Registered Nurse, RN A

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01728)

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Executive summary

1. This case relates to the failure of a nurse to maintain professional boundaries with her client. The nurse, employed by a support service (contracted by the NZ prison service to provide mental health services), provided services to a prisoner between 2017 and 2019, before ending her employment to return home overseas. Following the end of her employment, the nurse engaged in frequent telephone calls of a personal nature with the man.

2. This report highlights the importance of maintaining professional boundaries between healthcare professionals and patients, especially when patients are in a vulnerable position, for example living in a facility such as a prison, or receiving mental health care. It also shows that the power imbalance between a healthcare provider and their patient is not necessarily displaced by the end of the professional relationship, because of the level of knowledge held by the health professional about the consumer's sensitive and personal information.

Findings

3. The Deputy Commissioner found that the nurse breached Right 4(2) of the Code by initiating and engaging in contact of a personal and often intimate nature after the end of the therapeutic relationship. The Deputy Commissioner also found that because of the continuing power imbalance and the nurse's explanation that the relationship was meeting her spiritual needs, the relationship between the man and the nurse was exploitative, and therefore the nurse also breached Right 2 of the Code.

Recommendations

4. The Deputy Commissioner recommended that the Nursing Council consider the nurse's fitness to practise and whether any reviews of competence and/or conduct are required, should she return to New Zealand and seek to renew her practising certificate.

5. The Deputy Commissioner recommended that the support service, the nurse's former employer, circulate an anonymised copy of this report to staff, to reinforce the importance of maintaining professional boundaries.

Complaint and investigation

6. The Nursing Council of New Zealand (NCNZ) referred to the Health and Disability Commissioner (HDC) a notification made by the NZ prison service (the prison service) about the services provided by a former employee, Registered Nurse (RN) A, to a prisoner, Mr B. The following issue was identified for investigation:

- *Whether RN A provided Mr B with an appropriate standard of care during 2017 to 2020 (inclusive).*

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7. Further information was received from:

Support service	Group provider
Prison health service	
Ms C	Mental health clinician at the support service
Nursing Council of New Zealand	

8. Also mentioned in this report:

Ms D	Regional Clinical Director at the prison service

9. This report is the opinion of Deputy Health and Disability Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

Information gathered during investigation

Introduction

10. This report discusses whether RN A maintained professional boundaries with her client, Mr B.

Mr B

11. Mr B[1] (in his thirties at the time of events) has been in prison since 2011. While in prison, he received mental health support and counselling through services provided by a support service. The support service was contracted by the prison service for a mental health programme (the programme) which commenced in 2017. Previously, Mr B had accessed ACC sensitive claims counselling. Currently he is serving an indefinite term of preventative detention at Prison 1.

RN A

12. RN A began working for the support service as a registered mental health nurse in 2017. She was recruited for the programme and provided mental health support to inmates at Prison 1 during this time. In 2019, RN A terminated her contract with the support service and indicated that she intended to move back to her home country. RN A's New Zealand practising certificate expired. Currently she is registered in her home country and holds a practising certificate.

Appointments with Mr B: May 2017–January 2019

13. RN A provided mental health services to Mr B from late May 2017 until 18 January 2019 at Prison 1.

14. Mr B's care plan, dated 6 July 2018 and completed by RN A, outlined that he had a childhood history of trauma, substance issues, and sex addiction. It also outlined that he was

[1] Mr B does not support this complaint and has not provided information to HDC.

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experiencing feelings of worthlessness, sleep issues, weight loss, poor concentration, and excessive guilt, which had improved since the initial referral, and that future sessions would focus on reducing anxiety. The clinical notes for his first appointment outlined that he had suicidal ideation, and clinical notes throughout refer to his severe depression.

15. Primarily, RN A's sessions with Mr B included cognitive behavioural therapy and mindfulness techniques. Based on the clinical notes, Mr B was using breathing, stretching, and mindfulness exercises to deal with stress or anger, as well as verbal discussion of his feelings or behaviours with RN A.

16. RN A also assisted with arranging, and attended, multi-disciplinary meetings and an interview with a group providing spiritual advice and teachings to prisoners. In addition, she arranged for mental health support and telephoned Mr B when he was in another region for a court appearance, and attempted to arrange his participation in a group rehabilitation course.

Sessions on 26 March 2018 and 16 April 2018

17. The clinical notes indicate that discussions about, and issues with, boundaries arose during sessions.

18. On 26 March 2018, RN A's clinical notes state that Mr B was reluctant to attend the day's appointment, and staff had to locate him and bring him to the session. He displayed negative body language, including limited eye contact and sitting so that he faced RN A side-on. RN A recorded in the notes that they discussed their therapeutic relationship, and the concept of "transference of emotions". RN A wrote that any exploration of Mr B's emotions was quickly shut down by Mr B, who assured her that he was fine despite his withdrawn body language and his explanation that he had been struggling with "yukky" feelings throughout the previous week.

19. In this meeting, RN A wrote that they discussed how "there is a 'playful' atmosphere" in their sessions, and that she reiterated boundaries. She documented: "There has been no inappropriate behaviours in session, however I did discuss this playful atmosphere I have been detecting in session." She recorded that Mr B had been using metaphors such as "Are you petting a rabbit?" and "Are you mind cradling?", but refused to explain the meaning when asked by RN A. At the end of the session, Mr B expressed that he was "confused" and did not know whether he wanted the sessions to continue. RN A also documented that Mr B said that he does not usually "ask for help".

