



Chief Ombudsman’s opinion under the Ombudsmen Act

Legislation	Ombudsmen Act 1975, ss 13, 22
Agency	Ruru Specialist School Board of Trustees, Ministry of Education, Education Review Office
Complaint about Ombudsman	Use of seclusion Peter Boshier
Case number(s)	407247
Date	7 November 2017

This report has been amended for publication. Names and other personal information have been removed for privacy reasons.

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Introduction

1. In October 2016, I announced my intention to investigate the use of seclusion in schools. This followed complaints from the parents ('Mr and Mrs M') of a student ('N') at Ruru Specialist School (Ruru) in Invercargill, and from the parent of a student at Miramar Central School (Miramar) in Wellington.
2. This report sets out my opinion in relation to Mr and Mrs M's complaint.

Summary

3. In July 2015, Mr and Mrs M complained to the Ombudsman about the alleged abuse of their son N and other students, by staff at Ruru. Their concerns included that N was secluded in a room that Ruru referred to as its '*safe area*'.
4. I have investigated the use of the '*safe area*' at Ruru to manage N's behaviour, as well as related actions and omissions by the Ministry of Education (the Ministry) and the Education Review Office (ERO).
5. While I have found no evidence of unlawful actions (under the legislation at the time) by any party, or that ERO acted unreasonably, I have formed the opinion that:
 - a. Ruru acted unreasonably in using its '*safe area*' to manage N's behaviour. In particular:
 - i. it failed to consult with Mr and Mrs M about the proposed use of the room or inform them about its actual use;
 - ii. it failed to clearly and accurately record transportation to, and use of, the room;
 - iii. the room was unsuitable in location and form for the purpose for which it was used; and
 - b. the Ministry's failure to provide schools with clear and unambiguous up-to-date guidance in relation to the use of seclusion was an unreasonable omission.
6. I recommend that Ruru: provides N and his parents with an apology for its failings if Mr and Mrs M wish to receive this¹; provides me with copies of its current policies and procedures for incident reporting and the use of physical interventions to transport students; and provides me with a report on its most recent audit of behaviour management plans.

¹ See footnote 18 for further context.

Background

7. On 22 July 2015, Mr and Mrs M complained to the Ombudsman about the alleged abuse of their son, N, and other students, by staff at Ruru.
8. The events leading to Mr and Mrs M's complaint date back to 5 November 2014, when there was an incident involving N, then aged 13, as he boarded a bus to return home from school. It is understood that N was unhappy about the seating arrangements on the bus and, on the basis of an account from the driver, Mr and Mrs M were concerned about the way in which a teacher-aide dealt with the situation. Mr and Mrs M initially raised their concerns about this and other matters with the Principal and Deputy Principal. On 23 November 2014, they submitted a complaint to the Chairperson of the Board of Trustees (Board Chair), outlining concerns about communication, emotional harm, and treatment (including unexplained bruising and bullying).
9. On 25 November 2014, Mrs M wrote a further letter to the Board Chair, outlining a third party's allegation about a teacher, including that the teacher had put a student into a cupboard when he played up. Mrs M noted that she had passed this information on to the Deputy Principal earlier, but had heard nothing further. In a letter dated 1 December 2014, the Board Chair advised Mr and Mrs M that she had discussed their concerns with the Principal and Deputy Principal and was satisfied their complaint had been adequately investigated. The Board Chair stated that without the informant's name the school was unable to conduct a *'full'* investigation as requested, but if they would ask the informant to contact the Principal further steps could be considered.
10. On 2 December 2014, Mr and Mrs M withdrew their son from Ruru. The following day, they met with the Board Chair, the Principal, and the Deputy Principal. At the end of the meeting, the Mr and Mrs M asked to see the *'little room'*, referring to a room their son had previously mentioned. They were shown a small room in the corner of a classroom, which Ruru referred to as its *'safe area'*. Mr and Mrs M were shocked by what they saw and left immediately.
11. Mr and Mrs M raised their concerns about Ruru with the Police and Child, Youth and Family, and with the Ministry. On 10 December 2014, the Ministry advised that the *'safe area'* had been closed and that it would be investigating matters arising from the complaint.
12. The Ministry commissioned a human resources consultant to carry out the investigation, which was completed in February 2015. N was identified as one of five children placed in the *'safe area'* between 2011 and 2014. The Ministry-appointed investigator ('Ms O') outlined a number of concerns about the way in which Mr and Mrs M's complaints had been dealt with, and about Ruru's use of its *'safe area'*.
13. Ms O made 17 recommendations in respect of Ruru, and a final recommendation that the Ministry convene a national working party to consider the use of seclusion and restraint in schools and to investigate best practice models.

14. In March 2015, ERO commenced its scheduled review of Ruru. ERO was made aware of Mr and Mrs M's complaint by the Ministry, Ruru, and Mrs M. However, the review team was not informed of Ms O's report during the review or before issuing its draft review report for Ruru, in April 2015. ERO was subsequently advised of the outcome of Ms O's investigation and her recommendations. It then suspended the 2015 review and a further review was undertaken in 2016. The 2016 review report referred to Ms O's investigation, noting that the Board had responded to the recommendations with changes to policies, procedures, and practices. ERO indicated its intention to carry out its next review of Ruru in four to five years' time.

Chief Ombudsman commences investigations

15. On 14 October 2016, I confirmed my intention to investigate the use of seclusion in schools. I advised that my investigations would include the actions of Ruru and Miramar, the extent of the practice, and any related actions or omissions of government agencies.
16. I asked the Ministry to issue an advisory to schools requiring that the use of seclusion in schools be discontinued pending the outcome of the investigations.
17. This investigation in respect of Mr and Mrs M's complaint is in accordance with section 13(1) of the Ombudsmen Act 1975, which makes it a function of Ombudsmen to investigate the administrative conduct of agencies, such as school boards of trustees, the Ministry, and ERO, which affect anyone in their personal capacity.

Use of seclusion prohibited

18. On 3 November 2016, the Ministry advised schools that the use of seclusion in schools was no longer acceptable. It issued '*Guidance for New Zealand Schools on Behaviour Management to Minimise Physical Restraint*' (2016 Guidance), effective immediately.
19. The Ministry also advised that a legislative change was being proposed to reinforce the prohibition on the use of seclusion in schools (and to provide schools with further certainty regarding acceptable practice in relation to the use of restraint).
20. On 15 May 2017, the Education (Update) Amendment Act 2017 was enacted. This provided for the insertion of a new section in the Education Act 1989 relating to seclusion. Under section 139AB, the use of seclusion at or on behalf of a registered school or early childhood service is prohibited.
21. The 2016 Guidance was reviewed to align with the new legislation and in August 2017, the Ministry issued '*Guidelines for Registered Schools in New Zealand on the Use of Physical Restraint*' (2017 Guidelines). These guidelines refer to the legislative ban on the use of seclusion in schools and early childhood services, and the availability of further information about seclusion on the Ministry's website.

Police investigations

22. Mr and Mrs M were advised that the matters they had raised in their complaint to the Police did not give rise to criminal offending and no further investigation was warranted.
23. Following a complaint to the Independent Police Conduct Authority (IPCA) in August 2015, the Police undertook to reinvestigate some matters. That investigation was completed in March 2017. On 21 March 2017, the Police released a media statement advising that there was no evidence to support any criminal charges.
24. Mr and Mrs M have recently advised that following a further complaint to the IPCA, it (the IPCA) is investigating the Police re-investigation.

Complaint

25. Mr and Mrs M's initial complaint to my Office was wide ranging. They identified more than 60 specific issues in respect of Ruru and its staff, the Ministry, ERO, and CYF, with additional concerns raised in subsequent correspondence. Their concerns in relation to Ruru, the Ministry, and ERO included the following:
 26. Ruru
 - a. the alleged physical assault of their son by a teacher-aide in November 2014, and the way in which this was subsequently dealt with;
 - b. the emotional abuse of N by staff;
 - c. a failure to investigate unexplained bruising;
 - d. inadequate communication with them, and between management and the Board;
 - e. the use of a seclusion room at Ruru, and
 - f. a range of information and communication issues relating to the seclusion room and the Ministry's investigation, including deception and misinformation.
 27. The Ministry
 - a. the adequacy of the Ministry's investigation; and
 - b. pressure to make alternative schooling arrangements for N, following his removal from Ruru.
 28. ERO
 - a. the adequacy of its review of Ruru;
 - b. its response when alerted to their concerns and the Ministry's investigation; and

- c. a failure to report on the existence and use of a seclusion room at Ruru over a 16-year period.

Investigation process

29. In December 2016, I advised Mr and Mrs M that the issues arising from their complaint that I intended to investigate were:
 - a. whether Ruru acted unlawfully, unreasonably, unjustly, oppressively, or improperly discriminatorily by using its 'safe area' to manage N's behaviour;
 - b. whether, by act or omission, the Ministry unreasonably or unlawfully caused or contributed to the seclusion of N;
 - c. whether, by act or omission, the Ministry unreasonably or unlawfully caused or contributed to the use of seclusion generally;
 - d. whether ERO took sufficient and appropriate action in respect of the complaint about Ruru; and
 - e. whether ERO had appropriate systems in place for the oversight and monitoring of seclusion in schools.
30. I advised Mr and Mrs M that in all the circumstances, I did not consider an Ombudsman's investigation in respect of their other concerns to be necessary, on the basis that they had already been investigated by the Police or the Ministry, or they were not matters about which I could reasonably form an opinion, or because an investigation would not achieve the resolution they were seeking.
31. Under the Ombudsmen Act 1975, I have the authority to hear or obtain information from such persons as I see fit, make such enquiries as I see fit, and regulate my procedure as I see fit.²

² Section 18 provides that:

(3) An Ombudsman may hear or obtain information from such persons as he thinks fit, and may make such inquiries as he thinks fit. It shall not be necessary for an Ombudsman to hold any hearing, and no person shall be entitled as of right to be heard by an Ombudsman [...]

(7) Subject to the provisions of this Act and of any rules made for the guidance of Ombudsmen by the House of Representatives and for the time being in force, an Ombudsman may regulate his procedure in such manner as he thinks fit.

Section 19 provides that:

(1) Subject to the provisions of this section and section 20, an Ombudsman may from time to time require any person who in his opinion is able to give any information relating to any matter that is being investigated by the Ombudsman to furnish to him any such information, and to produce any documents or papers or things which in the Ombudsman's opinion relate to any such matter as aforesaid...

