Nurse Manager, Mrs C

General Practitioner, Dr E

Rest Home Licensee, Mr D

A Report by the Health and Disability Commissioner

(Case 04HDC07008)

Parties involved

Mr A	Consumer/Resident
Ms B	Complainant/Acting Manager, the rest home company
Mrs C	Provider/Nurse Manager
Mr D	Provider/Licensee of the rest home
Dr E	Provider/General Practitioner
Mrs F	Acting Nurse Manager
Miss G	Resident
Ms H	Resident
Mrs I	Resident
Ms J	Resident
Mr K	Nurse
Ms L	Diversional therapist
Dr M	General practitioner
Dr N	Psychiatrist
Dr O	Psychiatrist
Caregiver P	Caregiver
Caregiver Q	Caregiver
Caregiver R	Caregiver
Caregiver S	Care giver

Overview

This case concerns the responses by a nurse manager, a general practitioner and a rest home licensee to inappropriate sexual behaviour (including incidents of abuse) by a male dementia patient. It highlights the risks faced by vulnerable residents of rest homes (in particular, dementia patients) in the absence of a timely and effective response to incidents of inappropriate behaviour and abuse, particularly where staff become desensitised to such behaviour.

Complaint

On 3 December 2003, the Commissioner received a complaint from Ms B, Acting Manager of a health care company, about the services provided to Mr A by a rest home. The following issues were identified for investigation:

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Mrs C and Mr D
Whether Mrs C, Nurse Manager of the rest home and Mr D, licensee of the rest home:

- *took appropriate action to assess, monitor and manage Mr A's sexually inappropriate behaviour to ensure the safety of other residents*
- *responded appropriately to the sexual assault of Miss G on 10 September 2002 by Mr A.*

An investigation was commenced on 30 July 2004.

On 24 November 2004 the investigation was extended to include the actions of general practitioner Dr E, as follows:

Dr E
The adequacy of the care and treatment provided by Dr E to Mr A, including:

- *whether Dr E took appropriate action to assess and treat Mr A's sexually inappropriate behaviour*
- *whether Dr E responded appropriately to the sexual assault of Miss G on 10 September 2002 by Mr A.*

Information reviewed

- Complaint from Ms B
- Clinical records from the rest home, Dr E and a public hospital
- Responses from Mrs C, Mr D and Dr E
- Information from Mr K and Dr M.

Independent expert advice was obtained from Dr Tessa Turnbull, general practitioner, and Ms Jan Featherston, registered nurse.

Information gathered during investigation

Licensee Mr D established the rest home in partnership with two qualified nurses in 1985. (His two partners subsequently withdrew in 1990 and 1995.) The rest home provided dementia level care for people assessed as requiring D3 and D4 level[1] care.

[1] D3 and D4 patients are defined as those who require ongoing assistance by staff with specialist dementia knowledge in a secure rest home environment.

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The rest home was partly funded by private fees and partly under a contract with the Ministry of Health.[2]

The rest home had two separate units and typically housed 30–32 residents, although it was licensed for a maximum of 41 residents. The first unit contains 11 beds with mostly single rooms, was the independent living unit and housed the more physically able residents. It was staffed by two people in the morning and one person at night and had a high diversional therapy input. The second unit comprises of 25 beds with mostly double rooms, housed more dependent residents and was staffed by three carers during the day and two at night. Neither unit was left unattended at any time.

In September 2003, the rest home was purchased by the rest home company. On 21 November 2003, the rest home caregiving staff discovered a long-term resident, Mr A (aged 75 years and suffering from dementia), in a female resident's room in the unit behaving in a sexually inappropriate manner. The incident report stated that Mr A was found in the room of Miss G (aged 72 years and with a degree of intellectual disability and an inability to communicate verbally), had removed her incontinence panties and was touching her thighs. Acting Nurse Manager Mrs F was informed by staff that Mr A had a long history of inappropriate sexual behaviour, which was often directed towards female residents in the home. This included a previous serious incident of sexual assault on Miss G in September 2002.

Mrs F had not been made aware of Mr A's behaviour during a period of handover with incumbent Nurse Manager Mrs C (who had taken a period of stress leave). Mrs F informed the Acting Manager of the rest home company, Ms B, and an internal investigation was commenced. Ms B became concerned that, on the basis of the written evidence of staff members and review of documentation, a situation of long-term sexual abuse may have been allowed to continue. Mrs C subsequently ceased her employment at the rest home.

Investigation by new owner of rest home

The nursing progress notes reveal many occurrences of Mr A touching female residents. His behaviour included lifting their skirts, touching their breasts and genital areas, and the removal of incontinence pads. Mr A also masturbated and exposed himself in public.

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[2] The Ministry of Health introduced a national aged residential contract from 1 June 2002, which was updated in June 2003. (Prior to 1 June 2002 a regional contract with the Ministry of Health was applicable to the rest home.) The national contract covered rest home, dementia and geriatric hospital level care delivered in a residential setting. Section E of the national contract described the additional requirements for specialist dementia services — with the stated object of providing "safe and therapeutic care in an environment that enhances the quality of life [of subsidised residents affected by dementia] and minimises the risks associated with their 'confused' states". Responsibility for this contract was devolved to District Health Boards on 1 October 2003.

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General practitioner Dr E provided services to the rest home on contract and reviewed Mr A on a three-monthly basis. Dr E's medical records made occasional references to inappropriate sexual behaviour on the part of Mr A.

Caregiver staff advised Mrs F that there were four residents whom Mr A was known to target: Miss G, Ms H, Mrs I and Mrs J. One of the staff also noted that there was a female respite resident whom Mr A had molested in the toilets.

On 27 November 2003, caregiver P stated:

> "We caught him [Mr A] several times with women in [the unit] prior to me going on night shift …
>
> When I was on night duty, I would catch him going into the ladies bedrooms. Because I know what he was like I kept an eye on him all the time. He sneaked down the hallway to go into the women's rooms ...
>
> I caught him in [Ms H's] room about a year ago, and reported this. I didn't do an incident report as I understood I didn't need to for [Mr A], I didn't feel that this should be happening. When I saw him in [Ms H's] room he had [Ms H's] pad down and his hands down in her vagina. I wrote in the Progress Notes 'Found [Mr A] in [Ms H's] room, he had her pad down, inappropriate sexual behaviour.'
>
> …
>
> I used to shift him away from those ladies [Miss G, Ms H and Mrs I]. He only went for the one who could not speak and as far as I was concerned he knew exactly what he was doing.
>
> I would say to [Mr A] '[w]hat do you think you are doing this is inappropriate behaviour'. He would say 'I was just seeing if they were wet'. When approached he would become violent, swore and threatened that he would kill us and it was hard to get him out of a room.
>
> In the lounge I have seen [Mr A's] hands on [Miss G's] breasts, or [Mr A] approach [Ms H] and lift her skirt up. It happened quite often in the lounge. It happened all the time.
>
> I told senior staff and [Mrs C] just told me to write it in the notes. We were told to write it down as sexually inappropriate behaviour. I understand this to mean that he [Mr A] had been touching women where he shouldn't be."

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On 27 November 2003, caregiver Q stated:

> "I don't recall being told anything about [Mr A] when I started, but after a wee while I read care plans for [Mr A]. [Mr A's] care plan had notes to watch him around ladies.
>
> What is still bugging me is that it was not taken seriously. I was told that it was just Dementia. And I don't know what I can do with only me on [duty]. I felt it was my job to look after the residents. I felt it was my fault that [Mr A] was able to get to [Miss G].
>
> It's been worrying me, and I worry about who will be his next victim. He goes to women who can't talk … I am aware that there have been other situations, but I did not see them. It seemed that it was just like they tried to hide it. It's not fair on the residents."

On 28 November 2003, caregiver R stated:

> "Sexual behaviour in [Mr A] is fondling, touching of vagina and breasts of other residents, the words he uses, telling staff he would like to slip it up us …
>
> …
>
> [Mr A's] behaviour was discussed amongst staff and at meetings, and staff was told if you see something you do what you can to divert him elsewhere. You advise him firmly the behaviour is not appropriate.
>
> I would be fair and say the behaviour was frequent but I never reported it because everyone, all the staff knew and [Mrs C] and [Mr D] knew as well, because it was talked about.
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> …
>
> I've seen [Mr A] fondle [Ms H]. He was always trying to get his hands down [Mrs I's] top and down her pants.
>
> …
>
> I have seen him fondle a number of women. It was always intervened with, but not written up in an incident report …
>
> It is bewildering that [at the rest home] this was seen as the way it was meant to be. How behind and primitive we were. I've always thought [the rest home] care was good. But I know now it was not done right. [Miss G's] relatives did not even get a phone call."

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On 28 November 2003, caregiver S stated:

> "I have known [Mr A] for the entire time he had been here. He has been sexually inappropriate since he was here. He was like that before he came and I was told that he was here because no-one else would have him ... [Mrs C disputes that she understood Mr A was at the rest home for this reason.]
>
> He likes to touch women's breasts, tries to get his hands under their skirts. In the earlier days he had a girlfriend and he was not as bad. Once she stopped coming he got worse.
>
> I have witnessed a number of events. Just recently he tried to touch [the first female resident], he tried to touch her breast but she knocked him out. He tried to touch [the second female resident's] breast but she wacked him one too. Nothing happen[ed] about this, we were told that this problem was why he was here. He is more active in the afternoon, we can see the signs, and we know how to stop him.
>
> …
>
> No-one ever suggested that [Mr A] shouldn't remain at [the rest home]. I didn't know that we could take it further, I thought that this was Dementia and this was part of it … I never thought there was any alternatives. Now I know that there are, I feel guilty."

Mrs F commented that caregiver staff felt they were not able to speak out about Mr A, because of an oppressive management culture at the rest home. Many of the staff were traumatised by the experience of caring for Mr A and subsequently took the opportunity to speak with a counsellor or to Ms B. She stated:

> "More than four staff members became distressed as they volunteered incidents they remembered as happening; reported and documented and [there] were numerous meetings where they were told — forget it and not to cause trouble."

Mrs C

Mrs C commenced working at the rest home in August 1997 in the role of Nurse Manager. She recalled that Mr A was known to exhibit inappropriate sexual behaviour, which was symptomatic of his dementia.

Mrs C stated she received no report from staff of sexual abuse or inappropriate sexual behaviour by Mr A towards Ms H, Mrs J or Miss G (prior to the incident of 10 September 2002).

Mrs C stated that the behaviour reported to her, prior to September 2002, included lewd remarks and masturbating in inappropriate places. In general, Mr A's behaviour affected other residents only visually. Mr A's family were "not interested so there was no need to keep them informed of all the incidents".

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Mrs C informed me that she was not aware of Mr A touching other residents, apart from holding hands and occasionally touching Mrs I's breasts (particularly when she exposed them). Mrs C commented that Mrs I's daughter and general practitioner were "well aware of what was happening" and did not express any concern as Mrs I was not distressed by Mr A's behaviour. Mrs C stated:

> "I talked to the GP and I talked to [Mrs I's] daughter about it and I talked frankly about [Mrs I's] behaviours including those in relation to [Mr A] to both her GP and to her daughter."

In contrast, Mrs I's general practitioner, Dr M, stated that she was not provided with any information about Mr A's inappropriate sexual behaviour. She stated:

> "The complaint was a surprise to both myself and [Mrs I's] daughter as neither of us had any knowledge of [Mr A's] behaviour and neither of us had any complaints about her [Mrs I's] care at [the rest home].
>
> …
>
> She [Mrs I] was seen by me on the 1 September 2003 and I noted her mobility had decreased and she needed two people to help move her. I was not provided with any information concerning [Mr A's] sexually inappropriate behaviour."

Dr M commented that Mrs I would not have been aware of the significance of such behaviour. Overall, she felt that Mrs I was maintained in a safe environment while at the rest home.

Mrs C recalled that the matter concerning Mrs I was "definitely" discussed with Dr E, the rest home's contracted general practitioner. (Dr E does not recall being made aware of any inappropriate sexual behaviour by Mr A towards Mrs I that required any intervention by him.) Mrs C stated that she had "frequent discussions" with Dr E about Mr A's behaviour. Mr A was regularly reviewed by Dr E, and Mrs C believed that "if [Dr E] had concerns he would refer [Mr A] for further assessment by psychiatric services for the elderly". Mrs C thought that it was not her role to refer residents for reassessment.

Mrs C emphasised that she did not consider Mr A was a risk to other residents, but his behaviour could be categorised as a "nuisance". She "continued to manage Mr A's behaviour as the previous Nurse Managers had done". Mrs C updated Mr A's care plans every month. He was monitored closely, and staff were instructed to re-direct him when he demonstrated inappropriate sexual behaviour. Mrs C stated:

> "During my previous 20 years of working in aged care facilities, there had always been at least one resident/patient who demonstrated sexually inappropriate behaviour and they were always monitored and managed in the same way that [Mr A] had been monitored when I arrived at [the rest home]."

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Mrs C commented that she met with Mr D weekly and discussed any concerns. Mr D primarily undertook an administrative role. She stated:

> "[Mr D] was the owner and licensee and he took care of the finance and came in every day to collect his mail. His involvement was not really any more than that, other than when I was away and then I was aware that he took a much more hands-on role."

Mrs C explained that the policies and procedures in place when she began working at the rest home had initially been compiled by a previous member of staff who had been the director. She stated:

> "As far as I am aware these policies were not approved by anyone. Subsequent changes or new policies were created by myself under the advice of the health auditing team, which included [an auditor]. I put in place policy 27 [Elder Abuse and Neglect] and ensured that the staff had training on it. The policy was very clear that a serious incident such as a sexual assault should be reported to the Police and the staff had training on this."

