Psychiatric Nurse, Mr U

Auckland District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC18422)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

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

Investigation Summary

Complaint
The Nursing Council referred concerns about psychiatric nurse Mr U to our Office in early December 2006. The concerns related to Mr U's unprofessional conduct towards Ms A during her hospital admission to an Auckland District Health Board (ADHB) mental health unit, and as an ex-patient after discharge. The Nursing Council viewed Mr U as a risk to public safety.

Investigation process
On 16 February 2007, an investigation was commenced into whether registered nurse Mr U provided services to Ms A in accordance with professional and ethical standards in July/August 2006, during which period it is alleged Mr U initiated a sexual relationship with Ms A. Also investigated was the appropriateness of care provided by Auckland District Health Board to Ms A in July/August 2006.

A considerable number of parties are involved in this complaint — see *Appendix 1*. Information from all parties was gathered and considered. This report outlines the various standards, including the Code of Health and Disability Services Consumers' Rights (see *Appendix 2*) that are relevant when determining whether or not an individual or an organisation has met accepted standards of practice.

Commissioner's report
The purpose of the report is to set out the information received from the various parties, and to determine whether or not there has been a breach of the Code of Health and Disability Services Consumers' Rights (the Code).

The provisional report concluded that Mr U did breach the Code and that Auckland District Health Board was not vicariously liable for his actions. However, comment was made about the reference provided to Mr U when he resigned from ADHB, as it made no mention of the concerns about his practice. The report recommended that ADHB address the appropriateness of providing references in these circumstances.

The parties were invited to respond to the findings.

Conclusion
In his response to the provisional report, Mr U admitted a sexual relationship with Ms A. The Director of Proceedings has been asked to review the case and consider taking proceedings against Mr U.

1.0 Overview

Ms A has been involved in psychiatric services since mid-adolescence. She is described by staff who have cared for her as a "very vulnerable person".

Several internal complaints were made by Mr U's colleagues in relation to his non-observance of standard practices aimed at protecting vulnerable female patients such as Ms A. One colleague claimed that Mr U had told him that he was having a sexual relationship with Ms A. This allegation was supported by Ms A. Mr U initially denied having had a sexual relationship with Ms A but admitted that he became too involved in her care.

Mr U resigned from his position following an internal investigation into his conduct. ADHB advised that the concerns related to both Mr U's state of mind and his competence. It is not clear from the documentation provided by ADHB whether a decision was made relating to the allegations about Mr U's relationship with Ms A. Mr U was required to undertake a six-week supervision process and was instructed to have no further contact with Ms A. These requirements were not met.

Issues such as sexual misconduct are often difficult to prove when it is one person's word against another's, and there is little or no evidence to support the allegation. In this case, Mr U has confirmed that he did have a sexual relationship with Ms A. A health professional has an obligation to his or her clients to provide a service that minimises potential harm and optimises the client's quality of life. It is therefore important to maintain professional boundaries.

Mr U failed to maintain appropriate professional boundaries and cultivated a relationship with Ms A that jeopardised her mental and physical well-being.

2.0 Investigation — Mr U

2.1 Mr U's Background and Qualifications

Mr U completed his Bachelor of Nursing in 1998. He was employed at Auckland Hospital's acute mental health unit (the Unit) from December 2003 until 10 December 2006. He advised that he was "generally aware" of a registered nurse's responsibilities in relation to the Health Practitioner's Competence Assurance Act 2003 and the Mental Health Nursing Standards. Mr U stated that the roles and responsibilities of health professionals working at the Unit were drafted in "about 1997". Mr U said that during the period he worked at the Unit, this document remained in draft. He was aware that the registered nurses' responsibilities were also outlined in the Mental Health Nursing Standards and that he was "generally aware of the legislation due to his involvement as a union representative."

Mr U stated that his understanding of the responsibilities of a registered nurse working at the Unit are to:

"

- Work in partnership with the consumer (i.e. the patient).
- Formulate and participate in strong collaborative care planning centred on the consumer's needs. This involves the nurse dealing with other professionals i.e. nurses, doctors, specialists, social workers, occupational trainers and the like, not to mention the consumer.
- Administer medication to consumers as prescribed by qualified medical staff.
- Observe and monitor psychiatric signs and symptoms.
- Document these symptoms and report any changes in mental state that are observed. These reports are done both orally and in writing. There is a requirement to provide written reports at the end of each shift in relation to each consumer who is the subject of care.
- Formulate ongoing management plans in relation to consumer care. This covers in-patient care, multi-disciplinary care and planned discharge for a return to the community as appropriate.

  The emphasis in the discharge of responsibilities differs depending upon where one is employed within the unit. For instance, when one is employed at ICU (Intensive Care Unit) the focus is very much on containment of the acute phase of the diagnosed mental illness and settling mood and symptoms to enable the consumer to become more comfortable. S/he can then be transferred to a less secure environment safely. This would involve transfer to one or two open wards within the unit."

2.2 Admission to the Unit 30 June 2006

On 30 June 2006, Ms A was admitted acutely to the ICU of the Unit. She was suffering from extreme anxiety, exhibiting distress and agitation, and had considerable difficulty sleeping. Staff managed her anxiety with counselling and medication. Ms A was prescribed antipsychotic and anti-anxiety medications, a sedative and an antihypertensive.

During this admission, a treatment plan was formulated for Ms A by the Unit's Clinical Director, psychiatrist Dr C, psychiatrist Ms G and psychologist Ms D. Dr C noted their plan to move Ms A from the ICU to a ward. Ms A was to take

responsibility for her own safety. He noted, "any attempts on our part to take on the role of 'keeping [Ms A] safe' significantly increases her risk of suicide". The plan was that Ms A was not to rely on admission to the Unit to control her extreme anxiety, but should utilise distraction techniques. If Ms A self-harmed or attempted suicide while an inpatient, she was to be discharged immediately. Dr C discussed his decision with Ms A.

