1. EXECUTIVE SUMMARY

The initial review of the complaints that have been received have identified the following issues in regard to the care of the special needs clients by s49-sch4

1) The special needs clients are not provided with the agreed level of care and attention as required under the service agreements and there are numerous instances where special needs clients are left unsupervised for extended periods;
2) That has failed to provide a safe environment for the special needs clients during the time the clients are under the care of
3) Inconsistency of support workers and availability of careers appropriate to client's needs; and
4) Lack of appropriate communications with service provider and client carer.

1.1 Findings

As no systemic issues have been identified in relation to the compliant matters that have been made to the department, there are no specific recommendations to be made concerning the provision of suitable care to departmental funded clients.

As a number of the issues discussed with are currently the focus of a revision of current policies and procedures or are to be addressed with the introduction of new systems and procedures it is recommended that a compliance review be undertaken in 2017.

1.2 Recommendation

It is recommended that you note the contents of this report and:

1) approve that a compliance review of be undertaken in 2017; and
2) sign the attached advice to advising of the outcome of the Compliance Investigation.

RELEASE

1. Executive Summary

On s49-sch4 2017 the (the Centre) referred a number of 'serious concerns' to Compliance Services (CS) for investigation.

The 'serious concerns' alleged by the Centre were as follows:

1. Physical harm caused to a departmentally funded client as a result of the application of inappropriate, unsafe and medically non recommended physical restraints applied to the client;
2. The delayed response in the provision of appropriate training to the clients support workers leading to increased risk of harm to the client; and
3. The unauthorised use of 'restrictive practices' on the client which is a breach of the *Disability Services Act 2016* (DSA).

Section 16, of the *Community Services Act 2007* (CSA) allows for Authorised Officers from the department to conduct investigations as to whether a 'serious concern' exists as defined in section 16 of the CSA.

In investigating the alleged serious concerns, Authorised Officers considered the information held on the medical files and departmental client files and records with a view to determining the degree of harm to the client (pursuant to section 16(c) of the CSA).

Risk of harm considers potential for actual physical harm and any inadequacies in organisational systems and processes which heighten the risk of harm, e.g. use of untrained or inadequately trained staff.

To determine whether Restricted Practices were authorised for use by on the client, Authorised Officers considered the legislation under the DSA, the Short Term Approval (STA) application submitted by the additional time limiting conditions placed on the STA by the department that required to address, and the response times of The departmental policy in relation STA was also considered.

A compliance investigation has been undertaken in relation to the serious concerns within the context of the parameters of the CSA and DSA.

In brief the findings of the investigation by CS in relation to the 3 serious concerns identified by the Centre are as follows:

1. Physical harm to the client – unsubstantiated;
2. Increased risk of harm to the client due to delayed provision of adequate staff and training – substantiated; and
3. Unauthorized use of restrictive practices – substantiated but with some mitigation.

This report outlines the evidence based findings from the compliance investigation dealing with each of the above findings.

RTI RELEASE

1. EXECUTIVE SUMMARY

This matter was first referred to the Compliance Investigations Unit (CIU) on s49-sch4 2016 following the receipt of a number of complaints concerning allegations of abuse, neglect and harm involving a dob: a Department of Communities, Child Safety and Disability Services (the department) funded client under the care of The CIU commenced preliminary enquires in relation to the specific issues raised as they related to the client.

An interim report was published by the CIU on 2017.

In summary the findings from the CIU investigation as stated in the interim report were:

1) **Allegation of Assault**:– UNSUBSTANTIATED;
2) **Failure to provide adequate supervision – Failure in Duty of Care**:- Sufficient information available to substantiate that did fail in its duty of care to
    a. **Failure to Provide 1:1 care as funded by the department** - UNSUBSTANTIATED; and
3) **Critical Incident Reporting (Unreported Hospital Admissions)**:- Sufficient information available to determine that has failed to follow proper reporting policies and procedures in regards to Critical Incident Reporting.

In addition to the above the CIU also identified issues concerning 1) Inconsistencies in invoicing for Fee-for Service clients and 2) Inadequate security for a water hazard located at property.

To ensure that was given full consideration of procedural fairness was advised of the findings of the compliance investigations and provided with an opportunity to respond.

1.1 Substantiated Findings summary

As a consequence of enquires undertaken with regards to the complaints received concerning the care provided to and the response provided by to the initial findings from this investigation, the following conclusions have been reached:

1) **Failure to provide adequate supervision – Failure in Duty of Care**:- The CIU is of the opinion that there is sufficient information available to substantiate that did fail in its duty of care to

RTI RELEASE

The information provided by s49-sch4 in its response does not address the fact that the incidents involving did occur and that they did occur on more than one occasion.

