

Inappropriate relationship between mental health patient and nurse 20HDC01025, 10 February 2022

This case relates to a claim made by a woman in her twenties who had a complex mental health history, that a much older psychiatric nurse, employed by a DHB, breached professional boundaries by having an inappropriate relationship with her.

Both the woman and the nurse agreed on several matters, including that they communicated privately outside the work environment, and that he took her out in his car five to six times. On one occasion he picked her up at a shop and drove her home and, although he was aware of her suicidal ideation, he took no steps to arrange help for her.

They also agreed that when the woman stayed at a motel for two nights, the nurse drove her to the motel, bought food for her, and visited her at the motel each day. They agreed that the nurse gave the woman money, gave or loaned her a camera, and ordered and paid for red high-heeled shoes for her.

The nurse denied that he had a sexual relationship with the woman or that he ever touched her. He alleged that the woman blackmailed him into meeting her by threatening to make allegations of sexual assault if he did not comply. He also stated that he is physically incapable of performing sexually and used this as a basis to claim that they did not have a sexual relationship. In spite of being allegedly blackmailed for something he is unable to do, he at no time reported this threat to his DHB managers or recorded it in the clinical records. He said that was because he was on leave at this time and he was embarrassed by the situation.

Findings

The Deputy Commissioner found that the nurse failed to comply with professional and ethical standards and, accordingly, breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). His conduct was considered exploitative and, accordingly, a breach of Right 2 of the Code.

The Deputy Commissioner found that the DHB did not breach the Code.

Recommendations

The Deputy Commissioner recommended that the nurse provide a written apology to the woman.

The Deputy Commissioner recommended that the DHB report to HDC on the implementation of its system for clinical supervision, including an audit of staff compliance with the system, and conduct an audit of mental health staff to confirm that the expected staff appraisals have been completed.

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