20. On 16 April 2018, the clinical notes describe Mr B being upset with RN A after they attended a multi-disciplinary team meeting together. RN A recorded that she asked Mr B why he was sitting sideways and avoiding eye contact, and he responded by swivelling on his chair to face her and saying, "There now you can rest your legs on me." She wrote that they discussed the therapeutic relationship and Mr B's difficulty relating to her. RN A recorded: "I gently explored with him that I might not be the best person to support him at this time." Mr B expressed to her that she had let him down by placing expectations on him, and he felt that she had let him down in other ways, but he could not articulate how. In their next

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meeting, on 23 April, Mr B apologised for his behaviour in the previous sessions, and said that he had felt "detached" and "unaware of his behaviour".

21. RN A told HDC that during her employment with the support service, there was no personal relationship or personal communication between herself and Mr B to report to her employer.

Number of appointments

22. The limit on the number of consultations permitted to occur between RN A and Mr B is unclear.

23. The Regional Clinical Director at the prison service, Ms D, raised concerns with HDC about the number of appointments that occurred between RN A and Mr B, and stated that RN A met with Mr B for over 60 consultations. Based on the clinical documentation supplied to HDC, notes are recorded for approximately 54–55 appointments[2] (excluding cancelled and rescheduled appointments), alongside two to four assessments following each referral.

24. The "Initial Report" prepared by the Integrity Assurance Team at the prison service (which outlines enquiries made by the prison service when it was made aware of an alleged relationship) states that the contract with the support service "allows for six sessions per prisoner, which may be extended to ten if required", and that further sessions require approval by the support service manager. Ms D said that the support service became aware of the number of sessions between RN A and Mr B only once RN A advised that she would not be renewing her contract, and, as she was leaving, "no further action was taken at the time".

25. In contrast, the support service told HDC that RN A's contract contained no session limits and no need to seek managerial approval for extra sessions. The support service also noted that the reporting template for clinicians at the time allowed for 20 sessions per referral, and that Mr B was referred by prison service staff on three separate occasions, which would give a total of 60 sessions. RN A recalled the same. Similarly, the clinical notes show that three separate referrals were made by staff[3] for Mr B to participate in the programme.

26. In the referral dated 7 October 2017, a new limit of 20 sessions per referral is referred to. RN A told HDC that the programme began in early 2017 and was funded for two years. She recalled that towards the end of the programme, session numbers were reviewed and new guidance was introduced, which allocated six sessions per separate referral, and required manager approval for up to 10 sessions.

Communications after resignation

27. After leaving her role at the support service in February 2019, in May 2020 RN A asked for her personal telephone contact details to be shared with Mr B, and proceeded to be added

[2] This number is approximate as there are some discrepancies in the clinical notes surrounding the total number of appointments, such as mis-numbering of the appointments, recording of the wrong date for appointments, and the recording of notes for different appointments on the same date.

[3] 17 May 2017, 5 October 2017, and 26 June 2018.

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to his call list and to receive calls from him. RN A said that in the context of the COVID-19 pandemic, she requested that her details be provided to Mr B because she had become concerned after seeing global media reports about prison conditions during the pandemic. New Zealand was in COVID Alert Level 4 from 25 March 2020 until 27 April 2020, when it moved to Alert Level 3 until 13 May 2020. RN A told HDC that making contact with Mr B was in line with her spiritual beliefs in promoting peace, love, wellbeing, and tolerance to all, and that she "did not seek any personal and/or professional gain, nor to provide any therapeutic support".

28. During his imprisonment, Mr B moved between Prison 2 and Prison 1, and when RN A made her requests, each prison called her to authorise her private contact details. Both prisons have provided HDC with the call lists, which confirm RN A as an approved contact. On his call list at Prison 2, Mr B listed RN A as his "Friend" (10 May 2020) and later "Partner" (30 May 2020).

29. The prison service records, and has access to, telephone calls made by prisoners in its facilities. This is stated clearly in a recorded message at the beginning of a call, which subsequently gives the person receiving the call the option to accept or decline the call. Accordingly, both RN A and Mr B were aware that the telephone calls were being recorded. Based on the recordings provided to HDC by the prison service, a total of 47 calls were made between RN A and Mr B from 15 May 2020 to 17 September 2020 (a period of five months).[4]

30. Eight of these calls were made while Mr B was at Prison 2, and the remaining 39 were made at Prison 1. The calls at Prison 2 are considerably longer than the calls made from Prison 1. The majority of the calls at Prison 1 end when the voiceover states "one minute remaining", suggesting time limitations on the prison calls. The calls at Prison 1 never exceeded 16 minutes in length (see the call log table in Appendix E).

31. The prison service has not stated explicitly when Mr B and RN A last had contact. In their call on 31 May 2020, Mr B mentioned to RN A that he had received her email through the prison's "Email a prisoner" programme. These emails were not provided to HDC. The "Email a prisoner" initiative allows emails to be sent to a prisoner, and the recipient replies through regular post. These emails are screened before they reach the prisoner.

Phone call content

32. The initial report prepared by the prison service states that the telephone calls "suggest a personal relationship between [Mr B] and [RN A] exists". The report says that there was one call (not specified) made to RN A from Prison 2 in which "[Mr B] makes explicitly sexual comments to [RN A] which were not rebuked".

[4] HDC received the recordings of these telephone calls. While all calls were made within these dates, there were no calls made during the month of June. During their phone call dated 2 July 2020, Mr B explained to RN A that he had been transferred to Prison 1 after an incident with the prison guards at Prison 2, and had not been able to call RN A since then.

