# Social Worker, Ms B
# District Health Board

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 19HDC01069)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report concerns the care provided to a man by a social worker, and highlights the importance of maintaining professional boundaries and utilising supervisor support and guidance.

2. In August 2018, the social worker was contracted through the district health board (the DHB) to assist the man to find a home suitable for his needs. Between the period of August 2018 and February 2019, the social worker had a high level of contact with the man, helping him with daily tasks such as food shopping, and would also visit him outside of work hours. It was found that her relationship with the man had moved beyond that of a professional one. The social worker did not seek her supervisor's guidance on how to manage the situation, and did not request that the man be re-assigned to another social worker.

3. The DHB was concerned that as the man was considered to be a vulnerable adult, creating dependence could be damaging to him.

### Findings

4. The Deputy Commissioner found that the social worker failed to adhere to the Social Workers Registration Board Code of Conduct and Core Competence Standards by failing to maintain professional and ethical boundaries with the man when she was his social worker from August 2018 until February 2019. The social worker further failed to keep accurate records during this time. As a result, the Deputy Commissioner found the social worker in breach of Right 4(2) of the Code.

5. The Deputy Commissioner was satisfied that the DHB had procedures in place at the time of these events that, if followed, would have guided the social worker to adhere to the Social Workers Registration Board Code of Conduct and Core Competence Standards when providing care to the man. Accordingly, the Deputy Commissioner did not find the DHB in breach of the Code.

### Recommendations

6. The Deputy Commissioner recommended that the social worker establish a six-month mentoring and continuing education plan with the Social Workers Registration Board, in relation to the Code of Ethics and with an emphasis on professional boundaries. He also recommended that the Social Workers Registration Board consider whether a review of her conduct is warranted, and report back to HDC on the outcome of its consideration.

## Complaint and investigation

7. The Social Workers Registration Board referred a complaint to the Health and Disability Commissioner (HDC) regarding the services provided by a social worker, Ms B. The following issues were identified for investigation:

- *Whether the DHB provided Mr A with an appropriate standard of care in 2018 and 2019.*
- *Whether Ms B provided Mr A with an appropriate standard of care in 2018 and 2019.*

8. This report is the opinion of Deputy Health and Disability Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

9. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms B | Social worker/provider |
| District Health Board | Provider |

10. Further information was received from a residential rehabilitation service.

## Information gathered during investigation

### Background

11. At the time of events, Mr A was a vulnerable 45-year-old man with a history of criminal offences and gang affiliation. He suffered from post-traumatic stress disorder, and had also had addiction problems with prescription medication in the past.

12. Mr A was living in accommodation with stairs. However, surgery on his leg was booked for 20 August 2018, and he required a different living situation. Mr A asked to see a social worker to assist him to find new accommodation. Despite being unable to mobilise up stairs, Mr A was otherwise independent.

13. On 17 July 2018, the DHB received the referral for social worker assistance to help Mr A to find a home suitable for his needs. The referral was assigned to registered social worker Ms B, an employee of the DHB's community service.

14. This report concerns the care provided to Mr A by Ms B during the period August 2018 to February 2019.

### Care provided to Mr A

15. Ms B first began providing social work care to Mr A on 14 August 2018. Mr A's surgery was undertaken on 20 August 2018 and he was formally discharged back to his accommodation on 4 September 2018. Ms B organised for Mr A to move into a residential rehabilitation

service[1] temporarily so that he could recover from his surgery whilst looking for a more suitable place to live. Mr A was admitted on 18 September 2018.

16. During the period that Ms B was Mr A's social worker, she had a high level of contact with him, both at his own accommodation and the residential service, and supported him with housing, pharmacy visits, medical visits, and WINZ[2] visits. She also took Mr A clothes shopping, bought him groceries, helped him to open a bank account, and gave him emotional support when he was feeling down. Mr A felt comfortable enough to disclose sensitive information about his past to Ms B. She also did things that she had never done for another client, such as visit him outside of work hours, and on multiple occasions she used his ATM card. Ms B clarified that she did not have Mr A's pin number, and used the pay wave function on his ATM card to buy groceries at his request. The DHB stated that holding onto a client's money card, even with the client's consent, is not appropriate behaviour of a social worker, particularly as Mr A was capable of handling his own finances.