Mr D

The minutes from the rest home staff meetings show that Mr D often attended. Mr D confirmed that he visited the rest home daily and was aware of Mr A's inappropriate sexual behaviour. Mr D stated that he did not have a direct personal role in the management and assessment of Mr A's behaviour or in the operation of policies. Mr D was not aware that Mr A could not be managed properly and considered that appropriate systems were in place to ensure that he was adequately monitored. Mr D's lawyer submitted:

> "The policies and procedures in place to ensure quality of care and safety for residents are as documented. Our client did not have a great part to play in the day to day operation of these policies. He was not qualified to do so. It was his role to ensure that the Rest Home complied with its legal obligations and he believes that it did. However, he cannot give a description of specific polices and procedures and must rely on the management and staff for that purpose.
>
> …
>
> A specific role, which our client had with the organisation, was that of purchasing officer. Our client would also assist with any serious problems with staff. This would involve sitting in on disciplinary hearings with the staff when on the few occasions these occurred."

Mr D does not hold any formal qualifications in the operation and management of rest homes. Mr D commented that he had justified confidence in Mrs C's abilities to manage The rest home as she was highly qualified and experienced (with over 20 years' experience in care for the elderly). Residents, family and senior staff all spoke

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highly of her. Mr D explained that when Mrs C was on leave, the management role was undertaken by the assistant nurse manager, enrolled nurse Mr K.

Mr D stated that all staff had either completed or were participating in an elder care programme. This course is offered by a training organisation. There is an initial course for basic rest home care and a second course for dementia care.

Dr E

Dr E was contracted to review the rest home residents every three months, unless there was something urgent to attend to. (His visits had been weekly, seeing half of the residents one week and the other the next, but in 2001 this was reduced to a three-monthly review of all residents because of Health Funding Authority concerns about over-servicing.) Dr E stated:

> "I had a regular weekly session at [the rest home] and the nursing staff put together a list of the patients who were due to be seen on the three monthly roster and those who needed to be seen for a particular problem. As a general rule, during those sessions at [the rest home] I would see approximately 2–5 patients. There was never sufficient time to look through the nursing records over the past three months, which would typically be 12 pages for each patient."

Dr E advised that Mr A was admitted to the rest home in 1992 with alcohol-related dementia. His health had generally improved since his admission and he was usually pleasant and stable. He was managed on multi-vitamins, thiamine, Melleril and haloperidol. Mr A had a longstanding history of intermittent inappropriate behaviour, which to Dr E's knowledge was never a "significant risk" to the safety of female residents. Dr E's primary involvement with Mr A was to prescribe a variety of creams for a facial skin condition. The only information provided to him about Mr A's inappropriate behaviour was "verbally by the nursing staff". Dr E stated:

> "I was never given to understand that the inappropriate behaviour was more sinister than masturbating or [the] opportune groping many male patients with dementia exhibit. During my three monthly reviews of the patients, I relied on discussions with the Nurse Manager to inform me of any problems. I have no recollections of the Nurse Manager, or any of the other nursing staff, stating to me that [Mr A's] behaviour was anything more than nuisance value. He was seen as a pest, not as someone who was dangerous, until November 2003."

Dr E was aware that Mr A habitually wandered into other patients' rooms and exposed himself. However, he was not aware of any physical assaults, prior to the incident in September 2002, and until that time he was not asked by nursing staff to assist with Mr A's behaviour.

Dr E does not believe it was possible to make any judgements about the severity of the behaviour displayed by Mr A from the "nebulous" descriptions in the nursing

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progress notes. (Dr E did not review Mr A's nursing progress notes until during the course of this investigation.) He stated:

> "Comments like '*sexual behaviour*' recorded in the nursing notes are too broad to be able to draw any conclusions about the types of behaviour that [Mr A] had engaged in. This would be information within the nursing staff's knowledge."

Dr E does not recall there being any specific guidelines about when or how he would be consulted.

Care plans and incident reports
Mrs C's care plans for Mr A clearly outlined the need for staff to closely monitor his behaviour and redirect him when displaying inappropriate behaviour. Mr A's 1996 nursing care plan stated:

> "Goal: to manage [Mr A's] behaviours correctly with a minimum of fuss and without causing distress to him or others
>
> Nursing interventions:
>
> - speaking to [Mr A] firmly when he displays inappropriate behaviour
> - if does display inappropriate sexual behaviour ask him to go/stay in his room and leave him alone until he settles
> - be consistent and set firm boundaries
> - administer medication as prescribed
> - ensure safety/comfort of others
> - be aware of his whereabouts
> - document any inappropriate behaviours and management if effective."

The plan is initialled as being regularly reviewed by Mrs C and was assessed as being effective. It remained generally unchanged during Mr A's residence at the rest home, with the addition of the behaviour modification plan of September 2002.

There is no documented evidence of the exact nature of Mr A's behaviour or warning about the possible risks of his behaviour to other residents. Mrs C explained that the lack of detail on Mr A's file was "probably" because his behaviour was well known.

Caregiver staff did not routinely complete incident forms when Mr A demonstrated this behaviour, but were encouraged to record the incidents in the progress notes. Staff were told Mr A's behaviour was part of dementia and his behaviours were commonplace.

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Mrs C explained that incident reports were required when any adverse event took place that affected a resident or staff member. Incident reports were reviewed and care plans amended when required, with any changes being discussed with Dr E.

Mrs C stated:

> "As this [sexually explicit behaviour] was part of [Mr A's] behaviour incident forms were not completed. I was aware of this aspect of [Mr A's] behaviour but believed the other residents involved were not distressed by him.
>
> …
>
> [Mr A's] behaviours were well known to staff and were considered normal."

Ms B subsequently described the state of the incident reports:

> "Incident and accident monthly summary reports were readily located but the actual incident/accident reports were located in resident's files, loose in cupboards and amongst loose residents' notes. There was no evidence of collation, follow-up or risk assessment completed as part of the incident/accident process."

Mrs C stated that Mr D took responsibility for the storage of clinical progress notes and incident forms. Mr D commented that there was a "very good system" of record-keeping and maintaining patient files at the rest home. He stated that his role was limited to storage of previous residents' files.

Mr D was asked to comment on the recommendations from the Ministry of Health routine audits (dated 10 December 2001 and 18 August 2003), which requested immediate improvements in the completion, monitoring and analysis of incident reports.[3] He stated:

> "In 2002 the forming and processing of incident reporting was reviewed but was still non-compliant in 2003. At that time it was agreed that [the rest home company's] policies and procedures would soon be adopted. Incident reports were monitored and analysed, but due to the small size of the rest-home, the information did not have anywhere to go."

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[3] Under the Ministry of Health contract, the rest home was required to have appropriate risk management policies, processes and procedures to avoid preventable harm and risk.

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Mrs C also commented:

> "Incident reports were monitored and analysed but as we were such a small operation the information did not have 'anywhere to go'."

The facility liaison persons for the Ministry of Health audits were Mrs C and Mr D.

Clinical records
Nursing progress notes for Mr A make the following references to inappropriate behaviour from 2001 until September 2002 (after which time his management was reassessed).

During 2001:

- 8 January: sexual behaviour. Settled in bed.
- 13 January: got very agitated with [the third female resident] at tea time and slapped her across [the] shoulder. Sent [Mr A] next door for some time out.
- 19 February: sexual behaviour this morning toward staff members in [the unit]. Calmed down after morning tea.
- 24 February: [Mr A] got very agitated and aggressive towards ([the third, fourth and fifth female residents) calling them bitches etc. The three women were wandering in the hallway and [Mr A] was trying to help them out.
- 3 March: rather aggressive towards [Mrs J] about the 'Devil' getting her. Managed to divert him to mow the lawns.
- 4 March: settled at first, got agitated with 'moaning women'.
- 21 March: stirring up the ladies this afternoon — teasing and some inappropriate grabbing of some of the women while in the garden — reasonably ok in the evening.
- 1 April: stirring up the ladies and grabbing.
- 8 April: [Mr A] had been removed to other unit at the beginning of the shift for engaging in inappropriate behaviour — other than this I have no idea of how he has been this evening.
- 15 April: inappropriate behaviour this evening removed from residents.

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- 4 May: has been next door all evening but I hear that he has on several occasions been engaging in a sexually inappropriate manner including some sexual harassment of [the sixth female resident] at shower time.

- 11 May: spending a lot of time in [the seventh female resident's] room (?), please keep an eye out.

- 30 May: very 'touchy' this morning. Helped with dishes.

- 6 June: enjoyed quoits — got sexual towards me but managed to divert him.

- 15 June: tried to physically abuse [the first male resident] in [the unit].

- 21 June: inappropriate behaviour in front of the ladies.

- 9 July: 'touchy' with other female residents.

- 25 July: busy sexual behaviour.

- 10 August: inappropriate behaviour towards the ladies, upset [the eighth female resident].

- 13 August: inappropriate behaviour towards [the eighth female resident].

- 28 September: mood swings, amorous at times.

- 2 November: [Mr A] verbally abusive, he wants to go to work … a lot of swearing and women hating.

- 4 November: reacted both violently and abusively when [the second female resident] said something to him — he became threatening and abusive to anyone within spitting distance.

- 22 December: bad sexual behavior most of the time.

During 2002:

- 21 January: in amorous mood, stayed in [the unit].

- 27 January: spent afternoon in [the unit] as he was displaying inappropriate sexual behaviour.

- 23 March: please keep an eye on [Mr A] as he has been displaying inappropriate sexual behaviour towards [the ninth female resident].
- 26 March: bad sexual behaviour.

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- 24 April: inappropriate behaviour, taken outside for some fresh air.
- 14 May: little too frisky, went back to [the unit].
- 20 May: Got angry with [the tenth female resident] and pushed her out the front door.
- 23 May: in an amorous mood.
- 10 June: amorous this morning.
- 30 June: 10.30 pm arrived at 10.30 pm and saw through the dining room window [Mr A] with his pants down engaging in sexual behaviour with [Mrs I] in the lounge. Diverted [Mr A's] attention elsewhere successfully. Defused situation as other residents were in the lounge.
- 21 July: early morning caught [Mr A] in [Ms H's] room. Hands were under the sheets; he said he was checking to see if she was dry — I said that is the nurse's job. [Ms H] looked quite frightened.
- 4 August: very aggressive towards [the second male resident]. Grabbed [the second male resident's] neck in the toilet.
- 2 September: up early morning, walking in other ladies room touching their private part. Would not listen or stop. Had to keep an eye on him since 5.30. Incident form filled.
- 2 September: spoke to doctor commenced oxazapam 10mg. Report on drowsiness etc.
- 10 September: found in [Miss G's] room @ 0530hours fiddling with [Miss G]. Noticed he has blood on his hand, removed, and told it is not acceptable that sort of behaviour around any ladies here. ACC1 form filled out.
- 12 September: please give [Mr A] 2 haloperidol and 1 oxazapam @ 2100hours. Report on drowsiness."

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Dr E's medical records
Extracts from Dr E's medical records for Mr A prior to September 2002 state:

- 14 October 1998: has been displaying increased exhibitive behaviour and aggression — Melleril.
- 28 October 1998: behaviour improved on Melleril.
- 17 February 1999: sleepy at times, try reducing/withholding Melleril mane and review in 2-6 /52.
- 14 August 2002: has occasional outbursts of ebullient behaviour, which he can have oxazepam tabs10 1-2 prn up to 20mg/day.

2 September 2002 incident
As noted above, on 2 September 2002, Mr A was found in the room of another resident in the early morning. The incident report stated:

> "We were getting [Mrs J and Miss G] up and heard [the eleventh female resident] calling out help help. We run in to see what was wrong. Saw [Mr A] sleeping on top on [the eleventh female resident] with his hands in her private parts (lower part)."

Mrs C was on leave at the relevant time and enrolled nurse Mr K was the Acting Manager. Mr K notified Dr E and requested that he review Mr A's medication. Dr E reviewed Mr A later on 2 September. He recorded "inappropriate behaviour" in the medical records and prescribed sedation and oxazapam. No further action in relation to Mr A's behaviour was taken by the rest home staff.

10 September 2002 incident
On 10 September 2002 a serious incident was reported by a night staff caregiver. Mr A was found sexually interfering with Miss G (an intellectually disabled resident unable to speak or write), causing vaginal bleeding. The progress notes recorded:

> "[L]ast round at 0530 hrs [hours], heard her [Miss G] screaming, went to check and saw [Mr A] fiddling with her, asked him what he's doing, that's when I noticed he had blood on his hands. Removed him, [Miss G] was very agitated, try to calm her. Washed. Still has blood coming from her private part (vagina) and on pad. Very unsettled and frightened."

The incident report stated:

> "Found [Mr A] s @ 0530 hours in [Miss G's] room, she was screaming on top of her voice, went in saw him molesting [Miss G's] and noticed blood in his hand. [Miss G's] was sitting on side of bed. She was very agitated and unsettled."

The staff member subsequently advised Mrs F:

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> "[Miss G] can't talk and was making loud noises and it sounded unusual. When I went there the door was open and I saw [Mr A sexually interfering with Miss G]. I saw him [sexually interfering in her genital regions]. He was moving his hand up and down. He was sweating. He may have been there for possibly ten minutes. I asked him what he was doing. He said he was checking her pad. I asked him to go."

Mr K notified Dr E of the second incident.

Dr E's review
Dr E reviewed Mr A on 11 September 2002 and suggested further sedation with haloperidol. He noted:

> "Further sexually inappropriate behaviour towards female residents particularly at night."

Dr E also reviewed Miss G on 11 September and noted that she had been "sexually assaulted" by Mr A, with some blood evident on Mr A's hand and on Miss G's pad. Dr E recorded that Miss G was "upset and very quiet today". He recalled:

> "The possibility of alleged sexual assault was raised when she has been found bleeding, with blood staining on a pad, raising the possibility of trauma. She was noted to be rather quieter than usual and did not wish to be examined. Suspicion fell to [Mr A] because he had been seen in the vicinity, but there was no direct evidence to link [Mr A] to [Miss G's] symptoms.
>
> …
>
> I have no recollection about an incident report or the level of detail in the incident report. All I recall being told was that there was a possible sexual assault.
>
> …
>
> The information and the impression I recall being given to me by nursing staff, did not indicate that [Mr A] posed a serious risk to residents."