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33. The content of the phone calls is personal in nature. Eleven calls contain sexually explicit comments primarily made by Mr B,[5] and both Mr B and RN A engage in personal discussions about their families, marriage, drug use, and their relationship.

34. In the first phone call[6] between Mr B and RN A, Mr B asks, "Why don't you send me some love like last time I spoke to you?" and says, "Love you," before ending the call. In their phone calls on 22 May and 24 May 2020, Mr B talks to RN A about them getting married. In the first call, RN A replies that she thinks Mr B will realise he could "do better" than her, and that he would not turn up to visits with her. In the second call, she rebukes Mr B's marriage comments but with reference to uncertainty of where their relationship stands. There is no discussion of appropriate boundaries or attempts to terminate the call. When Mr B asks why she is uncertain, RN A states, "I'm still in the friendzone," and comments on the lack of clarity around their relationship. Mr B replies that they can just "stay [in the friendzone] for a bit … no rush", to which RN A states that he may feel there is no rush, but she does not.

35. Mr B sometimes references past appointments in their calls, including multiple specific references to yoga. He calls it "yummy yoga" and describes watching RN A do yoga during a session. RN A's clinical notes do not mention RN A participating in yoga, and do not mention yoga occurring during appointments, only that it was discussed.[7]

36. Mr B regularly uses names for RN A such as "baby", "babes", or "darling", and discusses her body. RN A comments multiple times that she finds talking over the phone uncomfortable or awkward. In August and September 2020, RN A begins reciprocating when Mr B says "love you" with "love you too" before they end the call,[8] and sometimes also tells Mr B that she misses him.[9] In a telephone call on 13 September 2020, RN A asks, "What took you so long phoning," and says that "it's not cool not phoning". Their previous phone call had been on 7 September.

37. During the telephone conversations, Mr B asks RN A numerous times to send him things, such as shoe catalogues, pictures of her, pictures of the "outside", and letters. Mr B references wanting to send things to RN A, but refuses to specify what he wants to send when she asks. He also references having a "mountain" of letters he has written that he is waiting to send her once she gives him an address. In their call on 14 July 2020, Mr B makes

[5] 23 May 2020, 24 May 2020, 31 May 2020, 9.05am 14 July 2020, 8.39am 3 August 2020, 9.28am 3 August 2020, 10.35am 5 August 2020, 11.02am 8 August 2020, 9.22am 9 August 2020, 10.11am 11 August 2020, 9.15am 13 September 2020.

[6] Dated 15 May 2020, from Prison 2.

[7] On 22 August 2017 and 28 November 2017, there are notes that RN A discussed with Mr B whether he would be interested in going to yoga, and on 7 February 2018 Mr B's feedback on the previous session was "got some yoga and mindfulness". The notes for the previous session do not mention yoga.

[8] RN A replies words to the effect of "love you"/"love you too" on 5, 7, 8, 9, 11, 19, and 30 August 2020, and on 5, 7, and 13 September 2020.

[9] For example, she states, "I miss you too," on calls dated 8 August 2020, 30 August 2020, 13 September 2020, and 17 September 2020. In other calls when Mr B asks whether RN A misses him, she replies "yes" or words to that effect (2 July 2020, 3 August 2020, 5 August 2020, 9 August 2020, 15 August 2020, 17 August 2020, 19 August 2020, 26 August 2020, and 13 September 2020). The exception to this is on 4 July 2020, when she replies, "Oh I don't know," followed later by, "It's just a bit awkward on the phone."

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sexually explicit comments about RN A and says he misses her, to which she replies, "Write it down," and, "Put it in a letter." In their call on 3 September 2020, RN A gives Mr B a New Zealand address to which he can send letters for forwarding on to her, and in their call on 5 September, Mr B says that he has sent a letter. On 13 September 2020, RN A says that in late August she sent a book to Mr B.

Discovery of phone calls

38. Mr B also mentions in his calls to RN A that nurses had made comments to him about calling her. In their call dated 2 July 2020, Mr B tells RN A that nurses recognised her name on the call list, and that she was also recognised when he applied for approval to have her as a phone contact. Mr B told RN A that the nurses had asked if she was coming back, and he replied probably just to visit. Mr B said that the nurse told him that it was all right for her to visit. Mr B also stated that the nurse told him that RN A would "steer [him] on the straight and narrow".

39. On 10 August 2020, mental health clinician Ms C (a clinician assigned to Prison 1 from the support service) met with Mr B for a planned appointment, following his fourth referral to the support service. In a statement to HDC, Ms C said that Mr B mentioned RN A, and asked if the support service had any jobs, as RN A was looking for work.

40. Ms C told HDC that Mr B said that he and RN A were still in contact and "she was planning to move back to be with him". Ms C said that Mr B also told her that he and RN A had prepared a backstory prior to beginning their professional relationship at Prison 1 in case the relationship was questioned.

41. After this appointment, Ms C confirmed that RN A's personal details were on Mr B's approved contact list, and escalated the matter to the Clinical Operations Manager at the support service the same day. On 12 August 2020, the Clinical Operations Manager referred the matter to Ms D, who notified Te Kaunihera Tapuhi o Aotearoa: Nursing Council of New Zealand (NCNZ).

42. In Mr B's phone call to RN A dated 15 August 2020, he says that Ms C had heard from other nurses that Mr B was in contact with RN A, which prompted her discussion with him about any possible continuing relationship. Mr B tells RN A over the phone that his meeting with Ms C was "awkward" and "they all heard about us". When RN A asks if he is all right, he replies that it was just awkward and says, "I don't care … to be honest I'm proud of it."