The response provided by is typical of what was experienced by the CIU in undertaking this investigation being a total reluctance by to accept any level of fault or responsibility with regard to this issue.

2) **Critical Incident Reporting (Unreported Hospital Admissions)**:- The CIU is of the opinion that there is sufficient information available to determine that has failed to follow an acceptable and proper reporting regime in regards to Critical Incident Reporting as required under the terms of Service Agreement

1.1.1 Supplementary Issues

Incorrect Invoicing for Fee-for Service clients:- Dependent on the adoption of the recommendation contained in this report, matters surrounding concerns raised by the office with regards to Fee-for-Service billing will no longer be an issue.

Adequate security for water hazard located at property:- In response to the concerns raised in the interim report published 2017 and the recommendation that the Region make the necessary enquires to determine the suitability of the current barrier surrounding the pond area at the CIU has held initial discussions with the Region in progressing this issue.

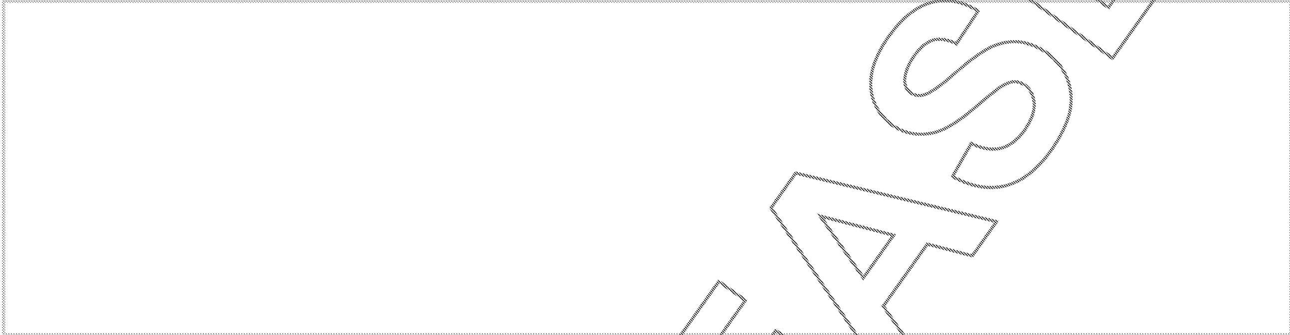
1.2 Recommendation

As a result of the findings from the CIU investigation as detailed in the interim report published on 2017 and giving full consideration to the response provided by it is recommended that the department does not undertake any further placement of departmental funded clients with

1. EXECUTIVE SUMMARY

On s49-sch4 2017, Ethical Standards received concerns regarding the alleged conduct of Residential Care Officer (RCO), Accommodation Support and Respite Services (AS&RS), Region.

