Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272

Complaint

The Commissioner received a complaint from the consumer's mother in early July 1997 about the standard of care provided to her daughter, the consumer, while a resident at a mental health acute in-patient service provided by a Crown Health Enterprise, and at a mental health residential service provided by an Iwi Health Authority. During this time the consumer was under a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992. The complaint is that:

- *While under the care and supervision of the psychiatric hospital run by the Crown Health Enterprise, the consumer ran away on one occasion and on another occasion consumed the contents of a large bottle of bourbon.*
- *The consumer was allegedly sexually violated by a mental health worker, the caregiver, at the Iwi Health Authority.*
- *The psychiatric hospital did not inform the consumer's mother when it was first made aware of the allegation of sexual misconduct. In addition, the psychiatric hospital failed to notify the Police and the Children and Young Persons Services (CYPS) immediately. The Police were not notified until five days after the allegation.*
- *If the consumer had been adequately supervised at the psychiatric hospital, the incident would have never occurred. The consumer was not provided with adequate support or counselling after the alleged offence.*
- *The consumer's mother's final concern is with the way the matter was handled by the Iwi Health Authority. In particular, the manager of the facility, the Trust Manager, investigated the matter when she is the mother of the alleged offender (the caregiver).*

On 18 May 2000 the investigation was extended to include the complaint that:

- *When notified of alleged sexual misconduct between the consumer and a staff member at the Iwi Health Authority during February 1997, the consultant psychiatrist at the psychiatric hospital did not take appropriate actions and did not contact appropriate agencies, including the Police and CYPS.*

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272 continued

Investigation Process

The Commissioner received the complaint in early July 1997, and an investigation was commenced on 11 August 1997. Investigations were simultaneously undertaken by the New Zealand Police, the District Inspector for Mental Health, the Iwi Health Authority and the Crown Health Enterprise. The Commissioner obtained information from the following people:

The Consumer's mother	
The Consumer	
The Former Chief Executive Officer	Iwi Health Authority
General Manager,	Mental Health Services, Crown Health Enterprise
District Inspector of Mental Health	
Chief Executive Officer,	Iwi Health Authority
Trust Manager	Iwi Health Authority and also a staff nurse at the psychiatric hospital
Team Leader	Mental Health Services at the Crown Health Enterprise
Manager	Mental Health Services at the Crown Health Enterprise
Constable	New Zealand Police
General Manager,	Mental Health Services at the Crown Health Enterprise
Caregiver	Iwi Health Authority
Chief Executive Officer,	Child Youth and Family Services
Consultant Psychiatrist,	Crown Health Enterprise
Chief Executive Officer,	Crown Health Enterprise

The clinical notes from the consumer's stay at psychiatric hospital were obtained and reviewed by the Commissioner.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272 continued

Background

The consumer was admitted to the public hospital in early November 1996 after she had attempted to commit suicide. After admission, the consumer was made subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992. She was then transferred to the psychiatric hospital, a mental health acute in-patient service provided by the Crown Health Enterprise. At the time of her admission the consumer was 14 years old. Subsequent to her admission in November 1996, the Police made a referral to the care and protection co-ordinator of the Children and Young Persons Service (CYPS). In December 1996 the District Inspector of Mental Health, made a referral to CYPS because of concern about the consumer's future placement and other issues regarding her care and protection. In January 1997 CYPS provided assistance to the consumer, which resulted in a recommendation that she remain under the care of the psychiatric hospital.

Information Gathered During Investigation

Absent Without Leave Incident

In early December 1996 the consumer was resident in the acute ward at the psychiatric hospital where, according to nursing notes, she was to be observed every 15 minutes. The consumer was last seen in the acute ward that day at 11.00am. The staff nurse, discovered the consumer missing at approximately 11.15am and notified the on-duty psychiatrist. The staff nurse then contacted the Police and immediately tried to contact the consumer's mother. Staff at the psychiatric hospital were not able to contact the consumer's mother until later that afternoon, by which time Police had located the consumer and another client who had gone with her. The staff nurse on duty in the afternoon, arranged for transport to collect the consumer and the co-client the following day and for their accommodation overnight at another psychiatric hospital.

The following day, two staff nurses, and a psychiatric assistant, drove to the Hospital to collect the consumer and the other client.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The consumer's mother stated to the Commissioner that her primary concerns in relation to the incident were that the consumer was not adequately supervised and that the consumer's "*rights to responsible care and protection were not upheld*". In addition, the consumer's mother was concerned that the psychiatric hospital only notified her after the consumer had been found, which was almost half a day after they had discovered her missing.

In response to this complaint, the Customer Relations Officer at the Crown Health Enterprise, wrote the following letter to an MP who was enquiring on behalf of the consumer's mother:

> "[The consumer] *was a client in the 'open' ward at the* [psychiatric hospital] *and therefore able to move out of the building and walk in the hospital grounds.* [The consumer's] *file shows that, on the day in question, she was in* [the psychiatric hospital] *at 11.00am. However, at 11.15am after noting* [the consumer's] *absence, Police and the crisis team were advised.*
>
> [The consumer's] *file shows that staff at 11.15am unsuccessfully attempted to contact* [the consumer's] *mother by phone. Contact with* [the consumer's mother] *is logged at 7.30pm on the same day, approximately eight and a half-hours after police and crisis were advised.*"

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Information Gathered During Investigation *continued*

Drinking Incident

In late December 1996 at 9.15pm a staff nurse and an enrolled nurse gave permission for the consumer and other clients at the psychiatric hospital to sit on the hill on the road side opposite the unit with some visitors. The nurses' progress notes state that staff *"periodically checked"* the group. According to the incident report, staff observed the group from the unit. At one stage the staff nurse, who was also Manager of the Iwi Health Authority, visited the group and spent time with them, noticing nothing unusual, and advised the clients to return to the unit in 15 minutes. At 10.20pm the enrolled nurse, went over to request that the clients return to the unit. The nurse sat for a while and walked back with the clients to the unit. The notes completed by the enrolled nurse on her return made the following comments in relation to the consumer:

> "[The consumer] *was noticeably giggly, staggering when walking. I went and checked with staff if anything unusual was up with* [the consumer]*, had she had any visitors that might have supplied her with illicit drugs/alcohol although at this time no alcohol could be smelt. On return to* [the consumer]*, she was in the kitchen, unable to stand on her own,* [the consumer] *was reluctant to come to bedspace, with assistance from* [co-client] *and myself we took* [the consumer] *to bedspace, she thrashed about with arms and legs, wanting to get up, she then settled briefly before beginning to retch, I sat her up, leaned her over the bed, she vomited, smell of alcohol. I sent* [co-client] *to inform staff for some assistance.*"

The notes indicate that the consumer was taken to the intensive care (ICU) seclusion unit and nursed under constant observation. She continued to vomit and smelt strongly of alcohol. The on-call psychiatrist was notified. The resident medical officer was also notified and arrived to examine the consumer at 11.20pm. The notes state that the consumer's mother was informed of the incident that evening and she was "*angry, wants to know who supplied the alcohol*".

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Information Gathered During Investigation *continued*

According to the notes, the three other clients who were on the hill that evening were questioned about the incident and denied having any knowledge about the alcohol. Later that evening, another client approached staff and stated that a visitor had brought the alcohol into the unit. After receiving this information, enrolled nurse proceeded to search the area and found an empty bottle of bourbon.

The consumer was transferred from the acute area into an 'open seclusion' area later that evening where she could be kept under constant observation. Blood glucose tests were conducted.

The incident report completed the following day indicates that the Police were notified about the persons responsible for buying the alcohol and bringing it onto the unit. In this regard, the notes state:

> "[…] *Police notified of the persons responsible for bringing alcohol onto the unit,* […] *Police (Detective) unable to lay charges, but are aware of the incident, will assist with non-trespass order if any further incidents involving same people.*"

The incident report also notes that:

> "*Alcohol policy discussed in client meeting with client. Further education given to* [the consumer] *regularly about the effects of alcohol.*"

The consumer's mother stated to the Commissioner that her main concern in relation to this incident is, once again, that the staff at psychiatric hospital did not adequately supervise the consumer.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The staff nurse's response on behalf of Crown Health Enterprise in relation to this incident is as follows:

> "*The matter of* [the consumer] *gaining access to alcohol was also fully documented and confirms that alcohol was introduced to the unit by another client's visitor. Police were contacted and advised that as there was insufficient evidence, charges could not be laid against the suspected instigator. Subsequently further 'in house' steps were taken to alleviate the possibility of alcohol being introduced by this and other similar sources. I can assure you that subsequent to* [the consumer] *having access to alcohol, she was under constant observation and a full medical check-up was actioned.*"

Alleged Sexual Violation

In early February 1997 a client alleged to nursing staff at the psychiatric hospital that the consumer, who was then 14 years old, told her that she had had sexual intercourse with a worker at the Iwi Health Authority Maori Trust Home.

