's safety at a much earlier stage.

m. There is no evidence of any analysis of trends or recurrence of the incidents between Mr A and the aggrieved person for the period 2015

to 2017. Each incident has been considered separately but a more systematic review including seeking specialist assessment and intervention was warranted given incidents appear to have involved the aggrieved person more than any other service user. Such review should have taken place at team meetings and/or the Area Incident Management team meetings. However the infrequency of team meetings for the day programme would have impeded such a review. The Area Incident Management team meetings failed to provide the oversight and critique effectively.

n. There was a lack of communication and team cohesiveness to provide effective support to the aggrieved person and Mr A. The lack of service leadership also impacted on communication with the team at the day programme and across services and between the support team and management of the service and particularly to convey the incident to other staff and managers at the time.

o. It was the responsibility of the Service Manager and Area Manager to take appropriate action to address the management of risk with the two men. This did not occur. This failure appears to have contributed to a general culture of complacency in regards to safety concerns.

p. Some staff members' understanding of organisational reporting requirements for any alleged abuse, and what actions they needed to take, was very poor. While staff had completed the defendant's abuse training, not all had received specific training on incident reporting (and those who had, received that training in 2006 and 2007); the infrequency of staff meetings at the day programme also would have impeded the opportunity for reinforcement of staff understanding

and confirmation of staff practice or organisational policies and procedures.

q. The aggrieved person's vulnerability for possible exploitation was not sufficiently assessed in his internal risk assessment and therefore his management plan and other personal support information lacked key guidelines and focus in this regard.

r. Mr A's risk assessment and management plan and other support information did not adequately reflect the risk of sexually inappropriate behaviours or clear approaches to reinforce socially acceptable behaviours.

s. IDEA Services did not meet its support obligations as an intellectual disability services provider for either the aggrieved person or Mr A in relation to the events occurring in June 2017, but also for a significant period of time leading up to that date.

IMPACT ON AGGRIEVED PERSON

132. In the months following the critical events of June 2017, the aggrieved person was observed by Ms D and family to be withdrawn and sad. Ms D reports the aggrieved person asked for help with tasks he had not needed help with before; frequently requested to be showered, and to have his clothing and underwear changed, even when they were not dirty; had ongoing issues with toileting; and had difficulty sleeping.

133. The aggrieved person's behaviour deteriorated. He became agitated at things that would not usually bother him and became verbally abusive towards family members. It became necessary to increase his medication to restore his sleep patterns and manage the behavioural changes. The

aggrieved person also began displaying sexualised behaviours he had not displayed before.

134. Further, the aggrieved person became obsessively focused on his toy cars, which were noted to be a coping mechanism for him. It was suggested by a child psychologist who had worked with the aggrieved person for some time that his focus on the toy cars was a way of blocking out thoughts and flashbacks of the abuse.

135. In January 2018, registered psychologist, Ms E, completed an assessment of the aggrieved person and diagnosed him with Other Specified Trauma-and-Stressor-Related Disorder which had developed in response to the events set out in this summary of facts.

EXPERT OPINION

136. Sandie Waddell, health and disability services auditor, provided expert advice to the Deputy Health and Disability Commissioner. Ms Waddell found the defendant had departed from the acceptable standards of care for a disability services provider in its care of the aggrieved person. Ms Waddell's advice to the Deputy Commissioner included the following:

    a. The apparent dysfunctional relationships between core staff and casual staff at the day programme, between staff and the Service Manager, and between the Service Manager and Area Manager were of concern. The resulting performance of all those immediately involved was compromised by the lack of clear and regular communication, inadequate supervision of direct reports, and non-adherence to organisational policy and procedure.

    b. Information available on the files of both the aggrieved person and Mr A was not used to guide staff in providing safe care. Casual staff were

not all aware of the specific supervision requirements for both men and of the need to keep both of them within eyesight at all times.

c. The responses of the Service Manager and Area Manager (to the incidents) did not reflect the standard that would be considered acceptable in the sector. This resulted from a lack of adequate team supervision and leadership, poor communication practices and an apparent lack of knowledge by the team involved at the day programme on the appropriate procedures and reporting requirements following an incident of this nature.

d. Given the history of incidents between the two men, it is surprising there is no evidence of a review of the appropriateness of both men attending the same vocational service, which would be expected, and in line with organisational policies and quality measures.