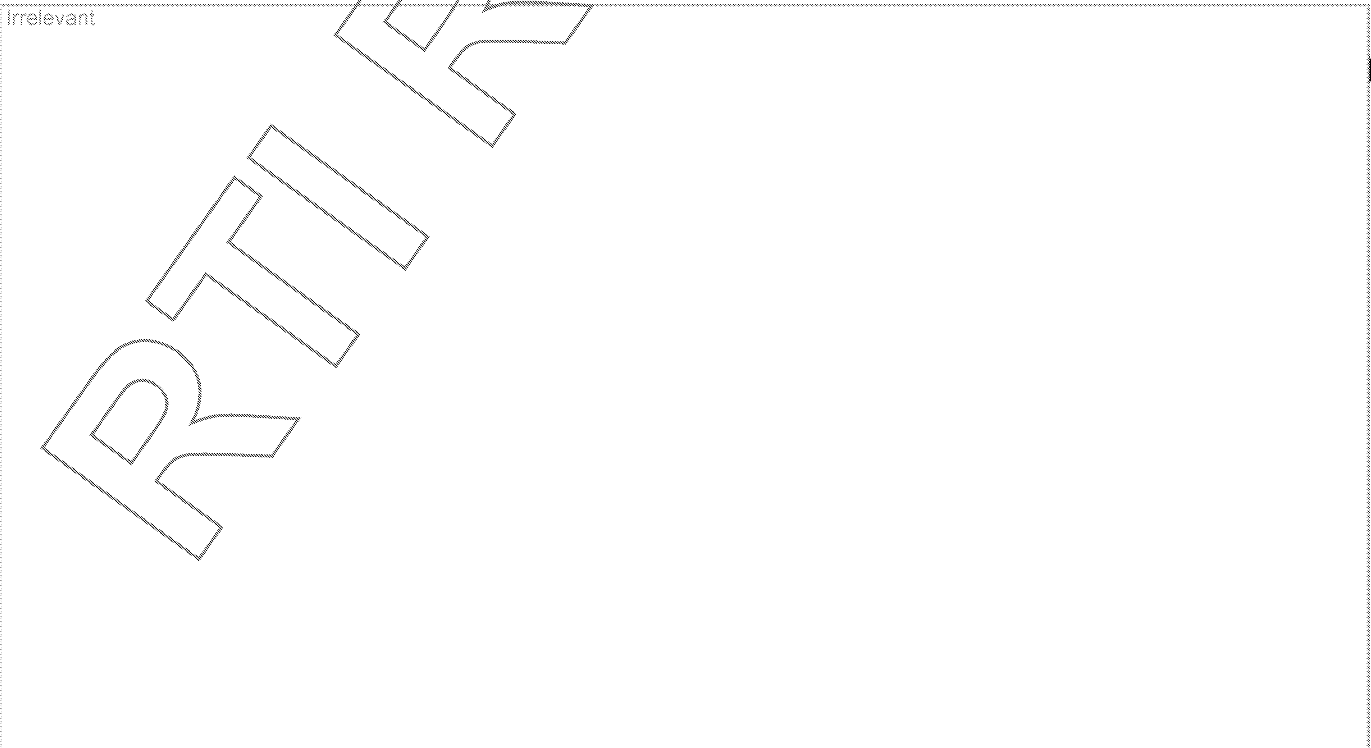
Within the information it was alleged that whilst rostered to support service users at a departmentally supported residence on 2016, 2017 and 2017, breached duty of care to and service users, relevant to their personal hygiene, medication, manual handling, dressing and transfer requirements.



Ethical Standards conducted an investigation into the allegations which included a review of departmental documentation and electronically recorded interviews with complainants, witnesses and the subject officer.

The investigation found, on available evidence, the allegation that between 2016 and 2017, Residential Care Officer, failed in duty of care to service user **is capable of being substantiated** on the balance of probabilities.

The investigation found, on available evidence, the allegation that between 2016 and 2017, Residential Care Officer, failed in duty of care to service user **is capable of being substantiated** on the balance of probabilities.



RTI RELEASE

1. EXECUTIVE SUMMARY

s49-sch4 was a service user with significant support needs. required full support, both at home and within the community.

is a service user with significant support needs. resided with at an AS&RS supported residence located at

On 2017, Ethical Standards received information from Senior Advisor, Human Resources Services in relation to an allegation raised against Residential Care Officer (RCO), Accommodation Support and Respite Services (AS&RS), Region. **(Attachment 2)**

On 2017, Direct Services Team Leader, AS&RS reported to Service Manager, AS&RS, via email, that:

- On 2017, was working with RCO, AS&RS at an AS&RS supported residence located at believed left service users unsupervised observed standing out the front of and did not see the service users in the area.
- On 2017, visited and observed alone however, quickly walked inside when became aware of presence.
- On 2017, entered to have a discussion with in relation to the service users' whereabouts during the incident on 2017. Upon entry, observed in the shower, and sitting at the dinner table. told that left the service users in on the grassed area at the side of the road.
- On 2017, following conversation with walked out of towards vehicle, and noticed that had followed to the bottom of the driveway. then showed where had left the service users the previous day. then realised that had left unattended in the shower.

In a Service User Report Form (SURF) dated 2017, RCO, AS&RS reported that at arrived for shift at Whilst conducting shift handover with became aware that had fallen earlier that morning and sustained significant facial injuries. Furthermore, had not written any reports in relation to the incident, or verbally reported it to management prior to arrival to shift.

On 2017, Ethical Standards commenced an investigation in relation to the allegation, including a review of documentation and interviews with

The investigation found, on available evidence, the allegation that between s49-sch4 2017 and 2017 failed in duty of care of service users residing at **is capable of being substantiated** on the balance of probabilities.

Irrelevant

RTI RELEASE

1. EXECUTIVE SUMMARY

On s49-sch4 2017, Ethical Standards received information in relation to allegations against and Residential Care Officers (RCOs), Accommodation Support and Respite Services (AS&RS) Region.