(2) An Ombudsman may summon before him and examine on oath—

32. After reviewing a range of information from Ruru, the Ministry, and ERO, I met with Mr and Mrs M (and briefly with N), and with representatives from Ruru, in April 2017.
33. It was evident from these meetings that Mr and Mrs M's understanding as to what had occurred at Ruru and with their son was significantly different from Ruru's account. There were high levels of mistrust on both sides. I was aware that a number of staff and ex-staff from Ruru who were interviewed during the initial Police investigation had declined to be interviewed by the Police during the 2016–17 re-investigation into related matters.
34. In these circumstances, I sought to proceed by way of a further meeting to be attended by Mr and Mrs M and Ruru, at which I would hear relevant evidence from key people.
35. That meeting took place in Invercargill over 1½ days in June 2017. I heard from a number of staff and ex-staff from Ruru on the basis of prepared statements, in respect of which additional questions were asked. I did not require sworn evidence.
36. I heard from the following people:
 - a. the Principal;
 - b. Ms P, senior staff member;
 - c. Mr Q, former senior staff member;
 - d. Ms R, teacher;
 - e. Ms S, teacher-aide; and
 - f. Ms T, former teacher.
37. In July 2017, I met with ERO and the Ministry to discuss matters relating to both this complaint and the complaint about Miramar.
38. Having considered further Mr and Mrs M's complaint and their outstanding concerns, the enquiries and investigations already undertaken, and the changes that have since been made at a national level, I have determined that this investigation should focus on the questions and issues set out below. I note that the room that Mr and Mrs M allege was used to seclude N was referred to by Ruru as its 'safe area'. For the purposes of clarity and consistency, I refer in this report to 'Room A'.
 - a. How often was N placed in Room A?

(a) any person who is an officer or employee or member of any department or organisation named or specified in schedule 1 and who in the Ombudsman's opinion is able to give any such information as aforesaid; or

(b) any complainant; or

*(c) with the prior approval of the Attorney-General in each case, any other person who in the Ombudsman's opinion is able to give any such information—
and for that purpose may administer an oath.*

- b. Was N locked in *Room A*?
 - c. Was the door shut when N was in *Room A*?
 - d. Was N secluded?
 - e. Did Ruru act unlawfully by using *Room A* to manage N's behaviour?
 - f. Was the use of *Room A* to manage N's behaviour unreasonable?
 - g. Did Ruru communicate appropriately with Mr and Mrs M?
 - h. Was Ruru's record-keeping adequate?
 - i. What alterations were made to *Room A* after Mr and Mrs M's complaint?
 - j. The Ministry's response to Mr and Mrs M's complaint about Ruru
 - k. The Ministry's response to Ms O's recommendations
 - l. Ministry advice and guidance to schools regarding the use of seclusion, prior to Mr and Mrs M's complaint
 - m. The Ministry's awareness and oversight of the use of seclusion in schools
 - n. ERO's response when alerted to the complaint about Ruru and the Ministry's investigation into that complaint
 - o. ERO's systems for ensuring it was advised of and able to respond to any complaints or investigations regarding the use of seclusion
 - p. ERO's systems for reviewing seclusion or time-out rooms and their use, in the context of its role and responsibilities.
39. In light of the process used to investigate this complaint, I do not intend to set out in detail all of the evidence gathered. Rather, I include relevant contextual information and the information I have relied on in making my findings.
40. In August 2017, I provided Ruru, the Ministry, and ERO with my provisional findings (first provisional opinion) and invited their comment. After considering their submissions, I issued a second provisional opinion, in September 2017. All parties, including Mr and Mrs M, were invited to comment. As will be evident from what follows, this final opinion takes into account comments from all parties.

Defining seclusion

41. Prior to the Ministry's 2016 Guidance, there was no agreed definition of seclusion in the context of a school. There was a lack of clarity as to what constituted seclusion, how it differed from time-out, and acceptable practice for the management of challenging student behaviour, including that which posed a risk to students and staff.

42. The 2016 Guidance defines seclusion as:

When a student is involuntarily placed alone in a room, at any time and for any duration, from which they cannot freely exit. The door may be locked, blocked or held shut.

This may occur in any room that is lockable or, even if not locked, where a level of authority or coercion leads to a student believing that they must not or cannot exit the room in which they are confined.

43. Consistent with this, the Education Act 1989 was amended in 2017 to include at section 139AB:

(1) *A person to whom this section applies must not seclude any student or child who is enrolled at or attending a registered school or an early childhood service.*

To seclude, in relation to a student or child, means to place the student or child involuntarily alone in a room from which he or she cannot freely exit or from which the student or child believes that he or she cannot freely exit.

44. Although this is the definition I have adopted for the purposes of this investigation, I must necessarily take into account the fact that, at the time of the events leading to this complaint, that definition had not been articulated as it has now.
45. Where schools have or had dedicated rooms used for managing students exhibiting difficult behaviour, they have variously used terms such as time-out rooms, safe rooms or safe areas, quiet rooms, calm rooms, low stimulation rooms, and low sensory rooms. The name of the room is of little consequence; it is the nature of the room and the way in which it is used that matters.

Relevant information

Agency roles

School boards

46. The way in which schools in New Zealand operate changed considerably following the enactment of the Education Act 1989, which gave effect to the *Tomorrow's Schools* system of education. This introduced the self management of schools through individual boards of trustees.
47. Boards of trustees are responsible for the governance of a school and control of the management of the school. The board is responsible for ensuring its school provides its students with a safe environment and quality education. The Education Amendment Act 2013 provides that, except to the extent that any enactment or the general law of New Zealand provides otherwise, *'a school's board has complete discretion to control the management of the school as it sees fit'* (s 16).

48. A school's principal is the board's chief executive in relation to the school's control and management. Under section 76(2) of the Education Act 1989, except to the extent that any enactment or the general law of New Zealand provides otherwise, the principal is required to comply with the board's general policy directions but otherwise *'has complete discretion to manage as the principal thinks fit the school's day to day administration'*.
49. Section 78 of the Education Act 1989 provides for the government to make regulations providing for the control, management, organisation, conduct, and administration of schools. National Administration Guidelines (NAGs) relate to school administration. Under NAG 5, a board of trustees is required to:
- a) *provide a safe physical and emotional environment for students;*
 - [...]
 - c) *comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees.*

Ministry of Education

50. The Ministry is the government's lead advisor on the education system, with responsibility for strategic matters including property expenditure, the curriculum, and major policy matters. This includes administering a range of legislative and regulatory controls, and providing services that support the governance, management, and operation of education providers.

Education Review Office (ERO)

51. ERO provides independent external evaluation of schools (and early childhood services). The evaluation of a school has two purposes: accountability and educational improvement. Evaluation for accountability purposes involves reporting on goals and standards, including checking on compliance matters.
52. An ERO review considers a range of matters, including student health and safety. ERO evaluates a school's provision of a safe and healthy learning and working environment and a board's compliance with statutory legislation and legal requirements.

N

53. Mr and Mrs M describe their son as profoundly affected by Autism Spectrum Disorder. A Behaviour Assessment report from October 2011 refers also to a provisional diagnosis of Attention Deficit Hyperactivity Disorder and pronounced sensory sensitivity, with his parents reporting that sensory processing issues can have an enormous impact on N's ability to function as *'an emotionally regulated individual'*. It was noted that school attendance could be *'extremely difficult'* due to N's anxiety levels, and that he struggled with certain noises, busy environments, tactile sensitivity, and smells. He was described

as very bright and *'an effective verbal communicator with an extremely inquisitive mind'*. He can be highly anxious, which can result in challenging behaviour including physical and verbal aggression. The report describes several *'behaviours of concern'*, including self harm and harm to others.

54. N was enrolled at Ruru from 2011 until 2014, mostly attending a satellite class at Donovan Primary School (Donovan). His class teacher from 2011 to 2013 was Ms T. N had been home schooled for two years prior to starting at Ruru.
55. In light of the information provided to me by Mr and Mrs M about their communication with N regarding this matter, and my brief meeting with him, I did not consider it appropriate for me to interview N.

Information provided by Ruru and its staff

56. Ruru provides education for students with high and complex needs, from ages five to twenty-one years. It has a roll of approximately 60 to 65 students. It has a base school (Ruru base) and satellite classes at three host schools and the Southern Institute of Technology.
57. Ruru has consistently maintained that *Room A* was not a seclusion room, it has never used seclusion, and its focus in respect of managing difficult behaviours, including crisis situations, is on de-escalation to minimise the use of restrictive interventions.
58. In 2006, Ms P became the teacher in charge of behaviour management at Ruru and the school decided to adopt Safe Crisis Management (SCM), a specialised programme focused on preventing and managing crisis events through the use of de-escalation techniques. SCM was developed in the United States and adapted for use in New Zealand by the former Principal of Halswell Residential College, Paul Kennedy.³ In 2007, Ms P completed SCM instructor training (meaning she was qualified to train staff at Ruru in SCM) and Ruru formally adopted the programme.
59. SCM provides that in the case of particularly challenging behaviour where it is necessary to reduce the risk of harm posed by a student to themselves or others, physical restraint may be used. This is viewed as a last resort and its use is *'highly controlled, monitored, and recorded'*. In very limited circumstances, it may be necessary for a student to be placed in a safe area. At Ruru, this would be effected by the Crisis Intervention Team, a group of staff led by Ms P or, in her absence, the teacher responsible for behaviour management. In 2013, that was Mr Q.
60. *Room A* at Ruru was built in 1999 in the corner of a classroom at Ruru base, as part of a Ministry-approved upgrade of several areas within the school.
61. Ruru considers that, aside from one occasion when use of the room was not recorded, *Room A* was always used in accordance with its *'Safe Area Procedure'*. This stated that

³ SCM training in New Zealand is run by PACK Education, under license from JKM Training (USA).

the purpose of the room was to ensure student and staff safety, and the room was for use when there were behaviours posing a risk of harm to self, others, or property damage. The *'Safe Area Procedure'* included the following:

If necessary student to be facilitated to Safe Area with as little eye contact as possible and in silence.

When student is in Safe Area/Quiet Area, student will remain there for a specified time. Door is not to be closed.

The staff member who facilitates the student to the Safe Area/Quiet Area takes responsibility and stays with the student visually observing all behaviours.

The *'Safe Area Procedure'* also required an Incident Report to be completed and copied to the Principal whenever the room was used.

62. Staff noted that aside from the occasions on which students were put in *Room A* by staff, students would sometimes take themselves into the room.
63. Ruru also had a procedure for the use of physical intervention with students (*'Safe Crisis Management Physical Intervention'*). This identified three levels of physical intervention:
 - a. level (1) supportive physical interventions, which may include holding a student by the arm and leading them to a safe place, where the student does not resist;
 - b. level (2) supportive physical interventions/transport, which involves physical intervention to move an anxious/unwilling student who is resisting redirection, to a place of safety; and
 - c. level (3) restraint, where SCM-certified staff are required to maintain control of a student against their wishes.
64. The procedure required Incident Reports to be completed whenever level (2) or (3) interventions were used.
65. Staff from Ruru described N's behaviour as extremely difficult and unpredictable at times. It included hitting, kicking, biting, self harming, screaming, pushing, and throwing things. Staff also stated that at times he could be loving, kind, and sweet. Ms T stated that N was particularly unpredictable during his first 18 months at Ruru, but that his anxiety and stress levels reduced over the next 18 months and during the last few months he was in her class in 2013, he was very happy.