Iwi Health Authority Maori Trust Home

The Iwi Health Authority provides an adult mental health residential service and, in a separate facility, provides activities and observation to mental health consumers. At the time of the alleged incident, the consumer was still a resident at psychiatric hospital under a compulsory treatment order, but was attending a twice weekly day programme at the Iwi Health Authority. The consumer told the Commissioner that she started attending the Iwi Health Authority when the authority manager, who was also the staff nurse at the psychiatric hospital, told her about the centre. However, the Trust Manager stated in her report in mid February 1997 that the consumer's placement came about as follows:

> "[The consumer] *first came to the attention of the* [the Iwi Health Authority] *through* [Maori Mental Health worker from the psychiatric hospital]. [The Iwi Health Authority] *was viewed as being a future placement for* [the consumer]*, at the* [psychiatric hospital] *was not. CYPS had nothing to offer as she was not a priority, CAF* [Child, Adolescent and their Family Service] *had nothing to offer, Social Welfare had nothing to offer, and* [the consumer] *did not – would not – return to* [hometown].

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

In the meantime a meeting was held at the [psychiatric hospital] *for* [the consumer] *to attend a day activity. Present were* [psychiatric hospital] *staff – a clinical nurse leader and day activity staff leaders, and day activity staff members* […]. *The outcome for* [the consumer] *was to attend day activities twice weekly.*

…

A meeting was set by [the psychiatric hospital] *staff to discuss the outcome of the meeting held between* [psychiatric hospital]*, CYPS, CAF and Social Welfare. The Iwi Health Authority was not asked to attend, but a meeting was held for me to attend with the* [psychiatric hospital] *staff that same day.*

The outcome of this meeting was that all services agreed that [the consumer] *would come to* [Iwi Health Authority]. *This decision I disagreed with and laid the possibility of* [the consumer] *going into a whanau environment.*

I disagreed on:

- [The consumer] *does not suffer from a mental disorder as such;*
- [The consumer*'s*] *age;*
- *The mix of Turoro* [clients] *that we already had in respite;*
- *The whole stigma of mental health.*"

The Chief Executive Officer at the Crown Health Enterprise, stated to the Commissioner that while the Trust Manager raised concerns about admitting the consumer to the Iwi Health Authority for residential care, no concerns were raised about the appropriateness of her placement in the day programme and that the Trust Manager was supportive of this suggestion.

The consumer's placement at the Iwi Health Authority was intended to be part of a day programme. However, the nursing notes indicate that often the consumer stayed for evening meals and the Iwi Health Authority staff telephoned the unit to extend the time she was spending at the service. On some days the nurses at the psychiatric hospital recorded the times that the consumer left and returned to the unit. At other times there is nothing in the nursing notes to show this.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The Chief Executive Officer from the Crown Health Enterprise stated to the Commissioner that from the end of January 1997 a schedule was confirmed which limited the consumer's attendance at the Iwi Health Authority to the hours of 9.00am to 5.00pm. The Chief Executive Officer at the Crown Health Enterprise reported that there was only one exception to this schedule noted, when the consumer returned to the unit at 5.20pm in early February 1997. The Chief Executive Officer stated that the lack of documentation recording the times at which the consumer returned from Iwi Health Authority most likely reflects that no breach of the leave requirements had occurred.

The consumer stated to the Commissioner that she was often late returning to the unit and that she was occasionally out until 10.00pm. The consumer stated that unit staff appeared very "*laid-back and careless*" in their attitude towards enforcing her leave schedule. It also appears that much of the consumer's time at the Iwi Health Authority was spent in an unstructured manner. For example, the consumer stated to Police that:

> "*I used to go into his* [caregiver's] *room to see his little puppy dog. I also used to go into his room to watch his television or listen to his CD player*.
>
> *The* [caregiver] *and I used to spend time in his room together, but at that time there was nothing in it.*
>
> *I also used to go for a ride with the* [caregiver] *in his car if we were going anywhere.*"

In her interview with the Commissioner's staff, the consumer indicated that if she wanted to stay on at the Iwi Health Authority later than the last bus to the psychiatric hospital, the caregiver would often drive her home. The consumer also stated that she often drove his car and that they went to the beach together.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The psychiatric hospital nursing notes indicate some staff had concerns after consumer started attending the Iwi Health Authority. For instance, the nursing notes at end January 1997 state that the consumer returned from leave with a pierced nose stud in place. This was after a day spent at the Iwi Health Authority. Bt the end of January 1997 it is recorded in the nursing notes that:

> "*SB* [seen by] *the Dr. Quite concerned about stud in nose ... MMHW* [Maori mental health worker] *contacted* [Iwi Health Authority] *about concerns nursing staff here have re stud in nose and returning at an inappropriate time from leave.*"

There is no documentation relating to the response the Iwi Health Authority provided when these concerns were raised or any follow up conducted by the psychiatric hospital's staff.

At the end of January 1997 a psychiatric registrar recorded in the doctor's progress notes:

> "*Responding well to* [Iwi Health Authority] – *however has returned with 'love bite' on neck and newly inflicted nose stud. Nurses suspect she is romantically inclined to co-attendee there? Is* [Iwi Health Authority] *able to offer sufficient supervision for a 14 year old?*"

The nursing notes at the end of January 1997 stated:

> "*After discussions with staff it was noted that the leave that* [the consumer] *has taken is not what was agreed to last pm with the doctor. 16.15 hrs* [4.15pm] *PC* [phone call] *to* [Iwi Health Authority] *to confirm that* [the consumer] *was not there and being involved in organised group activities. Given* [phone] *number of staff members from* [Iwi Health Authority] *where* [the consumer] *is.*
>
> *16.30* [4.30pm] *phone call to the doctor confirming his leave orders. As he said he believed that* [the consumer] *was to attend organised official activities with group from* [Iwi Health Authority] *not out for the day with a staff member. I, SN* [staff nurse] *was to ring them and have* [the consumer] *return to unit.*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

16.45 [4.45pm] *phone call to* [an Iwi Health Authority worker] *explaining the situation. His response was 'I thought the* [Health Authority Worker] *had arranged for* [the consumer] *to spend the day with me and my family.' I explained that the doctor was of the understanding that* [the consumer] *was attending official group activities and as this is not the case please return* [the consumer] *to the unit now not at 8pm. His response was 'alright'.*

1730hrs [5.30pm] [the consumer] *returned to unit ....*"

The Chief Executive Officer, from the Crown Health Enterprise stated to the Commissioner that the Crown Health Enterprise relied on the Iwi Health Authority to properly supervise the consumer while she was in their care. The Chief Executive Officer further stated that as the Regional Health Authority purchased services from the Iwi Health Authority, the Crown Health Enterprise was entitled to expect that "*formal activities of good practice were in place*".

The nursing notes during late January 1997 indicate that the Maori mental health worker at the psychiatric hospital, worked hard to liaise between the psychiatric hospital, the Iwi Health Authority and the consumer's mother. The notes indicate that a number of telephone calls were made to try and resolve issues of supervision and the program at the Iwi Health Authority.

Alleged Incident of Sexual Violation

The consumer stated to the Commissioner that she had sexual intercourse with a caregiver at the Iwi Health Authority, on one occasion. In mid February 1997 the consumer made the following statement to police:

"I'm not completely sure but it was either end towards the end January 1997 I went to the [Iwi Health Authority] *at around 9.00am. It was the day the sports were on at the* […] *Pa celebrations.*

Up until this day nothing had changed between the [caregiver] *and I, we were still just friends.*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

On this day we just did the normal things that we did on most other days, nothing out of the ordinary.

All the [Iwi Health Authority] *staff were all there at sometime during the day.* [The caregiver] *was there for most of the day, really it was just an ordinary day, until we went out to* [the Pa].

Everyone from the Centre went out to the […] *Pa Celebrations in the afternoon. Everyone else went out in the van, except the caregiver and I. We travelled out to* […] *in his car.*

Absolutely nothing was happening out there so [the caregiver] *and I decided to come back into town. It would have been about 7.30 – 8.00pm when we came back into town.*

I'd obtained permission that night to stay out late with the centre because of the […] *Pa celebrations. I obtained this permission from the* [a staff nurse]. *I don't know her last name.*

[The caregiver] *and I came back into town on our own. We decided to get some videos to watch. We both decided to do this because there was nothing else to do. We hired two videos from the Video shop on* [……] *Street. We hired 'Masters of Illusion' and 'Barbed Wire'.*

We then went back to [the Iwi Health Authority] *to watch the videos. We got back there around 8.00pm and started watching 'Masters of Illusion' in the lounge. We sat on separate seats to watch the video.*

After about 30 to 45 minutes the video became boring, it was just totally unrealistic.