Dr E recommended careful monitoring of Mr A and separation from Miss G. He did not consider referring Mr A for reassessment as he was not aware of any serious risk to the female residents. Dr E considered that his role was to provide sedation in relation to Mr A's "annoying behaviours" within the context of nursing management strategies. He submitted:

> "Primary responsibility for initiating reassessment of [Mr A] lay with the rest home. They decide who they admit, who they can manage, and how these patients are managed. I assist them with providing medical advice and arranging the reassessments for unmanageable patients."

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Management of Mr A after 10 September 2002

On 11 September 2002, a behavioural modification plan for Mr A was instigated by Mr K, as Acting Manager, and a senior divisional therapist. The plan emphasised keeping a "close eye" on Mr A, including the frequent checking of his location, and the introduction of a motion sensor attached to his door to immediately alert staff if he left his room during the night. Mr A was to be supervised in his use of the bathroom and praised for positive behaviour. Mr A was also moved from the first unit to the second unit, the higher dependency area. (It was the policy of the rest home that neither unit was left unattended at any time.) Mr K stated:

> "As far as the services to the named resident [Mr A] I was to follow the care plans, any major decision was to be done by the Nurse Manager.
>
> …
>
> At the time of the incident with the measures we had in place I did not think of reassessment or notifying relatives or other agencies, as I thought with the medical intervention and the monitor and the staff being more aware of the behaviour plan until the Nurse Manager returned from leave [would be sufficient] and I don't think anything more was done after she did return.
>
> …
>
> I never got much backing from either the director or the Nurse Manager."

Mrs C commented that she always totally supported Mr K.

The rest home's policy 27, in a section entitled "Signs of Elder Abuse and Neglect", stated that if actual or potential abuse is suspected the staff member must report it immediately to the senior person on duty and the Nurse Manager. The Nurse Manager was required to notify the resident's medical practitioner and relatives. The policy does not provide a definition of what constitutes abuse, but lists the following as signs of sexual abuse:

- Bruising or bleeding in the genital area
- Venereal Disease
- Difficultly in walking or sitting
- Pain or itching in the genital area
- Recoiling from being touched
- Fear of bathing or toileting.

The policy required the Nurse Manager to notify other appropriate bodies, such as the Police or a counsellor, "depending on the severity of the incident". Such notification did not occur following the assault on Miss G by Mr A (or the 2 September incident involving the eleventh female resident).

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The behavioural modification plan was signed as approved by Mr D. Mr D confirmed that he was made aware "that an event of some sort had occurred" on 10 September 2002, but was not given the precise details. He was not informed whether Dr E or the Police had been consulted, and his only involvement was to authorise the purchase of a motion monitor. Mr K confirmed that Mr D's role was to approve the purchase of the motion sensor.

Dr E explained that he did not have any input into the behaviour modification plan, or any other strategies designed by the nursing staff. He also commented that he was informed only that inappropriate behaviour and a "possible assault" had occurred, and if the detail in the incident report had been provided to him, he would certainly have considered a referral or immediate transfer.

Mrs C said she reviewed the behaviour modification plan on her return and considered it to be adequate because it had been made in consultation with Dr E. She did not consider notifying the family because the incident had been properly dealt with in her absence. She believed a considered decision had been taken by Dr E not to inform the family or other appropriate authorities. Mrs C trusted Dr E and did not consider it was her place to make a referral, if he did not do so.

Mrs C commented that the behaviour modification plan (including the use of the motion sensor) was "extremely effective" and there were no further incidents involving Mr A until November 2003.

Subsequent events

The nursing progress notes document the following further instances of Mr A exhibiting inappropriate behaviour after September 2002:

2002

- 16 September: went next door, masturbating, put in the garden for distraction.
- 21 September: awake most of night and in and out of bed talking inappropriately to staff. Said he was going to smash the alarm.
- 29 September: [Mr A] punched [the twelfth female resident]. She was sitting beside him and could not see what happened but [the twelfth female resident]. hit him back. [Mr A] got very angry.
- 4 October: frisky mood this morning. Found him showing inappropriate sexual behaviour in front of other residents.
- 12 October: was seen in lounge tonight with his hand on [Mrs I's] breast.

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- 26 October: seen [Mr A] with inappropriate sexual behaviour towards [Miss G]. Hand up [Miss G's] dress. Agitated with staff after incident. Denying he was doing anything.

- 16 November: [A staff member] found [Mr A] in [Miss G's] bedroom; he pulled [Miss G's] blankets down. When asked he said he was checking why [Miss G] screamed. No screaming was heard by staff.

- 24 November: inappropriate behaviour toward women. Attempted to get in the toilet with [the eleventh female].

- 27 December: inappropriate behaviour towards [Mrs J] in the lounge. Head and hands down nightie on her breasts. Said he was looking to see what she was looking for. Also holding [the twelfth female resident's] vagina and breast in passageway. Said he was seeing if she was OK.

2003

- 20 January: had to be taken away from [Mrs J] as he was groping her.

- 31 January: saw [Mr A] coming out of [Ms H's] room. Pad interfered with. Sent back to his room and settled.

- 3 February: please keep [Mr A] in [the unit] as [the thirteenth female resident] is becoming extremely friendly.

- 5 March: became frisky after lunch, put in garden to water it until settled.

- 22 March: removed from another resident who was encouraging [Mr A] to touch her.

- 11 May: redirected from approaching a female resident in bed, said he was just going to help her.

- 24 May: seen attempting to touch female resident's breasts, needs to be watched!!

- 29 June: quite friendly towards some of the ladies this afternoon — settled once they were in bed.

- 22 July: some inappropriate touching of female residents, watch closely.

- 11 August: walking around a lot and looking at the ladies and try[ing] to touch them.

- 24 August: inappropriately touching the ladies.

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- 25 August: inappropriately touching and talking to female residents.
- 7 September: touching female residents, watched closely.
- 10 September: touching female residents — watching.
- 3 October: happy mood, did touch both [the second female resident] and [Miss G] a.m, so may need to keep a close eye on him.
- 11 October: had to be moved away from [Mrs J] as he was putting his hand on her breast.
- 12 October: inappropriately touching female residents and made several sexual comments to staff.
- 16 October: being a little too friendly to the ladies.
- 23 October: amorous mood in morning, needed to stay in room.
- 21 November: when checking on him hourly found him in [Miss G's] room, he said he was checking to make sure she was dry.

Dr E's medical records
On 6 November 2002, Dr E reviewed Mr A and recorded:

> "Has been satisfactory regarding aggression and inappropriate behaviour regarding other residents. Continue with other medications and review in 3/12."

On 5 August 2003, Dr E recorded:

> "Oxazepam and haloperidol discontinued as there has been no behavioural problems."

Ministry of Health issues-based audit
On 10 June 2003, the Ministry of Health conducted an impromptu issues-based audit of the rest home after concerns about the standard of care provided to residents were drawn to its attention. The report identified particular concern in relation to incident reports; that no specific corrective actions were documented by the Nurse Manager on each incident form nor any record of the success of interventions.

On 31 July 2003, the auditor noted that the "Quality Improvement Plan"[4] subsequently provided to her by Mr D was very general in nature and contained no

[4] Under the terms of the Ministry of Health contract the rest home was required to develop and implement a quality improvement programme.

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information about how the relevant standards were to be implemented or monitored. The auditor stated:

> "The specific risks and specialist care delivery system associated with the provision of dementia care within a secure environment are not addressed in this document."

Mr A's re-assessment
As noted above, on 21 November 2003, Mr A was discovered in Miss G's room behaving inappropriately. The Acting Nurse Manager, Mrs F, immediately requested that Dr E arrange for Mr A's re-assessment.

Dr E's clinical notes state:

> "[Mr A] has been exhibiting aggressive sexual behaviour towards other female residents and staff — increasingly difficult to manage and staff unable to cope. For urgent assessment under section 8B. Application filled out."

Dr E stated that, apart from the September 2002 incidents, he was not made aware of any other incidents of concern until November 2003, when he responded to an urgent request for reassessment after Mr A's behaviour had escalated. Mr A had become physically aggressive, and was constantly entering other patient's rooms.

The public hospital
On 25 November 2003, Mr A was transferred to a public hospital for review by consultant psychiatrist Dr N, who considered that Mr A's inappropriate sexual behaviour was a serious risk to others and that he needed compulsory treatment under the Mental Health Act. Dr N noted in his medical records that Mr A's previous inappropriate sexual behaviour had been poorly documented.

Mr A remained an inpatient at the public hospital until 25 March 2004. His discharge summary (written by a consultant psychiatrist) stated:

> "[Mr A] was urgently referred for admission after serious sexually inappropriate behaviour at his D3 rest home. There had been a long history of sexually inappropriate behaviour but this had culminated in the genital touching of a non-consenting demented woman in the rest home.
>
> …
>
> This [behaviour] was attempted to be managed in the rest home environment in several ways. First, by closer supervision, although there were limits to what was possible; secondly, by trying to involve [Mr A] in an activities programme tailored to meet his needs — this had partial success. Various medications were trialled, mainly thioridazine [Melleril] up to a dose of 90mg a day, oxazepam up to a dose of 20mg a day and haloperidol up to a dose of 1mg a day, but none were

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> successful. A further strategy was to use a movement sensor pad, but it was not clear whether this had been effective. No triggering factors have been uncovered. An attempt by the rest home to move him from a low dependency to a high dependency unit, so that he could have more supervision unfortunately back-fired. Whereas previously the women that he attempted to have sexual contact with were able to express their opinions about it, in the high dependency unit the women were less able to raise the alarm."

Mr A was transferred to a second public hospital and assessed as requiring D6 level[5] care. Mr A subsequently died.

Reflections on this case
— Mrs C
Mrs C stated that she was unaware that Mr A's inappropriate sexual behaviours, such as masturbating and verbal comments, were a form of sexual abuse. She stated:

> "They [sexual behaviours] had continued since 1989. I knew they were inappropriate but not that they amounted to sexual abuse as no one ever appeared distressed by them."

Mrs C has since reviewed her practice and now has a zero tolerance to such behaviour and has such residents immediately reassessed. She also provides more specific documentation and regrets not providing Mrs F with fuller information about Mr A before leaving the rest home.

— Dr E
On review of the nursing records, Dr E was surprised at the frequency of Mr A's recorded inappropriate behaviour, although he found it difficult to accurately assess the extent of Mr A's behaviour from the progress notes. There was insufficient time to read the nursing records when he visited the rest home and he relied on verbal reports from the nursing staff to obtain a summary of what had occurred since the last three-monthly review. He noted that the pattern of behaviour revealed from the nursing notes was of a patient who, with hindsight, probably should not have been at the rest home. Dr E stated:

> "As a result of this incident, I would probably suggest earlier referral to a geriatrician where there are allegations of inappropriate behaviour. In future dealings with rest home, I would look for well-established, clear patient's management procedures that facilitate the role of the GP in patient management."

— Mr D

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[5] D6 patients are defined as those who can no longer be maintained in a rest home setting and require hospital level care.

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Mr D submitted that the term "sexual abuse" was an unduly emotive term to describe the actions of Mr A, as he was demented and lacked sufficient mental capacity to understand the difference between right and wrong. He felt it was inaccurate to describe the incident involving Miss G as an "assault" as Mr A lacked the ability to form any intent and Miss G lacked the ability to give or withhold consent.

Independent advice to Commissioner

General practitioner advice

The following expert advice was obtained from Dr Tessa Turnbull, general practitioner:

"Expert Advice Required: To advise the Commissioner, whether in your expert opinion, general practitioner [Dr E] provided [Mr A] with an appropriate standard of care including:

1. Was [Mr A's] overall medical care managed appropriately by [Dr E]?

Yes, with the exception of the management of [Mr A's] sexually deviant behaviour. [Mr A] was a sexual predator as a result of dementia and [Dr E] and [the rest home] inappropriately managed this aspect of his medical care after September 2002.

Background:

[Mr A] was admitted to [the rest home] in 1992 with moderate dementia considered to be largely alcohol related as he had a history of severe alcohol dependence. Cerebrovascular degeneration almost certainly contributed to the progressive dementia. He was treated for this with multivitamins, thiamine 100mg, and melleril 10mg. Sexually inappropriate behaviour was recognized to be a major problem by the nursing staff and care givers at [the rest home] although [Dr E] says, 'I was never given to understand that the inappropriate behaviour was anything more sinister than masturbating or opportune groping many male patients with dementia exhibit.'

[Dr E] reviewed his patients at [the rest home] routinely every 3/12 or more often for urgent matters. He visited weekly seeing 2–5 patients each time. He would have been accompanied on his rounds by a registered nurse who would have given him details of any interval problems and overseen new instructions and the three monthly examination and medication review.

These are extracts taken from [Mr A's] nursing continuation notes between January 2001 and August 2002:

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8/1/01: sexual behaviour.

19/2/01: sexual behaviour this morning toward staff members in [the unit].

21/3/01: stirring up some ladies this afternoon — teasing and some inappropriate grabbing of some of the women while in the garden.

1/4/01: stirring up the ladies and grabbing.

8/4/01: [Mr A] has been removed to other unit at the beginning of the shift for engaging in inappropriate behaviour.

4/5/01: I hear that he has on several occasions been engaging in a sexually inappropriate manner including some sexual harassment of [the sixth female resident] at shower time.

11/5/01: spending a lot of time in [the seventh female resident's] room, please keep an eye out.

15/6/02: tried to physically abuse [the first male resident] in [the unit].

25/7/01: busy sexual behaviour.

10/8/01: inappropriate behaviour towards the ladies, upset [the eighth female resident].

13/8/1: inappropriate behaviour toward [the eighth female resent].

22/12/01: bad sexual behaviour most of the time.

21/1/02: in amorous mood, stayed in [the unit].

23/5/02: in an amorous mood.

10/6/02: amorous this morning.

30/6/02:10.30 pm arrived at 10.30 pm and saw through the dining room window [Mr A] with his pants down engaging is sexual behaviour with [Mrs I] in the lounge. Diverted [Mr A's] attention elsewhere successfully. Defused situation as other residents were in the lounge.