Use of *Room A* for N

Incident reports

66. According to the Incident Reports, *Room A* at Ruru was used on four occasions in each of the years 2011, 2012, and 2014. Three of the four Incident Reports from 2011 relate to N. The key information from those Incident Reports is as follows:

Date	Reason for use	Other comments	Staff involved	Duration	Parents informed?
28/3/11	Unsettled, yelling, screaming, throwing himself to ground and around classroom. SCM to transport N away from furniture to prevent hurting himself.	Transported to Ruru by SCM team, lashing out and hitting/kicking staff during transport.	Ms T, Ms U, Ms S, Ms P, Ms R	6 mins	Yes
29/3/11	Became upset, ran from end to end of classroom, falling to floor spontaneously, yelling and screaming. SCM to transport N away from furniture and students in event he may hurt himself or others accidentally.	Crisis team called to assist as behaviour causing disruption. Self harming when team arrived. Hit and kicked staff.	Ms T, Ms U, Ms S, Ms P, Ms R	5 mins	Yes
5/7/11	Unsettled, yelling and screaming, throwing himself around classroom (self harming). SCM to transport N away from furniture to prevent hurting himself.	On arrival of SCM team, lashing out at staff, attempting to kick and hit staff. N bit a staff member.	Ms T, Ms U, Ms P, Ms R	6 mins	Yes

67. Staff involved in these incidents had varying levels of recall, with the most detailed account provided by Ms P. The description of what generally occurred on these occasions was as follows:
- a. If N's behaviour was escalating and he was unable to be calmed, Ms T or a teacher-aide telephoned Ms P, as head of the Crisis Intervention Team.
 - b. Ms P and two other members of the team, Ms U and Ms R, drove from Ruru base to Donovan, approximately 800 metres away.
 - c. Ms U, as the driver, remained in the van.
 - d. Staff assessed the situation on arrival. If it was considered necessary to take N back to Ruru base, he was '*transported*' to the van using SCM physical interventions such as the '*bicep grip*' or '*extended arm transport*'.⁴ On some occasions, N calmed to the point that he was able to walk to the van without physical interventions.
 - e. A teacher-aide from Donovan who had witnessed the antecedent events and behaviour, Ms S, would accompany N and the team back to Ruru base.

⁴ '*Transport*' in this context means using physical interventions to move an anxious or unwilling person who is resisting redirection to a place of safety.

- f. The situation was reassessed on arrival at Ruru base. If it was determined that N should be put in *Room A*, students from the classroom in which *Room A* was located were taken elsewhere.
 - g. N was transported from the van into *Room A* by Ms P and Ms R.
 - h. Once N was in *Room A*, Ms P and Ms R would withdraw.
 - i. Ms S would stand outside the room, holding the door slightly ajar. Ms S stated:
[Initially] I would have my back to N to give him limited attention to de-escalate. The door would be open about a body width and I would turn and look at N every 30 seconds to evaluate where he was at.
As N de-escalated, the door would be opened more and more to the point where it was completely open against the wall.
I would then offer N a drink of water or to go to the toilet and then he would be asked to come out.
 - j. Ms P completed the 'Record of Usage' form, located next to *Room A*. A decision would be made on when or whether N should return to Donovan.
68. Staff explained that on some occasions, the Crisis Intervention Team was called but this did not result in use of *Room A*. On one occasion, no input was needed as N had calmed by the time the team arrived at Donovan. On some occasions, N was able to be de-escalated at Donovan by taking him to another area or to do another activity. On other occasions, N was taken back to Ruru base but had de-escalated on arrival, such that it was unnecessary to use *Room A*.
69. Staff were asked what prevented N, when he was in *Room A*, from attempting to push the door open and exit the room. They acknowledged that he could have done this but they did not recall him doing so.
70. In response to my second provisional opinion, Ruru stated that the level of physical intervention by staff was appropriate to the behaviour.
Ideally, no physical intervention was used but if N posed a threat to himself or others, staff had a duty of care to intervene. Staff must make a dynamic risk assessment which is proportionate—meaning balancing consequential risks associated with taking action, against the risks associated with inaction or alternative actions—all the while “in the moment” and thinking on their feet.

Use of *Room A* in 2013

71. Ruru initially advised that *Room A* was used for N on only the three occasions documented in its Incident Reports. In the course of this investigation, it was established that the room was used on one further occasion for N, when Mr Q was in charge of behaviour management at Ruru in 2013.

72. Mr Q stated that he *'vaguely'* recalled three occasions when he was asked to go to Donovan to assist staff with N and take him back to Ruru base. He recalled that after returning to Ruru base with N:
- a. on one occasion, N was *'guided'* into *Room A*;
 - b. N's behaviour settled over a short time, the door was open at all times, and he and a teacher-aide were present at all times to supervise N;
 - c. he does not recall a folder next to *Room A*, for recording use of the room; and
 - d. on the two other occasions when he brought N back to Ruru base, N was calm on arrival and was taken to the gymnasium to use the trampoline.

Information provided to Mr and Mrs M

73. Ruru acknowledges that when N started at the school, his parents were not shown or told about *Room A*. The Principal's explanation was that with the room used so rarely, this was not part of the standard orientation for the parents of new or prospective students.⁵
74. Ms T recalled that on one occasion, N arrived at school quite distressed and upset. Mrs M told her that N had said he didn't want to go into the *'little room'*, and asked what this was about. Ms T responded that *'it was a room at Ruru that students go to to calm down'*.
75. In respect of the occasions on which N was put in *Room A*, Ms T said she believes she told Mr or Mrs M about the behaviour, that she had called Ruru base, and that N had spent time there, but she does not think *Room A* formed part of her conversations with them.
76. In response to my second provisional opinion, Ruru noted that the Incident Reports indicated that Ms T had informed Mr and Mrs M, and it trusted that this had occurred.
77. In response to my first provisional opinion, Ruru advised that another member of staff recalls showing Mr M *Room A* in 2011. The staff member explained that when N was unsettled one morning, she took him and Mr M to the classroom in which *Room A* was located, and that N took himself into *Room A* while she sat in the doorway and spoke to him quietly until he had calmed. The staff member recalls Mr M indicating he thought it was *'great for N [as] he likes quiet small spaces ... the size of a wardrobe and places like that'*.

⁵ In response to my second provisional opinion, Mr and Mrs M's legal representative stated that the responsibility of Ruru to inform parents about the use of *Room A* increases, rather than decreases, with the rarity of its use and *'[this] correlates with the general duty found in other contexts that the higher the invasion of the personal right, the heavier the onus is on the imposing party to inform the person whose rights have been affected'*.

Additional Incident Reports

78. Ruru subsequently provided all of the Incident Reports where some form of physical intervention was used with N. It also provided its 'Anecdotal Notes', forms on which teachers record, on a weekly basis, their observations of each student and any action required.
79. From the nine additional Incident Reports and the Anecdotal Notes, I note the following:
- a. physical interventions were required on six occasions in addition to the three occasions that culminated in use of *Room A*;
 - b. there are no Incident Reports to describe the situation in which physical interventions were used to take N back to Ruru base, but he was not put in *Room A*;
 - c. one report refers to N being '*placed in his quite area*' [sic] (21 May 2012);
 - d. one report refers to N being assisted to '*a safe area*' and supported to '*a quiet area*', and that the consequences of his behaviour were '*Quiet Area*' and '*Behaviour Management Assistance*' (21 May 2013);
 - e. one report lists '*Quiet Area*' and '*Loss of Computer*' as the consequences following an incident, although there is no clear reference in the description of events or staff reflection to a quiet area being used (29 August 2013);
 - f. the Anecdotal Notes refer explicitly to the Crisis Intervention Team being called for support on nine occasions, all of which were in terms one and two of 2011;
 - g. the Anecdotal Notes for week two of term two and week two of term three in 2013 refer to N being sent to Ruru '*for disruptive behaviour*' (14 May 2013 and 7 August 2013) but there are no corresponding Incident Reports; and
 - h. the Anecdotal Notes for week six of term two in 2013 refer to N being taken to Ruru twice due to '*major disruption*' (13 June 2013), but there are no corresponding Incident Reports.
80. In response to the observations above, Ruru noted that:
- a. all classrooms had designated quiet areas, and there were other quiet or break away spaces where N could calm, including a pop-up tent, an adjacent classroom, and areas outside the classroom;
 - b. '*consequences*' refer to actions taken after an incident, and are different from the de-escalation process;
 - c. '*disruptive behaviour*' does not always lead to physical intervention; and
 - d. the language used in these reports could be confusing for an outsider reading them but staff knew what was meant, and procedural changes were made in 2015 to remove any ambiguity.

[Paragraphs 81-83 withheld for reasons of privacy. They contain information from an ex-staff member, which I have not relied on in making my findings.]

Additional information from Mr and Mrs M

84. Mr and Mrs M explained that they moved to Invercargill so that N could attend Ruru. They had researched the school and understood it would provide their son with ‘*a holistic 21st century learning environment*’.
85. Mr and Mrs M state that were not shown *Room A* and were not aware of its existence, until they asked to see it in December 2014. They have described the room that they saw as ‘*barbaric*’.
86. Mrs M was also a member of the Board and notes that she was not made aware of *Room A* in that capacity.⁶
87. Mr and Mrs M advised further that:
 - a. they were never informed when N was put in *Room A*;
 - b. they were sometimes told that N had returned from Donovan to Ruru base because he’d had a bad day, but they were not told if or when this involved the use of physical restraint;
 - c. within a few weeks of N starting at Ruru, there was a dramatic escalation of difficult behaviours and *[information withheld for privacy reasons]*;⁷
 - d. they and professional support staff spent a lot of time analysing the changes in N’s behaviour and strategising, unaware of how his behaviour was being dealt with at Ruru;⁸
 - e. had they been aware of *Room A* they would never have enrolled him at Ruru; and
 - f. they consider the way in which N was treated at Ruru has had an enormous impact on his physical, emotional, and psychological wellbeing.
88. After learning that their son had been put in *Room A*, Mr and Mrs M asked him about it on one occasion, in early 2015. At that time, N named several other students who had been in the room but said that he had not spent time in there. Mr and Mrs M believe

⁶ Mrs M resigned from the Board in March 2015.

