Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC02334)

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Introduction

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

2. The report discusses the care provided to Mr A by Mr B and Te Whatu Ora.

3. Mr A was admitted to an acute inpatient mental health unit at a public hospital. During his time as a patient, he was indecently assaulted by a psychiatric assistant, Mr B. Following his discharge, Mr A reported the incident to Police. Subsequently, Mr B was charged with indecent assault and was convicted and sentenced.

4. Mr A also raised concerns about the lack of support and acknowledgement from Te Whatu Ora following the incident.

5. The following issues were identified for investigation:

- *Whether Mr B maintained appropriate professional boundaries with Mr A in Month1[1] 2021.*
- *Whether Te Whatu Ora|Health New Zealand provided Mr A with an appropriate standard of care in 2021.*

[1] Relevant months are referred to as Months 1–8 to protect privacy.

Background

6. On 18 Month1, Mr A, aged in his twenties at the time of events, was admitted to Te Whatu Ora to undergo a further assessment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) after he was assessed as having a mental disorder.

7. Mr A was discharged on 19 Month1, and on 22 Month1 he disclosed an incident to his key worker. Mr A said that he had been indecently assaulted[2] by a psychiatric assistant while he was an inpatient between 18 and 19 Month1. Further details about the incident are outlined below.

8. Following his discharge on 19 Month1, Mr A received multiple calls from Mr B asking if Mr A wanted to meet. Mr A recorded one of the phone calls, which subsequently was provided to Police. With the support of his key worker, Mr A reported the indecent assault and subsequent contact from Mr B to Police.

9. Te Whatu Ora was notified of the incident through both Mr A's key worker and the Police. Te Whatu Ora told HDC that a full investigation into the allegations was commenced as a result. Te Whatu Ora said that at the time, it concluded that while the allegation of an indecent assault could not be substantiated, it had established that Mr B had accessed Mr A's patient details and contacted Mr A to meet outside of work. Te Whatu Ora confirmed that it did not accept that Mr B's purpose for contacting Mr A was credible and, as a result, Mr B's employment was terminated with immediate effect.

10. Subsequently, Police charged Mr B with indecent assault relating to Mr A.

Te Whatu Ora — follow-up care

11. It is recorded that following Mr A's discharge on 19 Month1, he would be transitioning to community care with the involvement of a psychologist and Mr A's key worker. Mr A had a scheduled appointment with a psychologist on the day after his discharge, and a further appointment with his key worker and another psychiatrist in the following 2–3 weeks.

12. After Mr A disclosed the indecent assault to his key worker on 22 Month1, it was noted that Mr A declined the offer of supportive telephone calls but said that he would contact his key worker if necessary. Mr A had a further appointment with his key worker on 25 Month1, and it was noted that he had upcoming appointments with a psychologist, his key worker, a psychiatry registrar, and a community-based organisation that aims to eliminate harmful sexual behaviour. Mr A was told to contact his key worker for support if required.

13. Mr A met with his key worker on 1 and 3 Month2. The clinical records note that Mr A said that he was doing well and felt that he had enough support from friends, family, and the Mental Health Service (MHS). It was recorded that Mr A would continue with his current key worker in addition to his psychology support.

[2] 'Indecent assault' is defined as 'the doing on the person of an indecent act that, without the person's consent, would be an indecent assault of the person', and can include unwanted sexual touching or exposure.

14. On 9 Month2, Mr A had a one-on-one session with his key worker. It was noted that Mr A wanted to be discharged back to the care of his GP and that he would be comfortable contacting MHS if required. As he knew the Community MHS team, Mr A said that he could make direct contact with his key worker over the next six months. Mr A reported that he if needed further support, he could contact his key worker.

15. Following a multidisciplinary team (MDT) meeting, it was agreed that community support would be continued as opposed to discharging Mr A, given the concerns about the fluctuations in his mental state and the recent indecent assault. It was agreed that Mr A would continue with fortnightly sessions with his key worker. At an appointment with his key worker on 25 Month2, Mr A was noted to be accepting of further MHS support, and another appointment was scheduled with the psychologist on 3 Month3.