[The caregiver] *said to me 'Guess what the time is'. I said 'Eight o'clock'. He said 'No it's 8.30'. I said 'Oh what, I'll go and ask if I can stay a bit longer to watch the end of this video'. He said 'If you want to, go on then'.*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272 continued

Information Gathered During Investigation *continued*

I went and used the telephone in the office and rung [the psychiatric hospital]. *I spoke to* [the staff nurse] *again and asked her if I could stay to the end of the video. The staff nurse wanted to know what I was doing. She asked to speak to* [the caregiver], *just to make sure it was alright.* [The caregiver] *spoke to* [the staff nurse] *and told her that we were watching videos and that he'd bring me home about 10.00pm.*

[The caregiver] *and I went back into the lounge and started watching the video again. We sat on the same sofa. It was the closest one to the T.V., it has a blanket over it. The blanket has triangle patterns on it, like 'Indian' patterns. Its not really a mattress, it's just like a mattress on legs.*

After a few minutes [the caregiver] *started tickling my feet. I had bare feet.* [The caregiver] *was lying parallel with me. He was resting on his elbows so that he could see the television over my head.*

After he'd been tickling my feet for a while he started kissing my neck. I then turned around and we began kissing each other on the mouth. By then I had completely layed down and he was lying on top of me.

He then said 'There's a condom in my room, do you want me to go and get it'. I said 'Yep'.

He then got up and went to his bedroom. When he returned he had a condom in his hand. The condom had a white wrapper with blue writing on it.

Before he went into his room to get the condom he'd felt my tits up a bit. But no clothing was removed at this stage.

When he got back, [the caregiver] *took his shorts and underpants off. He then put the condom over his penis. His penis was erect.*

I was wearing a pair of black trousers, underpants, and a lace crop top. I took my trousers and underpants off while he was putting the condom on.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

[*The caregiver*] *layed me down on the same sofa. He then lay on top of me. He spread my legs apart and put his penis in my vagina. It was right inside my vagina. He then started kissing me at the same time. While he was on top of me his penis was going in and out of my vagina. I could feel him going up and down on top of me.*

When he put his penis in my vagina, it wasn't sore, but it wasn't pleasant either.

[The caregiver] *had his penis in my vagina for about three to five minutes. At the end he started going up and down on top of me faster. In the end he was too heavy, so I asked him to get off. He just said 'Oh yeah', I don't know if* [the caregiver] *ejaculated, 'comed'.*

When [the caregiver] *got off me he went away to the toilet. When he got back from the toilet he said to me 'We shouldn't have done this'. But at the same time he had this big smile on his face. I just smiled and said 'I know'.*

While he was away in the toilet I got dressed and fixed up the sofa. I then rewound the videos.

When [the caregiver] *came back from the toilet he grabbed the videos and the dog and we got into his car. He then drove me back to* [psychiatric hospital] *and dropped me off at the back of* [the psychiatric hospital]*, near I.C.U. When he dropped me off, he gave me a kiss. When he gave me a kiss, my nose ring fell out and it's still in his car somewhere.*

On this evening [the caregiver] *was wearing dark blue rugby shorts, purple coloured skivvy and a little black leather vest. The vest has bits of brown in it and little tassles on the side. I think he was wearing boxer shorts under his blue shorts.*

This was the first time I'd had sex with anyone. I haven't had sex with [the caregiver] *again or anyone else since then."*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

In late January 1997 staff documented concerns in the nursing notes that the consumer appeared sullen and her mood was labile (unstable). Her mood improved and in late January 1997 she was noted to be bright, happy and spontaneous. However, during the early part of February 1997 nursing staff recorded that the consumer's mood was again labile, she had expressed suicidal thoughts and she stated that she was depressed. In early February 1997 the consumer went missing from her school, later turning up in the company of the Trust Manager. In the evening the consumer advised nursing staff that she had taken one sleeping pill and six anti-depressants that day. The nursing notes record that the doctor was notified about the attempted overdose and the day's events. The doctor ordered hourly observations and then, if the consumer was stable, two hourly observations throughout the night. The notes record the consumer as *"mobilizing well"* and interacting with co-clients.

The first documentation of the consumer's allegations of sexual intercourse appeared in the notes of the psychiatric hospital on the evening in early February 1997. Nursing notes in early February state that:

> "*At 1915 hours* [7.15pm] [the registered nurse] *was approached by co-client ... it was mentioned that* [the consumer] *had been screwed twice before by a health worker at* [the Iwi Health Authority]*"*.

Later that night it was recorded in the nursing notes that:

> *"PC* [phone call] *received from unit manager regarding above issues. Due to* [the consumer's] *age and the legal ramifications he has requested a full investigation be carried out. On call psychiatrist to be notified and* [the consumer] *to be interviewed at earliest possible time. Sexual abuse team for* [the consumer] *and the unit and to establish the processes involved."*

Entries in the after hours co-ordinator book in early February 1997 stated:

> *"*[The consumer] *– stated to fellow clients that she slept with a client at* [Iwi Health Authority] *& a staff member. Later denied same – the* [Trust Manager] *informed of accusations & S.I.R.* [special incident report] *completed.*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

Re: -[The consumer] *allegations of sexual activity.*
P/C [phone call] *from* [clinical leader]. *He is upset about not being notified. Wants investigations carried out in am. Wants* [the consumer] *&* [co-client] *kept separate until further investigations i.e. medical exam to establish* [whether] *sexual intercourse has taken place. Spoke to O/C* [on-call] *House Surgeon about the medical & legal process. Spoke to sexual abuse team for guidance on legal/medical procedures. Information given to staff to pass on to dayshift. (inc contact person & daystaff).*"

That night at approximately 10.20pm, a staff nurse contacted the Trust Manager to inform her of the allegation made by a co-client and the name of the staff member involved.

It is recorded that the consultant psychiatrist, as the on-call psychiatrist, attended to the consumer at 8.15am in early February 1997. The consultant psychiatrist recorded in the doctor's progress notes that the consumer denied that she had had sexual intercourse with anyone. The consultant psychiatrist made a file note which states:

> "*Patient confessed to nurse that she had intercourse. She consented to intercourse, had sexual intercourse with another person that used to be a patient here. She will not consent to be examined physically and cannot see why an issue is made out of this.*
>
> *My opinion currently, not to go ahead and involve Police or her mother at this stage. This will be reconsidered.*"

The consumer stated to the Commissioner that when approached by nursing staff she was treated as though she had done something wrong and was then taken to see the consultant psychiatrist, who she did not know and who intimidated her. The consumer stated that she felt uncomfortable talking to the consultant psychiatrist and so lied to him. The consumer stated that she would have felt more comfortable talking to a female staff member and that the way she was treated made her feel like "*trash*".

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

A staff nurse recorded that she spoke to the consumer at 1.30pm:

> "*... about procedures that had taken place concerning incident and conversation with* [the consumer]. *She stated that she had had sex with a staff member from* [the Iwi Health Authority] *on the night of the celebrations at* […] *Pa and that her and the staff member concerned had gone out to* […] *but nothing was happening so they went and got some videos and went back to* [the Iwi Health Authority] *to watch them. She also stated that there was no one else there at the time.* [The consumer] *challenged as to why she had denied the incident when talking to* [the consultant psychiatrist]. [The consumer] *stated that she didn't know what the big deal was as she had consented to having sex, legalities of sex with a minor explained which she was already aware of.* [The consumer] *also stated pregnancy was not an issue as she used a condom.*"

According to the nursing notes, the on-call doctor for the Doctors for Sexual Abuse Care (DSAC), was telephoned and she advised that the Police be contacted as the consumer is a minor. The notes further state that the consultant psychiatrist was contacted regarding this recommendation and Consumer's comments to the nurse:

> *"*[The consultant psychiatrist] *contacted again re* [the consumer's] *statement to myself but still doesn't want the Police contacted at this stage and feels the team needs to discuss issues tomorrow."*

> *"*[The consultant psychiatrist] *decided that it should be a team decision to be looked at in am. The Mother informed pregnancy test negative.* [The consumer] *denied any sexual activities yesterday. Unit Manager aware of all progression of the incident".*

The notes state that at 4.30pm the consumer's mother telephoned the psychiatric hospital to enquire as to the situation.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

It appears from the consumer's mother's statement to the Police in early February 1997, and from the Trust Manager's report to the Iwi Health Authority in mid February 1997, that the first person to contact the consumer's mother about the allegation was the `Trust Manager, who telephoned her about 10.00am on 6 February 1997. The consumer's mother stated that the psychiatric hospital had not attempted to contact her regarding the allegations.