⁷ In its response to my second provisional opinion, Ruru advised that its records indicate: *[information withheld for privacy reasons]*.

⁸ In its response to my second provisional opinion, Ruru noted that Ms T was also involved in the analysis and strategising about N’s behaviour at Ruru, and there were many lengthy emails to and from his parents about his behaviour, changes, and challenges.

that he responded as he did because if he admitted to having been in the room, he would be admitting to having misbehaved.

89. It was evident at the end of the meeting in June 2017, at which Mr and Mrs M had had the opportunity to hear from Ruru staff directly, that their views and concerns were largely unchanged. Mr M indicated that, if anything, what they had heard amplified their concerns.
90. In response to the information indicating that Mr M saw *Room A* in 2011 (see paragraph 77), Mr M advised he is adamant he was not shown the room in 2011 and that he saw it for the first time in December 2014.

Information from the Ministry

Key findings from Ms O's investigation

91. With respect to the investigation of Mr and Mrs M's complaints, Ms O found that:
 - a. the Board did not adequately follow the school's complaints procedure;
 - b. there was a blurring of lines on account of Mrs M being a member of the Board;
 - c. the Board minimised the seriousness of potential abuse allegations raised by Mrs M; and
 - d. the Board fell well short of its obligations.⁹
92. With respect to the use of *Room A*, Ms O noted that given the complexity of behaviour within the school's population, *'it is important to acknowledge that there may be times when the [student's] behaviour escalates to a point where staff intervention (both physical and non-physical) is required to safeguard the student, other students, and/or staff'*.
93. Her comments with regard to 'safe areas' generally and *Room A* at Ruru included the following:
 - a. The New Zealand School Trustees Association (NZSTA) had little information available about the use of 'safe areas' in schools, and could offer no guidelines. NZSTA advised that many schools had historically used old storage rooms as areas where students could be isolated if required.
 - b. Current research increasingly states that seclusion and restraint should be seen in the context of risk management only, it should not be used for punitive

⁹ Both Ruru and N's parents expressed concerns about the investigation commissioned by the Ministry, including that they did not have the opportunity to comment on Ms O's report before this was provided to the relevant parties in March 2015. I acknowledge these concerns. However, Ms O gathered information and identified a number of issues relevant to my investigation. I have taken the parties' comments about the investigation into account, and drawn my own conclusions.

reasons, and these practices must eventually be eliminated as they are inconsistent with a recovery approach.

- c. Parents and caregivers need to give permission for the use of a safe room and be explicitly informed if and when the room is used.
 - d. Ruru's procedures for use of *Room A* and physical restraint were '*loosely written*' and '*open to interpretation*'.
 - e. She found *Room A* to be '*dark and grimy*', and she '*could not describe the atmosphere in the room as pleasant*'.
 - f. The practice of transporting children from a satellite class to the base school to be held in *Room A* placed unnecessary and additional stress on the student and staff, is unsafe, and needed to be reviewed.
 - g. Documentation relating to use of *Room A* needed to be significantly improved.
 - h. *Room A* at Ruru should be closed. If the school continued to use a safe room, it should adapt or build one that more closely aligns with Health and Disability Service Standards (2007).
94. Ms O also noted that there was clear evidence in all of the documentation sighted that '*staff put considerable skill into managing and de-escalating the crises, thus seldom requiring the use of intrusive interventions or the use of [Room A]*', and that she had no concerns about staff levels of skill in SCM.
95. With specific regard to N, Ms O noted that:
- a. N's individualised Behaviour Management Visual Plans (BMPs) made no reference to any form of removal to *Room A*, explicitly or otherwise.
 - b. N's BMPs for 2011, 2012 and 2013 stated that he should not be touched or crowded. Transporting N in the van to *Room A* would contradict that instruction.
96. Ms O concluded with 17 recommendations for Ruru, and a final recommendation that the Ministry convene a national working party to consider the use of seclusion and restraint in schools and to investigate best practice models.

The 2016 Guidance

97. The Ministry responded to Ms O's final recommendation by setting up an Advisory Group, which convened for the first time in June 2015. The group included representatives from the School Trustees Association, education unions, principals' groups, the Ministry of Health, the Ministry of Education (including Ms O), and Child Youth and Family's High and Complex Needs Unit. The Advisory Group met once or twice a month between June and October 2015, and considered a range of information, including a series of background papers prepared by Ms O and legal advice.

98. By October 2015, two sets of guidelines had been formulated: *‘Physical Restraint’* and *‘Transitional Guidelines as we work towards the Elimination of the Use of Seclusion in New Zealand Schools’*. The draft guidelines were submitted to the Ministry to be finalised and disseminated. This involved seeking further legal advice and having a working group formulate a training package to support schools with the proposed guidelines. That group convened for the first time in February 2016. Further stakeholder consultation was undertaken and, from late July 2016, the Ministry began trialling the training package. By August 2016, a final draft of the training package had been prepared. At that stage, the Ministry’s intention was still to support schools to work towards the elimination of seclusion.
99. In October 2016, the Minister for Education directed the Ministry to work on ending the use of seclusion in schools as soon as possible. The two sets of draft guidelines were combined into one document and amended to reflect the change in approach. On 3 November 2016, the Acting Secretary for Education wrote to all schools advising that the use of seclusion was no longer acceptable and the 2016 Guidance was issued.
100. The Ministry identified that the issuing of guidance would likely encourage schools to stop using seclusion but may not end the practice entirely. Legislative change was proposed accordingly.
101. The Ministry acknowledged that the process of developing the new guidance took longer than anticipated, attributing this in part to it being developed by a cross-sector led group. In addition, there were areas of disagreement that took time to work through and consult on.
102. The Ministry acknowledged that it could have acted sooner and perhaps provided schools with interim guidance on the areas where there was agreement, such as the use of preventative and de-escalation techniques for managing behaviour.¹⁰

Previous guidelines

103. As outlined above, the 2016 Guidance included a definition of seclusion and advice that its use is no longer acceptable. The use of seclusion in schools is now prohibited by law.
104. Prior to this, the Ministry had developed guidelines in 1998 on *‘Managing Extreme Behaviour in Schools’* (1998 Guidelines). These were described as primarily a resource for classroom teachers. They were revised in 1999 and 2005, and effective until the 2016 Guidance was issued. The 1998 Guidelines did not refer to seclusion, but they referred to time-out rooms as follows:

¹⁰ As noted in paragraph 21, the 2016 Guidance was updated in August 2017 to align with the new legislation—see: <https://www.education.govt.nz/assets/Documents/School/Managing-and-supporting-students/Guidance-for-New-Zealand-Schools-on-Behaviour-Mgmt-to-Minimise-Physical-....pdf>.

Timeout is when a student is removed from other students for a specified period of time. Sometimes special timeout rooms are used. Timeout is often misused and misunderstood.

Timeout rooms should not be used. They are not necessary and can result in teachers and schools being accused of using inhumane and cruel punishments.

A major disadvantage of timeout is that it does not teach the student alternative appropriate behaviours. Use Mini-timeout or Easy Change.¹¹

105. In October 2007, the Ministry issued 'Time-out and Physical Intervention Practice Guidelines' (2007 Guidelines). These were developed for internal use by Ministry Special Education staff working with children and young people who presented with challenging behaviour in an early childhood or school setting. The 2007 Guidelines stated:

Isolation (Seclusion)

Sometimes when teachers refer to time-out, they are referring to a procedure, which involves removing the child/young person to a 'time-out room'. This is one type of time-out and is discussed in these guidelines under the heading of isolation. Isolation involves placing the child/young person in an environment such as a room, by him or herself, for a specified period. [...]

The Ministry of Education, Special Education does not recommend any form of time-out procedure in an Early Childhood/School setting, which involves a child/young person being shut in a room, or screened area, by him or herself without any way of getting out unless someone comes to release them. This is a form of isolation (seclusion) and is not an appropriate practice in an Early Childhood/School setting.

106. The 2007 Guidelines also outline circumstances in which physical intervention and restraint may be appropriate:

Physical intervention/restraint can only be used in an emergency or as part of a planned safety procedure when an incident of serious and challenging behaviour is occurring and the child/young person and/or others is in immediate physical danger.

The types of restraint described include 'Mechanical/Environmental' restraints, such as fastening doors so that a young person is not able to leave the room.

¹¹ Mini-timeout is described as 'a planned procedure where a student removes him or herself to a specified space nearby for a brief period of time, usually less than a minute. Students choose to use Mini-timeout.' Easy Change is 'a planned alternative activity in which students can be motivated to walk unassisted (but accompanied) ... to engage in an alternative previously practised activity which has a calming effect...'

107. Ruru has advised that it was never provided with the 1998 Guidelines nor any of the subsequent revisions, and that it was not provided with the 2007 Guidelines until after the Advisory Group was set up in 2015.

Safe Crisis Management programme

108. The Ministry advised that having reviewed its records, it has no information to indicate that the Ministry held or communicated an official position on the SCM programme used by Ruru. It noted that individual Ministry advisors or practitioners may have tacitly or explicitly acknowledged or endorsed the use of the programme, but it is unable to confirm this.

2016 survey of schools

109. In October and November 2016, the Ministry undertook a survey of all 2529 state, state integrated, partnership and private schools in New Zealand, to identify which schools were using seclusion and to work with those schools to eliminate its use. Stage 1 of the survey involved schools self-identifying as using or potentially using seclusion. Stage 2 involved Ministry staff visiting the schools that had self-identified using seclusion in 2016 and discussing current practice.

110. Of the 36 schools that self-identified as potentially using seclusion:

- a. five had not used seclusion in 2016;
- b. 14 were considered to have used appropriate time-out behaviour management practices that did not constitute seclusion; and
- c. 17 were considered to have used seclusion in 2016.

111. Of the 17 schools that were considered to have used seclusion, five were special schools (ie, schools for students with high needs).

112. The Ministry acknowledged that in relying on schools to self-report, there was a risk that some schools may not have reported the use of seclusion. It noted this could have occurred for a variety of reasons, including the lack of clarity that had existed in the terminology used.

113. By the end of November 2016, the Ministry confirmed that all of the schools that had self-reported using seclusion in 2016 had ceased the practice and were using appropriate behaviour management techniques.

Information from ERO

Responsibilities and review process

114. ERO advised that the reviews carried out by or on behalf of the Chief Review Officer are formal assessments of the education service provided by schools and that:

- a. it does not have powers of investigation and enforcement in relation to health and safety issues;
 - b. the focus of an ERO school review is to look at the school's performance in learning, teaching, leadership, and governance;
 - c. before a review, ERO requires schools to complete a Board Assurance Statement and Self-Audit Checklists (BAS);
 - d. the BAS is a tool devised by ERO for school boards, as a self-audit checklist on compliance matters; and
 - e. the use of the BAS by ERO is *'very much based on a "trust" approach to statutory (and best practice) compliance by school boards'*.
115. It also maintained that the Education Act 1989 *'does not contemplate ERO investigating or monitoring issues such as seclusion in schools'*, although I note that ERO does report on health and safety issues arising from a review, which would include any risks to health and safety of students associated with the use of seclusion. ERO advised further that its reviews are against best practice, guidelines, policy and advice and that there were no established best practice guidelines for the use of seclusion at the time of the 2015 review.