17. The Acting Service Leader of the residential service reported that whenever Mr A was on the telephone, it was always to Ms B, and noted that she was "highly invested" in his case. Ms B admitted that she did have a vested interest in this case, as she did not want Mr A's disruptive behaviour to jeopardise her relationship with the residential service, so that she could place other clients there in the future. She stated: "I did go above and beyond my role …"

18. On 16 February 2019 (a Saturday) at approximately 9pm, a residential service nurse found Mr A's misplaced unit key outside on the street. The nurse went to Mr A's room to return the key and, finding it locked, unlocked the unit door with the key. When she entered, she found Ms B sitting in the corner of the room while Mr A was in the bathroom. The DHB stated that Ms B had not obtained permission to work outside of her normal hours, and had not followed the DHB's guidelines[3] by visiting at this time. Ms B did not sign in to the residential service on this day, and she did not document the visit in Mr A's social work notes or disclose it to her supervisors.

19. Ms B told HDC that she was visiting Mr A outside of hours only to drop off his ATM card. She said that it was meant to be a quick visit, but when she arrived she found that his television was not working, so she attempted to fix it. She stated that she "panicked" about what the situation might have looked like to the nurse who came in, which is why she did not document the visit.

20. Later that evening, Mr A asked to speak to the nurse on duty in the nurses' clinic. He confided that he had been seeing his social worker, Ms B, for the last few months. He said

[1] Where the patient lives on site to focus on his or her rehabilitation goals before returning to community living.
[2] Work and Income New Zealand.
[3] The DHB guidelines include keeping safe, sign-in and sign-out procedures, and the appropriate timing of visits made to clients. The DHB told HDC that Ms B was actively involved in developing these guidelines and was aware of them.

that she wanted a relationship with him, but that he did not want this. He stated: "I thought it was just sex she's telling me she wants to leave her husband and move in with me but I don't want that." Mr A then told the nurse that he was going to stay with a relative for a few days so that Ms B would not know where he was.

21. The DHB was contacted about Mr A's allegation on 18 February 2018, and it commenced an internal investigation into the allegation the same day.

**DHB investigation**

22. During the investigation, it was found that Ms B was very invested in Mr A's case, and would visit or contact him at least once and occasionally twice per working day. It was also found that Ms B had deleted all of her text messages with Mr A from her work phone. The DHB stated that Ms B had contact with Mr A that would be higher than expected for a client such as Mr A, and that by doing this she had set up expectations in Mr A of a social work service that would not be deliverable by others. Further, the DHB said that Mr A was considered to be a vulnerable adult and, as such, creating dependence could be damaging to him.

23. Mr A was interviewed by the DHB as a part of the investigation. He recanted his statement about a sexual relationship with Ms B, and told the DHB that he had lied about this and did not mean to do so. However, when asked about his relationship with Ms B, he stated: "We got really close. I told her things about my past."

24. Ms B strenuously denied having a romantic relationship with Mr A, but admitted that they had become close. She said that she realised that a professional boundary had been crossed as early as September 2018, and that her friendship with Mr A was affecting her workload. In her interview with the DHB, she stated: "I knew what I'd done [was] wrong … I knew that I'd spent a crazy amount of hours [looking after Mr A]."

25. Ms B also admitted that she had never visited other clients outside of working hours and had never used another client's ATM card. She stated that she would talk to Mr A every day on the telephone, including late at night and on the weekends. Not all of these telephone calls were documented in Mr A's social work notes. Ms B told the DHB that she was trying to build up trust with him, as he had not had this with other professionals, and that she gave him extra time to support him and provide a listening ear.

26. Ms B told HDC that her supervisor was "fully aware" right up until the end of December of her comings and goings and how long she was spending with Mr A. However, the DHB stated that Ms B did not raise any concerns or awareness that boundaries were becoming increasingly blurred between her and Mr A. Ms B told HDC that she was "fully aware" of her ethical responsibilities, but when asked by the DHB why she did not seek her supervisor's assistance or advice on the boundary blur, she stated that she knew this was expected of her, and does not know why she did not do so.