During the night of 3 July, a male patient entered Ms A's room, exposed himself and made sexual comments. Ms A was extremely upset by the incident. However, Dr C decided to discharge her the following day and arranged for her to see Ms D at an Auckland District Health Board mental health community support service (the community support service) as soon as she was discharged. Dr C told Ms A that she needed to rebuild her relationship with Ms D and her supports in the community. Ms A was discharged from the Unit on 5 July.

2.3 Re-admission on 17 July 2006

On 17 July, Ms A was readmitted to the Unit because of increased concerns for her safety.

The next day, Ms A was found semi-conscious in her room in the ward. Staff suspected that she had attempted to asphyxiate herself. The senior staff member on duty discussed the incident with Dr C, who directed that, in line with the treatment plan devised for Ms A (which she had agreed to) she was to be discharged immediately. However, after grave concern for Ms A's safety was expressed by a family member, it was agreed that she should stay in hospital.

During the afternoon of 19 July, Mr U recorded in Ms A's clinical records that he had entered her room, woken her and taken her to the ward smoking area for a cigarette and an "informal debrief". In doing so, Mr U took no account of accepted practice at the Unit in relation to patients with Ms A's diagnosis, who are to be cared for by experienced female staff members, or that only female staff were to enter female patients' rooms.

Mr U recorded his conversation with Ms A — that she denied having self-harmed the previous day. He recorded his support of Ms A's wish to remain in the unit and suggested an alternative therapy approach to that devised by Dr C. Mr U explained that his reason for entering Ms A's room and waking her that afternoon was "precautionary" because he was concerned that her blood pressure, which was affected

by one of the medications she was taking, had not been taken during the earlier shift. Mr U recorded Ms A's blood pressure as being 95/65 mmHg.[1]

Mr U said that he did not take a female staff member with him because there was no guideline requiring him to do so. Later that shift Mr U made a further note in Ms A's record in which he was critical of the clinicians' treatment plan for Ms A and that she was "accepting of writer's rationale". He suggested that Ms A would "benefit from DBT[2] as [Ms A] needs tools/strategies that she can self-implement when feeling in crisis, and so become proficient in managing own crises instead of having her alters[3] be the focus of her therapy".

Ms A stated that she knew Mr U from a previous admission, but his attitude towards her during this admission was different. He seemed to take an interest in her and talked a lot about having a friendship and doing "fun things" together.

Massage incident 19 July
On the night shift for 19/20 July, Mr U and team support worker Ms K were assigned to work on the ward. Bureau nurse Ms L was also assigned to the ward that night. It was a quiet night and, after Ms K and Ms L finished their routine tasks, they adjourned to the ward office to watch a DVD Ms K had brought in.

Mr U brought Ms A into the room. He told them that Ms A was not able to sleep so he had brought her to watch the DVD. Ms K and Ms L were surprised by Mr U's action in bringing Ms A into the ward office — something that is not allowed. Both Ms K and Ms L stated that when Ms A sat down, Mr U lifted her legs onto another chair and began to massage her legs with oil. They felt very uncomfortable about Mr U's actions but did not challenge him. The massage continued for about half an hour, but Ms A continued to be agitated and Mr U took her back to her room. Ms K stated that it is common for staff at the Unit to use foot baths and massage to manage anxiety and mood, but she had never seen staff massage a patient's legs.

When Ms L and Ms K did their rounds to check the patients they saw Mr U sitting on a chair beside Ms A's bed, reading a book. Later he was sitting outside her room. He stayed there until about 6am.

[1] Blood pressure is measured in millimetres of mercury. The normal range varies with age, but a young adult would be expected to have a systolic (upper) pressure of around 120mmHg and a diastolic (lower) pressure of 80mmHg. These are recorded as 120/80.

[2] Dialectical Behaviour Therapy is a systemic cognitive-behaviour treatment for borderline personality disorder, especially for individuals with chronic patterns of suicidal or other dysfunctional behaviours. DBT calls for the patient to accept reality while maintaining a strong and conscious commitment to change.

[3] Multiple personalities.

Mr U stated that he massaged Ms A's ankles and calves "briefly" as she was complaining about akathesia.[4] He said that the massage relieved the problem. Mr U noted in Ms A's clinical record that he had massaged her legs to relieve her anxiety, which arose from "unwelcome sexual advances" from two of the male patients. He noted that he offered to sit outside her room and play music to reassure her so that she could sleep.

On 20 July, Dr C recorded in Ms A's notes: "Females only to nurse [Ms A]."

On the afternoon shift of 20 July, staff nurse Ms M spent some time trying to calm Ms A and settle her in bed. However, later in the shift, while doing a ward round to check on the patients with team support worker Ms O, she was surprised to find Ms A up and dressed and applying makeup. Ms M stepped outside the room and expressed her surprise to Ms O, who responded, "She's getting ready for the night shift." Ms O told her about the massage incident of the previous night. Ms M advised Ms O to report the matter to Charge Nurse Ms N.

Night shift 20/21 July
On the night shift for 20/21 July, staff nurse Mr J was the senior staff member on duty with Mr U and an unqualified staff member. Mr U told Mr J that he had spent time in Ms A's room the night before talking and counselling her to get her to settle. Mr J told Mr U that it was not appropriate for him to be in Ms A's room. Mr J arranged for a female staff member to settle Ms A. He said that Mr U "reluctantly accepted" the direction that he was not to go into Ms A's room.