ERO's 2015 review of Ruru

116. ERO's on-site review of Ruru took place from 9 to 12 March 2015. At that time, the review team was aware of Mr and Mrs M's complaint but not the report commissioned by the Ministry. It appears that:
- a. There had been some communication between ERO and the Ministry about the complaint from Mr and Mrs M, in February 2015. This included an email that referred to the complaint being investigated by Ms O. However, that email was overlooked and not passed on to the review team.
 - b. During the on-site review, the Principal discussed Mr and Mrs M's complaint with the review team, but not Ms O's report.
 - c. Late on 11 March 2015, Mrs M emailed the head of the review team and noted the Ministry's investigation. That email was not sighted until the following afternoon, the last day of the site visit. The head of the review team replied to Mrs M, noting that ERO doesn't investigate or become involved in particular issues but would advise a complainant to seek resolution by using the school's own processes, as she appeared to have done.
117. On 26 March 2015, ERO's draft review report (known as the Unconfirmed Report) was emailed to Ruru for comment. The report stated that the school's priority was *'to provide a safe and supportive learning environment'* and that staff *'purposefully implement positive behaviour management strategies so that the focus can be on learning and*

successful interactions between students and staff. It was noted that, in addition to the BAS, ERO had checked a number of items with the potential to have a high impact on student achievement. These included the *'emotional safety of students'* and the *'physical safety of students'*.

118. On 31 March 2015, the Board Chair advised ERO that no changes were requested. The same day, the Ministry informed ERO's Deputy Chief Review Officer for the Southern region about Ms O's report and recommendations.
119. ERO then advised Ruru that it was withholding confirmation of the evaluation and that it was necessary to reconsider the findings in the Unconfirmed Report, particularly in relation to the provision of a safe physical and emotional environment.
120. On 3 August 2015, ERO advised that the report from the review carried out in March would be set aside, and a further review carried out in 2016.
121. The 2016 review report, dated 8 August 2016, included the following:

In 2014 [the Ministry] commissioned a report in relation to how well the school was providing a safe emotional and physical environment for students. The [Ministry] has informed ERO that the board has responded to the recommendations in the report and has made changes to policies, procedures and practices. The changes have improved the quality of relevant documentation, follow up and reporting about behaviour management and student safety.

Changes made

122. ERO advised that following these events it:
 - a. updated the Compliance Checklist for 2017 to provide greater clarity in the recording of complaints and other matters brought to ERO's notice during a review;
 - b. updated the Compliance Checklist to ensure review teams check and record how schools manage students with challenging behaviour;
 - c. revised the BAS for consistency with the 2016 Guidance;¹²

¹² The BAS has been further updated to align with the 2017 Guidelines. Section 3 of the Self-Audit Checklist relates to *'Health, Safety and Welfare'*. Within this section, question 3 refers broadly to behaviour management, while question 30 asks specifically whether the school board has *'developed policies, procedures and practices on good behaviour management practice, including elimination of seclusion and the need to minimise physical restraint for students and staff wellbeing that follow the Ministry of Education's Guide'*. Question 31 requires the school board to answer 14 specific questions about the use of physical restraint. Question 20 refers specifically to the welfare and safety of students at off-site locations, where premises outside the school are being used to provide education to students on a long-term or full-time basis.

- d. clarified with review officers its expectations in relation to the recording of how schools manage complaints; and
 - e. formalised its schedule of regional liaison meetings with the Ministry and agreed to the timely exchange of information.
123. Following my meeting with ERO in July 2017, it also agreed to amend the Compliance Checklist to ensure schools are asked directly about significant complaints and investigations.

Discussion—Ruru

How often was N placed in *Room A*?

124. It has been Mr and Mrs M's view throughout this investigation that N was placed in *Room A* far more often than Ruru has documented or acknowledged. That view is based in part on the number of times they were told that N had been taken from Donovan back to Ruru base.
125. I am satisfied that there were occasions on which the Crisis Intervention Team was called to Donovan but this did not result in N being put in *Room A*, either because the behaviour of concern was able to be managed at Donovan, or he was sufficiently calm on arrival at Ruru base such that *Room A* was not needed. Several staff said there were occasions when N was able to be de-escalated by redirecting him to another place and activity, such as the trampoline or the gym.
126. There were, however, marked variations in staff recollections as to the number of times the Crisis Intervention Team was called to Donovan because of N's behaviour, and the number of times he was returned to Ruru base.
- a. Ms P recalled that the Crisis Intervention Team was called approximately seven times. On three occasions N was taken back to Ruru base and put in *Room A*. On at least one occasion, he was calm when the team arrived at Donovan and so remained there. On two or three of the remaining occasions, N was taken back to Ruru base but not put in *Room A*.
 - b. Ms T recalled that in N's first few terms the Crisis Intervention Team was called quite regularly—perhaps twice a week—and that on about three-quarters of those occasions N was taken back to Ruru base. If that was the case, it would seem he may have been returned to Ruru base somewhere in the region of 40 to 60 times.
 - c. Ms R was uncertain but thought that she was called to Donovan as part of the Crisis Intervention Team on perhaps five or six occasions.
 - d. Ms S was also uncertain but indicated that N was returned to Ruru '*often*'.

- e. Mr Q, who was in charge of the behaviour management at Ruru in 2013, recalled being called to Donovan for N on three occasions in that year.
127. I do not consider that it is possible to draw any conclusions about the number of times N was placed in *Room A* from the number of times the Crisis Intervention Team was called or the number of times he was taken from Donovan to Ruru base.
128. However, according to Ruru's '*Safe Crisis Management Physical Intervention*' procedure, staff were required to complete an Incident Report for all incidents involving level (2) and (3) interventions—that is, when physical interventions were required to transport a student resisting direction to a place of safety, or restraint was required to maintain control of a student for reasons of safety. This is consistent with the information provided to me orally in June. I would therefore have expected to see a number of Incident Reports reflecting the situation in which physical interventions were used to take N to Ruru base, but *Room A* was not used. No such reports have been provided.
129. In my first provisional opinion, I noted two possible explanations: whenever N was taken to Ruru base but not put in *Room A*, he went voluntarily without the need for physical interventions, or physical interventions were used and Incident Reports were not completed. I stated that on the basis of the accounts provided by staff, the latter appeared more likely. In response, Ruru has advised that staff were not required to complete Incident Reports for actions that were part of a student's BMP. In the case of N, the use of '*SCM transport*' was part of his BMP so Incident Reports were not required. That exception does not appear to be provided for in the '*Safe Crisis Management Physical Intervention*' procedure.
130. Ruru's position is that N was placed in *Room A* on the three occasions documented in its Incident Reports, and the one further occasion in 2013, described by Mr Q. There is no evidence to show that N was placed in *Room A* more often than that. However, as discussed further below, I do not consider Ruru's records to be wholly reliable and, accordingly, I do not rule out the possibility that N was put in *Room A* on more than four occasions.

Was N locked in *Room A*?

131. Mr and Mrs M believe that when they saw *Room A* in early 2014, access was controlled by swipe card—that is, the room was able to be locked.
132. I am satisfied from the evidence I have seen, including accounts from staff and other witnesses, photographs from 2011 and 2014, and plans from 1999 for the installation of swipe card on some doors, that there was no lock on the door of *Room A*.
133. The photographs from 2011 and 2014 also show that there were handles on both the inside and the outside of the door.

Was the door shut when N was in *Room A*?

134. Ruru and its staff consistently stated that when a student was placed in *Room A*, the door was held open in accordance with the '*Safe Area Procedure*'. The staff present when N was placed in *Room A* advised that that was what occurred on those occasions.

135. There is insufficient evidence for me to conclude otherwise.

136. However, I am somewhat surprised that a student in a heightened state, placed involuntarily in a small room, would not attempt to get out including by pushing against the door (which opened outwards). In those circumstances, I would think it potentially more dangerous for both the student and the staff member, for the staff member to attempt to hold the door slightly ajar.

137. At the meeting in June 2017, I referred to an entry on an Incident Report completed for another student who, it appeared, was put in *Room A* in 2012. It states:

I put him in a SCM hold and moved him to the safe area. He very quickly calmed and after 2 minutes I opened the door. [...] When he was in the safe area I shut the doors between the 2 rooms because another student kept wanting to open the door to the safe area.

138. In response to my concern that the references in this report to opening the door implied that the door was closed, Ruru has advised that the teacher who completed this report has explained that the door referred to in this case was a concertina partition door between two classrooms, not the door to *Room A*. The teacher said that on this occasion, the student was put in the classroom in which *Room A* was located while the rest of the students continued to be taught in the adjoining room. Ruru noted:

We appreciate the confusion but in this incident report Room A was not used as the student was managed by isolating him to a classroom space for a time to de-escalate.

139. If this is the case—that even though the words '*the safe area*' are used three times in the Incident Report, the teacher was not referring to *Room A*—it reinforces my concerns below about confusing record-keeping.

Was N secluded?

140. As noted above, it was not until the Ministry issued the 2016 Guidance that seclusion in the context of a school was clearly defined.

141. Although N's time at Ruru preceded that guidance, it is not unreasonable to consider whether N was secluded, as this is now defined.

142. The definition refers to a student being **involuntarily** placed **alone** in a room, from which they **cannot freely exit**. It refers to the door being locked, **blocked** or held shut, and in the absence of a lock, to **a level of authority or coercion that leads a student believing that they must not or cannot exit**.

143. As indicated above, I have some concerns about the accuracy of the information provided by Ruru and its staff regarding the use of *Room A*. However, even if I accept as accurate the account provided by staff as to what occurred when N was placed in *Room A*, the key facts are as follows:
- a. Physical interventions were used to put N in the room. He was not there voluntarily.
 - b. He was alone in the room. A staff member was outside the room, holding the door slightly ajar. The staff member had their back to the door, avoiding eye contact and maintaining silence.
 - c. Even if the door was not locked or shut, it was effectively blocked. N was not able to exit freely.
144. In addition, I have little doubt that in these circumstances, there was a level of authority and coercion that would have led N to believe he could not exit the room.
145. What staff describe may have been consistent with SCM. I consider that it would, however, constitute seclusion as this is now defined in the 2016 Guidance and the Education (Update) Amendment Act 2017.