27. Ms B explained that she deleted her text messages with Mr A only to save power on her telephone, and said that she does this with all of her client communication. She told HDC

that the DHB did not specify the fact that text messages are not allowed to be deleted. She stated that she did not sign in to the residential service as she was not aware that she needed to. When asked what stopped her from telling her supervisor of the visit, she stated: "[Because I] knew I was doing wrong, had done wrong."

28. Ms B told the DHB:

> "This was a Māori male who has a lot of trust issues with other females in particular. He knew he was not liked at [the residential service] in particular by [the manager] who wanted him out of the facility and as a Māori social worker we had a connection … interactions between Māori often are seen as more intimate than with Pākehā relations."

29. The DHB's investigation report stated:

> "We consider [Ms B's] relationship with [Mr A] as having moved beyond a Professional social work relationship to one more close, akin to that of friendship … [Ms B] had opportunity to seek assistance or advice on how best to deal with the relationship between herself and [Mr A]. [Ms B] also had the opportunity to request that [Mr A] be re-assigned to another social worker through the usual escalation process. [Ms B] did not utilise these opportunities."

30. At the end of the investigation, the DHB concluded that although the claim of a sexual relationship with Mr A could not be substantiated, Ms B's behaviour was still in breach of the Social Workers Registration Board Code of Conduct and Core Competence Standards. It was recommended that the DHB invoke the Discipline and Dismissal policy, but Ms B resigned before a formal disciplinary decision was made.

**Further information**

*DHB*

31. The DHB told HDC that Ms B was oriented to its policies and procedures when she commenced employment in 2009, and that discussion of the Code of Ethics and the Social Workers Registration Board Code of Conduct are a part of a social worker's orientation package at the DHB. It also highlighted that it is a social worker's responsibility to ensure that he or she adheres to the guidelines set out by the New Zealand Social Workers Registration Board.

32. The DHB stated:

> "We believe that [the] DHB has taken all practicable and reasonable steps to ensure that [Ms B] was aware of [the] DHB's policies and processes, that she was aware of her professional obligations in terms of ethical behaviour and boundaries as a registered social worker, and [Ms B] was provided with an open and safe environment for her to discuss, reflect or seek support from the Social Work Practice Supervisor in regards to, but not limited to, [Mr A's] case."

33. The DHB said that in response to this complaint it initiated the following changes to its community service:

a) It is in the process of implementing centralised scheduling of all social work appointments, so that all new and follow-up appointments will be booked by the administration team rather than the individual social worker. This will allow the DHB to have greater visibility of a social worker's workload and whereabouts.

b) When the Social Work Practice Supervisor is providing caseload oversight in one-on-one sessions, the supervisor now asks the social worker to talk through all open clinical cases and review all of the associated documentation.

c) It is investigating the implementation of an automated report that flags the need for a formal case review by a supervisor. A case will be flagged if it has been open for more than six weeks or there have been an above average number of visits to a client.

d) All community service staff members have been reminded that they need to sign in to any residential or day facility they visit, and it has been reinforced that they are not to handle their client's cash or cash alternatives (such as ATM cards, gift cards, and PIN numbers).

*Ms B*

34. Ms B told HDC that this experience will make her more conscientious and aware of keeping herself safe in her working practice in the future. She stated:

> "I have done a lot of learning from this and how important it is to utilise supervision and your colleagues to discuss issues and to go with your gut feeling, as I should have referred [Mr A] onto another colleague to follow up with and not listen to what the client was expressing."

**Responses to provisional opinion**

35. Mr A told HDC that he did not wish to be involved in this investigation.

36. Ms B was provided with an opportunity to respond to the relevant sections of the provisional opinion, and her comments have been incorporated where relevant.

37. The DHB was provided with an opportunity to respond to the provisional opinion, and advised that it had no comments to make.

## Relevant standards

38. The Social Workers Registration Board has a Code of Conduct that sets out the minimum professional standards of integrity and conduct that apply to registered social workers and to the social work profession in general. The Code stipulates:

"**Principle 1: Act with integrity and honesty**

You are expected to:

1.1 act honestly and ethically in all personal and professional behaviour
1.2 comply with all legal, professional, and ethical obligations and any other relevant standards, including those in the Social Workers Registration Act 2003
1.3 be responsible for your own actions and decisions
1.4 be reliable, dependable, and trustworthy
1.5 communicate in an appropriate, open, accurate, and straightforward way

…

**Principle 5: Protect the rights and promote the interests of clients**

You are expected to:

…

5.4 recognise and use responsibly the power that comes from any social work role, keeping the dignity of the client front of mind

…

5.8 maintain personal and professional boundaries and not form inappropriate relationships with clients or those close to them

…

5.13 end the relationship with the client if it is clear a continued relationship would not benefit them and provide for alternative professional help if necessary.