21/7/02: early morning caught [Mr A] in [Ms H's] room. Hands were under the sheets; he said he was checking to see if she was dry — I said that is the nurse's job. [Ms H] looked quite frightened.

[Dr E] would not have had direct access to these nursing notes but he was aware of [Mr A's] sexually directed behaviour and the need to modify it. His continuation notes show this awareness:

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14/10/98: has been displaying increased exhibitive behaviour and aggression — melleril.

28/10/98: behaviour improved on melleril.

17/2/99: sleepy at times, try reducing/withholding melleril mane and review in 2–6 /52.

14/8/02: has occasional outbursts of ebullient behaviour, which he can have oxazepam tabs10 1-2 prn up to 20mg/day.

The nursing care plan in 1998 states that the goal was to manage [Mr A's] inappropriate behaviour correctly with a minimum of fuss and without causing distress to him and others by:

1. speaking to him firmly when he displayed inappropriate behaviour

2. if [Mr A] displays inappropriate sexual behaviour ask him to go to/stay in his room alone until he settles

3. be consistent and set firm boundaries

4. administer medication as prescribed

5. ensure safety/comfort of others

6. be aware of his whereabouts

7. document any inappropriate behaviours and management.

In general, these actions seem to have worked between 1/98 and 6/02 according to the registered nurses' evaluation notes.

Two serious incidents happened in September 2002:

On 2 September 2002 staff responded to a female resident calling for help and on entering her room found [Mr A] lying on top of her with his hands in the region of her genitals.

[Dr E] reviewed [Mr A] later that day. He recorded 'inappropriate behaviour' in the medical records and prescribed oxazapam for sedation.

On 10 September 2002 an incident was reported by a night staff carer where Mr A was found [interfering with the genital area] of [Miss G] (a severely intellectually disabled resident who is unable to speak or write), causing vaginal bleeding.

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On 11/9/902 [Dr E's] notes record: 'further sexually inappropriate behaviour towards female residents particularly at night. Suggest further sedation with haloperidol, review in 6 weeks.'

This indicates [Dr E] was aware of the serious nature of [Mr A's] behaviour.

The rest home staff devised a behaviour modification plan at this time, which included close observation, praise for positive behaviour and the attachment of a sensor monitor to [Mr A's] door. When these chimed staff were instructed to attend immediately. Later a sensor pad was placed beside [Mr A's] bed to alert staff when he got out of bed.

The nursing notes seem to indicate that the combined effect of the medication and management plan had little effect on [Mr A's] behaviour:

16/9/02: masturbating, put in the garden for distraction.

4/10/02: frisky mood this morning. Found him showing inappropriate sexual behaviour in front of other residents.

12/10/02: was seen in lounge tonight with his hand on [Mrs I's] breast.

26/10/02: seen [Mr A] with inappropriate sexual behaviour towards [Miss G]. Hand up [Miss G's] dress. Agitated with staff after incident. Denying he was doing anything.

16/11/02: [A staff member] found [Mr A] in [Miss G's] bedroom, he pulled [Miss G's] blankets down. When asked he said he was checking why [Miss G] screamed.

24/11/02: inappropriate behaviour toward woman. Attempted to get in the toilet with [the eleventh female resident].

27/12/02: inappropriate behaviour towards [Mrs J] in the lounge. Head and hands down nightie in her breasts. Said he was looking to see what she was looking for. Also holding [the twelfth female resident's] vagina and breast in passageway. Said he was seeing if she was OK.

In spite of this ongoing record, [Dr E's] clinical notes seem to indicate that [Mr A] behaviour was satisfactory:

6/11/02: 'has been satisfactory regarding aggression and inappropriate behaviour towards other residents. Continue with current medications and review in 3/12.'

[Mr A's] sexually abusive behaviour, however, continued:

20/1/03: had to be taken away from [Mrs J] as he was groping her.

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31/1/03: saw [Mr A] coming out of [Ms H's] room. Pad interfered with. Sent back to his room and settled.

3/2/03: please keep [Mr A] in [the unit] as [the thirteenth female resident] is becoming extremely friendly.

5/3/03: became frisky after lunch, put in garden to water it until settled.

22/3/03: removed from another resident who was encouraging [Mr A] to touch her.

11/5/03: redirected from approaching a female resident in bed, said he was just going to help her.

29/6/03: quite friendly towards some of the ladies this afternoon — settled once they were in bed.

22/7/03: some inappropriate touching of female residents.

24/8/03: inappropriately touching the ladies.

25/8/03; inappropriately touching and talking to female residents.

7/9/03: touching female residents.

10/9/03: touching female residents.

3/10/03: did touch both [the first female resident] and [Miss G].

11/10/03: had to be moved away from [Mrs J] as he was putting his hand on her breast.

12/10/03: inappropriately touching female residents and made several sexual comments to staff.

16/10/03: being a little too friendly to the ladies.

23/10/03: amorous mood.

[Dr E's] clinical notes:

5/8/03: oxazepam and haloperidol discontinued as he has had no behavioural problems.

Maybe the medication prescribed by [Dr E] helped night sedation but [Mr A's] inappropriate sexually directed behaviour was unchanged or accelerated.

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> On 21 November 2003, after a change in management, [the rest home] caregiver staff discovered [Mr A], in a female resident's room behaving inappropriately. This occurred after the monitoring system, which had been allowed to lapse, was reinstated. The incident report stated that [Mr A] was found in [Miss G's] room touching her legs and had removed her incontinent panties.

On 25/11/03 [Dr E] notes state: [Mr A] 'has been exhibiting aggressive sexual behaviour towards other female residents and staff — increasingly difficult to manage and staff unable to cope. For urgent assessment under section 8b.'

Consultant psychiatrist [Dr O] states:

'[Mr A] was urgently referred for admission after serious sexually inappropriate behaviour at his D3 rest home. There had been a long history of sexually inappropriate behaviour but this had culminated in the genital touching of a non-consenting demented woman in the rest home.

This (behaviour) was attempted to be managed in the rest home environment in several ways. First, by closer supervision, although there were limits to what was possible; secondly, by trying to involve [Mr A] in an activities programme tailored to meet his needs — this had partial success. Various medications were trialled, mainly Thioridazine up to a dose of 90mg a day, Oxazepam up to a dose of 20mg a day and Haloperidol up to a dose of 1mg a day, but none were successful. A further strategy was to use a movement sensor pad, but it was not clear whether this had been effective.

No triggering factors have been uncovered. An attempt by the rest home to move him from a low dependency to a high dependency unit, so that he could have more supervision unfortunately back-fired. Whereas previously the women that he attempted to have sexual contact with were able to express their opinions about it, in the high dependency unit the women were less able to raise the alarm.'

I believe [Dr E] managed [Mr A's] sexual deviancy reasonably well until late in September 2002. At that time [Dr E] understood that there was predatory sexual behaviour on [Mr A's] part. [Dr E] prescribed medication to attempt to sedate [Mr A] at night and [the rest home] put in a behaviour modification plan and instituted monitoring. Both were clearly unsuccessful strategies.

It was at this point, late in 2002/early 2003, that [Dr E] should have sought expert input from a physician or psychiatrist for the elderly. It was [Dr E's], rather than [the rest home's], responsibility to do this.

2. Was it reasonable for [Dr E] to consider [Mr A's] behaviour was not a risk to other residents?

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No, I do not think so after September 2002. There was an escalating pattern of deviancy of which [Dr E] seems to have been aware. However, there was an air of complacency and acceptance of [Mr A's] behaviour, which percolated between [Dr E], the nursing management and the caregivers.

3. Did [Dr E] take appropriate steps to inform himself of the extent of [Mr A's] behaviour?

[Dr E] appears to have had good communication with the nursing staff who were his source of information and to have visited at appropriate intervals. As [Mr A's] primary physician, [Dr E] should have ensured that he knew the extent of the deviancy and referred him appropriately after the serious events of September 2002.

4. Did [Dr E] take appropriate action to assess and treat [Mr A's] sexually inappropriate behaviour? If not, what else should he have done?

In August 2002, [Dr E] prescribed oxazepam for 'occasional outbursts of ebullient behaviour'. After the events of November 2002, [Dr E] recommended careful monitoring of [Mr A] and separation from [Miss G]. He prescribed night sedation with haloperidol. Both the medications had little or no effect on [Mr A's] deviant behaviour. [The rest home] also put in a behaviour modification plan. All were clearly unsuccessful and poorly followed through strategies.

As previously stated, as [Mr A's] primary physician, [Dr E] should have ensured that he knew the extent of [Mr A's] deviancy and referred him appropriately after the serious events of November 2002 and the failure of the strategies to alter these.

5. Did [Dr E] undertake appropriate reviews of [Mr A]?

Yes, I believe so.

6. Should [Dr E] have referred [Mr A] for reassessment/specialist treatment?

Yes, following the unsuccessful interventions of September 2002.

7. Did [Dr E] respond appropriately to [Mr A's] sexual assault of [Miss G] on 10 September 2002? If not, what else should he have done?

After the events of September 2002, [Dr E] recommended careful monitoring of [Mr A] and separation from [Miss G]. He prescribed night sedation with haloperidol. Both this medication, and the earlier prescription of oxazepam, had little or no effect on [Mr A's] deviant behaviour.

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Instead, [Dr E's] clinical notes on 5/8/03 state that oxazepam and haloperidol were to be discontinued as [Mr A] 'has had no behavioural problems'.

8. Was the medication regime prescribed by [Dr E] to assist control [Mr A's] behaviour appropriate?

The haloperidol was for night sedation and the earlier oxazepam was to be given if [Mr A] showed 'inappropriate behaviour'. These are inappropriate medications to modify ongoing sexual deviancy.

9. What further actions, if any, should [Dr E] have undertaken concerning [Mr A]?

As [Mr A's] primary physician, [Dr E] should have ensured that he knew the extent of [Mr A's] deviancy. He should have trialled more appropriate medication after advice or referred him appropriately after the serious events of November 2002 and the failure of the strategies to alter these.

If, in answering any of the above questions, you believe that [Dr E] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

[Mr A] was a sexual predator as a result of dementia and endangered the safety of frail elderly residents at [the rest home]. [Dr E's] colleagues would not consider that his medical care ie monitoring and sedation was appropriately managed by [Dr E] after September 2002. Indeed, his failure to identify [Mr A's] escalating abuse evidenced by his clinical notes on 5/8/03 ie 'has had no behavioural problems' would be regarded with moderate concern and disapproval."

Nursing advice
The following independent expert advice was obtained from Ms Jan Featherston, registered nurse:

"**Expert Advice Case 04/07008/WS**

I have been asked to provide [an] opinion as to whether Nurse Manager [Mrs C] and Licensee [Mr D] provided [Mr A] with an appropriate standard of care.

I have reviewed the documentation provided by the Commissioner's Office.

Background
[Mr A] had been a long term resident at [the rest home]. His diagnosis was dementia. He had a history of alcohol abuse and inappropriate behaviour. The clinical notes show that [Mr A] could be both verbally and physically aggressive.

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[Mrs C]

Was [Mr A's] overall nursing care managed appropriately by [Mrs C]?

There are two areas to consider when answering this question:

1. Was [Mr A] provided with an adequate standard of care?

It is my opinion that he was. There is a long history of disturbing behaviour both verbal and physical. When this behaviour happened staff were able to deter [Mr A] to other activities. The progress notes stated on many occasions that he was diverted to go outside and water the garden etc. He obviously enjoyed the activities at the facility and in reviewing the documentation his medical needs were met.

2. What else could have been done for [Mr A]?

In this area there are a number of areas that I think could have been done better. When [Mr A] did act inappropriately there was very little assessment undertaken on this. No risk management plan was put in place, which identified the high level of risk of the behaviour occurring again and the increased severity of that behaviour. If this had occurred then an assessment would have been sought from an outside agency and alternative placement sought to protect other residents.
There are many residents in facilities such as this that display inappropriate behaviour. Such behaviour includes masturbating in public and attempting to touch other residents in an inappropriate manner. Staff attempt to manage this as best they can with activities and diversional tasks. Many times this is not successful. It is the nurse manager's and medical officer's call as to when they seek outside support. Either this can be in the way of medications or alternative placement. The Psychiatric Geriatric Service is best qualified to provide the support and answers for staff and families.

[Mr A] had in my opinion reached the stage once the physical abuse had occurred it would have been appropriate for staff to contact such a service and look at alternative placement for this man. He was not only a risk to himself but to other residents.

It is my opinion that [Mrs C] did not provide an adequate level of care in the last year of [Mr A's] stay.

I believe that this would be viewed with moderate disapproval from peers.

Did [Mrs C] have appropriate systems to monitor and control [Mr A's] difficult behaviour, and to ensure the safety of the female residents? If not what else could have been done?

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It is my opinion that [Mrs C] attempted to provide appropriate systems in the surroundings and the environment that was available. Unless residents are given one on one nursing care, there is no way that residents can be watched twenty-four hours a day.

The care plan outlined what interventions should be followed and the behaviour modification plan also identified strategies on how to deal with [Mr A's] behaviour.

It is my opinion that such things as restraint would not have been an option for [Mr A].

Was [Mrs C] correct to consider [Mr A's] behaviour was a 'nuisance' rather than a risk?

[Mr A's] behaviour in my opinion was at a 'risk level'. The type of behaviour that [Mr A] displayed is not uncommon in dementia units and in day-to-day management it is a nuisance in that staff must keep a close eye on him to prevent any close contact with other residents. The notes show that if staff redirected [Mr A] to carry out 'chores' then he could be managed. The notes also show that [Mr A] also had verbal disagreement with other residents not just female residents.

It was a 'risk' area for the other residents but could be described as a 'nuisance' for the staff dealing with [Mr A] on a day-to-day basis.

Did [Mrs C] take appropriate steps to ensure she was fully informed about [Mr A's] behaviour?