43. The final phone call recording available was dated over one month after Ms C notified Ms D of the alleged relationship.

Further information

RN A

44. RN A told HDC that she received general orientation training from the prison service about policies and procedures required from contractual staff in 2017.

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45. RN A stated that as a result of this incident, she will not provide her private contact details to a former health consumer again, regardless of her personal spiritual and religious world views.

Support service

46. The support service told HDC that RN A attended the standard orientation in 2017, and a five-day orientation at the prison service, including agreeing to and signing the prison service's Code of Conduct, which specifically discusses the need for appropriate boundaries. The support service advised that RN A reported to the Clinical Operations Manager, from whom she received regular individual staff supervision, and also reported to the Clinical Nurse Specialist for clinical and case oversight, and also had group supervision, peer supervision, and individual supervision external to the support service.

47. The support service advised that its staff were not aware of the personal communication or relationship prior to August 2020. Once made aware, the support service conducted a review of the notes and files it held.

The prison service

48. The prison service told HDC that RN A did not report to an individual within the prison service, and reported to her supervisor at the support service, and unit staff provided operational support whilst she was on site. The prison service advised that RN A attended an induction at the National Office, which covered the topics of "getting got" (which involved alertness by staff of manipulation by prisoners and keeping themselves safe in a prison environment), and integrity.

49. The prison service stated that it was not made aware of any concerns regarding RN A's conduct or performance until Ms D was notified of the matter in August 2020. This then raised concerns about whether there was a personal nature to Mr B and RN A's relationship. The prison service advised that it then conducted an audit of the number of sessions being conducted by clinicians at the support service to ensure that there were no other cases of contractors working outside the scope of the services stipulated in the contract without supervision, and Ms D prepared a submission to notify the Nursing Council of New Zealand.

50. In relation to approval of RN A as a telephone contact for Mr B, the prison service advised the following:

- RN A was approved on 10 May 2020 at Prison 2. Prison 2 was unaware that RN A had provided mental health services to Mr B.
- RN A was approved on 19 June 2020 at Prison 1, but staff were unaware of the specific relationship between RN A and Mr B. The prison service advised that Mr B had informed the Principal Officer at Prison 1 that the number belonged to an ex-staff member, but did not specify that there was a personal relationship occurring. The Principal Officer contacted the telephone number, and RN A agreed to be on the approved telephone list. Prison 1 noted that as the description was "ex-" staff member, and because it was an overseas number, the risk to RN A appeared to be low.

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Response to provisional opinion

Mr B

51. Mr B was provided with a copy of the "information gathered" section of the provisional opinion and did not respond to HDC with any comments.

RN A

52. RN A was provided with relevant sections of the provisional opinion, and she advised that she did not wish to make any comments.

The prison service

53. The prison service was provided with a copy of the provisional opinion, and it provided a response.

54. The prison service told HDC that it is in the process of introducing a system to triage health referrals before they are allocated to a team for assessment. It advised that this will be overseen by the prison service's mental health registered clinicians, and will provide additional assurance regarding patient pathway management.

55. The prison service also assured HDC that it will continue to support its contracted providers in maintaining an appropriate level of clinical oversight to their work, but noted that clinical responsibility remains with contracted providers within the terms of their contract for service provision. The prison service told HDC that it is also providing additional clinical support to contracted providers working in prison sites through peer review and reflexivity in team meetings.

Support service

56. The support service was provided with a copy of the provisional opinion. It told HDC that it agrees with the comments of the provisional report, and is happy to make available an anonymised version of this report to its clinicians.

57. The support service told HDC that it is establishing a process to respond if a person is referred for therapy more than once. It plans to escalate referrals of this kind to a Nurse Specialist for discussion and consideration of whether allocation to a different clinician is appropriate. If another clinician is unavailable, the Nurse Specialist will discuss professional boundaries with the regular clinician.

Opinion: RN A — breach

Introduction

58. As a healthcare provider, RN A was required to provide services to Mr B that complied with professional, ethical, and other relevant standards. RN A was also required to comply with the Nursing Council of New Zealand's Code of Conduct, and Guidelines on Professional Boundaries.

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59. From May 2017 to January 2019, RN A provided mental health services to Mr B. RN A advised that during the time she was providing health services to Mr B, there was no personal relationship or communications.

During the therapeutic relationship

60. Mr B was a patient of RN A over approximately one and a half years. She had access to his personal medical information, including discussion of his past childhood sexual abuse and documentation of his mental wellbeing.

61. This relationship was therapeutic in nature, and there is no clear evidence that a personal relationship existed at the time when Mr B was RN A's patient. While the prison service was concerned that an excessive number of appointments had occurred between Mr B and RN A, the evidence available to me suggests that at the time of events, there were no limits on the number of sessions. In addition, the evidence suggests that Mr B was referred to RN A on three separate occasions, and each referral was approved by a manager. I am therefore satisfied that the number of appointments in themselves were not a concern or a factor to indicate anything inappropriate.

62. I note that in the very first phone call made between the two on 15 May 2020, Mr B says, "Why don't you send me some love like last time I spoke to you?", and says "love you" before ending the call. This is suggestive of a personal relationship existing prior to that point. Whilst there is a gap of over a year between RN A's resignation and this phone call, it seems possible that the relationship had developed before she resigned.

63. However, there is not enough clear evidence for me to be satisfied that there was any impropriety during the therapeutic relationship.