Did Ruru act unlawfully by using *Room A* to manage N's behaviour?

146. At the time of these events, there was no provision in the Education Act 1989 or any other statute authorising school staff to seclude students posing a serious and imminent threat to themselves or others. It could be argued that if Parliament had intended for schools to have that option, it would have provided the necessary legislative authority, as it did in respect of mental health and intellectual disability, for example.¹³
147. When the Police wrote to Mr and Mrs M at the conclusion of the 2016-17 reinvestigation into matters arising from their complaint, they advised that there was insufficient evidence to support criminal charges against any individual or the school.
148. The Police explained that the law around unlawful detention and assault in New Zealand is principally contained in the Crimes Act 1961, with the Education Act 1989 also making reference to the use of force.
149. In relation to the allegation of unlawful detention in a seclusion room, the Police stated:

Various witnesses associated to the school were approached, and although several provided statements there were also several that declined, as is their right. From analysis of the statements that were made, there was no evidence that the use of the safe room demonstrated any criminal intent that may fit within the crimes mentioned.

¹³ Mental Health (Compulsory Treatment and Assessment) Act 1992, section 71; and Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, section 60.

150. Those crimes included, under the Crimes Act 1961, kidnapping (s 209), neglect/ill treatment (s 195), assault on a child (s 194), common assault (s 196), discipline (s 59), defence (s 48) and, under the Education Act 1989, corporal punishment (s 139A).
151. I have carefully considered all of the relevant information including, in particular, the evidence I heard from the staff who were directly involved in placing N in *Room A* in 2011 and 2013.
152. I am aware that Mr and M believe their son was put in *Room A* for punitive reasons. If that were the case, the use of physical interventions to put N in *Room A* would arguably have constituted an unjustified use of force. It would also, in my view have made it significantly more difficult to argue that this was not unlawful detention or false imprisonment.
153. However, Ruru's procedures for use of *Room A* and physical interventions referred to the purpose of those measures as ensuring the safety of students and staff. SCM is explicitly about crisis management. Given the time that has since elapsed since these events, the relevant staff members were unable to recall exactly what had occurred when N was placed in the room. However, they consistently stated that he was placed in *Room A* when he was assessed as posing a serious risk to himself or others. The Incident Reports completed in 2011 reflect that.
154. It is not possible for this investigation to establish definitively what happened on each of the occasions that N was placed in *Room A* at Ruru. However, on the basis of the information I have reviewed and the evidence I have heard, and given the law as it stood at the time, I do not consider that there are grounds for concluding that staff at Ruru acted unlawfully.
155. There is also the question of whether Ruru's use of *Room A* for N can be said to have contravened his human rights. The New Zealand Bill of Rights Act 1990 protects the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment (s 9), the right to freedom of movement (s 18) and the right not to be arbitrarily detained (s 22). While I have several concerns about Ruru's use of *Room A* for N (see below), I am not persuaded that in the particular circumstances of this case, its actions were a clear breach of those rights.
156. Article 7 of the United Nations Convention on the Rights of Persons with Disabilities provides for member states to take '*all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children*', and that '*in all actions concerning children with disabilities, the best interests of the child should be the primary consideration*'. Article 14 provides that '*the existence of a disability shall in no case justify a deprivation of liberty*'. Ruru stated that its staff acted at all times with the safety and well-being of its students, including N, and staff in mind. While that may be the case, I note although special schools comprise a very small proportion of the total number of schools in New Zealand (less than 2%), they made up more than a quarter of the 17 schools identified by the Ministry as having used seclusion in 2016. This is only part of the picture, with many students with disabilities

attending mainstream schools. However, it is a concerning indicator that the most restrictive behaviour management strategies and techniques have been used disproportionately with children with disabilities, such as N.

Was the use of *Room A* to manage N's behaviour unreasonable?

157. In addition to matters of communication and record keeping, which I will address separately below, I have the following concerns about the use of *Room A* for N.

Location

158. *Room A* was located at Ruru base but N was taught mostly at Donovan. The distance between the two sites was not great. Ms P acknowledged that if N was in a heightened state, any kind of physical restraint was likely to aggravate the situation. However, staff considered that there were occasions when transporting him back to Ruru base was the safest available option.
159. I consider that the practice of transporting a student from any of the satellite schools back to Ruru base, so that the student could be put in *Room A* if this was deemed necessary, was ill-advised.
160. This was especially the case for a student such as N, who was known to have particular sensory sensitivities. His BMPs indicated that SCM transport to a calm area may be required, but also that staff should avoid crowding or touching him.
161. Ruru has commented that these were separate points, the first of which applied in crisis situations and the second in *'everyday situations'*. I accept that there may have been times when N's behaviour meant some form of physical intervention was necessary, but the advice to avoid crowding or touching him when he was displaying challenging behaviour suggests he was unlikely to respond well to this. The practice of transporting him back to Ruru does not appear conducive to minimising the need for and use of physical interventions.
162. It is accepted that when a student's behaviour is extremely challenging, the staff dealing with the situation must take into account the safety of that student, other students, themselves, other staff, and possibly other people who may be nearby. However, on those occasions when N's behaviour was the most challenging, the process of returning him to Ruru base involved the use of physical interventions to get him into the van, while in the van, and to take him from the van to *Room A*. I agree with Ms O that the practice of transporting students from a satellite class to Ruru base was likely to place additional and unnecessary stress on the student and staff, and was unsafe.
163. In its response to my second provisional opinion, Ruru stated that it does not accept that the practice was unsafe, as staff were following SCM protocols. It considers that *'decisions to transport [N] back to Ruru were made by trained staff facing a complex situation'*, and removing him from the situation was part of his BMP and carried out in accordance with SCM.

164. The fact that Ruru's procedures provided for students at satellite schools to be taken back to Ruru base does not, in my view, mean that the practice was safe. Insofar as *Room A* was the designated safe area for students based at satellite schools, my concerns about its location, at Ruru base, remain.

The room

165. I have reviewed photographs of *Room A* taken in early 2015, December 2016, and June 2017. I have read Ms O's description of the room as it was in February 2015. I viewed the room in April 2017, by which time the door had been removed:



Figure 1: Room A in April 2017, after door was removed and room made into a 'sensory space' (photo: Chief Ombudsman)

166. I understand that rooms of this nature were intentionally small so as to minimise the risk of a student seriously injuring themselves. This room was approximately 1.3m x 1.8m, with a height of 3.3m. I found it to be very small.

167. While there was a reasonably large window providing natural light and ventilation, that window was on an internal wall. When I saw the room it had no door. I consider that when the door was in place, even held ajar, it would likely have been quite dark inside the room.

168. It is acknowledged that *Room A* was, like similar rooms at other schools, constructed with input, support, and approval from the Ministry. Ruru advised that Ministry property guidelines had restricted '*footprint*' measurements for special schools and the size of *Room A* was determined by that footprint.
169. Ruru has maintained that *Room A* was used to manage a crisis situation; it was not about punishment. For any child or young person, let alone someone with particular disability-related needs, sensitivities, and vulnerabilities, I consider that it would have been an uninviting and unpleasant place in which to spend even a short amount of time involuntarily.
170. Ruru notes that there were a number of students, particularly those who preferred low stimuli areas, who chose to use the space as a safe, peaceful retreat. While I do not doubt that, at issue here is how the room might be perceived and experienced by a student who is not in the room voluntarily and who is not free to leave.
171. In its response to my second provisional opinion, Ruru submitted that any concern with the form of the room is a matter that belongs with the Ministry. My concern about the form of *Room A* relates not to its construction in 1999 but rather to its suitability in the context of how it was used, more than ten years later, for students such as N. Had the room been used on a voluntary basis only, along the lines of the '*mini-timeout*' strategy described in the 1998 Guidelines (see footnote 11), any concerns about the form of the room in that context would have been relatively minor.

Safe Crisis Management and the '*Safe Area Procedure*'

172. In 2006, Ruru replaced its previous crisis management programme with SCM. I am satisfied that this was a considered decision and that staff at Ruru genuinely believed that SCM was the best option for their students and staff. Ms P and Ms R qualified as SCM instructors and all teaching staff were trained. SCM is used by a number of other schools in New Zealand.
173. Ruru initially stated that its '*Safe Area Procedure*' and practice were consistent with Ministry guidelines current at the time. It subsequently confirmed that it was never provided with the 1998 Guidelines, and was not provided with the 2007 Guidelines until 2015. In response to my first provisional opinion, Ruru submits that in fact the 2007 Guidelines did not address the use of a room in the way that Ruru used *Room A*, which was for safety reasons and in a manner consistent with the description of restraint.
174. Acceptable practice for the management of students exhibiting behaviour that poses a risk to themselves or others is not static. Over time, we develop better understandings of the ways in which the rights of children and young people should be met—including in and by schools. We learn more about what is therapeutically effective. We recognise the consequent need for changes in practice.
175. Insofar as Ruru's crisis management procedures and practices provided for the use of *Room A*, including for a student affected by Autism Spectrum Disorder, I do not consider

that they were consistent with current best practice. While no two children with autism experience this in the same way and have the same needs, it is widely accepted that they may benefit from access to a safe, comfortable, low-sensory space, which they can take themselves to—with prompting if needed—when they need a break. This was not the function or character of *Room A*. However, I accept that at the time, there was less understanding and consensus as to what constituted best practice than there is now.

176. Ruru's position is that its '*Safe Area Procedure*' was consistent with SCM, and that aside from the one occasion when there was a failure to record use of *Room A*, the room was used in accordance with that procedure.
177. Although the '*Safe Area Procedure*' refers to the '*Safe Area/Quiet Area*' I understand it related specifically to *Room A* at Ruru base. Given Ruru's position that the references in other Incident Reports to quiet areas and '*a safe area*' are not references to *Room A*, this is confusing.
178. The '*Safe Area Procedure*' refers to students remaining in the room for a specified period of time, but does not say how this should be determined.
179. Ruru was responsible for ensuring it provided its students with a safe physical and emotional environment. The use of *Room A* in respect of N was not consistent with this. I consider that the way in which the room was used to manage N's behaviour was unreasonable. However, I acknowledge that it was part of a recognised crisis management programme, and that Ruru was acting in the absence of clear, unambiguous, and up-to-date guidance on exactly how and in what circumstances a room such as *Room A* should be used.

Did Ruru communicate appropriately with Mr and Mrs M?