There is evidence that [Mrs C] was aware of the behaviour that [Mr A] displayed as this is shown in the care plans and the Motivational Therapy Activities chart. The nursing interventions that were documented in the care plan are appropriate and provide direction to care staff.
There was a behaviour modification plan documented (page 145).
The care plan was evaluated regularly.
In relation to the event that happened on the 10/9/02, the progress notes documented what staff found. The notes say that the medical officer saw [Mr A] and ordered haloperidol to be given.

In evaluating the progress notes it appears that [Mr A] displayed inappropriate behaviour approximately once a month. I believe that [Mrs C] as manager would have been aware of this. Staff in a small facility tend to discuss patients and plan cares in a more informal way than a bigger facility.
It must be noted that many of the progress notes have such entries such as:
'a little frisky'
'in an arousing mood'
'inappropriate behaviour'

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This type of entry is very subjective. It does not accurately state what type of behaviour [Mr A] displayed.

Did [Mrs C] appropriately consult with other parties concerning [Mr A]?

In reviewing the documentation I do not believe that there was adequate consultation with other relevant parties.
Families of other relatives in which [Mr A] came into contact with, in particular the four women he had either verbally abused or physically touched. These families should have been advised as it did place their relatives at risk.
[Mrs C] stated that the doctor was aware of [Mr A's] behaviour.
Other health professionals that could have been contacted include the Psychiatric Geriatric community team. It would have been appropriate to send a referral to them. The service would have come and assessed [Mr A] within the facility and provided support for the nursing and care staff. If [the] behaviour was unmanageable then they would of advised on placement.

Were staff members adequately trained and supported with respect to their care of [Mr A] by [Mrs C]/[the rest home]?

Statements show that care staff had achieved or were obtaining the Ace qualifications programme, which includes a dementia series. It is my opinion that care staff who provide 90% of the daily care are not trained in coping and managing such difficult behaviour. In saying that there were many times that Mr A was easily managed. Care staff and certainly permanent staff as [the rest home] appeared to have, learnt to cope through experience. Very few programmes in my experience teach staff how to manage such behaviour. Staff documented that (after the facility was sold) they did not feel supported and in general did not know how to cope with the behaviour that [Mr A] exhibited.

There was in my opinion no example of that in the progress notes. What would be a typical example if staff felt they could not cope is such things as 'what do we do'.

In that I am not saying that the behaviour did not worry staff.

Was [Mr A's] behaviour appropriately documented?

It is my opinion that the documentation was inadequate. It rarely explained what event[s] took place to cause [Mr A] to initiate the sexual behaviour. Staff did explain what action they took to divert the inappropriate behaviour; such things are listed as sweeping grounds etc.

I thought the care plans pertaining in particular to the 'Inappropriate Behaviour' was adequate. The nursing interventions were listed and included — 'ensuring the safety and comfort of others".

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The documentation is what would be found at most rest homes and dementia units. As previously stated the documentation was very subjective in nature.

Did [Mrs C] undertake appropriate assessment and review of [Mr A's] behaviour? If not what else should she have done?

As stated an assessment of [Mr A] should have occurred.

Did [Mrs C] take appropriate action in relation to [Mrs I]?

It is my opinion that appropriate actions and interventions were not initiated over [Mr A] and [Mrs I]. In a situation where a resident is unable to make an informed decision then staff must act to protect the resident. [Mrs I] may also have displayed inappropriate behaviour but by allowing continued contact with [Mr A], this did not protect either [Mrs I] or [Mr A].

Were the actions taken and systems concerning incident reporting at [the rest home] appropriate?

No, the actions taken and the systems were not appropriate. All accidents and incidents should have been assessed for the level of risk to either the individual resident or to the facility as a whole. All accident and incidents should be tabled at a management or staff meeting and discussion should occur which allows a risk assessment to take place. If this had occurred outcomes from these incidents would have been evaluated. Also residents are identified as at 'risk' and an accumulative number of accident/incident forms for the same resident about the same issue provides a key for staff and would indicate that some action is required.

It is not uncommon to find in a small facility that there is limited analysis of data as it is always the same person who holds the same role for many different things.

Should [Mrs C] have referred [Mr A] for reassessment prior to the incident in September 2002?

The progress notes indicate that [Mr A] displayed inappropriate behaviour before the event in late 2002.

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Staff described in the progress notes (from 2002):

'a little frisky'
'please keep an eye on [Mr A] as he has been showing inappropriate sexual behaviour to [the ninth female resident], if he carries on remove [Mr A] to other unit'
'had sexual behaviour'
'in a arousing mood'
'Inappropriate behaviour taken outside for some fresh air'
'got angry with [the tenth female resident] and pushed her out the front door'
'arrived at 10.30 and saw through the dining window [Mr A] with his pants down engaging in sexual behaviour with[Mrs I]in lounge'
'caught [Mr A] in [Ms H's] room hands were under the sheets he said he was checking to see if she was dry… [Ms H] looking quite frightened'
'Very aggressive towards [the second male resident's] grabbed [the second male resident's] neck in the toilet'
'Up early morning walking in other Ladies' rooms touching their private parts would not listen nor stop'
'Frisky mood this morning'.

It is my opinion that the behaviour of [Mr A] was deteriorating and that other residents would be at risk if [Mr A] was not watched constantly. It must also be said that with increasing dementia there is a high likelihood that the behaviour displayed will increase. The key that could have alerted staff was the behaviour that [Mr A] displayed with [Mrs I on 30 June 2002]. Senior staff even if they thought that [Mrs I] consented should have realised that there was a high chance of [Mr A] forcing himself on another resident.

Were the steps taken by [the rest home] staff in relation to the assault of [Miss G] in 10 September 2002 appropriate?

Staff carried out some immediate appropriate interventions once the assault had happened. One incident form was completed and [Miss G] was removed from her room to the lounge and given support. She was seen by the doctor.

Other interventions that would have been appropriate were:
- [Miss G's] family contacted
- A referral to reassess [Mr A]
- A de-brief of staff following a stressful event would have been appropriate.

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Were [Mrs C's] assessment and management of [Mr A] appropriate following the incident in September 2002?

Some of the actions that were put in place were appropriate — a sound sensor outside his room to alert staff when he left the room. Behaviour modification plan was appropriate.

It is my opinion that an assessment should have been sought before this.

Was the behaviour modification plan appropriate/effective?

The nursing care plan was appropriate in my opinion. There is evidence that it was evaluated regularly. I do question whether the registered nurse was aware of all of the incidents that occurred with [Mr A]. If her only way was to read the progress notes then she may have assumed that [Mr A's] behaviour was manageable.

In a smaller facility many staff report issues verbally and where there is a stable staff they report events to each other at hand over rather than documenting fully what has occurred. I am not saying this is right but it is common practice.

It must also be noted that where a certain behaviour has occurred over a long period of time complacency becomes inevitable. It is my opinion that this is what occurred with [Mr A]. The behaviour modification plan will not always be effective and no amount of documentation will stop events occurring.

What further actions, if any, should [Mrs C] have taken?

[Mrs C] should have sought assistance from the Psychiatric-Geriatric service.

There is enough documented evidence that [Mr A] was difficult and it would have been very appropriate for a referral to be sent.

[Mr D]

What were [Mr D's] responsibilities as the Licensee, for ensuring the safety of the residents?

The obligations of the licensee is that the home shall at all times conform to the standards (rest home regulations staffing).

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Requirements are:

- That the[re] [are] procedures for assessing the health needs of each resident on admission and while the resident remains at the home.
- That furniture, fixture and appliances are kept in good repair.
- That there is an adequate call system available for all residents.
- That adequate provision is made for storage and disposal of refuse and that adequate storage is provided for blankets, cleaning materials etc.

These requirements are from the Old People's Regulations dated 1987.
Most of the responsibility for daily care needs is passed on to the Manager.

Was it appropriate for [Mr D] to rely on his staff for day to day management of [the rest home]?

Most owners of facilities who are not health professionals do expect that the care manager / principal nurse / CEO or whatever name is given to the person who is seen in charge will deal with the day to day matters of the facility. This will include the care of the residents and meeting the obligations under the contractual arrangement with the DHBs and the Ministry of Health.

Were [Mr D's] actions in relation to events of 10 September 2002 appropriate?

It is my opinion that [Mr D's] reaction to this event was not appropriate. He appeared to dismiss this as a 'non event' or something that could be dealt with in house. This may have been because of lack of knowledge but in my opinion this is no excuse for not having an understanding of care issues and responsibilities.

Do you agree with the submission that the term 'sexual abuse' in relation to [Mr A's] behaviour is an unduly emotive term?

I do not agree with the submission 'unduly emotive'. This was clearly physical sexual abuse of another person who did not have the ability to consent or have the ability to understand the event. [Miss G] simply by her reactions did not consent and her behaviour following displayed that it emotionally upset her.

What further actions if any should [Mr D] have taken?

It was in my opinion up to [Mr D], in [Mrs C's] absence, to follow appropriate procedure. If he did not understand what that was then it was up to himself to seek support. There are many agencies that could have advised on what course of action he should take. The local DHB would have been the first port of call.

Summary

I believe the care that the residents received at [the rest home] was of a standard that is seen throughout the country. In all units such as this there are people who

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> display aggressive and difficult behaviour. Many of these people in a perfect world would be isolated to prevent harm to themselves but more importantly to others such as the women in this case. Staff always attempt to handle this type of behaviour with diversion and or medications. This is not always possible and it is at this point senior nursing staff and medical staff must know when to seek assistance and support from specialist agencies. It not only supports what they are trying to achieve but alerts other outside agencies to the issues that care staff are attempting to deal with.
>
> An earlier assessment of [Mr A] would have prevented the ongoing physical abuse shown to the female residents."

Responses to provisional opinion

Mrs C

Mrs C, in response to the provisional opinion, submitted that she was genuinely ignorant that Mr A's behaviour constituted sexual abuse. She had been "naïve and ignorant", but it was unfair to characterise her response towards Mr A's behaviour as complacent. Mrs C stated:

> "I did not know that the behaviours that were referred to in the progress notes were sexually inappropriate behaviours. I had never been involved in any sexual abuse or anything like sexual abuse or had any training on it and I really honestly believed that sexual abuse was vaginal penetration of the vagina. I really did not know that the other types of behaviours were sexually inappropriate.
>
> I agree that I thought [Mr A's] behaviour was inappropriate but I definitely did not know that it was sexually inappropriate or amounted to sexual assault and I definitely did discuss it with [Dr E].
>
> …
>
> At the time although I knew that … [Mr A's] behaviour was involving the touching of [genital regions] and breasts I did not know that this was sexual abuse or assault or inappropriate sexual behaviour from a gentleman with dementia. I really wish I had known that at the time and am extremely remorseful that I did not know."

Mrs C explained that she believed that the "sexual abuse" referred to in policy 27 did not cover such behaviours as the touching of breasts and was only applicable in circumstances where a resident had been raped. She stated:

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> "I did train the staff on this [policy 27] but I did not know that sexual assault was the type of behaviour that [Mr A] exhibited. I thought sexual assault was only rape and I trained staff on that. I had no training on the policy. I also did not know that the incident of September 2002 had not been reported to the Police."

Mrs C noted that my advisor agreed with her view that Mr A's behaviour was a nuisance, from a staff perspective. Mrs C did not contact the families of those residents targeted by Mr A as she did not know his behaviour constituted sexual abuse. She reiterated that an earlier assessment was not sought, as she considered any reassessment was Dr E's responsibility.

Mrs C emphasised that she discussed Mr A's behaviour with Dr E, who altered Mr A's medication regime in response. Mrs C explained that as she did not understand sexual abuse had occurred, she did not use this language in her discussions with Dr E. However, she definitely informed Dr E about Mr A's behaviour, which she now understands would have justified a referral for reassessment. Mrs C stated:

> "I would not have used language containing words like sexual assault or sexually inappropriate behaviour or sexual abuse to [Dr E] because I did not know this was what was happening but I definitely described [Mr A's] behaviours to [Dr E]."

Mrs C stated that the continued references to sexually inappropriate behaviours documented in the progress notes after the assault of Miss G in September 2002 were "not the same behaviour that occurred with Miss G in 2003 where there was vaginal penetration". She submitted:

> "At the time I truly did not know that what he was doing was sexual assault and I really believed that what he was doing was normal for patients or residents of rest homes who had dementia, and I really did not know that it was not acceptable. I now know better."

Mrs C confirmed that she assumed Mr A's behaviour was manageable following the institution of the behaviour modification plan, and she attempted to provide appropriate systems. Mrs C stated:

> "I did read the progress notes and I did assume that [Mr A's] behaviour was manageable … Your independent advisor is also correct in saying that where there is a stable staff they report events to each other at handover rather than documenting fully. This was in fact what happened and a lot did not get documented."

Mrs C commented that she had "no one to ask questions of and no support". In retrospect, she is surprised that she was offered the position of Nurse Manager, in light of her lack of experience. She stated:

> "I did not know what my level of responsibility as nurse manager was. I did not know what I did not know. I had no orientation for that job or any on the job training and my job description did not include anything like this.

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…

I did not have training on [incident reports] and I did not know that incident reports were required for any of the behaviours that were well known to staff: I believed that they were for unexpected events. Now I realise that this was another thing that I did not know."

Mrs C has reviewed her practice and is very remorseful about what occurred. She stated:

"[I] would definitely now have myself referred [Mr A] for reassessment and taken steps to have him transferred to a different level of dementia care."

Mrs C agreed that there was a cumulative picture that emerged in relation to Mr A's behaviour, which warranted reassessment, but only with the benefit of hindsight.

Dr E

In response to my provisional opinion, Dr E's barrister, Adam Lewis, submitted:

"…

5. The quality of Dr Turnbull's report is frankly disappointing. She fails to put herself into the position that [Dr E] was in at the time, has adopted an extremely hindsight-biased viewpoint, makes assumptions about [Dr E's] state of knowledge or his reaction to events, ignores [Dr E's] statements when it does not suit her hypothesis, and uses an emotive term to describe [Mr A]. Overall, her opinion lacks objectivity and impartiality.