It has been alleged that at about on 2017, and engaged in a verbal altercation during a shift handover at the AS&RS at The details of the allegations were:

- Incoming RCO, had an argument in the office of the residence with during which both parties used raised voices.
-
- touched on the arm/elbow.
- As was unable to complete the handover with contacted Team Leader and departed the premises.

Ethical Standards conducted an investigation in relation to the allegations, which included formal interviews with the subject officers, a review of relevant departmental records and deliberation of the Code of Conduct for the Queensland Public Service.

The investigation found, based on the available evidence, the allegation that between 2017 and 2017, Residential Care Officer, Accommodation Support and Respite Services Region, engaged in inappropriate behaviour whilst at a departmental supported accommodation residence, in the presence of a service user, **is capable of being substantiated** on the balance of probabilities.

The investigation found, based on the available evidence, the allegation that that Between 2017 and 2017, Residential Care Officer, Accommodation Support and Respite Services Region, engaged in inappropriate behaviour whilst at a departmental supported accommodation residence, in the presence of a service user, **is capable of being substantiated** on the balance of probabilities.

An additional concern, regarding the use of restrictive practices toward a service user, was identified during the investigation and is explored within the investigation report. *(See Section 7.1)*

RTI RELEASE

Local Management Action

s49-sch4

Subject Officers:

Background

On 2017, the Department of Communities, Child Safety and Disability Services (DCCSDS) received a complaint from . The allegation was that upon arrival at approximately 9.30am on 2017 at worker found service user unsupervised in the household vehicle parked in the garage. The roller door was up, the engine was running, and the air conditioning on. and were the Residential Care Officers working at the residence.

Methodology

I undertook the following activities during this local management process:

1. Accessed, obtained, retrieved and copied all departmental records considered relevant to these allegations;
2. Reviewed relevant legislation, departmental policies, procedures, guidance and operating manuals;
3. Accessed, or made reasonable attempts to access any other evidence (ie. not held by the department) which was considered relevant to the allegations;
4. Conducted an interview with the complaint and other persons who could potentially contribute information relevant to the investigation;
5. Conducted an interview with the subject officer(s) in relation to their alleged involvement in this matter and obtained their responses to the allegations.

Interviews

I conducted the following face to face interviews:

Date	Name	Position
2017		Residential Care Officer
2017		Residential Care Officer
2017		Team Leader

conducted the following telephone interviews:

Date	Name	Position
2017		

Collection of Documentary or Other Evidence

Documentary Evidence

accessed, reviewed and obtained copies of the following documents:

Document Title or Description	Attached (Yes/No)
invitation to interview	Yes
Summary/Transcripts of interviews	Yes
letter of explanation (bought to interview)	Yes
Team Leader Shift Report for 2017	Yes
AS & RS Team Meeting Minutes 2017	Yes
AS & RS Team Meeting Minutes 2017	Yes
Comments Form for (inc 2017)	Yes
Incident Report Form for 2017	Yes

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MCFA Voucher for s49-sch4	Yes
	Yes
	Yes
Google Maps and Street View of	Yes
Interior layout	Yes
Service Centre Houses and Service Users	Yes
Household Vehicle Information	Yes
Household Vehicle Log	Yes
MCFA Budget for	Yes
Banking Passport	Yes
Banking Passport Household for four Service Users	Yes
Banking Passport Vehicle for four Service Users	Yes
Daily Report Log from (inc 2017)	Yes
Sign On Card and Shift Roster	Yes
Medication List	Yes
Individual Profile	Yes
Shift Duties	Yes

Discussion

Relevant aspects of the investigation as included below.

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s49-sch4

RTI RELEASE

Outcome

It is not disputed that was placed in the household vehicle parked inside the carport by at approximately on 2017. The garage door was up and the car engine was running.

There is no physical or documentary evidence to support claim that was placed in the household vehicle so could be taken on an urgent banking visit at and then transferred into the care of worker so the outing could continue. From the documentary evidence sourced during the investigation and after interviews held with the relevant people, I have been unable to identify a reasonable explanation as to why placed in the household car. References to "urgent" banking being required are convenient, and there are irregularities highlighted after the four interviews were conducted.

On the basis of the above inquiries, I have formed the view that s49-sch4 did not place in the household vehicle because needed to undertake urgent banking.

I am therefore unable to provide a suitable explanation as to why was in the household vehicle.

On the balance of probabilities, I believe the internal sliding door between the garage and the house interior was closed when the worker arrived.