e. Correct procedures were not followed after the first incident on 9 June 2017. The Service Manager was not made aware of the first incident until the morning of the second incident, and staff had not phoned the Service Manager as required by the defendant's policies and procedures. Other staff working at the day programme and Mr A's residential placement were not made aware of the incident and the Service Manager did not act on the incident report when she received it (i.e.: no notification was made to the Area Manager or the aggrieved person's family). However, once the Area Manager learned of the 9 and 13 June 2017 incidents, her responses were immediate and appropriate.

f. The changes made to the 9 June 2017 incident report, to upgrade its urgency and classification, suggest staff were not clear about the different classifications and impact levels of incidents of this type.

This is a significant contributing factor to the subsequent lack of an immediate response.

g. The lack of effective leadership, communication, and supervision of staff was a crucial factor in the lack of appropriate responses in the management of the incidents, demonstrated by: a lack of regular team meetings (noting communication is essential); the Service Manager's apparent lack of understanding of the coding system for incidents or the level at which incidents become serious enough to be escalated; a lack of clarity around the roles, responsibilities, and workload of the staff; an apparent lack of specific instructions and support to staff from the Service Manager prior to and on the day of incidents regarding staff roles and the need for ongoing adequate supervision as set out in individual risk plans; and the lack of staff awareness of communication requirements following an incident including the need to inform the Service Manager of such incidents as occurred on 9 June as soon as possible.

h. Despite the Area Manager being aware of the lack of team meetings being held at the day programme with the Service Manager and her staff, no appropriate follow up occurred to determine if there were indeed any problems with the team and to work with the Service Manager to address these if any were subsequently identified.

i. At Area Incident Management team meetings, there were opportunities to initiate reviews that should have been conducted as trends did emerge for both Mr A and the aggrieved person and interactions reported with each other did show a pattern. This did not occur. The adherence to policy requirements regarding trend analysis and reviews was not apparent to provide sufficient support to the

Service Manager. The Area Manager did not follow up documentation that was overdue and all these actions will have been a contributory factor in the lack of cohesive approaches from all staff in the reporting process for the incidents under investigation.

j. The communication processes and relationship difficulties between the Service Manager and the Area Manager contributed to a lack of appropriate care to the aggrieved person which the Area Manager had the responsibility to address, as the senior manager. The failure to do so did not reflect sufficient adherence to acceptable management practice for this type of role.

DEFENDANT'S RESPONSE TO COMPLAINT

137. When the defendant became aware of the June 2017 incidents, it agreed an interim enhanced support plan with Ms D including the additional support of full 1:1 supervision and respite care to be provided until 24 September 2017. This additional support was not funded and continued until Ms D withdrew the aggrieved person from services on 25 August 2017.

138. Letters of apology were sent to Ms D by the Regional Manager and Chief Executive in June and July 2017 respectively. In the Chief Executive's letter, the internal investigation findings were outlined and acknowledged.

139. In recognition of what had occurred, the defendant wrote off the sum of $21,735 plus GST, being the cost for support delivered during 3 July – 20 August 2017.

140. Since early 2018, and in response to its own internal investigation, and the complaint to the HDC, the defendant has:

a. Completed a national Quality and Safety Review of Services in 2018 and has since actioned the review's recommendations;

b. Restructured its Service Manager role, with the new role seeing Service Managers spending more time with service users and their families to ensure that there is clear focus on transparency and communications with all stakeholders;

c. Introduced a new training programme for its management team, with an initial focus on Service Managers, and more recently, Area Managers;

d. Introduced a new electronic risk management system, which enables real-time incident reporting and monitoring for managers;

e. Introduced a new online client management system to replace the previous hard copy documentation framework.

f. Completed a project to develop and revise Easy-Read documents for support workers and a new operations manual for Service Managers, to increase all staffs' understanding of the defendant's policies and procedures; and

g. Established a new national Clinical Support team in 2018, which included the new Director of Nursing and a Senior Clinical Psychologist.

141. The defendant has also provided a further written apology to Ms D and the aggrieved person, and has complied with all other recommendations made

by the Deputy Health and Disability Commissioner in her report dated 13 November 2019.[6]

BREACH OF THE CODE

142. While receiving support from the defendant, the aggrieved person was repeatedly subjected to incidents involving another service user, including inappropriate physical and sexualised behaviour by that service user.