6. Dr Turnbull describes [Mr A] as a '*sexual predator*', a highly emotive term. Notwithstanding the fact that [Mr A] had dementia and his actions have to be interpreted against that background, Dr Turnbull has more information than [Dr E] had in forming that view. ... It is easier for Dr Turnbull to label [Mr A] in this way, when she was armed with all of the nursing records, prejudicial interviews with witnesses and the hospital files relating to [Mr A's] subsequent admission to [the public hospital]. None of that information was available to [Dr E] at the time that he was making his decision about [Mr A's] care. [Dr E] would undoubtedly have referred [Mr A] earlier if he had the same information that Dr Turnbull had, but he would never have labelled him a '*sexual predator*'. Dr Turnbull has to assess the matter based on the information that Dr E actually had at the time of these events.

7. The use of the term '*sexual predator*' is also unfair to [Dr E.] This investigation has at its heart two events in September 2002. Those events did not, I am instructed, suggest to [Dr E] that [Mr A] was a '*sexual predator*', or even a developing sexual predator. At most, it indicated some emerging crisis that required further sedation and review to see whether that had been effective, as judged by the information [Dr E] had at that time.

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8. Page [23] of the provisional opinion is an example of the extraordinary lengths it appears that Dr Turnbull has gone to in constructing a case against [Dr E]. Having outlined [Mr A's] nursing records between January 2001 and August 2002, she then compares them with [Dr E's] own records for [Mr A] from *October 1998* through to August 2002. The only entry of any relevance was the entry of 14 August 2002. Dr Turnbull uses that list as justification for saying that [Dr E] was aware of [Mr A's] sexually directed behaviour. Closer examination of the entries shows that cannot be valid. Entries for 28 October 1998 and 17 February 1999 are categorised by Dr Turnbull as '*sexually directed behaviour*', which is an unfair interpretation and gloss put on by Dr Turnbull. Those entries contain no reference to anything of a sexual manner. Dr Turnbull's efforts in this regard call into question her objectivity and impartiality.

9. There are other examples that call into question her objectivity and impartiality. Dr Turnbull, at page [27], presumes [Dr E's] state of knowledge when saying that:

   '*At that time [Dr E] understood that there was predatory sexual behaviour on [Mr A's] part.*'

   Dr Turnbull ignores [Dr E's] statements about his actual state of knowledge. [Dr E] repeats that he was not aware that [Mr A] was a predator and that was certainly not the impression given to him by the nurses' statements.

10. Dr Turnbull engages in numerous hindsight judgments during her opinion. An illustration is on page [27] when she states that:

    '*Both were clearly unsuccessful strategies.*'

    Dr Turnbull's ability to predict the future appears to be remarkable. [Dr E] could not possibly be expected to know, at that point in time, what the outcome of the changes in medication, coupled with the behavioral modification plan, would be. It is worth contrasting this with the management plan adopted by hospital staff when [Mr A] was admitted. [Dr N] recognises that the inpatient staff had great difficulty managing [Mr A]. By the end of [Mr A's] admission, he was under a combination of close observation and a behavioral modification plan.

11. At page [28], Dr Turnbull appears to make an extraordinary statement for an expert. She states that '[*Dr E] seems to have been aware*' of an escalating pattern of deviancy. This is pure supposition and again completely ignores [Dr E's] statements. There is no evidence that [Dr E] *was* aware, and rather more evidence that he was not.

12. At page [28], it can only be said by Dr Turnbull that [Dr E] needed to acquaint himself with the extent of [Mr A's] deviancy because she knew the full extent

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of his behaviour from the nursing records. [Dr E] did not. Rather, [Dr E] had, as has been confirmed by others, the nursing staff underplay to him the extent of [Mr A's] behaviour. Dr Turnbull's observations must therefore be invalid.

13. It must be remembered that [Dr E] was not being provided with the level of detail that was contained in the nurses' notes … [Mr D] also confirms that he was aware of some sort of event on 10 September 2002 but was not given precise details. It appears that there was indeed complacency among the nursing staff regarding his behaviour. Dragging [Dr E] in to that, as Dr Turnbull does on page [28], is utterly unfair.

14. Dr Turnbull appears to refuse to recognise the position that [Dr E] was in at the time. Despite repeatedly advising that he was not informed of the degree of seriousness of [Mr A's] behaviour, Dr Turnbull believes that [Dr E] should have disregarded the information being provided by nurses and that he should have spent precious time reviewing the nursing notes. Dr Turnbull appears to suggest that [Dr E] should have been more omnipresent than he could reasonably be expected to be in second-guessing the information provided by the nurses and the[n] predicting what [Mr A] may do in the future that the nursing staff would be unable to cope with. The criticism is at most that [Dr E] was more trusting of the nurses that Dr Turnbull thinks he should have been.

15. [Dr E] has received advice from [a colleague][6] in relation to this complaint. … [Dr E's colleague] has, however, confirmed that it is a common scenario for visiting doctors looking after residential homes to rely on nurses to provide information regarding any problems that may have occurred since the previous visit. It is not practical to look at nurses' notes for every patient, and there are additional financial constraints. … It may be of some reassurance to the Commissioner to know that [Dr E] no longer conducts rest home visits. There are financial constraints placed by rest homes on doctors to rush through as many patients as possible and not to spend excessive amounts of time on them. There is not the money or incentive for doctors to provide the level of in-depth analysis that Dr Turnbull seems to suggest, and [Dr E] would like to provide.

16. Finally, [Dr E] was interested to learn that there was a Ministry of Health audit. He was never aware that an audit had taken place and certainly nothing was brought to his attention at the time. He would have expected to be contacted if there had been some concern by the audit team in relation to the

[6] A copy of this advice was not provided to the Commissioner, nor was any information provided as to qualifications or experience of Dr E's colleague. Dr E's barrister, Mr Adam Lewis, noted that 'privilege is not waived over this report by Dr E'.

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policies and procedures of the rest home, his reviews of patients or [Mr A's] behaviour.

Opinion

17. [Dr E] wishes to make the following submissions on the provisional opinion.

18. At page [50] of the provisional opinion, it is stated that:

> '[*Dr E] was aware that [Mr A] was exhibiting sexual predatory behaviour.'*

The evidence says no such thing. [Dr E's] entry of 11 September 2002 says that there was a '*sexually <u>inappropriate</u> behavour*' which is some way off '*predatory*' behaviour.

19. The provisional opinion talks of [Dr E] making unjustified assumptions … about [Mr A], but the provisional opinion is littered with unjustified assumptions about [Dr E's] state of knowledge. Those have been outlined above.

20. The opinion states that [Dr E] could have made a cursory examination of the nursing notes. It is said that there was '*no impediment to him requesting the notes*'. That conclusion is simply not realistic in the context of what actually occurs in rest home visits. Time is short. There is no recompense to doctors under the contracts for this. The financial pressures on doctors during rest home assessments cannot be ignored. Reference to these notes, and reliance on them in forming a breach opinion, only serves to reinforce the overwhelming conclusion that the findings are made with hindsight. At the time of [Dr E's] treatment of Mr A he was entitled to rely on the information from the nurses and had no reason not to trust that information and go behind what the nurses told him.

21. In relation to the breach of Right 4(5), [Dr E] had no reason to question [Mrs C's] information to him. She was someone who he had worked with, he trusted at the time, and could reply on. Of course, Dr Turnbull's and the provisional opinion's conclusions are made with hindsight.

[Dr E's] present practice

22. [Dr E] would like to reassure the Commissioner that he has ceased doing rest home visits because of the unpleasant experience he has had with this complaint and investigation. In those circumstances, [Dr E] submits that the recommendations are not necessary.

23. [Dr E] is now much more suspicious of what nursing staff tell him. He wonders whether that really is a desirable outcome from the investigation, as it

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seems to him incompatible with trying to achieve cooperation between providers ...”

Mr D
Mr D, in response to the provisional opinion, reiterated his view that Mr A’s conduct did not amount to sexual abuse, because of the lack of intentional wrongdoing. He stated:

> “We [Mr D and his lawyer] are of the view that it is fundamentally wrong to characterise this behaviour as intentional wrongdoing given the complete lack of mental capacity of the people involved. It is for that reason alone that we consider it is incorrect to label this conduct as sexual abuse. We do not wish to suggest that the conduct is in any way acceptable or that it should be tolerated.”

Mr D emphasised that his comments were directed solely to the issue of intention.

Code of Health and Disability Services Consumers’ Rights

The following Right in the Code of Health and Disability Services Consumers’ Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

Opinion: Breach — Mrs C

Introduction
The Code of Health and Disability Services Consumers’ Rights (the Code) requires services to be provided with reasonable care and skill. Mr A was known to exhibit inappropriate aggressive and sexual behaviour due to his dementia, and specific nursing management strategies were used to control his behaviour. Mrs C said she was unaware that Mr A’s behaviour went beyond displays of explicit sexual behaviour. However, the nursing progress notes clearly show that Mr A’s behaviour often included the touching of other residents. Mrs C was aware that Mr A touched other residents in the breast and genital region, but claims that she did not know this behaviour was “sexually inappropriate”.

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As Nurse Manager, it was incumbent on Mrs C to fully inform herself about Mr A's behaviour and take appropriate action. Mrs C's view that the behaviour modification plan of September 2002 was successful is belied by the continued references to inappropriate sexual behaviour in the progress notes, until the further incident involving Miss G in November 2003. In failing to realise Mr A constituted an unacceptable risk to the safety of other residents, and to respond appropriately, Mrs C breached Right 4(1) of the Code. The reasons for my decision are set out below.

Management of Mr A until September 2002
Mrs C did not consider Mr A was a risk to other residents, but categorised his behaviour as a "nuisance" — from the perspective of staff who had to deal with him on a daily basis. She explained that Mr A was monitored closely and staff re-directed him when he demonstrated inappropriate sexual behaviour. Mr A's care plans included specific direction about how to manage his behaviour.

In response to the investigation, Mrs C advised that Mr A's behaviour only impacted on other residents visually and she received no reports of sexual abuse. She was not aware of Mr A touching other residents, apart from holding hands and occasionally touching Mrs I's breasts, particularly when she exposed them. Mrs C explained that Dr E and Mrs I's general practitioner (Dr M) and daughter were all aware of what was occurring in relation to Mrs I, but this is denied by Dr M and Mrs I's daughter. Dr E does not recall being made aware of any inappropriate sexual behaviour by Mr A towards Mrs I that required any intervention by him. There is no documentation of any such discussions.

Mr A's progress notes from 2001 show that he was often calm and settled. They note intermittent episodes of aggressive behaviour generally directed to female residents but occasionally male residents. The notes also make at least 25 references to inappropriate sexual behaviour in the period from 2001 and prior to September 2002. These include numerous occurrences where Mr A was documented as touching or attempting to touch other residents.

Mrs C commented:

> "At the time although I knew that … [Mr A's] behaviour was involving the touching of vaginas and breasts I did not know that this was sexual abuse or assault or inappropriate sexual behaviour from a gentleman with dementia. I really wish I had known that at the time and am extremely remorseful that I did not know."

Mrs C explained that she was "genuinely ignorant" that Mr A's behaviour constituted sexual abuse and it was unfair to characterise her conduct towards Mr A's behaviour as complacent. Mrs C stated:

> "I did not know that the behaviours that were referred to in the progress notes were sexually inappropriate behaviours. I had never been involved in any sexual

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> abuse or anything like sexual abuse or had any training on it and I really honestly believed that sexual abuse was vaginal penetration of the vagina. I really did not know that the other types of behaviours were sexually inappropriate.
>
> I agree that I thought [Mr A's] behaviour was inappropriate but I definitely did not know that it was sexually inappropriate or amounted to sexual assault and I definitely did discuss it with [Dr E]."

Mrs C explained that she did not contact the families of the residents targeted by Mr A as she did not know his behaviour constituted sexual abuse. Mrs C considered that any reassessment of Mr A was Dr E's responsibility.

My expert nurse advisor, Jan Featherston, noted that Mr A had a lengthy history of "disturbing behaviour both verbal and physical". His type of behaviour is not uncommon in dementia units and would have been a nuisance from the staff's perspective, but posed a risk for the rest home residents. The documentation of Mr A's behaviour by caregiver staff was highly subjective and often did not accurately describe his inappropriate behaviour, or the reasons for his behaviour. However, the care-planning documentation and motivational therapy activities chart demonstrate that Mrs C was aware of Mr A's continued difficult behaviour. Ms Featherston stated:

> "In evaluating the progress notes it appears that [Mr A] displayed inappropriate behaviour approximately once a month. I believe that [Mrs C] as manager would have been aware of this. Staff in a small facility tend to discuss patients and plan cares in a more informal way than a bigger facility."

My advisor considered that Mr A should have been referred to be reassessed by psychogeriatric services prior to the events of September 2002. As Nurse Manager, Mrs C had shared responsibility to ensure that this occurred, in conjunction with Dr E. An earlier assessment would have prevented the ongoing abuse of female residents. The behaviour documented in the progress notes from 2002 indicates that Mr A's behaviour was deteriorating, as would be expected to occur with increasing dementia. In particular, Mr A's touching of Mrs I should have alerted senior staff that there was a high chance of his attentions being directed towards another resident. Although Mrs I may also have displayed inappropriate behaviour, in circumstances where she was unable to make an informed decision she should not have been allowed to have continued contact with Mr A. In addition, the families of the women Mr A was known to have either verbally abused or touched inappropriately should have been contacted and informed about what had happened.

Management of Mr A following September 2002

Mrs C stated that she reviewed the behaviour modification plan introduced by Mr K following the incidents in September 2002. She considered the plan to be adequate because it had been made in consultation with Dr E. Mrs C trusted Dr E's judgement, and did not consider it to be her place to make a referral if he did not do so — she assumed that only doctors could make a referral to specialist services. Dr E explained

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that he had no involvement with the behaviour modification plan, and he was informed only that there had been a "possible" sexual assault.