64. Accordingly, I am unable to make a finding concerning the appropriateness of RN A's professional conduct during the therapeutic relationship with Mr B.

Initiating contact after end of therapeutic relationship, and inappropriate phone calls

65. For the reasons set out below, I find that professional boundaries were not maintained appropriately following the end of RN A and Mr B's therapeutic relationship.

66. When her employment with the support service had ended, RN A provided her personal contact details to be shared with Mr B. This included her personal phone number, and a New Zealand address for forwarding post. RN A acknowledges that while she did not seek any personal and/or professional gain through the phone calls, she also did not intend to provide any therapeutic support either. She told HDC that her reasoning for providing her phone number to Mr B was out of concern for him regarding prison conditions during the COVID-19 pandemic, which I consider to be more personal than therapeutic.

67. Mr B and RN A engaged in frequent phone contact. On 15 May 2020, Mr B called RN A for the first time on the personal number she had provided. From May to September, the pair talked on the phone 47 times. The calls are intense in their frequency, averaging 2–5 calls per week for every month (other than in June, when no calls occurred because Mr B had

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been transferred to a different prison), and duration. During his time at Prison 2, the calls with RN A ranged from less than 10 minutes in length to over 40 minutes. At Prison 1, the calls were shorter, often 10–20 minutes, but it appears that there were time constraints on telephone calls made by prisoners at Prison 1.

68. The calls were also intimate in nature. Mr B makes sexual and romantic comments to RN A in many calls, with 11 calls containing sexually explicit conversation. During these phone calls, RN A continues to engage in conversation with Mr B and makes little to no attempt to prevent the comments occurring again.

69. As a registered nurse, RN A had a professional duty to comply with the NCNZ's Code of Conduct and guidelines.

70. The NCNZ Code of Conduct (2012) (see Appendix A) outlines that nurses must maintain professional boundaries between themselves and health consumers. It does not specifically comment on whether these obligations exist after the conclusion of a therapeutic relationship.

71. However, an inherent power imbalance exists between a consumer and a healthcare provider. This imbalance arises from the nature of the relationship, and is more pronounced in contexts such as this, where the provider is privy to extremely intimate details about a person's life and the person's mental health. This imbalance, and the resulting impropriety of any relationship, extends beyond the conclusion of the therapeutic relationship. The NCNZ Guidelines on Professional Boundaries (see Appendix B) recognises this, noting that there is no arbitrary time limit that makes it safe for a nurse to have an intimate or sexual relationship with a health consumer who was formerly in their professional care. It reasons that such a relationship may be influenced by the previously therapeutic relationship where there was a clear imbalance of power. There is also potential for the consumer to be harmed. The guidelines further state that where the relationship was psychotherapeutic or involved emotional support, or the health consumer had been a mental health consumer, it may never be appropriate for a sexual or intimate relationship to develop.

72. In addition to the Code of Conduct and guidelines set out by RN A's professional body, I consider that RN A had an ethical duty to Mr B to maintain professional boundaries beyond the conclusion of the relationship. Mr B remained a vulnerable consumer in prison receiving care for his mental health. RN A continued to hold a position of power over him, given her recent therapeutic relationship with him, the fact that he was still in prison and she was not, and the level of knowledge she held about Mr B's sensitive and personal information. Whilst I appreciate that we do not have evidence of contact until over a year after she resigned, in my view the continued vulnerability of Mr B, combined with the high sensitivity of the information she had and the nature of their relationship, means that it was inappropriate nonetheless. I note that in the recorded phone conversations, Mr B appears to be the one who is making most of the comments that are concerning. However, RN A appears to have continued to call him, and neither rebuffed his advances, nor gave any other real indication that she was uncomfortable with the relationship.

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73. Therefore, by initiating contact with Mr B after their therapeutic relationship had ended, and then engaging in frequent phone calls of a personal and often sexual or intimate nature, I find that RN A breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

74. I also consider that, as explained above, the relationship dynamic was characterised by a power imbalance arising from the recent and intensive therapeutic relationship between RN A and Mr B. For that reason, and because of the continuing power imbalance arising from Mr B being in prison, and RN A explaining that the relationship was meeting her spiritual needs, I consider that this relationship was exploitative, and accordingly consider that RN A breached Right 2 of the Code.[11]

Opinion: Support service and the prison service — other comment

75. HDC acknowledges the speed at which the prison service passed on concerns to the Nursing Council, and appreciates that risk was considered low with RN A being outside of New Zealand. HDC takes every complaint made as a learning opportunity, and would encourage both the prison service and the support service to take time to reflect on the policy to allow repeated referrals for therapy to the same practitioner, and reaffirm professional boundaries with their staff members.

Recommendations

76. I understand that RN A is currently residing overseas, and her New Zealand practising certificate has expired. I recommend that should RN A choose to return to New Zealand to practise nursing, the Nursing Council of New Zealand consider RN A's fitness to practise, and whether any reviews of competence and/or conduct are required in light of this report.

77. I recommend that the support service circulate a copy of the anonymised version of this report to its staff to reinforce the importance of maintaining professional boundaries, and provide HDC with evidence that this has occurred, within three weeks of the date on which the anonymised report is published on HDC's website.

[10] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[11] Right 2 of the Code states: "Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation."

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Follow-up actions

78. A copy of this report with details identifying the parties removed will be sent to NCNZ, the support service, and the prison service, and they will be advised of RN A's name.

79. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Nursing Council of New Zealand: Code of Conduct (2012)

Principle 4.10 — Practise in accordance with professional standards relating to safety and quality healthcare.

Principle 7.13 — Maintain a professional boundary between yourself and the health consumer, and their partner and their family, and other people nominated by the health consumer to be involved in their care.

Principle 7.14 — Do not engage in sexual or intimate behaviour or relationships with health consumers in your care or with those close to them.

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Appendix B: Nursing Council of New Zealand: Guidelines: Professional Boundaries (2012)

Nurses must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers … The health consumer does not have access to the same degree of information about the nurse as the nurse does about the health consumer, thereby increasing the power imbalance.

It is the nurse's responsibility … to maintain the appropriate professional boundary of the relationship. The nurse has the responsibility of knowing what constitutes appropriate professional practice and to maintain his or her professional and personal boundaries. The health consumer is in an unfamiliar situation and may be unaware of the boundaries of a professional relationship. It is the responsibility of the nurse to assist health consumers to understand the appropriate professional relationship. There is a professional onus on nurses to maintain a relationship based on care plans and goals that are therapeutic in intent and outcome.

[Nurses] have the potential to harm the health consumer by increasing their vulnerability or dependence in the relationship with the nurse and could be detrimental to their health outcomes by compromising the nurse's objectivity and professional judgment.

Nurses can reduce the risk of boundary transgressions by … maintaining the appropriate boundaries of the nurse–health consumer relationship, and helping health consumers understand when their requests are beyond the limits of the professional relationship … Nurses should ensure that any approach or activity that could be perceived as a boundary transgression is included in the care plan developed by the health care team.

Discussing the nature of a therapeutic relationship with a health consumer if they believe that the health consumer is communicating or behaving in a way that indicates they want more than a professional relationship with the nurse.

Sexual relationships with former health consumers may be inappropriate however long ago the professional relationship ceased. There is no arbitrary time limit that makes it safe for a nurse to have an intimate or sexual relationship with a health consumer who was formerly in their professional care … Where the relationship was a psychotherapeutic one or involved emotional support, where the nurse was privy to personal information that could compromise the health consumer person if used out of a professional setting, or if the health consumer was previously a mental health consumer … it may never be appropriate for a sexual or intimate relationship to develop.

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Appendix C: The support service's Code of consumers' rights policy — relevant extracts

Policy:

All [support service] staff must be aware that every person using [the support service] has rights under the Code. Furthermore, all staff must comply with the actions required of them under the Code including their responsibility to inform people of their rights.

Procedure:

The Code sets out the legal rights for all users of health and disability services in New Zealand.

[Support service] employees will ensure that people who use our services receive a copy of the Code in accordance with [the support service's] Informed Consent Policy and Procedures.

…

Purpose/Whainga:

To outline the responsibilities of [the support service], staff and managers under the Code of Conduct. To outline the minimum standards of behaviour demonstrated by [support service] staff in the delivery of services to reflect the purpose and values of [the support service]. To describe through the Performance Management Guidelines a wide range of acceptable and unacceptable behaviours in the workplace, although the Code does not cover every issue that may arise.

Scope/Korahi:

All [support service] employees. The Code of Conduct (Code) also applies to persons engaged by [the support service] including contractors, consultants, students, volunteers and Board Members.

…

[The support service's] responsibilities include:

- Providing employees with adequate training, resources, information, and delegated authority where appropriate, to enable employees to properly carry out their duties.
- Exercising responsibility and diligence, and using our best endeavours to promote a cheerful, fair, trusting, safe and considerate employment environment.
- Assisting employees with any work-related matter or issue that may arise with due speed, diligence and consideration; in a way that is safe and inclusive for all participants, retains dignity, and promotes awareness, understanding and learning for individuals, teams and the organisation as a whole.
- Complying with relevant legislation and sound corporate governance practices in all its dealings with employees

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- Remaining committed to providing a safe workplace for all employees. [The support service] takes all possible precautions and follows all the guidelines as recommended under the Health and Safety in Employment Act 1992 and its regulations.

Employee Responsibilities:

No matter what your role is, or which location you work in, you are expected to:

- Contribute to a safe and healthy working environment for self, colleagues and clients
- Perform your duties in a professional manner, acting ethically, honestly, efficiently and in good faith always
- Live [the support service's] Values and set an example for others by contributing positively to the organisational and team culture
- Speak out when you feel that [the support service's] Values or behaviours outlined in the Code of Conduct are being threatened or compromised
- Ensure the security of personal property as [the support service] does not accept liability for loss or damage of any personal property on the premises or in organisation vehicles.

Management Responsibilities:

If you are in a management role, you are expected to:

- Act as a role model and hold yourself to the highest standards of conduct
- Always reinforce [the support service's] Values and the Code of Conduct to all staff, and ensure employees understand the behaviours expected of them
- Create a positive work environment where employees are comfortable raising questions and concerns, this includes adopting the Positive Management Philosophy
- Monitor employees' conduct to ensure compliance with our Code and provide constructive feedback to support staff to develop behaviours consistent with [the support service] …

Definitions:

For the purpose of this policy and its procedural steps (process), the following definitions apply:

…

- Serious misconduct is behaviour that significantly undermines the working relationship between the employee and the employer and/or threatens the wellbeing of the organisation, its employees, clients, visitors or property. Repeated instances of misconduct have the potential to be viewed as serious misconduct.
- Misconduct is behaviour or conduct that is considered unacceptable by [the support service]. It is considered to be less serious than Serious Misconduct; however, this could

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still result in disciplinary action being taken. Examples of misconduct and serious misconduct:

The list below provides examples of misconduct/serious misconduct. This is not an exhaustive list. Whether behaviour is misconduct or serious misconduct depends on the degree/severity of the behaviour.