Ms A was discharged on 21 July 2006.

2.4 Concerns raised about Mr U

On 24 July, Dr G emailed Ms N and the Unit Manager Ms P regarding her concerns about Mr U's relationship with Ms A. Dr G stated that Mr U's "self-documented descriptions of his activities raise what are for me very serious concerns". She stated:

> "I am very seriously concerned about such disregard of appropriate boundaries in someone who is struggling with ongoing abuse, unable to maintain boundaries for herself, and extremely vulnerable to intrusion and manipulation. I think there is reason to be concerned that her boundaries may be violated further, even outside the hospital."

[4] A pattern of involuntary movements induced by antipsychotic drugs such as phenothiazines.

When Ms N returned from study leave on 24 July 2006, Mr J reported to her his concerns about Mr U's practice in relation to Ms A. As part of her enquiry into Mr J's concerns, Ms N spoke to Ms L and Ms K.

On 25 July, Dr C wrote to the the Unit management also expressing concerns about Mr U's practice:

> "[Mr U's] judgement, in my opinion, is impaired. He appears to be poorly boundaried both in his clinical interventions with this most vulnerable service user and in his clinical documentation. I frankly am concerned about [Mr U's] motivations as well as his clinical competence …"

A summary of Dr C's concerns are attached as *Appendix 3*.

2.5 Ex-patient August/September 2006

Ms A cannot recall exactly how the relationship between herself and Mr U developed after she left the Unit. She said that she thought he sent her text messages. She cannot recall giving him her telephone number. Ms A stated, "It's a kind of a blur to be honest, coz, you know when I'm sick I'm on a high dosage of medication and it affects my memory. … The first time ... I can remember, he was around at my flat and he was saying how hard it was for him not to have it become sexual."

The community support service 14 August 2006

Ms D stated that when she saw Ms A at the community support service on 14 August, she was "unreasonably happy". (Ms D was aware that there had been rumours circulating about Mr U's involvement with Ms A at the Unit.) Ms D recorded the meeting, noting that Ms A was smiling a lot, which was unusual. Ms D considered that Ms A might be taking drugs. However, Ms A denied this and said that there was "someone new in her life". Ms A told Ms D that she was feeling safe in this relationship and she was limiting her contact with her new boyfriend to twice weekly. Ms A agreed to inform Ms D if she felt unsafe.

Disclosure 25 August 2006

On 25 August 2006, team support worker Mr Q attended a staff party. At one point in the evening he went outside for a cigarette with Mr U. Mr U told Mr Q that he was having a relationship with Ms A. Mr Q said, "I didn't know what to say." Mr U told him that he had been "crashing [at] her place" and that she was "good in bed". Mr U told him that he wanted to get Ms A "out of the mental health system and that he was going to help her do this and look after her". Mr Q said he was "really shocked" by Mr U's disclosure.

Mr U denied that he made any such comments to Mr Q. Mr U, however, acknowledges that he did say "it would be nice to have a relationship with someone like [Ms A] in different circumstances i.e. had she not been a patient".

Mr U stated that he does not know why Mr Q would make the allegations or his motivation in attributing those comments to him. Mr U then went on to allege that Mr Q had in fact made inappropriate comments about Ms A. Mr U acknowledged that making such an allegation "might be misconstrued as an attempt to deflect blame from himself".

Counselling appointment 28 August 2006
On 28 August, Ms D saw Ms A again. She noted that Ms A was to have had a pregnancy test, but had not done so as she was "still avoiding finding out if she was pregnant". Ms A told Ms D that she was "not having so much to do with her 'new boyfriend' at the moment because she is not feeling up to it". An appointment was made for Ms A to be seen the next day at a psychotherapy service.

Counselling appointment 8 September 2006
On 8 September, Ms D met with Ms A again. Dr G was also present and she and Ms D talked to Ms A about her lack of participation in the therapeutic relationship. Ms D told Ms A that there was an "elephant in the room" — a significant issue that was being avoided. Ms A told Ms D that she was feeling guilty about not telling her about Mr U. He had asked her to keep their relationship a secret. Mr U told Ms A that if it became known he could lose his job. Ms A told Ms D that she did not want to be responsible for Mr U losing his job. Ms A said she felt "trapped" because she did not like lying to Ms D and it made her therapy "quite hard because there was something, like this lie there, that I had to tell". Ms D recorded that Ms A was able to recognise the impact on the relationship of keeping secrets and "noticed immediately feeling more connected after discussing the 'elephant'".

Counselling appointment 25 September 2006
On 25 September, Ms A was very distressed when she saw Ms D for her routine therapy session. The content of the session focussed mainly around family issues, but she was also feeling angry and hurt about Mr U's behaviour towards her. She believed their relationship was "all about his needs", and that Mr U was only "using her for sex". Ms A found it hard to resist Mr U's approaches because she believed that this was all men had ever wanted from her. She said that Mr U promised to take her to "nice places" but he only came to see her when he wanted sex.

Ms A's contact with Mr U in 2007
Ms A recalls that she found out that Mr U was under investigation because of his relationship with her, when he sent her a text message and asked her to support him. Ms A was unable to recall the date she received his text.

Psychologist appointment 20 February
On 20 February 2007, Ms A attended an appointment with a psychologist, who noted that Ms A "had sex with [Mr U] approx two weeks ago and he hasn't contacted her since. She feels 'stupid', shamed and used and her capacity to trust people has further decreased."