The nursing notes in early February also state that the consumer requested to speak to her mother. After that phone call she asked for one-to-one time with a staff member. The nursing notes record:

> *"*[The consumer] *informed staff that she wanted to talk to the Police – ramifications of same discussed with* [the consumer]*."*

It was also recorded by nursing staff that the consumer "*has had numerous phone calls this duty*".

The consumer's mother, in her statement to the Police, recalled a conversation she had with her daughter by telephone over this period. She stated that the consumer told her that the reason she was denying everything that happened was because she was scared that she had done something wrong and did not want to get herself or other people into trouble. She felt that she had let the Trust Manager and other people down. She thought that she was the one in trouble.

A psychiatric hospital staff member rang the consumer's mother at approximately 7.00pm in early February 1997 and informed her that the consumer had alleged that she had sexual intercourse with a Iwi Health Authority worker.

It was recorded in the after hours co-ordinator's notes of 6 February 1997 that:

> *"*[The consumer] *– initially denied claims to* [consultant psychiatrist] *then at 10:30 disclosed to nurse that she had sex with* [an Iwi health authority worker] *on 25/1/97 after returning to* [Iwi health authority] *with him alone – she states she consented & was protected. On call doctor of sexual abuse team notified – advised to contact police.* [The consultant psychiatrist] *decided that it should be a team decision to be looked at in am. Mother informed. Pregnancy test –* [the consumer] *denies any sexual activities yesterday.*
> *The Unit Manager was aware of all progression of the incident."*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The nursing notes in early February 1997 contain details of actions taken by the clinical nurse leader who noted that he received a phone call from the consumer's mother in the morning. The consumer's mother was ringing to find out what decisions had been made and whether the Police had been notified. The clinical nurse leader records that he then discussed the incident with a doctor at the psychiatric hospital, who advised that CAF (Child, Adolescent and their and Family Service) be telephoned for advice. A psychiatrist at CAF, and the consumer's caseworker were not available, so the clinical leader telephoned the consultant psychiatrist. The clinical leader recorded in the notes that he informed the consultant psychiatrist:

> "*... that* [the consumer] *had stated to her nurse,* [Staff Nurse]*, that she did not wish the Police to be contacted. The* [Consultant Psychiatrist] *advises that due to* [the consumer's] *wishes we should not call the Police but as* [the consumer's mother] *is* [the consumer's] *legal guardian she has the right to do this. I notified* [the consumer's] *mother of the above.*"

According to the consumer's mother's statement to the Police, until this point she had presumed that the psychiatric hospital had notified the Police, and that it was the Police who were conducting the investigations she had been told about.

The clinical leader's records state that at 1.45pm the Director of Child, Adolescent and Family Services, telephoned to discuss the matter and that she recommended the involvement of CYPS. However, this recommendation does not appear to have been followed up and CYPS was not contacted.

Clinical notes indicate that the CAF team met on 7 February 1997 to discuss the consumer's "*... discharge from* [psychiatric hospital] *and finding issues*". The "*outcomes*" of this meeting were noted to be:

- "*see case note 7.2.97*
- *D/C* [discharge] *from* [the psychiatric hospital] *may be delayed as placement has broken down*
- *Funding for glade or other agency not available from* [the Crown Health Enterprise] – *unclear whether current RHA contract would allow funding – seems doubtful.*"

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

It is also recorded that the consultant psychiatrist discussed the matter with the Ministry of Health and with Crown Health Enterprise's solicitor, who advised that the decision about informing the Police was one for the consumer's mother. The notes state that the unit manager, advised that staff from the Iwi Health Authority had asked if a meeting could be convened at the psychiatric hospital to discuss the matter.

The after hours co-ordinator's notes of 7 February 1997 stated:

> "[The consumer] – *again has denied the sexual intercourse has occurred with* [the Iwi Health Authority] *workers. The Unit Manager has initiated into ward.*
>
> *9pm: Meeting – update on* [the consumer].
> *Mtg held this evening. Extra staff member to be placed on all shifts until review Monday."*

The consumer's responsible clinician recorded a telephone call she had with the consultant psychiatrist at 2.30pm in early February 1997. The consultant psychiatrist recorded that the consultant psychiatrist had been unable to contact the Crown Health Enterprise's solicitor, or the District Inspector. However, he had consulted the Ministry of Health who:

> "*Advised that the Unit should continue to keep* [the consumer's mother] *informed and that the mother can inform Police if she so wishes, and that the Unit should keep the mother informed at all times and also be supportive of her.*"

The consultant psychiatrist advised the Commissioner that he sought external legal advice from the Crown Health Enterprise's lawyers. The consultant psychiatrist stated that he was advised to take a cautious approach regarding the matter of privacy.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The consultant psychiatrist stated to the Commissioner that he made the decision not to contact Police or CYPS because:

"*I decided that the Police should not be contacted as* [the consumer] *denied the incident and did not appear distressed about the alleged sexual encounter.*

- *That afternoon* [the consumer] *admitted to staff that she had sex with a member of staff of* [the Iwi Health Authority]. *Staff challenged her as to why she had denied the incident when talking to me.* [The consumer] *stated to staff that she did not know what the big deal was as she had consented to having sex. Pregnancy was not an issue as he used a condom.*

- *Staff reported their findings to me. I saw her again that afternoon, this time she did not deny that she had sex. I discussed the need for Police involvement and the likelihood of a vaginal examination by a doctor.*

- [The consumer] *stated that the sexual intercourse was consensual and that she would not consent to having an examination done*.

…

- *She allegedly had sex with the staff member of* [the Iwi Health Authority] *a week before; he used a condom.*

- *She allegedly had sex the previous day with* […] *a 17-year-old at his flat. (*[…] *a fellow male patient was just discharged from the hospital. He lived very close to the hospital grounds.* [The consumer] *could very easily reach him if she wanted to sneak off to him).*

- *I believed the chance that physical evidence in relation to the staff member would be found was minimal.*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *Continued*

- [The consumer's] *safety remained an important factor to consider in this equation. I was not overly concerned for* [the consumer's] *safety. The matter did not seem to distress* [the consumer]. *In view of her diagnosis and the report of her variable mood we had to be cautious. Her doctor (a female) and the child psychiatrist in my opinion should address this sensitive issue. I was concerned* [the consumer's] *mental state could change especially when facing Police investigation.*

- *A further very important factor that needed to be considered in the equation was the issue of privacy: Medical ethics, The Privacy Act and the Company Standards demanded careful consideration of this aspect.*

- *I decided if I had to err it would be on the side of caution."*

Staff at the psychiatric hospital organised a meeting between themselves and the Iwi Health Authority that was to occur at the psychiatric hospital in early February 1997. The consumer was invited to attend the meeting and agreed to do so, but wanted to take a co-client with her as a support person. The meeting eventually occurred without the consumer attending because the other participants considered that the co-client was not an appropriate support person. The caregiver was also invited to attend this meeting.

The Chief Executive Officer of the Crown Health Enterprise stated to the Commissioner that this meeting had been planned prior to the allegations coming to light. The Chief Executive Officer stated that when the allegations came to light it was decided to proceed with the meeting. The Chief Executive Officer stated that the allegations were discussed at this meeting, which ultimately did not include either the consumer or the caregiver, and that the outcome of the meeting was that the consumer was not to attend the Iwi Health Authority Day Services and was not to be placed in the care of the Trust Manager.

The clinical leader recorded in the notes in early February 1997 that:

> "*It has since come to light that during today* [the consumer] *has been phoning the alleged male and threatening to report him if he did not give her $500.*"

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The consumer stated to the Commissioner that she did ask the caregiver for the $500. She stated that she told him that if he gave her the money, she would say that the incident never happened.

Nursing notes record that the consumer continued to have discussions with various staff members about the allegation over the next few days, and continued to express feelings of stress and suicide.

On the evening in early February 1997 it is recorded that the consumer asked a staff member if she could telephone the Trust Manager and apologise to her. The staff member advised the consumer that it was not appropriate.

A decision was made by management at the psychiatric hospital that the consumer would not attend School in early February 1997 nor would she return to the Iwi Health Authority for the time being.