Examples of serious misconduct include the following —

- Repeatedly failing or refusing to perform work assigned which lies within the job description.
- Being absent from work when this is not appropriate or failing to contact direct manager as soon as they were aware that they were unable to work.
- Negligence or unsafe practices which seriously affect safety or health, including failure to follow health and safety policies.
- Misuse or abuse of any power in the workers position.
- Reporting for work in an unclean, untidy, unhygienic or unpresentable manner (e.g. jandals, ripped clothing).
- Theft of any kind, from [the support service], other staff or clients. This includes borrowing money from clients. Employees may not hold client funds on behalf of a client unless this is in the client plan and the manager made aware.
- Taking or using any other person's personal property, in your work role without the person's consent and unauthorised taking of [support service] property or money for private use.
- Being discourteous or not treating others with respect and dignity. This includes using language and/or aggressive behaviour which may cause offence to another person.
- Not maintaining professional boundaries with a client (e.g. forming a friendship, entering a relationship or engaging in sexual conversation with a client).
- Harassment or bullying of any kind including sexual, gender and racial harassment.
- Being dishonest or deceitful when presenting information. This includes making a false declaration or submitting a false expenses claim. Including but not limited to time sheets, service delivery records, financial documentation, investigations.

…

- Failure to disclose a personal, financial, or professional relationship with a client that could lead to a conflict of interest, and failure to act on instructions relating to a conflict of interest.

[The prison service] Prisoner telephone policy

Telephone calls to and from prisoners are managed both to ensure that [the prison service] meets its legal requirements and to restrict the likelihood of illegal activity.

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…

C.02.01: Request by prisoner for approval of personal telephone numbers:

A prisoner must make a written application using C.02.Form.01 Prisoner telephone number request requesting their personal telephone numbers be approved by the unit PCO and entered on the Prisoner Telephone Call Control System (PTCCS).

Upon receipt of the C.02.Form.01 Prisoner telephone number request from a remand prisoner staff must check if there is a No Contact Conditions (NCC) alert. If there is an NCC alert inform the prisoner that the number cannot be approved (see 1.06 Complete arrival administration).

Upon receipt of the C.02.Form.01 Prisoner telephone number request, staff must check if the prisoner has indicated on the form that a court restriction (e.g. court order) exists for the person(s) at the telephone number requested.

…

C.02.02 Verification of prisoner personal telephone numbers

Upon receiving the completed application from the prisoner prison staff must:

a. Verify that name and number are correct
b. Check IOMS to determine if a no contact condition (or other contact restriction) is in place …
c. Obtain from each of the nominated call recipients their consent to receiving calls from the prisoner.
d. Enquire from the intended recipient whether the prisoner is subjected to a contact restriction …

Prison staff must contact all nominated call recipients using the number supplied on the prisoner’s form, and advise them:

a. Of the name of the prisoner who wishes to contact them
b. That they can refuse to receive any or all calls from the prisoner

If the call recipient refuses to accept calls from the prisoner, this must be noted …

If the call recipient consents to calls from the prisoner, staff must:

a. Advise that they will automatically be notified on picking up the phone that a call is being received from a prisoner and that they can either accept or refuse the call
b. Advise the periods of the day when they are likely to receive a call from the prisoner
c. Advise that calls are not to be diverted to another number
d. Note any restrictions on the receiving of calls

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e. Update, as necessary, IOMS Prisoner telephone number request (PDF)

C.02.Res.01 Recommended officer dialogue to intended recipients is a script that officers can use when verifying and confirming whether the recipient consents to contact.

Staff should record all decisions then sign and date the C.02.Form.01 Prisoner telephone number request.

C.02.03 Approval of prisoner personal telephone numbers

The unit PCO or other designated staff can refuse or approve to contact number, irrespective of the recipient's approval, if there are grounds to prohibit the number … or if there is a Court Order which prevents contact. This is due to the potential impact on security and the safety of staff, victims and other prisoners as well as legislative requirements.

…

C.02.08 Monitoring prisoners calls

Written notices (C.02.Form.02 Telephone call monitoring notice) must be prominently displayed near the telephones that prisoners are authorised to use advising prisoners:

a. That their personal calls will be recorded and may be monitored and disclosed, and
b. The purpose (in general terms) for which information obtained from monitoring is used, and
c. Which calls are exempt from being recorded and monitored.

Staff authorised to monitor calls will advise the custodial systems manager (or other authorised delegate), via a vetted PTMS disclosure, of any incident involving a prisoner misusing telephone privileges.

Misuse of the telephone may include, but not be limited to, the following points:

a. Introduce, attempt to introduce or conspire to introduce unauthorised items (contraband) into prison
b. To participate in:
    i. Three-way calling
    ii. Call diversion
    iii. PIN swapping/misuse
    iv. Any other unauthorised use.

The custodial systems manager (or other authorised delegate) may, if appropriate:

a. Charge the prisoner with a misconduct as per the POM MC.01 Filing a disciplinary charge instructions, and

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b. Remove the number(s) from the system before the outcome of the misconduct or investigation, if allowing the prisoner to continue to call the phone number(s) may threaten the maintenance of the law or security and good order of the prison.

An IOMS incident report must be created.

A prisoner being charged must receive a copy of the vetted PTCCS disclosure before any misconduct is heard.