16. Mr A remained engaged with his key worker and psychologist in Month3 and Month4. On 29 Month3, there is an entry discussing Mr A wanting to know whether he would hear from Te Whatu Ora regarding the incident, but he was told that this was unlikely as Te Whatu Ora might not yet have been made aware of the incident, and it would be best to speak to the Police officer looking after the case. It was noted that Mr A was accepting of ongoing MHS support at that time.

17. Mr A continued his engagement with his key worker and psychologist in Month5, and he continued to accept ongoing MHS support. On 16 Month6, Mr A was discharged back to his GP, and it was documented in his clinical record that Mr A felt ready for this. His final session with the psychologist was set for 23 Month6, and Mr A was told that he could self-refer back to the community team over the next 6–12 months if required. Mr A re-engaged with his key worker on 22 Month6 due to his mental state, and he attended the appointment with his psychologist the following day. It was documented that Mr A would be discharged from MHS, but that he would continue his appointments with his psychologist.

18. Mr A had further sessions with his psychologist in Month7, and he was discharged from the service on 4 Month8. It was noted that while Mr A's family wanted him to remain engaged with the service, he wanted to be discharged.

Outcome of Court proceedings

19. Mr B pleaded guilty to the charge of indecent assault relating to Mr A and was sentenced to 18 months of intensive supervision.

Te Whatu Ora response

20. Te Whatu Ora told HDC that Mr A was provided with support and follow-up care following the incident, and it was unaware that Mr A was expecting further acknowledgement regarding the incident other than that provided by his key worker. Mr A attended regular sessions with a clinical psychologist until Month8, when Mr A decided that he wanted to be discharged from MHS. Te Whatu Ora stated that Mr A was told how to contact MHS should he need to, along with a re-referral plan that involved Mr A contacting the crisis team if required.

Mr A's response

21. Mr A told HDC that as he was already working with both his key worker and a psychologist for a period of time before the incident, it appears that the response from Te Whatu Ora was to ignore the issue and return to a 'business as usual' setting regarding his treatment, with an expectation that the support he was receiving for mental health struggles prior to the incident would be sufficient. Mr A's position is that responsibility should not be on the victim to reach out to the organisation responsible in order to receive additional help, and it should be offered actively.

22. Mr A said that when he asked for a response from Te Whatu Ora, he was told that the matter could not be discussed with him as it was an active Police matter. His expectation following that communication was that once the Police matter had concluded, the issue of acknowledgement would be re-addressed, but that did not happen.

23. Mr A further stated that he first left his key worker after explaining to her that although he did not hold her personally responsible for the events that unfolded at Te Whatu Ora, it was difficult to communicate with her effectively because she was the one who had signed off on the order to have him admitted under the Act, and he was no longer receiving benefit from the appointments.

24. Mr A continued to see his psychologist, but told HDC that by this time, his mental health had declined significantly, and he had pulled away. The 'others' who wanted him to continue to access mental health services were his friends and family, and not anybody associated with Te Whatu Ora. He maintains that the response from Te Whatu Ora seems to indicate that an effort was made, or encouragement offered, by Te Whatu Ora employees to keep him in the services, when that was not the case.

25. Finally, Mr A said that while contact information and a re-referral plan was put in place, it did not work. Mr A told HDC that later in Month8, after significant deterioration due to the COVID-19 lockdowns, he contacted his key worker and was advised to speak to his GP, and, following this, he did not contact MHS again. After six months, the re-referral plan expired.

26. In response to this concern, Te Whatu Ora told HDC that Mr A spoke to his psychologist via telephone on 4 Month8, and it was noted that he was coping day to day with his partner and friend's support. While he recognised that others wanted him to continue with the service, he did not want to. It was recorded that Mr A was not 'actively suicidal' at this time, and was not wanting to self-harm, but that it was an effort to maintain his weight and food intake. It was documented that a re-referral plan was in place, which involved Mr A contacting the crisis team for re-referral as required, and that Mr A was discharged. There was no further contact between Te Whatu Ora and Mr A, and no apology or meeting was offered to Mr A.