Text Messages from Mr U 14 March
On 14 March 2007, Mr U sent Ms A a series of text messages. The first text message sent at 1.36pm read:

> "Fwd: Am close 2 stepin off tall building, not sure I can do this all again."

At 1.39pm:

> "Fwd: Am bein investigated by health n disability comision 4 rship wiv u. need ur support or i am toast."

At 1.46pm

> "Fwd: Hi need 2 talk, urgent."

3.0 Deputy Commissioner's Findings — Mr U

Ms A was entitled to be free from sexual exploitation and be provided with services that complied with legal, professional, ethical, and other relevant standards. A health professional has an obligation to his or her clients to provide a service that minimises potential harm and optimises their quality of life.

In the context of this case, Mr U, as a registered nurse, was required to respect the boundaries of a professional relationship with Ms A. As the Commissioner stated in Opinion 04HDC05983:

> "When [a health care provider] has a professional relationship with a client, especially a client with mental health needs, he or she must take extreme care to establish and maintain the boundaries of that relationship. A breach of professional boundaries is a breach of trust and can result in physical and/or emotional harm to the client."

Professional and ethical boundaries
There is no question that Ms A was a vulnerable client. She was diagnosed with Disassociative Identity Disorder and had been involved in psychiatric services since mid-adolescence for treatment for self-harm and ongoing sexual abuse. Ms A was considered by her clinicians to be "unboundaried" and extremely vulnerable to intrusion and manipulation. In a recent HDC Opinion,[5] registered counsellor Anita Bocchino commented on the vulnerability of sexually abused clients:

[5] Opinion 06HDC09325, 7 December 2006, page 7.

> "It is not at all unusual, and in fact, expected that such survivors of sexual abuse are more likely to form revictimising relationships and partnerships, … [and] will re-enact their early environments of victimisation."

The Unit's practice in relation to the management of patients like Ms A is that only experienced female staff were to accompany female patients with this history, in their rooms. Other staff involved in Ms A's care were aware of this practice and complied with it. The need to maintain professional boundaries was clearly set out in the ADHB policy "Guidelines for Safe Practice — Professional Relationships" — see *Appendix 4*, which states that "social contact and friendships between staff and patients are to be avoided" and that "sexual behaviour or sexual contact between staff and patients is … prohibited". The policy also stipulates that staff are to refrain from "undue familiarity", and are only to visit patients at their homes on "work related business".

During the time that Ms A was a patient at the Unit, Mr U cultivated a relationship with her. Mr U made opportunities to have contact with Ms A in a manner that overstepped professional boundaries as follows:

- On 19 July 2006, he entered her room and woke her to take her blood pressure, despite her known sleeping difficulties. Mr U's explanation for this was that he was acting in a "precautionary manner".

- Although Mr U should have been aware of the practice that only female staff were to enter the rooms of female patients, he did not take a female member of staff with him when he entered Ms A's room. Mr U believed there was no guideline that required him to do so.

- He noted in Ms A's clinical record that he also took the "opportunity for an informal debrief", recording his discussion with her about his concerns regarding her treatment management and that Ms A accepted his opinion.

- During the night shift 19/20 July Mr U took Ms A to the nurses' ward office where he massaged her legs for a period of time. Patients are not allowed in the ward office. He spent the remainder of the night either inside Ms A's room, or sitting outside the door. He said that he did so because she was "unable to sleep in room, feelings of fear/anxiety of persons entering the room".

- On 20 July, Dr C recorded in Ms A's notes: "Females only to nurse [Ms A]". Mr J told Mr U on the nightshift for 20/21 July that it was not appropriate for him to be in Ms A's room. Mr J arranged for a female staff member to come to settle Ms A. He said that Mr U "reluctantly accepted" the direction that he was not to go into Ms A's room.

- Mr U created opportunities for Ms A to talk about her fears, and for him to discuss with her his own therapy rationale, which was contrary to those

> designed by Ms A's psychiatrists, to encourage her to be less reliant on the hospital system.

In my view, Mr U's approaches to Ms A while she was an inpatient at the Unit were designed to alienate her from the team authorised to treat her, in order to enhance his influence over her.

Ms A is unable to recall how contact between herself and Mr U was established after her discharge from the Unit. However, on 8 September, when Ms A met with Ms D and psychiatrist Dr G at the community support service, she told them that she had kept secret her relationship with Mr U. Ms A said that she was feeling guilty about keeping the secret but Mr U had told her that he would lose his job if it became known.

The importance of maintaining professional boundaries in such situations, clearly set out in nursing ethical standards, has been recognised in other cases. In a recent report,[6] registered psychiatric nurse Ms Clarissa Broderick provided expert advice and made the following general comments about professional boundaries:

> "Implicit in Mental Health Nursing is the need to appreciate the boundaries of the nurse client relationship … It is usual for nurses to 'like' their clients within the context of the professional relationship. However the nurse has the responsibility to recognize the significant power imbalance that exists within the therapeutic relationship. The dynamics of a relationship that involve disclosure on the client's part, and empathy and understanding from the nurse, can arouse strong emotions for the client and feelings of dependence. To take advantage of these emotions, to form a 'friendship', intentionally or not, is unethical and exploitative …
>
> Nurses know it is not acceptable to accept invitations to meet socially with clients or ex-clients, nor is it acceptable to exchange phone numbers. It is a breach of the Nursing Council of New Zealand's Code of Conduct, and a significant departure from what would be considered acceptable."

On 14 March 2007, Mr U sent Ms A three text messages to tell her that he was under investigation by the Office of the Health and Disability Commissioner because of his relationship with her. He stated that he was "close 2 steppin off tall building", and that he needed her support "or I am toast". Mr U's text messages were a further attempt to coerce and manipulate a young woman to collude with his behaviour, which he knew was a serious departure from professional standards.