I rely on the initial comments contemporaneously made in Incident Form, particularly "*...doors to house were closed & nobody was observing*

During this investigation, there were issues identified with the service users' personal bank account balances. From at least 2017 to 2017, account exceeded the $1500 limit. The four services users' household and vehicle bank accounts also significantly exceeded the limit. Further investigation into policies and procedures may be warranted if there is a legislative requirement to remit excess funds immediately to the Public Trust.

Conclusion

admitted that placed into the vehicle in the garage on 2017, and stated reason for doing this is not supported by the evidence. On the balance of probabilities, the allegations that was sitting in a vehicle in the garage with the engine running, that the garage door was open but the door to the house was closed, and that no one was watching are capable of being substantiated. The allegation that failed in duty of care to is capable of being substantiated on the balance of probabilities. In addition, as is not independently mobile and is unable to exit the vehicle without assistance, applied an unauthorised restrictive practice which is a denial of human rights.

RTI RELEASE

Recommendations
It is recommended that:
1. The conclusions reached above are accepted by the delegate.
2. The delegate provides outcome advice to the complainant AND/OR subject officer
3. The delegate provides outcome advice to Ethical Standards.

s49-sch4

RTI RELEASE

I accept the recommendations/I do not accept the recommendations

Comments:

Local Management Action

s49-sch4

Subject Officer:

Background

Incident One

1. On 2017, Clinician, advised Team Leader, Accommodation Support and Respite Services (AS&RS) that the kitchen tap handles had been removed and were in a container near the sink. Staff had removed the handles as it was believed it would help manage water consumption. However, this was not based on medical or clinical advice.

2. The handles were removed from approximately 2017 and were replaced on 2017, following a meeting between AS&RS and

Incident Two

1. On 2017, whilst being supported to attend a community access outing, became confused which vehicle to enter as there were two vehicles parked in the driveway. repeatedly entered and exited both vehicles. Direct Services Team Leader (DSTL), AS&RS saw hold hands to prevent free entrance into the vehicle would not be travelling in. dropped to the ground and picked up by the arms. There were no injuries to

2. has a Positive Behaviour Support Plan for Restricted Access to Object, the Behaviour Recording Sheet was completed and forwarded to clinician,

Methodology

I undertook the following activities during this local management process:

1. Reviewed Positive Behaviour Support Plan.

Interviews

I conducted the following face to face interview:

Date	Name	Position
2017		Manager Service Centre

RTI RELEASE

I conducted phone calls:

Date	Name	Position
s49-sch4 2017		Residential Care Officer
2017		Residential Care Officer
2017		Residential Care Officer
2017		Residential Care Officer
2017		Residential Care Officer

Documentary Evidence

I accessed, reviewed and obtained copies of the following documents:

Document Title or Description	Attached (Yes/No)
Email from dated 17	Yes
Positive Behaviour Support Plan	Yes
Team Meeting Minutes dated 17	Yes
Team Meeting Minutes dated 17	Yes
Service User report Form Dated 17	Yes
2 x Section 40 Complaints	Yes

Discussion of Evidence

Incident 1

On 2017 Clinician, Clinical Services advised AS&RS not to introduce any restricted practices around access to the tap. This instruction was included into the house team minutes on 2017.

On 2017 the tap handles were found to be removed by The taps were replaced by Direct Services Team Leader, immediately. As there was no medical or health issues identified with consumption of water, removal of the tap handles is considered an unauthorised use of a restricted practice.

Unannounced visits by the Direct Services Team Leader and Manager can verify this practice has ceased.