…

Boundaries — The overwhelming majority of social workers maintain clear and professional boundaries with clients. However, like all professionals, you need to be vigilant in your efforts to avoid inappropriate dual relationships. Within the professional relationship there is almost always an imbalance of power due to your authority, specialised knowledge, ability to access privileged information, and influence as a social worker …

**Principle 10: Keep accurate records and use technology effectively and safely**

You are expected to:

10.1 keep clear and accurate records
10.2 make these records at the same time [as] the events being recorded or as soon as possible afterwards and clearly attribute them to yourself
10.3 not tamper with original records in any way

…

10.6 be aware of the dynamics, advantages, and limitations of technology-based interactions and the ways in which technology-based social work practice can be safely and appropriately conducted — it's your responsibility to:

- manage any associated risks when using technology — consider the destiny of data and be aware that all posts on social networking sites are public and permanent
- set and maintain clear and appropriate personal and professional boundaries in all forms of communication, including face-to-face contact, written, telephone, and online communications

Texting and emailing clients:

…

Email and texting are often seen as less formal ways of communicating and can create a perception that people are contactable and available at any time. Therefore you need to be aware that professional boundaries can become blurred when using these forms of communication. It is your responsibility to set clear boundaries around this. For example, you may want to agree with your client when text messages and or emails can be sent and when they will be answered."

39. The Social Workers Registration Board also has ten Core Competence Standards to which social workers must adhere. The Competence Standards include:

"**Competence Standard 7: Competence to apply critical thinking to inform and communicate professional judgements**

The social worker:

- demonstrates the ability to work autonomously and make independent judgements from a well-informed social work position and seeks guidance when necessary;

…

**Competence Standard 9: Competence to practice within legal and ethical boundaries of the social work profession**

The social worker:

- adheres to the SWRB Code of Conduct, any workplace code of conduct and the professional Code of Ethics;
- identifies and manages ethical dilemmas and issues that arise in practice and seeks supervision or guidance;
- recognises and responds appropriately to actual or potential conflicts of interest;
- demonstrates an understanding of relevant legislation, policies and systems which govern practice and performs any statutory duties with diligence and care;

…

- keeps clear and accurate records and ensures these records are made at the same time as the events being recorded or as soon as possible afterwards.

…

**Competence Standard 10: Represents the social work profession with integrity and professionalism**

The social worker:

- demonstrates active promotion and support of the social work profession, acts with integrity and ensures accountability;
- attends to professional roles and responsibilities with diligence, timeliness and care, acknowledges that social work positions carry power and uses authority responsibly;
- behaves in a professional manner, maintains personal and professional boundaries and is accountable for all actions and decisions;
- knows the limits of their own practice and experience, practices appropriate self-care and seeks advice where necessary;"

## Opinion: Ms B — breach

### Introduction

40. On 17 July 2018, the DHB was sent a referral from Mr A, who was requesting assistance with finding a home that would be suitable for his needs. Ms B was assigned as his social worker and provided him with care from August 2018 until February 2019. During this time, Ms B had a high level of contact with Mr A, she performed duties for him that were not required for Mr A's referral, and her relationship with Mr A developed beyond a professional one.

41. As Ms B's client, Mr A had the right to services that complied with legal, professional, ethical, and other relevant standards in accordance with Right 4(2)[4] of the Code of Health and Disability Services Consumers' Rights (the Code). The applicable standards in this case are the Social Workers Registration Board Code of Conduct and its ten Core Competence Standards, to which all social workers are expected to adhere.

### Care provided to Mr A

42. Competence Standard 10 of the Social Workers Registration Board's ten Core Competence Standards stipulates that a social worker must behave in a professional manner, maintain personal and professional boundaries, and be accountable for all actions and decisions.