A prisoner found guilty, by a hearing adjudicator or Visiting Justice, of any offence in relation to PTCCS will be subject to disciplinary action as considered appropriate by the adjudicator or Visiting Justice.

C.02.09 Removal of approved personal prisoner numbers and PIN

Approved numbers may be removed from the PTCCS when:

a. a call recipient advises they no longer wish to receive calls from the prisoner

…

b. the number is no longer approved …

c. pending the investigation of a complaint or offence or pending a misconduct hearing relating to an approved number.

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Appendix D: The prison service's Health Services External Provider Induction Process

Correct behaviour in prison:

General information:
Being in a prison environment means being in an environment where one seemingly small breach of good prison practice can cause a major breach in safety and security and put other people at risk. There are many aspects to safety and security in a prison. The following golden rules summarise the most important and fundamental principles that all of us must know and follow.

Golden rules for conduct in a prison:

- Maintain professional boundaries between staff and prisoners
- Never trade in any way with a prisoner
- Never ever give, or bring in to the prison any item for the prisoner. Likewise, never take out any item on behalf of any prisoner
- Never accept a gift from or give a gift to any prisoner or their friends and families. This includes acting on behalf of the prisoner to friends and family and vice versa
- Keep the identity and details of prisoners confidential from all people not entitled access to them as part of their job responsibilities. Do not discuss prisoner details with family friends
- Always comply with all rules and operating standards as set down by [the prison service]
- Restrict any physical contact with prisoners to that which is necessary to carry out your role correctly
- Never discuss information or pass on gossip about other prisoners, [prison service] staff, procedures or institutional problems with prisoners
- Do not enter into a personal or business relationship with a prisoner or their families
- Do not disclose your personal circumstances, home address or phone number or that of any staff to a prisoner or anyone not entitled to receive it
- Do not write down names and phone numbers of staff when taking messages — write phone numbers only and destroy the note when you no longer need it.

Acting professionally
There need to be clear boundaries to your relationships with prisoners. These are professional relationships. That is, they are a part of your work.

- If you do develop feelings for a prisoner that go beyond a professional relationship, take steps to minimise the risks
- You must not exploit your professional relationship with a prisoner i.e. abuse your position

Remember, you should be courteous with a prisoner but you must not become a prisoner's friend.

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Appendix E: Call log tables

Prison 2

Date	Time	Duration
15/5/20	11.41am	46 seconds
15/5/20	11.44am	8 minutes 18 seconds
16/5/20	11.41am	3 minutes 38 seconds
22/5/20	1.26am	42 minutes 45 seconds
23/5/20	Unavailable	22 minutes 36 seconds
24/5/20	Unavailable	28 minutes 50 seconds
25/5/20	Unavailable	37 minutes 6 seconds
31/5/20	Unavailable	9 minutes 43 seconds

Prison 1

Date	Time	Duration
2/7/20	9.15am	15 minutes 15 seconds
4/7/20	8.35am	15 minutes 29 seconds
4/7/20	8.51am	15 minutes
6/7/20	9.54am	11 minutes 51 seconds
10/7/20	Unavailable	15 minutes 9 seconds
12/7/20	9.05am	15 minutes 26 seconds
12/7/20	9.20am	9 minutes 32 seconds
14/7/20	9.05am	15 minutes 15 seconds
16/7/20	8.53am	15 minutes 21 seconds
16/7/20	10.44am	1 minutes 28 seconds
18/7/20	9.36am	14 minutes 59 seconds
18/7/20	10.37am	7 minutes 6 seconds
20/7/20	10.08am	35 seconds
1/8/20	9.21am	8 minutes 1 second
3/8/20	8.39am	15 minutes 23 seconds
3/8/20	9.28am	3 minutes 22 seconds
5/8/20	10.04am	15 minutes 34 seconds
5/8/20	10.35am	14 minutes, 8 seconds
7/8/20	9.11am	15 minutes 26 seconds
7/8/20	9.40am	6 minutes 28 seconds
8/8/20	11.02am	11 minutes 35 seconds
9/8/20	9.06am	15 minutes 30 seconds
9/8/20	9.22am	6 minutes 11 seconds
11/8/20	10.11am	15 minutes 29 seconds
15/8/20	10.02am	15 minutes 19 seconds
15/8/20	10.44am	2 minutes 31 seconds

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17/8/20	9.09am	11 minutes 15 seconds
19/8/20	10.40am	12 minutes 58 seconds
26/8/20	11.16am	2 minutes 56 seconds
28/8/20	9.35am	10 minutes 53 seconds
30/8/20	10.19am	15 minutes 3 seconds
1/9/20	9.08am	3 minutes 19 seconds
3/9/20	9.29am	7 minutes 28 seconds
3/9/20	9.41am	5 minutes 6 seconds
5/9/20	9.52am	13 minutes 17 seconds
7/9/20	9.55am	15 minutes 20 seconds
13/9/20	9.15am	13 minutes 18 seconds
15/9/20	9.38am	7 minutes 30 seconds
17/9/20	9.32am	4 minutes 37 seconds

Call summary table[1]

	May	June	July	August	September
Total calls	8	0	13	18	8
Average number calls per week	2	0	3	5	2
Average time of each call	19 minutes	0 minutes	12 minutes	11 minutes	9 minutes
Average minutes called per day	22 minutes	0 minutes	17 minutes	15 minutes	10 minutes

[1] Note that average times are rounded to the nearest minute, and average calls per week presume a total of four weeks per month.

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