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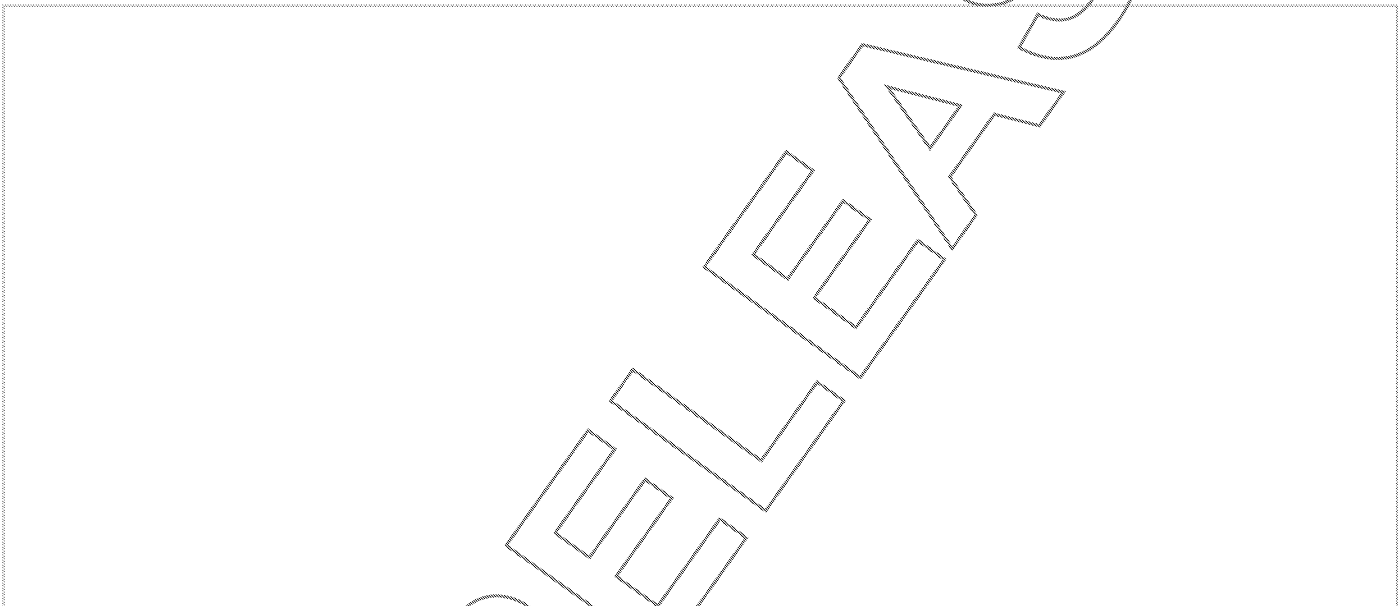
Outcome:

On the basis of the above inquiries, I have formed the view that the allegations are substantiated.

Regular s49-sch4 Team Members, attended a workshop on 2017 in relation to the legal implications of using restricted practices without the relevant consent. This meeting was chaired by the Manager of Service Centre, and the legal implications reiterated by the AO8 Manager,

Team Leader, did not attend.

has advised that is not confident that all the staff members were competent in understanding the requirements of the restrictive practices legislation.



Incident 2

On 17 physically restrained from entering other people's vehicles by holding hand and physically redirecting

Team Leader, spoke with regarding the unauthorised use of restrictive practices and noted in the house team minutes to allow time when entering a vehicle to alleviate concerns.

Outcome:

On the basis of the above inquiries, I have formed the view that the allegations are substantiated.

Positive Behaviour Support Plan was reviewed and consent provided by Guardian on 2017 and includes appropriate Physical Restraint.

Due to already completed activities I recommend no further action is warranted.

RTI RELEASE

Recommendations
It is recommended that:

1. The conclusions reached above are accepted by the delegate.
2. The delegate provides outcome advice to the subject officers
3. The delegate provides outcome advice to Ethical Standards.

s49-sch4

RTI RELEASE

I accept the recommendations/I do not accept the recommendations

Local Management Action

s49-sch4

Subject Officer:

Background:

and reside in a three bedroom home at supported by the Service Centre with a 24 hour awake model of support.

require support and prompting with all activities of daily living including personal care, medication management, meal preparation, domestic tasks and accessing the community.

is a Residential Care Officer (RCO) who has been rostered to provide support at

Assessment of Allegation:

It is alleged that inappropriately and without authority, provided alcohol to service users as a positive behaviour management strategy. This matter was referred to Ethical Standards Unit for assessment and it has been determined that the alleged conduct falls within category 3A of the Public Service Commission's CaPE framework and was returned to the region for Local Management Action.

Methodology:

I undertook the following activities during this local management process:

1. Conducted an interview with the complainant and other persons who could potentially contribute information relevant to the investigation (as detailed below in Section 5.2).
2. Conducted an interview with the subject officer(s) in relation to their alleged involvement in this matter and obtained their responses to the allegations.
3. Reviewed report book entries and Service User Report Forms (SURF'S)

Interviews:

I conducted the following face to face interviews:

Date	Name	Position
2017		Residential Care Officer

I conducted the following telephone interviews:

Date	Name	Position
17		Residential Care officer
17		Residential Care Officer

Collection of Documentary or Other Evidence:

Documentary Evidence:

RTI RELEASE

I accessed, reviewed and obtained copies of the following documents:

Document Title or Description	Attached (Yes/No)
File Note conversation between Team Leader s49-sch4 and RCO dated /17	Y
File note conversation - Manager and dated 2017	Y
File Note conversation - Manager and dated /17	Y
File Note conversation - Manager and dated /17	Y
File Note conversation - Manager and dated /17	Y
File Note conversation – Manager and dated 2017	Y
SURF from dated 17	Y
SURF from dated 17	Y
SURF from not dated	Y
Report Book entries	Y

Other Evidence:
Report Book entries
SURF's

Outcome:
On the basis of the above inquiries, I have formed the view that, on the balance of probabilities, inappropriately and without authority, provided alcohol to service users as a positive behaviour management strategy.