There was a direction from the Unit Manager in early February 1997 that only one staff member was to deal with the consumer on any shift. That night the consumer and a co-client were reported missing from the unit. At the time, the consumer was on 15 minute observations and had last been sighted at 10.45pm but by 11.00pm she was gone. In accordance with internal policy, the Unit Manager, the on-call psychiatrist, the Police and the consumer's mother were notified of the consumer's absence. At 11.40pm both the consumer and the co-client were returned to the unit by the Police. From then on the notes indicate that the consumer was placed under constant observation. She was placed for a time in the Intensive Care Unit because of this incident and seen by another consultant psychiatrist on the morning of early February 1997. The consultant psychiatrist recorded in the doctor's progress notes that in the interview the consumer was not depressed in mood or suicidal. Her assessment was that the consumer was mildly depressed. While the consumer was then taken off constant observations, she was left on fairly frequent monitoring and was only allowed escorted walks off the unit.

In early February 1997 the consumer's mother rang the Police and CYPS and advised them of the allegations.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation ***continued***

Despite being told it was inappropriate, the consumer succeeded in contacting the Trust Manager, the mother of the caregiver, by phone on the evening of mid February 1997. The nurse on duty was concerned about this contact and telephoned the Clinical Manager and consultant psychiatrist who directed that the consumer should be placed under constant observation for one hour and then, if she settled, observations should be reduced to every 15 minutes.

The Clinical Leader issued a direction in early February 1997, which is contained in a new care plan drawn up that day. The direction was that nursing staff were to monitor and ascertain the names of individuals that the consumer wanted to contact by telephone, that phone calls to the Iwi Health Authority be restricted, and that staff were to reinforce with the consumer the problems of contact with the Iwi Health Authority, and the alleged offender, and discourage such contact.

It is also clear from the notes that the Trust Manager had been working as a staff nurse at the psychiatric hospital, but had not been rostered on to the unit since the disclosure of the allegations. Chief Executive Officer at the Crown Health Enterprise stated to the Commissioner that this was by joint agreement between the Trust Manager and psychiatric hospital management.

In early February 1997, a Detective from the Police, and the District Inspector of Mental Health interviewed the consumer. As a result of this interview, the District Inspector conducted an investigation into the procedures adopted by Crown Health Enterprise's Mental Health Services following the consumer's allegation. In her report in early March 1997 to the consultant psychiatrist, the District Inspector concluded that there was a need for a review of the major incident procedure in respect of allegations of sexual assault of or by clients at the psychiatric hospital.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation ***continued***

The District Inspector drew a number of concerns to the consultant psychiatrist's attention, including the decision to notify the Iwi Health Authority of the sexual abuse allegations, the failure to notify the Police and CYPS, multiple interviewing of the consumer by staff and clinicians in relation to the allegations, the failure to follow special incident procedures, the appropriateness of the consumer's referral to the Iwi Health Authority (especially given that one of the workers had a police record for violent offences) and poor documentation of the consumer's visits to the Iwi Health Authority. The District Inspector advised the Commissioner that she did not receive any feedback on her report from Crown Health Enterprise and that her recommendations were not implemented.

Chief Executive Officer of the Crown Health Enterprise stated to the Commissioner that it was incorrect to state that Crown Health Enterprise had not implemented the District Inspector's recommendations. The District Inspector stated that the Incident Reporting Policy in early August 1997 was developed in part as a result of the District Inspector's report. The Chief Executive Officer stated that while the report does not detail external reporting requirements, it establishes the internal reporting and investigation management required. The Chief Executive Officer stated that this policy requires all incidents of a serious nature (including those relating to sexual assault or violation) be reported to the General Manager to ensure appropriate investigation takes place. The Chief Executive Officer further stated that the Crown Health Enterprise was unaware that an Iwi Health Authority worker had a Police record for violent offences and that it was powerless to determine another organisation's employment practices. The Chief Executive Officer stated that if the Crown Health Enterprise had been aware of this fact it may have had an impact on the decision to place a minor in the day services provided by the Iwi Health Authority.

The District Inspector also referred to a previous report by her to Crown Health Enterprise in early May 1995 on a case involving the alleged sexual abuse at the psychiatric hospital of a consumer with intellectual disability. In that report the District Inspector criticised the Crown Health Enterprise's lack of procedures for the mandatory reporting of alleged sexual abuse to the Police and recommended that this be reviewed. The District Inspector stated to the Commissioner that she did not receive any feedback on this report and that, to the best of her knowledge, her recommendations were not implemented.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation ***continued***

The Chief Executive Officer stated to the Commissioner that a Policy for Special Incidents was developed during April 1995 in response to the incident commented on by the District Inspector. This policy does not incorporate mandatory external reporting of alleged sexual abuse.

The Trust Manager, as manager of the Iwi Health Authority, conducted an investigation into this incident and completed a report at the direction of the Chief Executive Officer of the Iwi Health Authority. In her report at mid-February 1997 Trust Manager concluded that the Iwi Health Authority's response to the consumer's allegations was not unethical or unprofessional and did not compromise the consumer's well-being. The consumer's mother stated to the Commissioner that she was concerned that the Trust Manager, as the mother of the alleged offender, did not have the consumer's best interests in mind when conducting this investigation.

The Police Investigation

In early January 1999 the Commissioner received notification that the Police were not going to charge the caregiver in respect of the complaint. The Police advised that:

> *"After carefully reviewing this file, Police are of the opinion that the only applicable charge that could be laid against the suspect in this matter,* [the caregiver]*, is one of having sexual intercourse with a girl 12-16 years. This is a criminal offence against Section 134(1) of the Crimes Act 1961. Unfortunately this particular section of the Crimes Act has a statutory time limit of 12 months from the date of the offence until information is laid before the Court. We are clearly well outside this time frame."*

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Information Gathered During Investigation *continued*

The Police report into this allegation stated:

> *"I am of the view that* [the Crown Health Enterprise] *were remiss in not notifying the Police immediately upon the discovery of these allegations and that had it been reported to Police much earlier, the outcome of this investigation could well have been very different."*

The District Inspector stated to the Commissioner that she assisted Police in conducting their investigation and that this was greatly hindered by the failure of the Crown Health Enterprise to notify Police as soon as the allegations came to light and the repeated interview of the consumer by psychiatric hospital staff, which prevented useful interviewing at a later date.

The Chief Executive Officer of the Crown Health Enterprise stated to the Commissioner that Police were informed of the incident by the consumer's mother in early February 1997, one day after the consumer had confirmed with the psychiatric hospital that the sexual abuse had occurred. The Chief Executive Officer stated that the Police investigation was therefore not unduly hindered by the Crown Health Enterprise.

Caregiver

The Commissioner attempted to contact the caregiver during the course of the investigation. However, the Commissioner only received the following response:

> "*The Police have concluded their investigation, subsequently finding no just cause to continue. Therefore I am of the same opinion.*"

A case conference was organised by the psychiatric hospital staff and held in mid February 1997. At the case conference were the consumer, the consumer's mother, psychiatric hospital staff, CAF staff and a CYPS representative. At this meeting the consumer's mother expressed concerns about the safety of her daughter's continuing care at the psychiatric hospital and a plan for the consumer's future care was developed. Later that same day the consumer was discharged from the psychiatric hospital into the care of her mother.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Code of Health And Disability Services Consumers' Rights

The following Rights from the Code of Health and Disability Services Consumers' Rights are 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.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Relevant Policies

Crown Health Enterprise Mental Health Services – Policy for Incident Reporting

3 RESPONSIBILITY FOR COMPLETING INCIDENT REPORT FORM

*3.1 The person(s) involved in the incident must ensure an **Incident Report Form** is completed. When a staff member is incapacitated and unable to complete the form, the clinical nurse leader, senior nurse on duty or clinical co-ordinator on duty must ensure that the form is completed.*

3.2 When a client is involved in an incident, the person responsible for their care at the time of the incident, must complete the Incident Report Form, as soon as they are certain all people involved in the incident are safe.

3.3 When an unattended client or visitor is involved in an incident, the first staff member who goes to their assistance must complete the Incident Report Form.

4 RESPONSIBILITY OF PERSON REPORTING THE INCIDENT AND/OR SENIOR NURSE ON DUTY

4.1 Notify the Clinical Team Leader, Clinical Nurse Leader and Senior nurse on duty and any other relevant staff on the unit of the incident.

4.2 Notify the Responsible Clinician to determine response to incident, as soon as possible and document their instructions and response to the incident.

4.3 Whenever Maori clients are involved in an incident of any sort, [the Maori Health Service] *must be notified immediately.*

4.4 Complete the relevant Incident Report Form and nursing progress notes within the shift in which the incident occurs.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Relevant Standards ***Continued***

4.5 Place the completed Incident Report Form in the designated area for investigation by the Clinical Team Leader, Unit Clinical Director or Unit Director.