Sexual relationship

The information gathered during this investigation corroborates Ms A's allegation that Mr U engaged in a sexual relationship with her. Mr Q, Ms D and Dr G have

[6] Opinion 06HDC06218, 26 January 2007, page 18.

confirmed that they knew of the relationship at the time, and there are no significant inconsistencies in the information provided by them.

Mr U acknowledged that he spoke to Ms A on the telephone, accompanied her for walks on the beach and took her for coffee. He denied that he had a sexual or inappropriate intimate relationship with Ms A. However, information has been gathered that conflicts with Mr U's statement:

- On 25 August 2006, Mr U told Mr Q that he was having a relationship with Ms A and that he had been "crashing her place" and she was "good in bed."

- On 8 September Ms A told Ms D and Dr G that she felt guilty about keeping secret her relationship with Mr U. The only reason she kept the secret was because he told her that he would lose his job if their relationship became known.

- Ms A was consistent in her disclosures about the nature of the relationship. She said her meetings with Mr U at his home were "mainly about sex." In August 2006, Ms A avoided taking a pregnancy test against the advice of her psychologist because she was concerned that she might be pregnant to Mr U.

- In March 2007 Mr U sent Ms A a series of text messages to tell her that he was being investigated in relation to his relationship with her. The text messages indicated that he was extremely distressed and asked her to support him.

Mr U accepts that his behaviour in relation to Ms A was "unusual" and outside his normal practice. Mr U explained that he "was going through a very stressful period with a marriage break-up after 10 years of marriage and two children" and that "at the time his judgement may have been impaired by personal problems arising from the marriage break-up". Mr U believed that "he found it quite difficult to leave work at work, and his personal problems at home".

Mr U believed that Ms A was a "person who needed support and help" and he had "concerns" about the treatment she was receiving. Mr U stated that Dr C "seemed adept at improvising as opposed to being pro-active and/or having a clear multi-disciplinary approach to the care necessary to treat Ms A for her medical condition". Mr U was concerned about the "pseudo-parenting behaviour" of Dr C and Dr G towards Ms A and made a number of other criticisms regarding Ms A's treatment.

Mr U stated that Tikanga Best Practice (Mental Health) Implementation is a way of working that has been adopted across the ADHB but resisted within the Unit. He believes it is a way of working that is underpinned by Te Ao Māori (Māori world)

health paradigms that enables recovery of the individual and their whānau (family) whether they are Māori or by non-Māori.

Mr U stated that his attempts to implement Tikanga Best Practice have led to his troubles. He said that it is his "perceived right under the Treaty of Waitangi to assert my own right to tino rangatiratanga"[7] and it is his willingness to be involved and participate "at all levels is where I most threaten". Mr U believes he "threatens the status quo" because he is outspoken and believes that his heritage and his views are "why I seem to attract so much flak". He believes "most of my troubles" arise from his attempts to implement Tikanga Best Practice (Mental Health) which was "simply an anathema to the resident lesbian feminists" and, the "lesbian feminist theory underpins its version of clinical practice at [the Unit]".

I am disturbed by Mr U's claim that tino rangatiratanga gives him a right to implement clinical interventions in direct opposition to the clinical intervention that according to Dr C "has been a painstakingly coordinated multidisciplinary treatment with very close liaison between the community support service and the hospital team over the last few years".

Many organisations that work under Māori models of health service delivery have practices aimed at maintaining professional boundaries. There are also New Zealand Qualification Authority standards for Māori-based health services workers around professional boundaries. I am therefore unconvinced by Mr U's argument that working under a Māori health paradigm meant that he could work separately from the clinical team treating Ms A, and ignore professional boundaries.

Mr U said that he did not raise any of his concerns about the treatment plan for Ms A with Ms N, Ms P or psychiatrist. He said that he recorded his views "openly and honestly" in Ms A's clinical notes, "believing that it was his duty to do so".

Mr U's unilateral approach flies in the face of concepts underpinning tino rangatiratanga, which is based on a collective approach that includes the need to work under tikanga (Māori lore in terms of customs, values and beliefs), which in turn is based on treating others with dignity and respect.

Mr U advised that he understood that it was "inappropriate to have contact of any kind with a patient or ex-patient outside the in-patient area" and that his "relationship with [Ms A] could be viewed unfavourably". Mr U stated that he rationalised his contacts with Ms A as "an extension of the caring relationship that a healthcare provider must have in relation to the patients and/or ex-patient".

In response to the provisional report, Mr U admitted that he had a sexual relationship with Ms A. Mr U's admission came after 12 months of misleading this investigation.

[7] Tino rangatiratanga is self-governance by Māori through exercising mana (authority) of hapu (sub tribes and iwi (tribes).

Considerable effort was expended on investigating this complaint, including conducting an interview with Ms A, which exposed her to undue and unnecessary stress. I do not accept that his actions can be excused by the problems he was facing in his personal life, or that his motivation in establishing the relationship was because he wanted to be supportive and provide Ms A with a "mental health respite environment".

Mr U's actions in establishing this relationship with Ms A and involving her in deception were exploitative and potentially very dangerous to her well-being. He failed to maintain professional boundaries in his dealings with her and abused a position of trust.