This view is based on the following reasons:

Management action has already occurred; specifically, medical advice has been sought and it is identified that both are able to be offered an alcoholic drink on special occasions only decision maker has been contacted and has consented for to be

RTI RELEASE

supported to have an alcoholic drink as per medical advice. Strategies have been put in place to cease the provision of alcohol to the service users on a regular basis which has included feedback to the team and updating of client information and plans. Management will schedule a meeting with s49-sch4 to develop an Achievement and Capability Plan (ACP) by 2018 to support a better understanding of the use of positive reinforcement. As noted the use of alcohol in the report book, it is considered that there was no malicious intent in implementation of this strategy however is now fully aware of the possible harm that could be caused.

Recommendations

It is recommended that:

1. The conclusions reached above are accepted by the delegate.
2. The delegate refer to HR for advice on appropriate disciplinary action.
3. The delegate provides outcome advice to the complainant AND/OR subject officer
4. The delegate provides outcome advice to Ethical Standards.

I accept the recommendations/I do not accept the recommendations

RTI RELEASE

Local Management Action

s49-sch4

Subject Officer:

Background

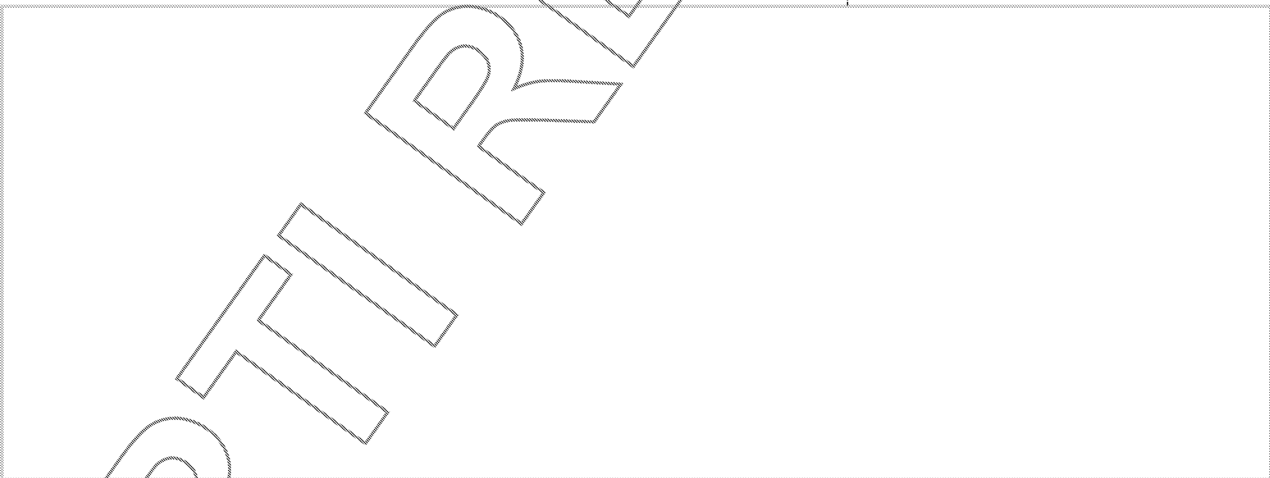
commenced as a Residential Care Officer (RCO) with the Service Centre in . Since then has has worked as a employee at

The house at is supported by the Service Centre and is the home of four clients including All four clients experience physical support needs including the use of hoists for all transfers. Support is provided 24 hours per day with awake overnight assistance and additional staff on duty from to support the activities of daily living including the following of detailed plans.

A plan is in place regarding how to support transfers and this plan outlines the need for two staff for all transfers and hoisting. All staff are supported during planning days and by Direct Services Team Leaders to understand and follow the plans available.

On 2017, RCO's, and reported that upon transferring to chair after shower that foot appeared to be in a different position. It was reported that did not seem to be any discomfort so they reposition and continued with the morning activities. After lunch, when and completed personal care, they noticed bruising which was not identified earlier in the day. The after-hours doctor was contacted and they requested upon examination that was taken to hospital for Xrays and further review.