4.6 Send a copy of the form, when injury had occurred, to the Occupational Health and Safety Co-ordinator.

5 RESPONSIBILITY OF CLINICAL NURSE LEADER OR NURSE IN CHARGE

5.1 Ensure severity of incident is identified so that appropriate resources and investigations can be mobilised. (When serious harm has occurred, the Health and Safety Co-ordinator must be notified immediately.)

5.2 Ensure the prescribed procedures and stated time frames of the policy are initiated and maintained, and that staff involved understand their responsibilities.

5.3 Ensure, where applicable, related personnel including the Risk Manager, [the Maori Health Service]*, Infection Control Officer, and Occupational Health and Safety Co-ordinator are notified as soon as practicable. (Appendix B).*

5.4 Where there appears to be an undocumented 'high risk' issue related to a client's behaviour/mental status, ensure a blue 'high risk' form is completed and placed in the front of the client's health record. A blue 'high risk' dot should be placed on the file cover.

5.5 Ensure debriefs and reviews of all incidents and particularly ***serious incidents*** *are facilitated for staff (Appendix C).*

5.6 Ensure, when applicable, Police involvement is initiated.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Relevant Standards *continued*

5.7 Ensure when Turoro Maori (clients), whanau, staff or visitors are directly involved in any incident, the appropriate [the Maori Health Service] *is notified as soon as practicable (Appendix B). N.B. If after hours the on-call* [the Maori Health service] *is to be notified.*

5.8 Ensure when incidents involve the Mental Health Act, the Director of Area Mental Health Services is notified as soon as practicable (Appendix B).

...

5.12 Ensure all incidents are appropriately investigated, findings documented, and recommendations instituted as soon as practicable.

5.13 Ensure, when applicable, reports on findings and recommendations are forwarded to the General Manager, MHS, the Operations Manager and the Clinical Directors. (N.B. This particularly includes incidents involving absconding, assaults, serious injury and other forms of violence)

5.14 Ensure a copy of the completed Incident Report Form plus additional forms and information is retained in the client's file.

5.15 Ensure details of the incident, or stage of investigation, is communicated to 'succeeding' manager or clinical co-ordinator on duty. This will predominantly be the Clinical Team Leader in charge of the unit.

6 RESPONSIBILITIES OF PSYCHIATRIST ON DUTY

6.1 Ensure severity of the incident is identified for level of clinical response.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Relevant Standards *continued*

6.2 Ensure, in consultation with the appropriate clinical team members, (e.g Clinical Team Leader, Clinical Coordinator, Clinical Director, Clinical Nurse Leader) that appropriate resources, particularly inter-departmental resources, are utilised. This may involve issues of transfer, or accessing medical and service personnel to help deal with the incident and people involved in the incident.

6.3 Ensure that instructions for immediate clinical interventions for clients are legibly documented.

...

6.6 Following a sexual assault or alleged sexual assault an examination should be carried out as soon as possible by the appropriate person. Where the client is 17 years of age or under contact the DSAC (Doctors for Sexual Abuse Care) rostered person. Where the client is 18 years or older, the Police Surgeon should be contacted in the first instance.

6.7 Ensure details of the incident, particularly reviews and recommendations regarding client(s) involved in the incident, are communicated to the 'succeeding' psychiatrist on duty. This will predominantly be the psychiatrist in charge of the patient and the unit where the incident occurred.

6.8 All incidents involving patients should be considered for a Clinical Review by the relevant Multi-Professional Team.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Relevant Standards *Continued*

Crown Health Enterprise Mental Health Services - Policy for Standards for Clinical Documentation.

3.5 All health professionals' progress notes should be recorded on the appropriate forms ....

Staff should be mindful of the fact that their records may be read by the patient, their lawyer and others. Progress notes are legal documents which may be used in evidence in a court of law. Therefore, care should be taken with accuracy, style of composition and subjective statements.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: No Breach Crown Health Enterprise

Absent Without Leave Incident

When the consumer disappeared from the acute ward at the psychiatric hospital in early December 1996 she was under 15 minute observation. Police and on-duty staff were notified as soon as the staff nurse discovered that the consumer was missing at the 11.15am check. The fact that the consumer was last seen in the acute ward approximately 15 minutes before she was noted missing, indicates that she was being monitored as directed. I am satisfied that under these circumstances there was little more that the psychiatric hospital could reasonably have done to prevent her from running away.

The consumer was a 14 year-old adolescent who was subject to a compulsory treatment order and considered to be mentally disordered. The consumer's mother, as the legal guardian, was legally entitled to be kept informed if anything untoward happened to the consumer. The nursing progress notes indicate that once the staff nurse noticed that the consumer had gone missing she endeavoured immediately to contact the consumer's mother. However, staff were unable to contact the consumer's mother until later in the afternoon. I am satisfied that the psychiatric hospital took reasonable steps to contact the consumer's mother and notify her of the consumer's disappearance.

Therefore, in relation to this incident, it is my opinion that the Crown Health Enterprise provided services to the consumer with reasonable care and skill and complied with Right 4(1).

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise

Drinking Incident

The consumer was entitled to have health services provided to her with reasonable care and skill. In my opinion the services provided to the consumer on the evening at the end of December 1996 when she was able to gain access to, and consume, a large quantity of alcohol, while under the supervision and care of the psychiatric hospital, did not meet this standard.

The nursing notes record that the consumer and other clients requested permission to sit with visitors on the hill opposite the psychiatric hospital at approximately 9.15pm. During this time staff observed the clients from a distance. At one stage the Trust Manager joined the group, detecting nothing unusual. The clients were allowed to sit on the hill until approximately 10.20pm when the staff nurse asked them to return to the unit. It was then that staff discovered that the consumer was intoxicated.

I am concerned that the consumer was given permission to leave the unit to sit on the hill with co-clients and visitors late at night. At the time, the consumer was only 14 years old, considered to be mentally disordered and subject to a compulsory treatment order. She had previously run away from the unit. Although the records indicate that the clients were observed from a distance, it was late in the evening and it would have been difficult to observe the group closely. While the Trust Manager went to visit them on one occasion, in my opinion the overall supervision of the consumer was inadequate.

In my view, it was foreseeable that something untoward could occur when clients were permitted to socialise with visitors, particularly when this interaction occurred outside the grounds of the unit. The consumer should not have been allowed outside the unit unsupervised, especially late in the evening and in the company of strangers. In my opinion, by not providing the consumer with adequate supervision, staff did not provide services with reasonable care and skill and breached Right 4(1).

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Opinion: Breach – Caregiver

Alleged Sexual Violation

The consumer was entitled to have health services provided to her in accordance with legal and ethical standards. In my opinion the services provided by the caregiver did not meet such standards. I am mindful that the Police did not press charges against the caregiver on the basis that the only applicable charge had a statutory time limit for prosecution of 12 months from the date of the offence, and this was unable to be met. The caregiver chose to provide no information to the Commissioner or respond to the allegation. However, there is sufficient evidence from the consumer and from other sources for me to conclude that, on the balance of probabilities, she and the caregiver did have consensual sexual intercourse.

It is always ethically unacceptable for a health care provider to enter into a sexual relationship with a consumer. The nature of the health care provider / consumer relationship places the consumer in a position of dependence and vulnerability. This is particularly the case where the consumer is a young person with mental health needs.

The caregiver was in a position of responsibility at the Iwi Health Authority as a caregiver. He was entrusted to care for and protect the well-being of the clients he worked with, including the consumer. The consumer was particularly vulnerable at 14 years of age with a history of psychological problems.

Under section 134(1) of the Crimes Act 1961 it is a criminal offence to have sex with a 14 year old.

As a result of the caregiver's behaviour, the consumer's rights, as a minor and an at-risk mental health consumer, were compromised. By engaging in sexual relations with her, whether consensual or not, the caregiver showed a total disregard for his responsibilities as the consumer's caregiver.

In my opinion the caregiver failed to comply with legal and ethical standards and therefore breached Right 4(2).

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion - Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise

In my opinion the Crown Health Enterprise breached Right 4(1) of the Code in relation to the alleged sexual violation. Although this matter occurred at the Iwi Health Authority, in my opinion the Crown Health Enterprise failed to exercise reasonable care and skill both in the circumstances giving rise to the alleged incident and in its response to the allegation.

Circumstances Giving Rise to Incident

The Trust Manager stated that she expressed reservations about the suitability of The Iwi Health Authority for the consumer's circumstances. The Chief Executive Officer of the Crown Health Enterprise stated that the Trust Manager expressed reservations only about the consumer's admission to a residential programme at the Iwi Health Authority. However, there is no evidence that the psychiatric hospital took adequate steps to assess the appropriateness of the consumer's placement at the Iwi Health Authority.