180. In my first provisional opinion I stated that on the question of what information was provided to Mr and Mrs M in respect of *Room A*, there appeared to be a fair degree of agreement between the parties. I suggested it was evident that prior to N being put in *Room A*, Mr and Mrs M were not shown the room, advised of its existence, or consulted on its use for N.
181. Ruru has recently advised that a member of staff recalled Mr M being present when N took himself into *Room A* one day in 2011, and that Mr M referred to N liking small, quiet spaces. Mr M is adamant he did not see *Room A* until December 2014.
182. My concerns about Ruru's communication with Mr and Mrs M stand irrespective of whose account is correct.
183. It is clear that Mr and Mrs M were provided with minimal information after each of the occasions on which N was placed in the room. The Incident Reports completed for the incidents in 2011 that led to N being placed in *Room A* all indicate that N's parents were informed. Although they may have been told in general terms about the incident or behaviours of concern, they were not fully briefed and they were not told that N had been put in *Room A*.

184. I am inclined to accept that Ms T did not deliberately set out to hide information from Mr and Mrs M. However, they said they were unaware that the days on which N was placed in *Room A* were any different from other days on which he had been unhappy or had a difficult time. In response to my first provisional opinion, Ms T said she believes that in her communication with Mr and Mrs M, she did differentiate between N becoming unmanageable as opposed to just having a difficult day. While that may be so, the use of *Room A* was not disclosed. On the one occasion when Mrs M asked about the '*little room*', after N had mentioned this, Ms T responded that there was a room at Ruru base where students go to calm down. This created a misleading picture.
185. There is nothing to indicate that Mr and Mrs M were provided with any information following the incident that led to N being placed in *Room A* in 2013, for which there is no Incident Report.
186. I accept that staff communicated regularly with Mr and Mrs M, and that this included discussion about SCM. However, in all the circumstances, it is evident that the information provided to Mr and Mrs M in respect of *Room A* was insufficient and misleading. Aside from the question of whether N should have been put in *Room A* at all, Ruru should have ensured that his parents were:
- a. shown the room and told about how it would be used for crisis management purposes, in advance of N being put in the room;
 - b. given the opportunity to discuss with staff an alternative strategy for N, in the event that they did not want him to be put in *Room A*; and
 - c. in the event that *Room A* was used, advised of this.
187. Ruru states that *Room A* was used rarely. It was a last resort, to be used only when efforts to de-escalate a situation using less restrictive techniques had failed. Even accepting this description of the room, Mr and Mrs M should have been informed as to how staff intended to manage N's behaviour in crisis situations, and how they did so.
188. Ruru failed to ensure that Mr and Mrs M were provided with the information that they, as N's parents, needed and to which they were entitled. While the need to provide parents with information of this nature was reflected in Ruru's procedures for behaviour management planning and incident reporting, those procedures were not complied with.

Was Ruru's record-keeping adequate?

189. Ruru's record-keeping was deficient in several respects. I do not consider it necessary to set these out in detail, but I note the following:
- a. Incident Reports relating to the occasions on which Ruru states N was put in *Room A* refer to '*the quiet area*'. Incident Reports relating to occasions on which N was allegedly not put in *Room A* include references to '*his quite area*' [*sic*], '*a safe area*', and '*a quiet area*'. This is confusing and, in my view, further grounds

for questioning whether N may have been placed in *Room A* more often than has been acknowledged.

- b. There was at least one occasion on which N was placed in *Room A*, with no record made in the 'Record of Usage' log and no Incident Report completed.
 - c. The Incident Report for 5 July 2011 does not record Ms S as one of the staff involved but Ruru believes that, as for the other two occasions in 2011 when N was placed in the room, she was the supervising staff member.
 - d. Staff reported that physical interventions were sometimes used to return N to Ruru base but *Room A* was not used. There are no Incident Reports in respect of those occasions. Although Ruru has stated that Incident Reports were not required for interventions provided for in N's BMPs, the '*Safe Crisis Management Physical Interventions*' procedure indicates otherwise.
 - e. The Incident Reports provide no detail about the information that was or was not provided to Mr and Mrs M.
 - f. Several of N's BMPs refer to him spending time in '*a safe place*'. It is not clear whether this means or includes *Room A*.
190. The importance of good record-keeping should not be underestimated. Clear and accurate records assist those involved in the care and education of a student to monitor, assess, and plan. Schools are subject to the Public Records Act 2005, which requires agencies to create and maintain full and accurate records of their affairs, in accordance with normal, prudent business practice. Records are also essential in the event of a complaint or investigation. As noted above, communication with Mr and Mrs M at the time of these events was inadequate. Ruru's records have been of limited help in providing them with the information that was not supplied to them at the time.

What alterations were made to *Room A* after Mr and Mrs M's complaint?

191. Mr and Mrs M have expressed concern throughout this investigation that after they complained about *Room A*, Ruru altered it in order to disguise its purpose and make it less unpleasant. They have been particularly concerned about the flooring and windows.
192. While it does not relate directly to the matters under investigation, in the interests of completeness I note the following.

Flooring

193. An email from Ms P to the Principal dated 10 November 2014 confirms that the room was carpeted at that time, but that the carpet needed to be removed. It is the Principal's recollection that the carpet was lifted in the period 25–27 November 2014, as the caretaker had been absent [*detail removed*] for a period prior to this (5–24 November 2014) and on 28 November 2014.
194. Mr and Mrs M saw the room on 3 December 2014, when the floor was exposed concrete.

195. The Principal advised further that a piece of vinyl was put down soon after this, as a temporary measure. That was the flooring in place when Ms O saw and photographed the room in early 2015. In February 2015, new carpet was laid. At the end of 2015 or early 2016, the door was removed and other minor changes made, so that students could then use the room freely as a *'sensory space'*.
196. The last recorded use of *Room A* as a *'safe area'* was on 19 November 2014. The room was closed for that use on 10 December 2014.
197. It appears, therefore, that the room had an exposed concrete floor for a period of 2–3 weeks. There is no evidence to indicate that students were placed in the room during that time.

Windows

198. Ministry plans from 1999 indicate that the existing window in what was to be *Room A* was to be made smaller. Ruru advises that this alteration was not actioned and the existing window was left in place.
199. Ruru has provided statements from two builders, obtained in April 2016 and June 2017, confirming that the windows currently in place, a fixed pane and an 8-blade louvre window, were part of the original construction and have not been altered.
200. It would appear that the exposure and reproduction of a photograph from Ms O's report resulted in a loss of detail and perspective, making the window appear smaller.¹⁴
201. There is no evidence to indicate that the windows in *Room A* were altered after Mr and Mrs M saw the room on 3 December 2014.

Discussion—Ministry

The Ministry's response to Mr and Mrs M's complaint about Ruru

202. Mr and Mrs M formally complained to the Ministry on Sunday, 7 December 2014.¹⁵ On 10 December 2014, Ministry staff informed Ruru of the complaint and the Ministry's intention to investigate. They advised Ruru to close *Room A*, which it did.¹⁶ The Ministry also advised Mr and Mrs M that their complaint would be investigated. On 22 December 2014, Ms O was contracted to investigate. Her investigation report was

¹⁴ See Appendix 1

¹⁵ This was preceded by a telephone call from Mr M to the Regional Director of Education on 5 December 2014. The matter was passed on to the Regional Manager for Special Education, who telephoned and emailed Mr M the same day.

¹⁶ As noted above, the room was re-opened at the beginning of 2016, after the door had been removed and the room repurposed as a *'sensory space'*.

completed at the end of February 2015 and provided to Ruru and to Mr and Mrs M on 4 March 2015.

203. The complaint from Mr and Mrs M raised significant concerns in respect of N and other students. In my view, the Ministry took appropriate action by obtaining Ruru's agreement to close *Room A* immediately, and appointing an independent investigator to investigate.

The Ministry's response to Ms O's recommendations

204. Ms O's recommendations relating to Ruru were followed up appropriately. Ruru developed an action plan and submitted this to the Ministry. The Ministry monitored the school's progress and, at the end of 2015, signed the plan off as complete.
205. The recommendation that the Ministry convene a working party to develop national guidance was acted on. However, that recommendation was made in February 2015. The working party convened for the first time in June 2015, but it was November 2016—eighteen months later—before the guidance was issued. But for the media attention from early October 2016, it may have taken still longer.
206. It is clear that the process of developing the new guidance was no easy undertaking. However, it would seem that, initially at least, the Ministry underestimated the complexity of the task. Ms O was contracted in May 2015, and the Advisory Group convened for the first time in June 2015. The fact that new guidance was not issued until November 2016 meant that in the meantime, most schools and staff continued to operate as they had been. It was during this period that the events giving rise to the complaint about Miramar arose, in addition to two further complaints that included concerns about the use of seclusion.
207. The Ministry attributes the delay at least in part to the fact that it was developed by a cross-sector led group, as well as the time needed to work through areas of disagreement. In addition, the Advisory Group recognised that schools which were going to need to change their practices would need training and support. While these are valid considerations, this was a matter of some urgency and I consider that the Ministry should have pushed to ensure the new guidance was available sooner, or provided interim guidance to the extent that this was possible.

Ministry advice and guidance to schools regarding the use of seclusion, prior to Mr and Mrs M's complaint

208. The Ministry was involved in approving plans for the construction or conversion of rooms in schools that could be used for a student in a heightened state needing a space away from other students in which to calm. This included the approval of plans in 1998–99 for the construction of a time-out room at Ruru. However, the Ministry considers that if schools were using those rooms for seclusion, that would have been contrary to its guidance.

209. The Ministry acknowledges that until the new guidance was issued in November 2016, there was a lack of clarity amongst schools about what was meant by seclusion, what was meant by time-out, and what did and did not constitute acceptable practice.
210. This was arguably evident from the Ministry's own guidance. The 1998 Guidelines, which remained effective until November 2016, did not refer to seclusion but did comment on the use of time-out rooms. It stated that in relation to the practice of removing a student from other students for a specified period of time, time-out rooms *'should not be used'*.¹⁷
211. However, there is also a question as to schools' awareness of the 1998 Guidelines and their availability. They were not provided to Ruru. Ms O noted in her report that the NZSTA was unable to offer any guidelines, and that despite contacting the Ministry she had been unable to locate any guidelines about the use of time-out facilities or safe rooms. It would appear she was not provided with the 1998 Guidelines. If neither the Ministry nor the NZSTA was aware of these, the extent to which they were known to, and accessible by, individual schools would seem highly questionable. I note that there was no evidence in the Ministry's responses to my provisional opinions to indicate that the 1998 Guidelines were provided or made available to schools.
212. The 2007 Guidelines, developed for internal use by Ministry staff working in special education, stated that the Ministry did not recommend any form of time-out procedure that involved a child or young person being shut in a room or screened area, by him or herself, without any way of getting out unless someone came to release them.
213. As I have said, acceptable practice in relation to the management of students exhibiting difficult behaviour has evolved over time. However, it would seem that by 1998 if not before, the Ministry was of the view that seclusion should not be used. I consider that it should have done more, sooner, to provide schools with clear and unambiguous guidance, and its failure to do so was unreasonable.