4.0 Investigation — ADHB

4.1 Actions taken by ADHB regarding Mr U's conduct

24 August 2006 — when Mr J, Dr G and Dr C expressed concern about Mr U's practice in relation to Ms A in July 2006, Ms N addressed those concerns. She spoke to other staff members who were concerned about Mr U's practice, and to Mr U. (Ms K, Ms O, Ms L and Ms M are mentioned earlier in the report as having been spoken to.) Ms N spoke to Mr U regarding his practice in relation to Ms A. She told him that female patients who have been sexually abused should not have male staff looking after them. She recalls that Mr U replied that Ms A would have to learn to trust men. When Ms N disagreed with him, he told her that she was being unreasonable because Ms A's clinician was a man.

Ms N conducted a Performance Improvement Plan with Mr U, which addressed such matters as his need to "explore the legal & ethical ramification of the clinical notes written on the 19th of July 2006". Mr U was to participate in individual fortnightly supervision with Mr J and monthly supervision with a registered nurse. Mr U was to provide Ms N with evidence of the supervision.

28 August 2006 — Mr Q informed charge nurse Mr R and Dr C about the conversation he had had with Mr U at the staff party on 25 August about his relationship with Ms A. As a result, ADHB took disciplinary action against Mr U in respect to the professional boundary concerns arising from Mr Q's statement. On 1 September, Mr R, an Acting Nurse Specialist and HR Consultant Ms S met with Mr U to discuss the allegations. Mr U denied having a sexual relationship with Ms A, stating that the relationship was a supportive friendship.

1 September 2006 — Mr R, the Acting Nurse Specialist, and Ms S, HR Consultant, met with Mr U to "gain information following on from a serious allegation re [Mr U] breaching professional relationships". Mr U told Mr R that he wanted to hear what he was accused of before he considered "what action and what support he would need".

The details of the allegation were discussed. Mr U said that the report that he was having a relationship with Ms A was "rubbish". He denied saying any of the things attributed to him by Mr Q. He denied having "slept with her" or having "crashed [at] her place". He said that he tried to be a friend "based on trust and respect". Mr U admitted to telephoning Ms A, taking her for walks on the beach and going to her house to take her out for coffee. Mr R told Mr U that he would be off work on special leave until the investigation into the allegations was concluded.

20 September 2006 — Ms B notified the Nursing Council of her concerns about Mr U's health and competence to practise. The Nursing Council forwarded Ms B's notification to the Office of the Health and Disability Commissioner. Mr U's response to this complaint has been summarised and included where relevant within this report.

6 October 2006 — Ms P wrote to Mr U regarding arrangements for a disciplinary meeting. Ms P stated, "We are disappointed and concerned about the length of time that has lapsed whilst trying to arrange a meeting with your representative." Ms P proposed a meeting with Mr U and his representative for the week of 9 October.

13 October 2006 — Ms B, Ms P and HR consultant Ms T met with Mr U and his legal representative to discuss concerns about Mr U's professional conduct. The following is a summary of the notes taken during the meeting:

- "[Mr U] responded by stating that the matter for him was the expectations of a 'psych nurse'. [Mr U] stated he is a recovery nurse not a psych nurse."

- [Ms B] read from the Code of Conduct for Nurses and Midwives regarding professional conduct and explained that "contacting a service user outside of the unit was an issue".

- The lawyer stated that the "service user was not an inpatient when [Mr U] made contact with her". He said that [Mr U] was "acting as a committed and caring nurse acting in the best interests of a patient". He also raised the gender issue and said that "it is offensive to state that a male nurse should not massage a female patient's legs".

The lawyer requested that Mr U be provided with clinical supervision for six weeks. Ms B agreed "as a gesture of good faith" to approach Mr U's clinical supervisors to see whether they would provide supervision.

18 October 2006 — Ms P confirmed in a letter that supervision would be arranged. She required an undertaking from Mr U that he would have no further contact with Ms A while he was an employee of ADHB.

2 November 2006 — Ms P wrote to Mr U (care of his lawyer) to remind him about the conditions of his continued employment by the ADHB. Ms P requested a further meeting with Mr U by 10 November 2006, so that they could discuss his future with the ADHB.

24 November 2006 — Mr U advised Mr J that he intended to resign and that his last working day would be 27 November. He said that he was relocating and hoped to find employment in "either an in-patient unit or in the area of psych liaison". Mr J recorded that Mr U declined his offer to provide further supervision. Mr U did not resign until December. His last working day was 10 December, and he did not relocate at that time.

4 December 2006 — Ms N and Ms P provided written references for Mr U. Neither reference makes any mention of the conduct that led to the disciplinary process, any concerns about Mr U's nursing practice, or the circumstances surrounding his departure. Ms P's reference states that Mr U was resigning his position following some "domestic issues that have impacted on his health".

5 December 2006 — ADHB signed a confidential settlement agreement with Mr U. It confirmed that the two references were part of its settlement agreement with Mr U and accepted that the terms of the agreement created risk for potential employers and their patients. However, in ADHB's view, risk to patients elsewhere cannot be readily addressed in an employment dispute, and the risk already existed by virtue of the Privacy Act 1993 and the restrictions it places on ADHB's ability to pass on personal information about competence concerns. ADHB stated that verbal reference checks are common practice in the sector and that it was unfortunate that in this case thorough reference checking did not occur.

6 December 2006 — Mr U resigned from Auckland City Hospital "for personal reasons" — effective from 10 December 2006. Mr U was subsequently employed by another District Health Board's Mental Health Service.

5.0 Deputy Commissioner's Findings — ADHB

5.1 Direct or vicarious liability

ADHB had an obligation to provide Ms A with appropriate care. As Mr U's employer, ADHB is vicariously liable for Mr U's breach of the Code unless it can show that it took reasonable steps to prevent it.