The District Inspector raised a concern that one of the Iwi Health Authority workers (not the caregiver), referred to in the nursing notes, was someone known in the area as having a Police record for violent offences. The Chief Executive Officer at the Crown Health Enterprise advised that the Crown Health Enterprise was unaware of this fact and is powerless to determine another organisation's employment practices. However, the Chief Executive Officer also stated that if the Crown Health Enterprise had been aware that an Iwi Health Authority worker had a Police record for violent offences, this may have had an effect on the decision to place a minor in a day programme run by the Iwi Health Authority.

Ultimately, while the consumer was under a compulsory treatment order and under the care of the psychiatric hospital, it had responsibility for her to ensure that at all times she received care and treatment of an appropriate standard. Accordingly, it had an obligation to ascertain information about the suitability of services provided by the Iwi Health Authority; for example, the specifics of the day programme, the nature of the monitoring and supervision at the Iwi Health Authority, the suitability of the staff employed at the Iwi Health Authority and the ability of the Iwi Health Authority to ensure the safety of an at-risk 14 year-old. There is no evidence to suggest that any of the issues concerning the suitability of a referral to the Iwi Health Authority were examined.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise *continued*

The programme agreed on prior to her attendance at the Iwi Health Authority was that Consumer would attend structured group activities at the facility two days a week. However, it appears that much of the consumer's time at the Iwi Health Authority was spent in an unstructured manner. The consumer was able to come and go at all times of the day and night. It appears that she often stayed at the Iwi Health Authority for evening meals and often telephoned the unit to extend the time she was spending at the Iwi Health Authority. Staff at the psychiatric hospital documented concern about the consumer remaining at the Iwi Health Authority during the evening.

In late January 1997 the nursing notes from the psychiatric hospital raise concern at the consumer returning from Iwi Health Authority late with a nose stud. Later that same day the Doctor documented his concerns about the nose stud and a "*love bite*". He noted staff speculation that the consumer was romantically involved with a co-client at the Iwi Health Authority. In his progress notes the Doctor asked "*Is Iwi Health Authority able to offer sufficient supervision for a 14 year old?*"

The notes also record further concerns about the hours that the consumer was keeping at the Iwi Health Authority. Although the Iwi Health Authority was only intended to provide a day programme to the consumer there was only one occasion, in late January 1997, where follow-up action was taken and a doctor instructed nursing staff to ensure that the consumer did not stay late. The Chief Executive Officer at the Crown Health Enterprise stated that from late January 1997 a schedule was implemented to limit the consumer's attendance at the Iwi Health Authority to the hours of 9am to 5pm. This schedule does not appear to have been enforced. In my opinion, staff at the psychiatric hospital did not adequately monitor the consumer's attendance at the Iwi Health Authority, did not follow up concerns about the hours the consumer was spending there. Even when staff at the psychiatric hospital were on notice that the Iwi Health Authority may not be offering sufficient supervision to the consumer, they took insufficient steps to protect her.

Between early February 1997, well after the alleged sexual incident, and mid February 1997, when the consumer was discharged from the psychiatric hospital, staff at the unit made numerous phone calls to try and resolve the issues of supervision and the programme at the Iwi Health Authority. However, in my opinion this kind of inquiry and intervention should have occurred at a much earlier stage, before the consumer attended the day programme, and staff at the psychiatric hospital should have been actively monitoring the suitability of the consumer's attendance at the Iwi Health Authority on an ongoing basis.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise *continued*

The Chief Executive Officer at the Crown Health Enterprise stated that the Crown Health Enterprise would have expected the Iwi Health Authority to provide adequate supervision to the consumer and that the Regional Health Authority funding and monitoring of the service meant that Crown Health Enterprise expected "*formal activities of good practice*" to be in place. However, the Crown Health Enterprise was responsible for ensuring that the consumer received treatment of an appropriate standard while under its care. I do not accept that monitoring by the Regional Health Authority absolved the Crown Health Enterprise of this responsibility.

In my opinion, by failing to adequately assess the Iwi Health Authority as a suitable facility for the consumer to attend and by failing to monitor and adequately supervise the consumer, the Crown Health Enterprise failed to provide services with reasonable care and skill and therefore breached Right 4(1).

Note-taking and documentation

The nurses' notes made by nurses at the psychiatric hospital relating to the consumer's comings and goings at the Iwi Health Authority are inconsistent. Sometimes they record the times that the consumer left and returned to the unit, but at other times there is no such detail. The Crown Health Enterprise Mental Health Services' policy for standards of clinical documentation in use during December 1996 and January 1997 does not require clinical notes to be comprehensive. The policy simply recommends that care be taken with accuracy, composition and subjective statements on the basis that notes may be read by other parties. It is in the consumer's best interests that clinical notes are accurate and comprehensive. Accurate and comprehensive notes help ensure that providers are able to co-operate so that consumers receive quality and continuity of services and, should enquiries arise at a later date, there is a clear record of what occurred. The Crown Health Enterprise's policy did not ensure that nursing notes were complete and included all relevant information. Therefore, in my opinion the Crown Health Enterprise breached Right 4(5).

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Crown Health Enterprise *continued*

Response by psychiatric hospital to the Allegation

Breach *Failure to notify*

Sexual intercourse with a minor, that is someone under the age of sixteen years, is a criminal offence regardless of whether the sexual intercourse was consensual. The organisation vested with the statutory duty to investigate alleged criminal offences is the Police.

In cases where there is an allegation of sexual violation by a provider, clinicians are often concerned about the effect on clients of involving outside agencies, for example the Police, as such involvement can be unsettling and may be unsafe. I accept that the clinical ramifications of involving other agencies is a factor considered by clinicians. However, the psychiatric hospital appeared to react to this serious situation in an ad hoc manner.

The incident reporting protocol in place at the Crown Health Enterprise required the psychiatrist to immediately notify the Doctors for Sexual Abuse Care (DSAC) once an allegation of sexual abuse involving a person 17 years or younger occurs. The clinical nurse leader was required to initiate Police involvement "*when applicable*".

In my opinion, the Crown Health Enterprise should have had in place a clear policy for dealing with such allegations, that gave specific guidance on the issue of when notification to the Police or other authorities was necessary.

The nursing notes recorded that the on-call doctor for DSAC was telephoned the morning after the psychiatric hospital staff became aware that the consumer may have had sexual intercourse. The on-call doctor advised that the Police should be contacted as the consumer was a minor. The consultant psychiatrist was advised of this, but decided not to do so, until further consideration. While this occurred, the consumer was interviewed and spoken to by many caregivers and ultimately it was decided not to contact the Police.

The District Inspector stated to the Commissioner that she had criticised the lack of mandatory reporting for alleged sexual abuse in a 1995 report to Crown Health Enterprise and recommended that this be reviewed. The District Inspector stated that she received no feedback from the Crown Health Enterprise on the report and, as far as she is aware, her recommendations were not implemented.

Continued on next page

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise *continued*

In my opinion, by failing to have a policy in place that required appropriate notifications and by failing to take the advice of a DSAC doctor, who was contacted in accordance with the protocol in place, the Crown Health Enterprise did not provide services with reasonable care and skill and breached Right 4(1). This is of particular concern given the District Inspector's 1995 recommendation that a policy be developed to deal with reporting of sexual abuse incidents.

I am also concerned that the psychiatric hospital did not inform the consumer's mother, as the consumer's legal guardian, of the allegation as a matter of priority. Rather, the Trust Manager informed the consumer's mother about the incident, after having been notified by the psychiatric hospital staff. The consumer's mother then had to call the psychiatric hospital herself to ascertain whether the allegation had in fact been made. In my view, the psychiatric hospital had an obligation to ensure that the consumer's mother was notified of the allegation, and I am concerned that the mother of the accused was contacted before the consumer's mother. In my opinion this reflects how little thought was given to the consumer's safety and well-being.

Further, I understand that CYPS had been periodically involved in the consumer's case since November 1996. CYPS records indicate that CYPS staff met with the psychiatric hospital to discuss care and protection issues for the consumer in January 1997. However, staff at the psychiatric hospital did not contact CYPS regarding the allegation. While the consumer's mother is the consumer's legal guardian, CYPS is the organisation vested with the statutory duty of ensuring the care and protection of children and adolescents. In my opinion, the psychiatric hospital should have notified CYPS as soon as it became aware of the alleged violation. Eventually, at a case conference involving the psychiatric hospital, CYPS, the consumer and the consumer's mother in mid February 1997, it was decided to remove the consumer from the care of the psychiatric hospital and place her in the care of her mother. In my view, such liaison should have occurred much earlier.

In my opinion, by failing to notify the consumer's mother and CYPS of the alleged sexual violation, the Crown Health Enterprise did not co-operate with other providers to ensure quality and continuity of services and breached Right 4(5) of the Code.