Response to provisional opinion

Mr A

27. Mr A was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion and did not have any further comments to make.

Mr B

28. Mr B was provided with an opportunity to comment on the provisional opinion. Mr B told HDC that he both respects and accepts the Deputy Commissioner's findings.

29. Mr B formally apologised to Mr A for the pain that he has caused him and his whānau and told HDC that he is incredibly sorry for what he did to Mr A and for the mamae/hurt caused. Mr B wished Mr A all best for the future and stated that he hopes that one day Mr A will be able to forgive him.

Te Whatu Ora

30. Te Whatu Ora was provided with an opportunity to comment on the full provisional opinion and had no additional comments to make. Te Whatu Ora stated that it is in the process of developing a policy that outlines the appropriate support to be made available outside its services, for any patient who is the victim of a staff assault or similar.

Opinion: Mr B — breach

31. First, I acknowledge the significant distress that these events have caused Mr A.

32. I have undertaken a thorough assessment of the information gathered in light of Mr A's concerns, and I consider that Mr B breached Right 2 and Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). The reasons for my decision are set out below.

Incident at inpatient unit

33. Mr B commenced employment with Te Whatu Ora as a rehabilitation assistant. He was employed as a healthcare assistant on a casual basis at Te Whatu Ora. He was later employed as a psychiatric assistant, and remained in that role until his employment with Te Whatu Ora was terminated following the investigation into Mr A's allegations.

34. Mr B's role as a psychiatric assistant involved providing care and support to consumers who accessed the Acute Mental Health Service, under the supervision of a registered nurse. The role included performing close observations.

35. Mr A was admitted to the inpatient unit on 18 Month1 due to concerns over his mental health, and he was placed under observation. Mr B was responsible for observing Mr A throughout the night of 18–19 Month1. It is accepted that during this time, Mr B approached Mr A and assaulted him indecently.

36. As this Office has stated previously,[3] an inherent power imbalance exists between a consumer and a healthcare provider. This arises from the nature of the relationship, and is more pronounced in contexts such as this, where the provider is privy to intimate details about a health consumer's life and their mental health. Trust is fundamental to the relationship, in ensuring that the consumer is assured that the provider is acting with the consumer's best interests in mind. It is critical that relationships between health

[3] Opinion 21HDC00086.

professionals and their clients stay within the professional realm, to avoid any exploitation or abuse of power.

37. I consider Mr B's actions to have been a gross abuse of power, given the power imbalance that is inherent in the relationship between consumer and provider, particularly in the context of mental health. Mr A should have been in a place of safety. Mr B would have been well aware that Mr A was in a vulnerable state, and Mr B took advantage of this, thereby exploiting Mr A's position at a time when he was at his most vulnerable.

Contact following incident

38. Mr B accessed Mr A's personal records at Te Whatu Ora to obtain his telephone number and, following Mr A's discharge, Mr B contacted Mr A by phone on four occasions on 20 and 21 Month1. On 20 Month1, Mr B spoke with Mr A to arrange to meet at Mr A's address. Mr A recorded the call and provided this to Police.

39. At the time of the events, Te Whatu Ora's Code of Conduct stipulated that staff must ensure that personal and confidential information is used only for the purpose for which it was intended. In addition, it stated that staff are to ensure that professional boundaries are kept in dealing with patients, including appropriate distance from personal affairs of the patient.

40. I consider that Mr B's action in accessing Mr A's personal records was unprofessional, unethical, and a breach of Te Whatu Ora's Code of Conduct. Mr B's attempts to use that information to contact Mr A to meet up were inappropriate, concerning, and a clear breach of professional and ethical boundaries, especially given the incident that had occurred earlier. As Mr A had been discharged, there was no justification for Mr B to contact Mr A, and I consider that this was a further example of the gross breach of trust that had already been demonstrated by Mr B as a healthcare provider.

Conclusion

41. Mr A was a vulnerable consumer, and he should have been in a place of safety. Mr B's actions towards Mr A were a gross breach of trust and took advantage of Mr A's situation. Despite Mr B not being a member of any professional association or affiliation, and therefore not subject to any explicit professional standards, he is nonetheless bound by the Code.