There were clear guidelines available to staff concerning the Board's expectation relating to patient/staff relationships. As previously discussed, the Board's policy, "Guidelines for Safe Practice — Professional Relationships" states that "social contact and friendships between staff and patients are to be avoided", and that "sexual behaviour or sexual contact between staff and patients is … prohibited".

The Unit also had "unwritten rules" relating to staff involvement with patients like Ms A. These "rules" were well known to the staff at the unit, and had been reinforced in

writing by Ms A's clinician when it became known that Mr U had entered Ms A's room unaccompanied by a female member of staff.

When Ms N was informed by Ms L and Ms K about the massage incident, she spoke with Mr U and reminded him of his professional responsibilities. When ADHB learned that Mr U had disclosed a sexual relationship with Ms A, appropriate action was taken. Mr U was invited to meet with senior staff to provide an explanation, conditions were placed on his continuing employment with ADHB, and supervision was organised. Mr U decided not to continue his employment with ADHB, and his resignation was accepted on 10 December 2006.

I am satisfied that ADHB provided appropriate care to Ms A and that the policies and systems operating at ADHB and the Unit at the time were appropriate, adequate and provided a clear expectation of the standard of behaviour expected of staff. In my view, Mr U was aware of his responsibilities and obligations.

The policies could, however, be improved by making it clearer that such contact with former patients is also unacceptable. It would also help to make the practice of female staff working with female patients who have experienced sexual abuse a documented policy. I am also satisfied that the appropriate corrective measures were taken to ensure that Mr U was practising safely within the Unit.

In my opinion, ADHB did not breach the Code and is not vicariously liable for Mr U's breaches of the Code.

6.0 Deputy Health and Disability Commissioner's opinion

6.1 Mr U

I consider that Mr U's conduct towards Ms A clearly transgressed professional boundaries and was in breach of ethical standards. Accordingly, in my opinion Mr U breached Rights 4(2) and 4(4) of the Code.

It is also my opinion that Mr U's conduct amounts to sexual exploitation as well as a departure from ethical standards, and is therefore in breach of Rights 2 and 4(2) of the Code.

6.2 ADHB

I consider that ADHB responded promptly and appropriately to the allegations about Mr U's relationship with Ms A. Senior nursing staff were sufficiently concerned that Mr U could pose a risk of harm to the public that Ms B notified the Nursing Council of her concerns, under section 34 of the Health Practitioners Competence Assurance Act.

Other comment
When Mr U resigned, he was provided with references that made no mention of the serious concerns relating to his practice. As a result, Mr U went on to gain employment at another District Health Board's in-patient mental health unit. ADHB stated that privacy constraints are relevant to this issue and outweighed the need to consider public safety. I do not agree with this stance and believe that the references should have included mention of the concerns about Mr U's practice.

In response to the provisional opinion, ADHB stated that the Board has never taken the stance that privacy constraints outweigh the need to consider public safety. The Board's legal advice is, "generally, that privacy constraints can prevent employers passing on adverse personal information". The Board pointed out that Mr U could have refused ADHB consent to pass on information. He could also have refused to authorise prospective employers contacting ADHB referees. ADHB submitted that this is different from providing inadequate written references, which the Board accepts should have been avoided. ADHB believes that public safety must always take priority, to the extent allowed by law.

Notwithstanding ADHB's submission, I remain of the view that it was irresponsible of ADHB to provide positive references for Mr U in such circumstances. Doing so had the clear risk of assisting an employee who was considered to pose a potential risk to public safety, to gain employment in a similar area without his new employer being aware of the need for supervision and safeguards. The obvious course of action would have been to refuse any reference other than a written record of service. I would expect future employers to carry out reference checks. However, providing a positive written reference and then relying on future employers to enquire as to whether it is true is disingenuous.

I am pleased that ADHB has seriously considered my comments regarding the provision of written references in this case and is implementing education for the Human Resources practitioners and managers to ensure that references do not place subsequent employers and their patients at risk.

7.0 Recommendations

I recommend that Mr U:

- provide a letter of apology to Ms A;
- undertake supervision and training on maintaining appropriate boundaries as a health care provider.

7.1 Proposed follow-up actions

- Mr U will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Nursing Council of New Zealand, with a recommendation that a competence review of Mr U's practice be considered.

- A copy of this report, with details identifying all parties removed, except Auckland District Health Board, will be sent to Mr U's new employer and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

8.0 Addendum

The Director of Proceedings considered the matter and laid a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal concluded that the actions of Mr U amounted to such a significant departure from accepted standards that discipline was warranted, and it upheld the charge of professional misconduct.

The Tribunal imposed the following penalties: censure, cancellation of registration, and the imposition of a number of conditions on any application Mr U might make to re-register with the Nursing Council of New Zealand. An order for costs of $7,500.00 was also made.

The Director decided not to issue proceedings before the Human Rights Review Tribunal.

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Appendix 1 — Parties involved

Ms A	Consumer
Mr U	Provider/psychiatric staff nurse
Ms B	Complainant/Nurse Leader
Dr C	Psychiatrist/Clinical Director
Ms D	Psychologist
Ms E	Staff nurse
Ms F	Charge nurse
Ms G	Medical Officer Special Scale
Mr H	Staff nurse
Mr I	Staff nurse
Mr J	Staff Nurse
Ms K	Team Support Worker
Ms L	Bureau staff nurse
Ms M	Staff Nurse
Ms N	Charge nurse
Ms O	Team Support Worker
Ms P	Unit Manager
Mr Q	Team Support Worker
Mr R	Charge nurse
Ms S	HR Consultant
Ms T	HR Consultant

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

Appendix 2 — Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

Right 2 — Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation. Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

Right 4 — Right to Services of An Appropriate Standard

> (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. …
>
> (4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Other relevant standards:

Nursing Council of New Zealand "Code of Conduct for Nurses and Midwives" printed August 2005.