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Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach Crown Health Enterprise *continued*

Failure to support the consumer following sexual allegations

The Crown Health Enterprise had a duty to provide the consumer with services with reasonable care and skill at a time of particular vulnerability and to minimise any potential harm to her. In my opinion the services provided by the psychiatric hospital did not meet this standard.

A great deal is recorded by nursing staff and clinicians, subsequent to the consumer making the allegation, about interviews with her relating to whether she was telling the truth or not. There are also various comments about her fluctuating mental state. It appears that a number of psychiatric and nursing staff interviewed the consumer. However, there was no care plan developed or implemented to identify and meet her needs until the meeting in mid February 1997 where it was decided to discharge the consumer into the care of her mother. No-one appears to have reassured the consumer in relation to the allegation, her role in it and the procedure. The consumer's mother, in her statement to the Police, recalls a conversation she had with her daughter by telephone over this period. She stated that the consumer told her that the reason she was denying everything that happened was because she was scared that she had done something wrong, and did not want to get herself or other people into trouble. She felt that she had let the Trust Manager and other people down. She thought she was the one in trouble and felt intimidated by the consultant psychiatrist. I accept the consumer's explanation. I see no indication in the nursing notes of any support being given to the consumer or any offers of counselling.

The psychiatric hospital had previously arranged a meeting at the Iwi Health Authority and was prepared to include both the consumer and the alleged perpetrator in that meeting, even after the allegations came to light.

In my opinion, by omitting to develop a care plan which identified and met the consumer's needs following the allegation, the psychiatric hospital failed to provide services with reasonable care and skill. The whole procedure following the allegation did not make the consumer's best interests, care and protection the paramount priority and, indeed, had the potential for causing further harm. For these reasons, in my opinion, the Crown Health Enterprise breached Right 4(1) and Right 4(4) of the Code.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach Iwi Health Authority Iwi Health Authority / Iwi Health Authority

The consumer informed the Police that she often went into the alleged offender's room alone with him and accompanied him unescorted in his car. Despite agreeing only to provide the consumer with a day programme, she often spent extra time at the Iwi Health Authority well into the evening. In my opinion, the unstructured nature of activities at the Iwi Health Authority was inappropriate for a young woman of 14 years of age under a compulsory treatment order.

In addition to the lack of structure in the day programme at the Iwi Health Authority, I am concerned at the lack of supervision during the consumer's visits. As a patient in the care of the Iwi Health Authority, the consumer was entitled to be free from any type of sexual harassment, or other exploitation. In my opinion, the sexual violation by a mental health worker would not have occurred if the Iwi Health Authority had adequately and appropriately supervised the consumer.

The Crown Health Enterprise referred the consumer to the Iwi Health Authority with the expectation that the Iwi Health Authority would provide the consumer with a structured programme to complement the services at the psychiatric hospital. The unstructured nature of the day programme at the Iwi Health Authority meant that the consumer had no regular routine and that there was no continuity of services between the two providers. Although the Trust Manager stated that she was reluctant to give her a place at the Iwi Health Authority because of her age, once the consumer had been accepted on the programme the Iwi Health Authority was obliged to provide structured and supervised services, as agreed to, and to ensure the consumer received on-going quality care.

In my opinion, the services that the consumer received at the Iwi Health Authority were not provided with reasonable care and skill and breached Right 4(1) of the Code.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Other Comment: Iwi Health Authority Iwi Health Authority / Iwi Health Authority	After the complaint was made to the Iwi Health Authority, the Trust Manager, as the manager of the facility, was asked to prepare a report in response to the consumer's mother's complaint. In my opinion, this was inappropriate given that the Trust Manager was the mother of the alleged offender. The conflict of interest was too great to ensure that the facility was acting in the consumer's best interests when investigating the matter.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Opinion: Breach – Consultant Psychiatrist

The consultant psychiatrist was the on-call psychiatrist responsible for the immediate management of the consumer's care following the sexual intercourse allegations. The consultant psychiatrist did not develop and implement a plan to identify and meet the consumer's needs during this time, nor did he reassure her or explain to her what the role of the Police would be. The consumer's medical notes record that on several occasions the consultant psychiatrist advised staff not to notify the Police, notwithstanding advice from DSAC.

The consultant psychiatrist advised the Commissioner that he decided not to contact the Police regarding the sexual abuse allegation because:

- The consumer denied the allegation.
- She later confirmed the allegation, but stated that she did not want the Police involved.
- She did not appear distressed.
- She would not consent to a vaginal examination.
- There was likely to be minimal physical evidence.
- He was concerned about her mental state if exposed to a Police investigation.
- She had a right to privacy.

The Chief Executive Officer at the Crown Health Enterprise stated that the consultant psychiatrist acted on the advice of the Ministry of Health in not contacting Police.

I accept that the consultant psychiatrist felt in a genuine quandary about how to proceed on the basis of the conflicting information he had been given. However, in 1995 the then District Inspector had advised the consultant psychiatrist of her concerns regarding the Crown Health Enterprise's lack of major incident procedures in relation to another alleged sexual abuse case and recommended that the procedures to deal with such matters be implemented. Neither the consultant psychiatrist nor the Crown Health Enterprise responded to these recommendations.

In my opinion, at the time of the later sexual abuse allegation, the consultant psychiatrist failed to respond in a timely or decisive manner that took properly into account the consumer's clinical needs and the need to report to the Police. The consultant psychiatrist thereby failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Actions: Crown Health Enterprise

I recommend that the Crown Health Enterprise:

- Apologises in writing to the consumer for its breaches of the Code. The letter is to be sent to the Commissioner who will forward it to the consumer.

- Arranges an external review of its major incident procedures in relation to dealing with allegations of sexual violation of or by consumers, to ensure that all aspects of the policy, including provision of care and support of consumers and reporting protocols are adequate. Such review should include consideration of the reports and recommendations made to the Crown Health Enterprise by the District Inspector during May 1995.

- Develops procedures in relation to the adequate and appropriate supervision of young mental health consumers and the interaction between such consumers and members of the public, to ensure that such contact is controlled and monitored.

- Reviews its policy on note-taking to ensure that all staff are aware that notes must be accurate and comprehensive.

- Develops a protocol to ensure that before any referral is made to another provider, the appropriateness of the service for the individual consumer is considered and documented.

- Reviews the National Mental Health Standards published by the Ministry of Health and ensures that it is complying with these standards.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Actions: Iwi Health Authority Iwi Health Authority

I recommend that the Iwi Health Authority:

- Apologises in writing to the consumer for breaching the Code. The letter is to be sent to the Commissioner who will forward it to the consumer.
- Organises an external review of the adequacy of its protocols for responding to allegations of sexual abuse of or by consumers.
- Reviews the National Mental Health Standards published by the Ministry of Health and ensures that it is complying with these standards.
- Ensures the caregiver is supervised when he is with female consumers.
- Develops a policy in relation to adequate and appropriate supervision of all health and disability consumers in its care.
- Arranges a visit by a Health and Disability Commissioner advocate for education on provider's obligations under the Code of Rights, which all staff (including the caregiver) should attend.

Actions: Caregiver

I recommend that the caregiver:

- Confirms in writing to the Commissioner that he has attended an education session on providers' obligations under the Code of Health and Disability Services Consumers' Rights given by a Health and Disability Services Consumer Advocate.
- Confirms in writing to the Commissioner that he understands, and will comply with, the recommendation that he be supervised whenever he is with a female consumer.

Crown Health Enterprise, Iwi Health Authority, Caregiver, Consultant Psychiatrist

Opinion – Case 97HDC7272, continued

Actions: Consultant Psychiatrist

I recommend that the consultant psychiatrist:

- Apologises in writing to the consumer for breaching the Code. This letter is to be sent to the Commissioner who will forward it to the consumer.

- Involves himself in the review of Crown Health Enterprise's major incident procedures in relation to dealing with allegations of sexual violation of or by clients and ensures he understands his obligations under the reviewed policy.

Other Actions

This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken against the parties involved.

I recommend that six months after the date of my final report, the District Inspector audits the procedures implemented by the Crown Health Enterprise / psychiatric hospital in relation to major incident procedures, supervision of young mental health consumers, note-taking and referrals to other agencies, and reports to the Director of Mental Health and me.

I recommend that six months after the date of final report, the Ministry of Health audits the policies implemented by the Iwi Health Authority in relation to the supervision of consumers and responding to allegations of sexual abuse of or by clients, and reports to the Director of Mental Health and me.

A copy of this opinion, with details identifying the consumer removed, will be sent to the Director of Mental Health, the Director-General of Health, the Medical Council of New Zealand, the District Inspector of Mental Health, the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Commission.