143. The defendant accepts there were a number of significant opportunities for the Service Manager and her team to prevent the reoccurrence of such incidents to the aggrieved person well before June 2017. These opportunities were missed owing to the inadequate supervision of Mr A and the aggrieved person by the Service Manager and her team; the failure to respond appropriately to the reported incidents to ensure that the inappropriate behaviour towards the aggrieved person was minimised; the lack of regular team meetings; a failure to address the concerns raised by Ms D, to ensure she received incident reports, and to notify Ms D of incidents relating to the aggrieved person; and a team culture where Mr A and the aggrieved persons' interactions, were minimised and normalised (with Mr A's behaviour often described as "stereotypical", "has happened before", and that the two men "had a history").

144. In light of the systemic level of the deficiencies identified across a number of staff and levels of management, the defendant was ultimately responsible for those failings and in particular, the critical events in June 2017. The defendant accepts that it had overall responsibility for the actions of its staff and had an overriding duty to keep the aggrieved person safe from harm, including from physical and/or sexual abuse.

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[6] 17HDC01082.

145. Right 4(1) of the Code states: "Every consumer has the right to have services provided to them with reasonable care and skill".

146. Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer".

147. The defendant accepts that it breached Rights 4(1) and 4(4) of the Code by not providing services to the aggrieved person with reasonable care and skill, and in a manner that minimised potential harm to the aggrieved person and optimised his quality of life. The defendant accepts this breach was due to systemic failures within its organisation. In particular, the defendant accepts that it failed to ensure that:

    a. Its processes that captured complaints, incidents, and issues did so in a way that kept the aggrieved person safe and resolved the concerns being raised by those incidents, and by Ms D;

    b. Its policies and procedures were applied in a way that led to learning and quality improvement to the ways in which the day programme could keep the aggrieved person safe and prevent the same or similar incidents between Mr A and the aggrieved person reoccurring;

    c. Its policies and procedures were well understood and implemented and embedded into day-to-day operations effectively. Across support worker, Service Manager, and Area Manager levels there was widespread non-adherence and/or misapplication of the Complaints Policy, Incident Reporting Policy and Abuse Policy, and therefore the organisation's system for preventing harm and abuse;

    d. There was no disconnect between how the defendant intended its policies to be applied and what was occurring in practice;

e. It had a positive organisational culture that treated the aggrieved person's safety as paramount, and that all staff took a zero tolerance approach to abuse; and

f. Staff were adequately trained on what constituted abuse, inappropriate behaviour, or a critical event.

148. Although the defendant had in place a system (its policies and procedures) within which incidents were reported, these incidents did not translate into meaningful learning for staff, nor did they lead to quality improvement of the service being provided to the aggrieved person. The significance of the systemic failures across the defendant's organisation is that they allowed the continuation of inappropriate behaviour occurring towards the aggrieved person for a period of two years, culminating in the critical events in June 2017.

149. Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive…".

150. The defendant accepts that it breached Right 6(1) of the Code by not providing to the aggrieved person, through Ms D, information that a reasonable consumer, in that consumer's circumstances, would expect to receive. In particular the defendant accepts that:

a. Ms D was not fully informed about the incident that occurred during the aggrieved person's residential trial in 2015;

b. Ms D should have been informed of all incidents relating to the aggrieved person;

c. Ms D was not informed of the critical event on 9 June 2017 when it occurred, and was not informed of the critical event of 13 June 2017 until three and a half hours after the event;

d. There was a sustained failure over a significant period of time to notify and inform Ms D about incidents when they occurred;

e. There was a sustained failure over a significant period of time to provide Ms D with incident reports that she requested;

f. The failures to provide Ms D with information about incidents relating to the aggrieved person resulted in missed opportunities to safeguard the aggrieved person from harm; and

g. The failure to provide Ms D with information about incidents that had occurred meant that she was not fully informed about serious and harmful events that had happened to her son.

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Greg Robins
Acting Director of Proceedings

I, for or on behalf of **IDEA Services Limited** agree that the facts set out in this Summary of Facts are true and correct.

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Ralph Jones, Chief Executive
For or on behalf of the defendant
IDEA Services Limited

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Date