> "Principle Two
>
> The nurse or midwife:
>
> Criteria
>
> 2.1is guided by a recognized professional code of ethics applied to nursing and midwifery;
>
> Conduct in Question
>
> Some examples of behaviour which could be considered as a basis for a finding of professional misconduct or imposing a penalty are listed below:
>
> …
>
> - Entering into a sexual or inappropriate intimate relationship with a client or ex-client …

Nursing Council of New Zealand's Competencies for the Registered Nurse scope of practice (September 2004):

> 1.6: Practises nursing in a manner that respects the boundaries of a professional relationship with the client. …

7.0 Ethical accountability:

The applicant practises nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities, culture and choice.

Mental health performance criteria

The applicant:

…

- Recognises ethical dilemmas and problems arising in a mental health nursing context.

…

- Consults with experienced mental health nurses when confronted with an ethical dilemma.
- Practises within recognised codes of ethics and codes of conduct.

Appendix 3 — Dr C's concerns about Mr U's practice

On 25 July Dr C wrote:

> "I feel I must lodge a complaint against staff nurse [Mr U] for both his clinical interventions with the service user [Ms A] and his HCC [clinical records] documentation thereof. I offer the following analysis, including excerpts from [Mr U's] notes [noted in bold], in explanation.
>
> Overview
> [Ms A's] has been a painstakingly coordinated multidisciplinary treatment with very close liaison between [the community support service] and the hospital team over the last few years. Her therapy with [Ms D] has, in my opinion, been exemplary under very fraught conditions … She was admitted informally to [the Unit] in a very agitated, suicidal and vulnerable state. Her admission ultimately lasted four days and [Mr U's] actions occurred during the night shift. …
>
> '**[Ms A] appears as tho she would benefit from referral to DBT, as [Ms A] needs tools/strategies that she can self implement when feeling in crisis, and so become proficient in managing her own crises instead of having her alters be the focus of her therapy**.'
> (N.B. [Ms A] has been and continues to be receiving DBT-based treatment)
>
> I have no difficulties with any staff member voicing strong opinions. In fact, I regard the exchange of clinical opinions as the life's blood of competent treatment. But, given [Ms A's] well-documented vulnerability to issues of abandonment and mistrust, I regard [Mr U's] unilateral 'collaboration' (without prior consultation with her team) in the second-guessing of the approach of her most vital support people as ill conceived and potentially very dangerous.
>
> [Mr U's] criticism extends to the inpatient team as well. Charge nurse [Ms N] and I became concerned during the course of [Ms A's] admission with the approach [Mr U] was taking. [Ms N] informed me on 20/07/06 that she had given instructions to the staff to the effect that only female nurses would be assigned to work with [Ms A]. After reviewing the clinical record and noting not only [Mr U's] practices but also the harassment [Ms A] had received from two male service users, I decided to restate this restriction in my clinical note of 20/07/06, reasoning that [Ms A] would benefit from the elimination of one powerful potential source of internal conflict and potential destabilisation while striving to regain her emotional footing. [Mr U] acted, in my opinion, to undermine this clinical decision. He writes in the clinical notes, once again in collaboration with [Ms A]:

'**[Ms A] informed of "nil male staff to nurse"; [Ms A] angry and venting her displeasure at this. [Ms A] encouraged to speak with drs this morning**.'**[again — need to find this entry]**

Summary
[Mr U's] judgement, in my opinion, is impaired. He appears to be poorly boundaried both in his clinical interventions with this most vulnerable service user and in his clinical documentation. I frankly am concerned about [Mr U's] motivations as well as his clinical competence as represented in the preceding commentary."

Appendix 4 — ADHB Policy

ADHB updated its policy "Guidelines for Safe Practice — Professional Relationships" in March 2002. The policy states:

> "**Ethical and legal obligations**
>
> Staff have an ethical obligation to patients and to their colleagues and are to practise within their professional guidelines, codes of practice and ethics where these apply.
>
> Staff have a legal obligation under the Human Rights Act not to abuse power.
>
> …
>
> Staff have a legal obligation to ensure the Code of Health and Disability Services Consumer Rights is upheld. ...
>
> **Professional boundaries**
>
> Social contact and friendships between the staff and patients are to be avoided as they may compromise the boundaries of professional relationships. …
>
> Sexual behaviour or sexual contact between staff and patients and their families under their professional care is prohibited.
>
> Staff are to refrain from undue familiarity and the use of endearments.
>
> ADHB discourages staff taking patients to the staff member's home. There may be extreme exceptions to this in which case staff are to have the permission of their manager. Permission and visits are to be documented in the patient's clinical record.
>
> Staff are to visit patients at home only on work related business.

Appendix 5 — Mr U's response to Provisional Opinion

In his response to the provisional opinion, Mr U admitted that he had had a sexual relationship with Ms A. Mr U said that when Ms A became frightened that she was about to be confronted by her abuser — a family member — he "welcomed her into my home" Mr U said, "I didn't see the harm, no warning bells went off in my head like it should, I would have normally."

Mr U said:

> "She appeared genuinely frightened and stated she felt safe being there. I just wanted to be supportive and provide a similar mental health respite type environment was my thinking at the time. At the time it was nice for me too having someone to talk to, who had been where I was walking, this was the real seduction, in letting it be about me and not [Ms A] is where it all came undone. … Perhaps I should have pushed her away, but in truth I cherished the closeness and intimacy, was afraid to hurt, to reject. … I do not believe I had considered any of my actions/their consequences and repercussions."