Mrs C did not consider notifying Miss G's family (or the Police) because she assumed that the incident had been properly dealt with in her absence. Mrs C considered that policy 27 was limited to rape — she claimed that she would certainly have notified Miss G's family and the Police of the incident if she had been present at the time. Mrs C did not take steps to establish whether the incident of September 2002 had been reported to the Police.

My nurse advisor considered that the introduction of the behaviour modification plan was appropriate. However, Mr A should have been referred for reassessment, Miss G's family notified, and staff provided with an opportunity for de-briefing. Ms Featherston stated:

> "[Mr A] had in my opinion reached the stage once the physical abuse had occurred it would have been appropriate for staff to … look at alternative placement for this man. He was not only a risk to himself but to other residents."

Mrs C commented that the behaviour modification plan (including the use of the motion sensor) was "extremely effective" in that there were no further incidents involving Mr A until November 2003. Yet Mr A's progress notes document approximately 30 further instances of Mr A displaying inappropriate behaviour following the incidents of September 2002. The following occurred in late 2002:

- 29 September: Mr A punched the twelfth female resident. She was sitting beside him and could not see what happened but twelfth female resident hit him back. Mr A got very angry.
- 12 October: was seen in lounge tonight with his hand on Mrs I's breast.
- 26 October: seen Mr A with inappropriate sexual behaviour towards Miss G. Hand up Miss G's dress. Agitated with staff after incident. Denying he was doing anything.
- 16 November: A staff member found Mr A in Miss G's bedroom; he pulled Miss G's blankets down. When asked he said he was checking why Miss G screamed. No screaming was heard by staff.
- 24 November: inappropriate behaviour toward women. Attempted to get in the toilet with the eleventh female resident.
- 27 December: inappropriate behaviour towards Mrs J in the lounge. Head and hands down nightie in her breasts. Said he was looking to see what she was looking for. Also holding the twelfth female resident's vagina and breast in passageway. Said he was seeing if she was OK.

In the 2003 progress notes, there are at least 20 further references to Mr A behaving inappropriately, including approximately 12 occasions where he was specifically noted to have been touching other residents, including interfering with Ms H's incontinence pad and the touching of other residents' breasts.

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Mrs C commented that the further references to sexually inappropriate behaviours were less serious than the incident involving Miss G. She stated:

> "I really believed that what he was doing was normal for patients or residents of rest homes who had dementia, and I really did not know that it was not acceptable. I now know better."

Mrs C explained that she attempted to provide appropriate systems for Mr A within the available environment. Mrs C assumed from the progress notes that Mr A's behaviour was manageable following the institution of the behaviour modification plan. She stated:

> "Your independent advisor is also correct in saying that where there is a stable staff they report events to each other at handover rather than documenting fully."

My advisor commented that the notes show that staff were often successful in redirecting Mr A's inappropriate behaviour. Ms Featherston acknowledged that Mrs C may not have been made aware of all the incidents concerning Mr A — particularly if she was solely reliant on the daily progress notes — and may have assumed Mr A's behaviour was manageable. Ms Featherston stated:

> "It must also be noted that where a certain behaviour has occurred over a long period of time complacency becomes inevitable. It is my opinion that this is what occurred with [Mr A]. The behaviour modification plan will not always be effective and no amount of documentation will stop events occurring."

Mrs C commented that she had "no one to ask questions of and no support". In retrospect, she is surprised that she was offered the position of Nurse Manager, given her "ignorance". Mrs C stated:

> "I did not know what my level of responsibility as nurse manager was. I did not know what I did not know. I had no orientation for that job or any on the job training and my job description did not include anything like this."

Mrs C stated that she has reviewed her practice and is very remorseful about what occurred. She stated:

> "[I] would definitely now have myself referred [Mr A] for reassessment and taken steps to have him transferred to a different level of dementia care."

Mrs C agreed that a cumulative picture emerged in relation to Mr A's behaviour that warranted reassessment, but only with the benefit of hindsight.

Risk management

Mrs F had difficulty locating incident reports, and found that there was no evidence of collation or risk assessment. Caregiver staff indicated that incident reports were not routinely completed for Mr A, as inappropriate behaviour on his part was expected.

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Mrs C explained that incident reports were required for any adverse or unexpected events that affected a resident or staff member. However, she said: "Mr A's behaviours were well known to staff and were considered normal."

Mrs C advised me that incident reports were reviewed and analysed, and care plans amended when required, with any changes being discussed with Dr E. Mr A was also regularly reviewed by Dr E, who would have referred him for reassessment if he had had concerns. She stated:

> "I did not have training on [incident reports] and I did not know that incident reports were required for any of the behaviours that were well known to staff: I believed that they were for unexpected events. Now I realise that this was another thing that I did not know."

Ms Featherston considered that Mrs C undertook an inadequate risk assessment process. She said:

> "When [Mr A] did act inappropriately there was very little assessment undertaken on this. No risk management plan was put in place, which identified the high level of risk of the behaviour occurring again and the increased severity of that behaviour.
>
> …
>
> All accidents and incidents should have been assessed for the level of risk to either the individual resident or to the facility as a whole. All accident and incidents should be tabled at a management or staff meeting and discussion should occur which allows a risk assessment to take place. If this had occurred outcomes from these incidents would have been evaluated. Also residents are identified as at 'risk' and an accumulative number of accident/incident forms for the same resident about the same issue provides a key for staff and would indicate that some action is required."

Notification of relatives

Policy 27 required the notification of the relatives of affected residents, together with the resident's medical practitioner and any other appropriate authority, when abuse of a resident occurred.

Neither Miss G's nor Mr A's families were contacted in relation to the incident of 10 September 2002. Under policy 27, the disturbing incident of 10 September met the threshold for notification to an external agency, but this also did not occur. Mrs C apparently reviewed the behaviour modification plan but made an unjustified assumption that the requirements of policy 27 had been met.

There is no evidence to support Mrs C's assertion that she discussed Mr A's behavior with Mrs I's family. Dr M's comment that Mrs I would not have been aware of the significance of such behaviour highlights the vulnerability of female dementia

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patients, and the importance of ensuring that they are appropriately protected from inappropriate sexual behaviour.

It is of significant concern that the families of those residents who were recorded in the progress notes as being abused by Mr A were not informed of what had occurred. Mrs C did not even consider contacting the families of victimised residents. Mrs C's view of what constituted sexual abuse (rape only) reflected an unreasonably high threshold.

Mrs C's failure to follow policy 27 meant that family members were unaware of what had occurred, and that vulnerable residents remained at risk.

Conclusion
Mr A's inappropriate behaviour was documented in the daily progress notes, although often it was described only in general terms. However, the notes describe behaviour that clearly went well beyond the "nuisance" type of exhibitionist sexual behaviour. There are numerous instances when Mr A behaved inappropriately and touched other residents in a sexual manner.

The statements provided by caregiver staff indicate that Mr A's behaviour was known and expected. There were many examples of "sexually inappropriate behaviour", often involving the touching of "vaginas and breasts" of other residents. Mr A's behaviour was apparently often upsetting to caregiver staff, but was not thought to meet the very high threshold for what constituted "sexual abuse" at the rest home. His behaviour was also not considered to pose a risk to other residents, prior to the assault of September 2002.

Mrs C regularly reviewed Mr A's care planning documentation. She should have become aware of the extent of Mr A's inappropriate behavior either by reference to the daily progress notes, discussions with caregiver staff, or by direct observation.

Mr A's behaviour towards Mrs I (notably on 30 June 2002) should have alerted Mrs C to the risk that his inappropriate behaviour posed to other residents. Mrs C should have ensured that Mr A was separated from Mrs I, and contacted her family and general practitioner, as well as the families of other residents targeted by Mr A.

Mrs C admits that she was aware that Mr A's behaviour included the touching of other residents' breasts and genitals (before and after September 2002) — but "definitely did not know that it was sexually inappropriate or amounted to sexual assault". She had not received any training about sexual abuse and thought that rape of a resident was required to meet the threshold of sexual abuse.

Although absent during September 2002, Mrs C had overall responsibility for the management of Mr A's nursing care and the maintenance of a safe environment for other residents. The measures introduced by Mr K following the assault on Miss G were generally appropriate as an interim step. However, Mrs C should have fully informed herself about the events of September 2002, taken steps to notify the Police

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and Miss G's relatives of the assault, and immediately requested that Dr E refer Mr A for reassessment.

Mrs C's view that Dr E would have referred Mr A for reassessment if he had had any concerns — and her assumption that the incidents of September 2002 were adequately dealt with in her absence — was an inadequate response for a Nurse Manager.

Mrs C's assertion that the behaviour modification plan of September 2002 was successful is correct only in that no further incidents reports were filed in relation to Mr A's sexual behaviour. However, in practice incident reports were filed only when residents or staff were "affected" by the behaviour, and Mr A's behaviour had come to be regarded as normal. The threshold for the completion of incident reports was significantly higher than it should have been. Any inappropriate touching of residents should be documented and reported, regardless of whether the recipient is upset. Otherwise, behaviours that may be of significant concern remain "buried" within the resident's individual progress notes.

Mrs C should not have assumed that Mr A's behaviour was adequately managed following the assault on Miss G. Mr A's progress notes document numerous further instances of inappropriate behaviour of sufficient frequency to warrant reassessment. These behaviours were similar to those that occurred prior to the assault on Miss G. There was a risk of another serious assault while Mr A remained at the rest home.

There is no evidence that Mrs C conducted any meaningful assessments or analysis of incidents involving Mr A. Incident reporting systems were criticised by the Ministry of Health in 2001 and 2003 and remained non-compliant. Mrs C's submission that she had no training on incident reports does not answer my advisor's criticisms. Once the problem had been highlighted by the Ministry audits, she should have sought external advice on how to develop and implement appropriate incident reporting systems.

Overall, I consider that Mrs C's remarkable lack of knowledge in this area of nursing practice is no excuse — particularly given her many years of experience in rest homes, and training as a registered nurse. Mrs C's submission that she was not a suitable candidate for the position of Nurse Manager is borne out by what occurred.

In my view, Mrs C demonstrated naïvety and complacency towards Mr A's behaviour. She allowed an environment to develop in the rest home in which staff became desensitised to incidents of inappropriate behaviour and abuse. Her ineffective response allowed a situation of long-term inappropriate sexual behaviour to continue, placing vulnerable residents at risk.

In these circumstances, Mrs C breached Right 4(1) of the Code.

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Opinion: Breach — Dr E

Dr E states that with the benefit of hindsight, Mr A "probably" should not have been at the rest home. However, he claims that he was unaware of the extent of Mr A's inappropriate behaviour as it was not drawn to his attention by nursing staff or ascertainable from the available documentation. He considered that his role was to provide medical care (including appropriate sedation) for Mr A, within the context of nursing management strategies, and that primary responsibility for initiating reassessment of Mr A lay with the rest home.

My expert general practitioner advisor, Dr Tessa Turnbull, considered that Dr E managed Mr A's inappropriate behaviour "reasonably well" prior to the September 2002 assault on Miss G. At that time, Dr E became aware that Mr A was exhibiting "sexually predatory behaviour", and he should have taken steps to inform himself about the extent of that behaviour, and sought expert opinion.

As Mr A's primary physician, Dr E was obliged to take appropriate steps to fully ascertain the nature of Mr A's illnesses, including any related behavioural concerns. In my view, Dr E should have sought reassessment of Mr A's placement at the rest home immediately following the incidents in September 2002. In failing to do so, he breached Right 4(1) of the Code. The reasons for my decision are set out below.

Management prior to September 2002
Dr E prescribed Mr A thioridazine, haloperidol and oxazepam to control his "exhibitive" and "aggressive" behaviour. Dr E knew that Mr A habitually wandered into other residents' rooms and exposed himself, but was not aware of any "significant risk" to the safety of female residents. He stated:

> "I was never given to understand that the inappropriate behaviour was more sinister than masturbating or [the] opportune groping many male patients with dementia exhibit. During my three monthly reviews of the patients, I relied on discussions with the Nurse Manager to inform me of any problems. I have no recollections of the Nurse Manager, or any of the other nursing staff, stating to me that [Mr A's] behaviour was any more than nuisance value."

Dr E commented that the descriptions of Mr A's behaviour in his progress notes were too "broad" to draw any conclusions about his behaviour, and there must have been substantial periods where he behaved appropriately. As noted in my discussion in relation to Mrs C, I consider that there were sufficient indicators in Mr A's daily progress notes to give significant cause for concern about his behaviour. A cursory review of the progress notes for the period prior to September 2002 would have revealed that his behaviour included inappropriate sexual behaviour, including intimate touching of other residents.

Mrs C stated that she had regular discussions with Dr E about Mr A's behaviour, and that Dr E altered his medication in response.

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Dr E submitted that Dr Turnbull's comment that the medical records confirmed that he was "aware of Mr A's sexually directed behaviour and the need to modify it" was unwarranted.

The medical records show that Dr E prescribed melleril for Mr A in mid- October 1998 as a result of "increased exhibitive behaviour and aggression". Mr A's behaviour was then noted to have improved (late October 1998). In early 1999 Dr E noted that Mr A was sleepy (at times) but made no reference to inappropriate behaviour. Dr E altered Mr A's medication on 14 August 2002 (introducing oxazepam, as required) — shortly prior to the two incidents in September 2002. Dr E made this amendment due to the "occasional outbursts of ebullient behaviour" — the daily progress notes record episodes of inappropriate behaviour in June, July and August (including one occasion when Mr A was found in a resident's room "checking to see if she was dry"). The "ebullient" or "inappropriate" behaviour on the part of Mr A clearly included a sexual component — but the lack of detail in the medical records makes it impossible to establish precisely what information was provided to Dr E.

Dr E was apparently unaware of any further particular concerns about Mr A's sexual behaviour after the prescription of melleril in October 1998 until around August 2002. However, the medical records demonstrate a general awareness on the part of Dr E of Mr A's inappropriate sexual behaviour ("a longstanding history of intermittent inappropriate behaviour") and that he was medicated to control his "annoying behaviours".