Investigation and scans at the hospital identified soft tissue damage that would take four to six weeks to heal and that it was likely to have occurred during hoist transferring. Pain medication was prescribed.



It is noted that the Team Leader and the Direct Services Team Leader spend significant time at to support and coach staff and that all team members understand the need to follow plans to ensure positive outcomes for clients and staff.

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Methodology

The following activities during this local management process:

1. Accessed, obtained, retrieved and copied all departmental records considered relevant to these allegations;
2. Reviewed relevant legislation, departmental policies, procedures, guidance and operating manuals;
3. Attended and inspected all relevant departmental facilities and/or premises;
4. Conducted an interview with the subject officer(s) in relation to their alleged involvement in this matter and obtained their responses to the allegations.

Interviews

I conducted the following face to face interviews:

Date	Name	Position
s49-s@/17		RCO

Collection of Documentary or Other Evidence

Documentary Evidence

I accessed, reviewed and obtained copies of the following documents:

Document Title or Description	Attached (Yes/No)
Service User Report form /17 (	Yes
Service User Report form 17 (	Yes
Service User Report form 17 (	Yes
Service User Report form 17 (	Yes
Report 17 (DSSO)	Yes
File note '17 (interview with	Yes
Memo reminding staff of the need for two person transfers	Yes

Outcome

On the basis of the above inquiries, I have formed the view that, on the balance of probabilities, the allegation that on 2017, failed to follow support plan, resulting in bruising to is substantiated. It is recommended that advice be sought from Human Resources regarding the appropriate disciplinary action to be taken.

The Service Centre Manager will follow up with regarding support to clients as per plans and the team at will be reminded by the Team Leader of the need for all staff to follow all plans to ensure the safety and wellbeing of the clients.

This view is based on the following reasons:

-
-
-

RTI RELEASE

Recommendations
It is recommended that:

1. The conclusions reached above are accepted by the delegate.
2. The delegate provides outcome advice to the complainant and subject officer.
3. The delegate provides outcome advice to Ethical Standards.

s49-sch4

RTI RELEASE

I accept the recommendations/I do not accept the recommendations

Comments:

Local Management Action

s49-sch4

Subject Officer:

Summary of Allegations

On the 2016, Residential Care Officer, inappropriately physically abused when dragged inside the house.

Background

Refer to the attached Assessment of Allegation for background information.

Methodology

The process undertaken to conduct relevant inquiries consisted of the following activities:

Interviews

I conducted the following face to face interviews:

Date	Name	Position
/16		RCO

Collection of Documentary or Other Evidence

Documentary Evidence

I accessed, reviewed and obtained copies of the following documents:

Document Title or Description	Attached (Yes/No)
File Note	Yes
SURF	Yes
PBSP	

Summary of Evidence

The investigation process consisted of interviewing the relevant person and examining documentary and physical evidence where appropriate and relevant to the investigation.

The evidence presented in this report has been transposed directly from meetings and documents provided by those persons associated with the investigation and other referral sources

has a current Positive Behaviour Support Plan in place to manage high and complex support needs. There are no physical restraint strategies within the Positive Behaviour Support Plan.

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s49-sch4

y

Discussion of Evidence

does not deny that pulled by the legs from outside of the door to inside of the house, however stated that believed that was placing at risk by not returning inside the house. did not consider the option of contacting the Team leader or DSSO for assistance during this event.

agreed that did not read the support plans in place including the Positive Behaviour Support Plan that contains a strategy to support when does not wish to return inside of the house.

It is Identified in the report book that had a sore hand on the 2016 that bleed slightly after shower however hence it is unclear if this issue can be related to the action taken by No other injuries were identified and is supported to visit GP regularly.

Summary of Findings

It has been alleged that inappropriately physically abused when dragged inside the house. On the basis of the evidence available at this time, the allegation is capable of being substantiated on the balance of probability. It is noted that this was not intentional abuse and that did not feel that had any other options to ensure the safety of

did not follow the strategies of Positive Behaviour Support Plan, placing at risk of harm.

Recommendations
It is recommended that:

1. The findings outlined in the summary findings section of this report be accepted by the delegate;
2. The delegate provides outcome advice to the complainant and/or subject officer; and
3. The delegate provides outcome advice to Ethical Standards.

RTI RELEASE

s49-sch4

I accept the recommendations/I do not accept the recommendations

Comments:

RTI RELEASE