[4] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Principle 5.8 of the Social Workers Registration Board Code of Conduct also states that a social worker is expected to maintain personal and professional boundaries and not form inappropriate relationships with clients or those close to them.

43. It is unclear whether Mr A's (subsequently recanted) allegation of a sexual relationship with Ms B is true or not. This allegation was not substantiated in the DHB's investigation, and I am of the view that further investigation by this Office would reach the same conclusion. Accordingly, I make no finding in this regard. However, what is clear from the facts is that the relationship between Mr A and Ms B evolved into something other than a professional one. The DHB considered that it had moved beyond a professional social work relationship to one "akin to that of friendship".

44. It is critical that relationships between any health professionals and their clients stay within the professional realm, to avoid any exploitation or abuse of power. The Social Workers Registration Board Code of Conduct states:

> "[L]ike all professionals, you need to be vigilant in your efforts to avoid inappropriate dual relationships. Within the professional relationship there is almost always an imbalance of power due to your authority, specialised knowledge, ability to access privileged information, and influence as a social worker."

45. Contrary to the above standards, Ms B and Mr A have admitted that they became "really close" during their time together. Ms B would visit or contact Mr A at least once and occasionally twice on working days, and would sometimes talk to him by telephone late at night and on the weekends. The DHB stated that this amount of contact was higher than expected for a client with Mr A's referral and presentation.

46. Mr A's social work referral was for housing support only; however, Ms B also supported him with pharmacy, medical, and WINZ visits. She took Mr A clothes shopping, bought his groceries, helped him to open a bank account, and gave him emotional support. Aside from being unable to mobilise up and down stairs, Mr A was otherwise capable of being independent, and should have been encouraged to do such things himself. Ms B also did things that she said she had never done for another client, such as visit Mr A outside of work hours and use his ATM card on multiple occasions. Ms B stated that she realised as early as September 2018 that a professional boundary had been crossed and that her friendship with Mr A was affecting her workload.

47. Ms B told the DHB that she was trying to build up trust with Mr A, as previously he had not had trust with other professionals. Whilst I acknowledge that Ms B was attempting to change Mr A's view of social workers and other health professionals, I believe she put little thought into how her actions would affect Mr A negatively — both emotionally and practically — once her work with him ended. It is concerning that Ms B went out of her way to develop a friendship with Mr A, while knowing that she had been assigned to assist him only until appropriate housing had been found. The DHB stated that a social worker is expected to empower their clients and help them to become independent. It was therefore not acceptable for Ms B to assist Mr A to the level she did when Mr A was

capable of doing such things himself. I agree with the DHB's statement that as Mr A was considered to be a vulnerable adult, creating dependence could have been damaging to him.

48. By allowing her relationship with Mr A to move beyond that of a professional one, Ms B allowed a clear, and acknowledged, breach of the Social Workers Registration Board's standards to occur.

49. Once Ms B realised that her relationship with Mr A had crossed a professional boundary, she had many opportunities to disclose the issue and seek collegial advice from her supervisors at the DHB. However, she did not do so. I believe that this became even more imperative once Ms B realised that the relationship was affecting her workload negatively. The DHB told HDC that Ms B was provided with an open and safe environment for her to discuss, reflect, or seek support from the Social Work Practice Supervisor in regard to, but not limited to, Mr A's case.

50. Ms B told HDC that she was "fully aware" of her ethical responsibilities, and that her supervisor was aware of how much time she was spending with Mr A. However, she did not raise any concerns about the professional boundary being blurred, or the time affecting her workload. When asked by the DHB why she did not raise this boundary blur with her supervisor, she stated that although she knew that this was expected of her, she did not know why she failed to do so. Competence Standard 9 of the Social Workers Registration Board Core Competence Standards states that a social worker identifies and manages ethical dilemmas and issues that arise in practice, and seeks supervision or guidance. I am of the view that the boundary blur that occurred in this case was an ethical dilemma, and that Ms B should have treated it as such. Ms B has not provided a reason why she did not seek guidance from her supervisor on this case, in accordance with Competence Standard 9.

**Documentation and record-keeping**

51. As set out above, Ms B had a high level of contact with Mr A during the time she was his social worker. She would talk to him every day on the telephone, including late at night and on the weekends, and text him often. On the night of 16 February 2019, she also visited Mr A after normal work hours.