42. As pointed out by the Human Rights Review Tribunal:[4]

> 'The obligations of the Code apply to those who provide health services, whether or not they belong to any professional association or similar body, and whether or not they are aware of the standards set out in the Code.'

43. I find that in indecently assaulting Mr A during his inpatient admission, Mr B sexually exploited Mr A and breached Right 2 of the Code.[5] I also consider that by indecently

[4] Opinion 12HDC01011.

[5] Right 2(1) states: 'Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.'

assaulting Mr A and using his personal information to attempt to meet with him after he had been discharged from the inpatient mental health unit, Mr B failed to adhere to legal[6] and other relevant code of conduct standards,[7] in breach of Right 4(2)[8] of the Code.

Opinion: Te Whatu Ora — adverse comment

44. Mr A was discharged from the inpatient unit on 19 Month1. Subsequently, he disclosed to his key worker that an indecent assault had taken place by a staff member while he was an in-patient, and Police were advised. Te Whatu Ora was then notified of the incident by Police. Te Whatu Ora was able to establish quickly that Mr B had accessed contact details and communicated with Mr A inappropriately, and Mr B's employment was terminated on 29 Month1.

45. Following Mr A's discharge from the inpatient unit, he was transitioned into community mental health care under the oversight of the same key worker and psychologist until his discharge from community care in Month8. A re-referral plan was in place, but this expired after six months, and Mr A had no further contact with Te Whatu Ora.

46. I consider that Te Whatu Ora could have gone further in its care of Mr A following the disclosure of the incident, and I set out my views below.

47. Te Whatu Ora was made aware of the allegations by Police, and immediately commenced an internal investigation. I consider that at this point, Te Whatu Ora had an opportunity (irrespective of the ongoing nature of the investigation into the indecent assault) to consider apologising to Mr A for the actions of Mr B. Given the seriousness of the allegations and Mr A's vulnerability, it was unhelpful for Te Whatu Ora to assume that Mr A would use usual supports for his existing mental health issues to deal with this additional trauma. Te Whatu Ora should have considered treating Mr A as it would for anyone else who experienced such an event. For example, it would have been reasonable for the service to offer to pay for external counselling of Mr A's choice (up to a reasonable number of sessions) whenever he felt ready to access this. Instead, it appears that there was a 'business as usual' approach to Mr A's care, which failed to acknowledge that he had been subject to an indecent assault while he was an in-patient of the very service that was supposed to be supporting him.

48. There was a further opportunity to take action when Mr B was convicted and sentenced. Te Whatu Ora could have met with Mr A to apologise for Mr B's actions, provide acknowledgement of the harm caused, and offer appropriate support for Mr A if and when he wanted to access it.

49. I am concerned that throughout the time following the incident, Mr A was treated as any other mental health client who was engaged with the community mental health service. No additional, specific consideration was given to what occurred when Mr A was an in-patient,

[6] By virtue of being convicted of indecent assault under the Crimes Act 1961.
[7] By virtue of his actions contravening Te Whatu Ora's Code of Conduct.
[8] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

and I am critical that, to date, there has been no acknowledgement of the harm caused or an apology provided to Mr A by Te Whatu Ora.

Recommendations

50. I have not made any recommendations in respect of Mr B, noting the actions that were taken by the justice system in response to this case. Given the seriousness of Mr B's breaches of the Code, I considered making a referral to the Director of Proceedings to consider further legal remedies. However, I have respected the expressed request from Mr A not to proceed with this action, and I acknowledge the distress these events have caused already.

51. In response to the provisional recommendations, Te Whatu Ora provided a formal written apology to Mr A for his experience while he was in Te Whatu Ora's care, and for the criticisms in care outlined in this report. In addition, I recommend that Te Whatu Ora develop a policy that outlines appropriate support to be made available outside of the service itself for any patient who is a victim of staff assault or similar. A copy of the policy is to be sent to HDC within six months of the date of this report.

Follow-up actions

52. A copy of this report with details identifying the parties removed will be sent to the Director of Mental Health and Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.