The Ministry's awareness and oversight of the use of seclusion in schools

214. The Ministry had its own staff and teams working directly with schools who were dealing with students exhibiting challenging behaviour. While that did not involve all schools or students it meant that, to some extent, the Ministry had both the means and opportunity to observe the ways in which schools were using their time-out rooms and to ensure appropriate behaviour management and crisis management techniques were being used.
215. The Ministry's role in approving the construction of rooms such as *Room A* at Ruru is also relevant.
216. The Ministry has advised that complaints about seclusion or other restrictive practices were dealt with in regional offices, with no central repository for complaints. As such, the Ministry was unaware of the number and nature of complaints received.

¹⁷ This would not preclude a student from removing themselves for a period of time.

217. In response to my enquiries, the Ministry advised that in addition to the complaints about Ruru and Miramar, six complaints about the use of seclusion had been received in the previous five years.
218. It is unfortunate that the Ministry was not more alert to the fact that some schools were using their facilities in ways that were contrary to its guidance and best practice.
219. It is appropriate that the Ministry has now recognised the need for complaints about seclusion to be escalated to National Office and centrally recorded.

Discussion—ERO

ERO's response when alerted to the complaint about Ruru and the Ministry's investigation into that complaint

220. In December 2014, the Ministry commissioned the investigation into Mr and Mrs M's complaint about Ruru, which included concerns about the use of a seclusion room. Ms O's report was completed at the end of February 2015, and provided to Ruru and to Mr and Mrs M on 4 March 2015. The report was not provided to ERO.
221. The following week, ERO undertook its scheduled review of Ruru, with a site visit from 9 to 12 March 2015. Prior to the visit and before Ms O had completed her report, ERO's Review Services Manager had received two emails from the Ministry. The first indicated that the Ministry had no concerns in respect of Ruru. The second referred to Ms O investigating on behalf of the Ministry. The second email was overlooked and not passed on to the review team.
222. In the course of the site visit, Ruru advised the review team of the complaint and showed them *Room A*. ERO states that the review team was led to believe that there was an ongoing investigation, and advised that the Board was carefully following its complaints process. Notes taken by the review team refer to *Room A* having been built and approved by the Ministry, and that when a student was put in the room, a teacher stood in the doorway and the door was open. At the time of ERO's review, however, *Room A* was not as it was when N was put in the room (it had been re-carpeted and was being used to store student resources), and ERO found no evidence that the school was using seclusion.
223. On the final day of the review, the head of the review team received Mrs M's email. This referred to the Ministry having recently conducted an investigation, but did not refer to Ms O's report.
224. Although it is not ERO's role to investigate individual complaints, it does have a role in ensuring schools have appropriate policies and practices for dealing with complaints. In these circumstances, I would not necessarily expect ERO to seek further information or otherwise become involved if, in the course of a review, it was made aware of a current complaint and was satisfied it was being dealt with appropriately.

225. However, if ERO is alerted to a complaint warranting investigation by the Ministry, I would expect it to make further enquiries. I would certainly expect that to occur in respect of a complaint raising concerns about student safety and mistreatment.
226. In this case, ERO was alerted on two occasions to an investigation by the Ministry—once by the Ministry itself and once by Mrs M. The email from the Ministry should have been passed on to the review team. That may have prompted the review team to seek further information from the Ministry. Had that occurred, ERO could have obtained Ms O's report before the site visit and considered whether or how it should proceed with the review. Alternatively, it could have asked Ruru more specifically about the investigation during the site visit, and obtained a copy of Ms O's report before issuing its Unconfirmed Report.
227. However, the complaint from Mr and Mrs M was discussed during the site visit and ERO did look into the use of *Room A*. ERO found no evidence that the room was being used for seclusion at the time of its review. On the basis of the information ERO had at the time, it was satisfied that the matter was in hand.
228. On 26 March 2015, sent its Unconfirmed Report to Ruru. ERO did not learn about the outcome of Ms O's investigation until 31 March 2015, with a copy of her report received just over a week later. ERO then took appropriate action, first advising Ruru that confirmation of the report from the March review would be withheld and then, that the 2015 review would be set aside and a new review carried out in 2016.

ERO's systems for ensuring it was advised of and able to respond to, any complaints or investigations regarding the use of seclusion

229. As noted above, ERO is not responsible for investigating complaints, including complaints about issues such as seclusion. However, I consider it problematic if ERO is able to commence and all but complete the review of a school, identifying no safety issues when, just a month prior, a Ministry-appointed investigator identified significant concerns relevant to student safety and well-being. These included concerns that the procedures for use of *Room A* were '*loosely written*' and '*open to interpretation*', that the practice of transporting students in a heightened state from the satellite schools back to Ruru base was unsafe, that documentation in relation to use of *Room A* needed to be significantly improved, and that the current safe area (ie, *Room A*) should be closed. It is essential that ERO has systems in place to ensure it is sufficiently aware of complaints received by schools and their management, and that any complaint investigated by the Ministry is brought to ERO's attention promptly. Relevant matters can then be taken into account in deciding, for example, whether or when to proceed with a review and whether there are matters that the review team should pay particular attention to.
230. ERO and the Ministry have both advised that senior staff from the regional offices of their agencies attend regular meetings, at which information of this nature is discussed. ERO has, at my request, also undertaken to amend its Compliance Checklist so that

schools are specifically asked about significant complaints, such as those investigated by the Ministry.

231. In response to my first provisional opinion, ERO noted that a school review process is not completed until a review report is confirmed. This means providing a board with the opportunity to respond to the findings in an unconfirmed report, considering the board's response, making any necessary changes, advising the board of the changes, and only then confirming the report.
232. I appreciate that the process is intended to provide for any errors or omissions to be addressed before a review report is confirmed. My concern in this case is that relevant information was available to ERO before it issued its Unconfirmed Report. Moreover, although ERO was, in the end, provided with a copy of Ms O's report before the 2015 review was completed (and the review consequently set aside) there was nothing in the process itself to ensure that would occur.

ERO's systems for reviewing seclusion or time-out rooms and their use, in the context of its role and responsibilities

233. ERO submits that the Education Act 1989 does not contemplate ERO investigating or monitoring issues such as seclusion in schools. ERO is, however, responsible for evaluating a school's performance in the delivery of education, including whether a school board is complying with requirements to provide students with a safe physical and emotional environment.
234. ERO notes that its approach to statutory and best practice compliance by school boards is, with the use of the BAS, '*very much a "trust" approach*'. It seems to me that this renders it all the more important for ERO to ensure its self-audit checklists and the questions asked in the course of a site visit capture all relevant matters in sufficient detail. This includes matters with the potential to impact directly on the physical and emotional safety of students, and that would certainly include a school's policies, procedures, and practices for the management of students whose behaviour poses a serious risk of harm to themselves or others. I would expect that to include an inspection of any rooms or spaces used for managing students at such times—particularly when potential issues have been expressly drawn to ERO's attention.
235. It does not appear that, at the time of its 2015 review of Ruru, the arrangements ERO had in place necessarily provided for relevant information to be captured. As noted above, Ms O had, in early 2015, identified significant concerns in relation to Ruru's procedures for and use of *Room A*. In contrast to this, there was nothing in ERO's Unconfirmed Report to suggest that health and safety concerns were not being managed appropriately. It noted:

School leaders have developed well-documented systems and procedures for all aspects of school operation. This applies particularly to the many procedures for the physical and emotional care of the school's students with very high and complex needs.

236. It is appropriate that ERO has, as a result of these events, taken steps to ensure review teams check and record how schools manage students with challenging behaviour. I note also ERO's advice that the BAS has been revised for consistency with the 2016 Guidance.

Chief Ombudsman's opinion

237. While I have found no evidence of unlawful actions (under the legislation at the time) by any party, or that ERO acted unreasonably, I have formed the opinion that:

- a. Ruru acted unreasonably in using *Room A* to manage N's behaviour. In particular:
 - i. it failed to consult with Mr and Mrs M about the proposed use of *Room A* or inform them about its actual use;
 - ii. it failed to clearly and accurately record transportation to, and use of, *Room A*;
 - iii. *Room A* was unsuitable in location and form for the purpose for which it was used; and
- b. the Ministry's failure to provide schools with clear and unambiguous up-to-date guidance in relation to the use of seclusion was an unreasonable omission.

Recommendations

238. Ruru, the Ministry, and ERO have already made a number of changes as a result of this complaint and Ms O's investigation. In addition, ERO agreed in the course of this investigation to amend its Compliance Checklist so that schools are expressly asked about significant complaints and investigations.

239. I appreciate that for Mr and Mrs M, those changes do not alter what happened in respect of N. However, their complaints were without question instrumental in effecting change at a national level—most notably the development of clear guidance on the use of physical restraint in schools and a legislative change to reinforce the prohibition on seclusion in schools.

240. I recommend that Ruru:

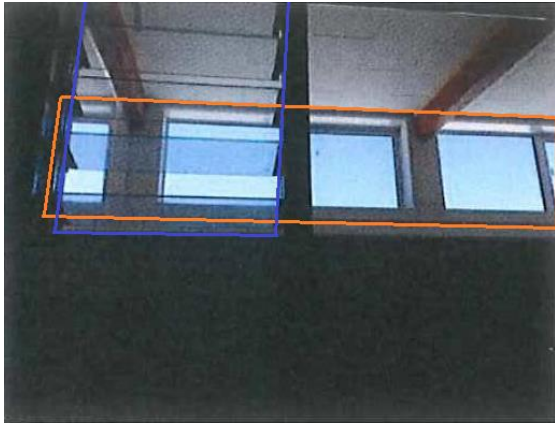
- a. provides Mr and Mrs M, and N, with a written apology for its failings, if requested to do so;¹⁸

¹⁸ Mr and Mrs M have indicated that they do not wish to receive an apology. They have been asked to confirm their position within two weeks of the date of this opinion being issued.

- b. provides me with copies of its current policies and procedures (and any associated forms) for incident reporting and the use of physical interventions to transport students;
- c. provides me with a report on its most recent audit of BMPs; and
- d. takes the following steps in respect of recommendations a to c:
 - i. within 15 working days of my Office confirming that Mr and Mrs M wish to receive an apology, provides me with a copy of the proposed apology for my review, before this is sent to Mr and Mrs M;
 - ii. within 1 month of this opinion being issued, provides me with copies of its current policies and procedures (and any associated forms) for incident reporting and the use of physical interventions to transport students, and a report on its most recent BMP audit.

Appendix 1.

Photos of *Room A* window:



From inside *Room A*, February 2015
(photo: Ms O)



From inside *Room A*, June 2017
(photo: Ruru)



From corridor, June 2017
(photo: Ruru)