52. Principle 10 of the Social Workers Registration Board Code of Conduct states that a Social Worker must keep accurate records and use technology effectively and safely. It stipulates that a social worker is expected to keep clear and accurate records, make these records at the same time as the events being recorded or as soon as possible afterwards, and not tamper with original records in any way.

53. Not all of the daily telephone calls with Mr A are documented in his social work notes, and Ms B deleted all of her text messages with him. She also failed to document her out-of-hours visit with Mr A on the night of 16 February 2019. Ms B explained in her interview with the DHB that she deleted her messages with Mr A only to save power on her telephone, and that she did this with all of her client communications. She also stated that

she did not document the 16 February 2019 visit as she "panicked" about what the situation might have looked like to the nurse who had seen her there.

54. Regardless of Ms B's explanations, Principle 10 of the Social Workers Registration Board Code of Conduct clearly states that a social worker must keep clear and accurate records, and not tamper with original records in any way. I am concerned that Ms B failed to follow these standards by omitting to document her daily telephone calls to Mr A and her visit on 16 February 2019, and by deleting all of her text messages with Mr A.

**Conclusion**

55. Ms B failed to adhere to the Social Workers Registration Board Code of Conduct and Core Competence Standards by failing to maintain professional and ethical boundaries with Mr A when she was his social worker from August 2018 until February 2019. She further failed to keep accurate records during this time. As a result, Ms B did not provide Mr A with a safe and empowering service as would be expected of a social worker, especially given Mr A's presentation as a vulnerable adult. In my view, Ms B breached her professional and ethical obligations as a social worker, and, accordingly, she breached Right 4(2) of the Code.

## Opinion: District Health Board — no breach

56. Ms B was an employee of the DHB when she was assigned to assist Mr A with his housing needs in July 2018. As stated above, I have found Ms B to be in breach of the Code for failing to maintain professional and ethical boundaries as set out by the Social Workers Registration Board.

57. Under section 72(2) of the Health and Disability Commissioner Act 1994, employers are responsible for ensuring that their employees comply with the Code. Pursuant to section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

58. The DHB told HDC:

> "We believe that [the] DHB has taken all practicable and reasonable steps to ensure that [Ms B] was aware of [the] DHB's policies and processes, that she was aware of her professional obligations in terms of ethical behaviour and boundaries as a registered social worker, and [Ms B] was provided with an open and safe environment for her to discuss, reflect or seek support from the Social Work Practice Supervisor in regards to, but not limited to, [Mr A's] case."

59. I am satisfied that at the time of these events, the DHB had procedures in place that, if followed, would have guided Ms B to adhere to the Social Workers Registration Board Code of Conduct and Core Competence Standards when providing care to Mr A. The DHB

told HDC that Ms B helped to create the relevant policy, and hence would have known about her obligations under that policy. Ms B has also told HDC that she was fully aware of her ethical responsibilities.

60. In addition, the DHB ensured that supervision was available to Ms B to provide her with the opportunity to raise any concerns. Despite realising that she had become too close to Mr A, Ms B did not take this opportunity. I also note that health professionals have a responsibility to comply with professional and ethical standards, and as a registered social worker, Ms B was bound to comply with the standards set by the Social Workers Registration Board.

61. I am of the view that Ms B's failures were that of an individual nature and do not allude to any systems or organisational issues at the DHB and, accordingly, I do not find the DHB in breach of the Code.

## Recommendations

62. I recommend that Ms B establish a six-month mentoring and continuing education plan with the Social Workers Registration Board, in relation to the Code of Ethics and with an emphasis on professional boundaries, and report to HDC on the substance of the plan and the arrangements made to ensure compliance with that plan, within three months of the date of this opinion.

63. I have not recommended that Ms B provide an apology to Mr A for her breach of the Code, as Mr A has advised HDC that he does not support this complaint.

64. I recommend that the Social Workers Registration Board consider whether a review of Ms B's conduct is warranted, and report back to HDC on the outcome of its consideration.

## Follow-up actions

65. A copy of this report with details identifying the parties removed will be sent to the Social Workers Registration Board, and it will be advised of Ms B's name.

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