My advisor commented that Dr E would not have had direct access to the nursing progress notes unless he requested them. I accept that Dr E was primarily reliant on the information provided to him by nursing staff, particularly Mrs C, and there is no evidence to suggest that between late 1998 and August 2002 she drew to his attention any particular concerns about Mr A's behaviour.

Management after September 2002

On 2 September 2002, caregiver staff completed an incident report after Mr A was found in another resident's room touching her genital region. Dr E noted "inappropriate behaviour" in his medical records and prescribed oxazepam for sedation.

On 10 September 2002, a further incident was reported by a night staff caregiver, where Mr A was found molesting Miss G, causing significant distress and vaginal bleeding.

Dr E commented that he was only informed that inappropriate behaviour and a "possible assault" had occurred; if the detail in the incident report had been provided to him, he would certainly have considered a referral or immediate transfer.

Dr E noted "further sexually inappropriate behaviour" in Mr A's medical records, and prescribed haloperidol. He recommended the careful monitoring of Mr A and

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separation from Miss G. Dr E also reviewed Miss G on 11 September and noted that she had been "sexually assaulted" by Mr A, with some blood evident on Mr A's hand and on Miss G's pad. (Dr E did not examine Miss G and it is therefore not possible to establish the precise extent of the vaginal injury.)

Dr E explained that he was not made aware of any further concerns about Mr A until November 2003 when Mrs F requested his reassessment. He stated:

> "Primary responsibility for initiating reassessment of [Mr A] lay with the rest home. They decide who they admit, who they can manage, and how these patients are managed. I assist them with providing medical advice and arranging the reassessments for unmanageable patients."

In contrast, Mrs C considered that it was not her place to refer Mr A if Dr E did not do so.

My advisor commented that Mr A was a "sexual predator" who endangered the safety of his fellow residents, and that there appeared to have been an "escalating pattern of deviancy which Dr E appears to have been aware of". As Mr A's primary physician, Dr E should have enquired as to the extent of Mr A's inappropriate behaviour. He should have referred Mr A for reassessment after the serious events of September, and trialled more appropriate medication. Dr Turnbull stated:

> "I believe [Dr E] managed [Mr A's] sexual deviancy reasonably well until late in September 2002. At that time [Dr E] understood that there was predatory sexual behaviour on [Mr A's] part. [Dr E] prescribed medication to attempt to sedate [Mr A] at night and [the rest home] put in a behaviour modification plan and instituted monitoring. Both were clearly unsuccessful strategies.
>
> It was at this point, late in 2002/early 2003, that Dr E should have sought expert input from a physician or psychiatrist for the elderly. It was Dr E's, rather than [the rest home's], responsibility to do this."

Mr Lewis criticised Dr Turnbull's view — that "[Dr E] understood that there was sexually predatory behaviour on [Mr A's] part" (after September 2002) and that Dr E "seems to have been aware of an escalating pattern of deviancy" — as "pure supposition". The term "sexual predator" was described as "highly emotive" and an unfair label. He submitted that the full extent of Mr A's behaviour was downplayed by nursing staff, and that there was no reason for Dr E to disregard the information provided by nursing staff or to check the daily progress notes. In addition, according to Dr E's expert (named but with no qualifications or experience specified, in advice withheld and in respect of which "privilege is not waived"), it is unreasonable to expect Dr E to have reviewed the daily progress notes; it is common practice for doctors to rely on the information provided to them by nursing staff.

Dr Turnbull commented that the combined effect of the medication and nursing management plan apparently had little effect on Mr A's behaviour. She stated:

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> "In August 2002, [Dr E] prescribed oxazepam for 'occasional outbursts of ebullient behaviour'. After the events of September 2002, [Dr E] recommended careful monitoring of [Mr A] and separation from [Miss G]. He prescribed night sedation with haloperidol. Both the medications had little or no effect on [Mr A's] deviant behaviour. [The rest home] also put in a behaviour modification plan. All were clearly unsuccessful and poorly followed through strategies."

In response, it was submitted that Dr Turnbull had a "remarkable" ability to predict the future and that her report was "extremely hindsighted and biased". Dr E could not be expected to have known what the outcome of the change in medication, coupled with the behavioural modification plan, would be.

Conclusion
I accept that Dr E was hampered by the lack of specific information from Mrs C, and was unaware of the full extent of Mr A's behaviour. However, I consider that there were sufficient "red flags" to prompt Dr E to enquire as to the extent of Mr A's inappropriate behaviour, when he was notified of the incidents in September 2002.

Dr E knew of the assault on Miss G by Mr A, which he described in his medical records. Dr E's statement that he was only made aware that the incident was a "possible" assault is at odds with his 11 September review of Miss G. Dr E's statement that he was told that there was no direct evidence to link Mr A with the assault stretches credibility.

I do not accept Dr E's submission that the rest home was primarily responsible for referring Mr A for reassessment. Dr E was, and had been for many years, Mr A's doctor. Mrs C may have inappropriately placed complete reliance on Dr E to refer Mr A for reassessment, but she was correct in her expectation that he should have given the matter his consideration following the assault on Miss G. It is hardly surprising that Mr A was not referred for reassessment when neither the rest home nor Dr E accepted that referral of residents was their responsibility.

Dr E was a key part of the multidisciplinary team caring for Mr A, and his responsibility to his patient (and other residents) went beyond the prescribing of medication. As Mr A's primary physician, Dr E had an obligation to ask specific questions of Mrs C to find out the full extent of Mr A's behaviour, and to monitor and follow up any medication he prescribed. There is no evidence that he did so. A cursory examination of the nursing progress notes would have given cause for concern. The notes reveal a patient whose behaviour should have been a significant concern.

I acknowledge that doctors who provide services to rest homes under contract operate under significant time constraints. It would be unrealistic to expect Dr E to have reviewed the progress notes on a regular basis. However, in September 2002 Dr E was notified of two instances of inappropriate behaviour within eight days, the second a serious sexual assault. Dr E should have fully informed himself from discussions with

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nursing staff and/or the contemporaneous documentation of precisely what occurred in September 2002. Had he done so, I am confident he would have appreciated the need to refer Mr A for reassessment.

Mr Lewis's submissions seek to attack the credibility of a respected and experienced (in general practice care of the elderly) independent advisor, and even go so far as to question her "objectivity and impartiality". I find this attack unjustified and unconvincing. The submissions fail to answer the basic point that Dr E, given the information that he admits to have known, showed (and in his latest response, continues to show) a lack of insight that his responsibility to his patient (and to the safety of other residents) might extend beyond upping the medication to control "annoying behaviours".

Mr Lewis referred to advice that "[Dr E] has received from [his colleague]". The second-hand evidence of an advisor to a party under investigation — where the advisor's qualifications and experience are not provided, his report is not disclosed, and it is claimed that "privilege is not waived" — can obviously carry no evidential weight.[7] However, although I discount evidence of Dr E's colleague, I accept that it is commonplace for doctors visiting rest homes to rely on nurses to provide information about the patient's condition since the last visit. Dr E's own notes show that he was given sufficient information in September 2002 to alert him to the need for further enquiries and follow-up action.

To his credit, Dr E does accept that in future dealings with rest homes, he would "look for well-established, clear patient management procedures that facilitate the role of the GP in patient management" and "probably suggest earlier referral to a geriatrician where there is an allegation of inappropriate behaviour". This is a thoughtful response. Sadly, Dr E has ceased to undertake rest home visits because of "the unpleasant experience" of this complaint and investigation, and is now "much more suspicious of what nursing staff tell him". Dr E "wonders whether that is really a desirable outcome from the investigation" or compatible with "trying to achieve co-operation between providers". The simple answer is that a lower threshold for questioning nursing staff and referring for specialist input is a warranted and sensible response; withdrawal from all rest home practice and suspicion of nursing advice seems a disproportionate and defensive response to these events.

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[7] In *Equiticorp Industries Group Ltd v Hawkins* [1990] 2 NZLR 175, Wylie J concluded that waiver had occurred when the contents of a privileged report prepared by the plaintiff's solicitor was referred to extensively in affidavits filed by the plaintiff in interlocutory proceedings. Relevant to the Court's decision was the fact the extracts from the report were included in the affidavits to add "credibility and weight" to the plaintiff's contentions, and thus to influence the Court in its consideration of the interlocutory application (p 179). In concluding that privilege had been waived, Wylie J referred to the principle articulated by McPherson J (in *Curlex Manufacturing Pty Ltd v Carlingford Australia General Insurance Ltd* [1987] 2 Qd R 335, 340) that "a party cannot ordinarily claim at trial to use part of a document in support of his case, while at the same time also claiming to conceal the remainder of it ..." (pp 182–183).

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In summary, Dr E could and should have taken steps to ensure that Mr A was appropriately placed at the rest home, and that other residents were not at risk. Dr E did not meet the standard of care expected of a responsible rest home GP. In these circumstances, Dr E breached Right 4(1) of the Code.

Opinion: Breach — Mr D

Mr D was the licensee of the rest home. Under section 3(c) of the Health and Disability Commissioner Act 1994, Mr D was a "health care provider" subject to the duties in the Code at the time of these events. As licensee, Mr D had an obligation to ensure that the rest home complied with the standards required by the Ministry of Health, as set out under the Old People's Regulations 1987. Mr D also had an obligation to comply with the detailed service specifications set out in the rest home's contract with the Ministry of Health, which contained specific provisions relating to the care and safety of dementia patients.

My nursing advisor stated:

> "Most owners of facilities who are not health professionals do expect that the Care manager / principal nurse / CEO or whatever name is given to the person who is seen in charge will deal with the day to day matters of the facility. This will include the care of the residents and meeting the obligations under the contractual arrangement with the DHBs and the Ministry of Health."

Mr D did not have a direct personal role in the operation of the rest home, and was not qualified to do so. He undertook a specific role as purchasing officer and in relation to staffing issues, and was responsible for the storage of previous residents' clinical notes. Mr D submitted that he was entitled to rely on Mrs C's abilities to manage the rest home, as she was highly qualified and experienced.

Mrs C met with Mr D weekly and discussed any concerns. She stated that Mr D primarily undertook an administrative role, but was more "hands-on" when she was absent.

Mr D knew that Mr A was prone to inappropriate aggressive and sexual behaviour, and had discussed this with Mrs C on several occasions. He believed that appropriate systems were in place to manage the situation.

Mr K confirmed that Mr D's only involvement with Mr A's September 2002 behaviour modification plan was to approve the purchase of the motion sensor.

I accept that it was reasonable for Mr D to rely on Mrs C in relation to the daily management of the rest home. However, in Mrs C's absence, it would have been prudent for Mr D to obtain full details about the incident of 10 September 2002 and,

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on her return, instruct Mrs C to ensure that appropriate procedures had been followed by the temporary management team. Mr D was apparently not provided with the full details of what occurred, nor did he enquire whether Dr E or the Police had been consulted.

My nursing advisor was critical of Mr D's reaction to the incident of 10 September 2002. She stated:

> "He appeared to dismiss this [the assault on Miss G] as a 'non event' or something that could be dealt with in house. This may have been because of lack of knowledge but in my opinion this is no excuse for not having an understanding of care issues and responsibilities.
>
> …
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> It was in my opinion up to [Mr D], in [Mrs C's] absence, to follow appropriate procedure. If he did not understand what that was then it was up to himself to seek support."

The fact that the assault on Miss G may not have been "intentional" behaviour by Mr A (in the sense that he lacked the mental capacity for a criminal offence) in no way excuses Mr D's failure to respond appropriately to what was clearly a serious incident. Mr D accepts that Mr A's conduct was not "in any way acceptable" and that it should not have been tolerated. As licensee, he had a responsibility to ensure that more was done to respond to the situation.

Under section 72 of the Health and Disability Commissioner Act 1994, a health care provider, if an employing authority (as Mr D was in this case), may be vicariously liable for acts or omissions by an employee.

Mrs C breached Right 4(1) the Code in relation to her oversight of Mr A's care. In particular, Mrs C did not undertake the appropriate review and analysis of incident reports or refer Mr A for assessment when it became clear his behaviour was abusive. Mrs C was employed by Mr D. Accordingly, he may be vicariously liable for Mrs C's breach of the Code, under section 72(2).

Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent an employee's breach of the Code.

The Ministry of Health routine audits of the rest home (10 December 2001 and 18 August 2003) requested an immediate improvement in the completion, monitoring and analysis of incident reports. The Ministry's issues-based audit (10 June 2003) identified concerns in relation to incident reports — a lack of information or evidence

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of corrective actions and follow-up. There was also no plan in relation to the management of the specific risks associated with the provision of dementia care.

Mr D acknowledged that the incident reporting procedures had been reviewed, but remained non-compliant. He stated:

> "At that time [mid 2003] it was agreed that [the rest home company's] policies and procedures would soon be adopted. Incident reports were monitored and analysed, but due to the small size of the rest-home, the information did not have anywhere to go."

The deficiencies in the incident reporting procedures had been known to Mr D as licensee of the rest home since December 2001. Mr D should have taken steps to ensure that the rest home was fully compliant with its contractual obligations. The lack of an appropriate system in relation to incident reports meant that the risks posed by Mr A were not addressed in a timely or effective manner. In addition, although policy 27 appropriately required the notification of external parties, including the resident's medical practitioner and relatives, the evidence indicates that the policy was not properly implemented in practice.

In summary, Mr D has not proven that he took such steps as were reasonably practicable to prevent his employee's omissions, and accordingly is vicariously liable for Mrs C's breach of the Code.

I note that Mr D is no longer involved in the rest home industry.

Recommendations

I recommend that Mrs C:

- apologise to Mr A's and Miss G's families for her breach of Code;
- provide a copy of this report to her current employer, and confirm to this Office that she has done so;
- update her skills in the care of dementia patients, and confirm to this Office that she has done so.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand with a recommendation that it review Mrs C's competence.

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- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

- A copy of this report, identifying only Mrs C and Mr D, will be sent to the Ministry of Health and the District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to Age Concern New Zealand, Alzheimers New Zealand, the National Gerontology Section of the New Zealand Nurses Organisation, and Healthcare Providers New Zealand, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.