Registered Nurse, RN B

District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC01604)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man with an intellectual disability and physical health concerns. The man resides in a secure facility and is a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. At the time of these events he was in his fifties.

2. The man alleged that he was assaulted by his primary nurse in the dining room at the facility. The district health board (DHB) investigated the complaint, and the nurse's employment was terminated as a result.

3. The Deputy Health and Disability Commissioner noted that the man was a particularly vulnerable consumer, and it was critical for the DHB to ensure that he was safe in the facility and that any concerns regarding his care were addressed immediately.

Findings

4. The Deputy Health and Disability Commissioner found that when the man fell, the nurse sat on the man's body, bounced on him, and did not remove himself promptly from this position, and that these actions amounted to an unreasonable restraint. In addition, the nurse did not document the man's fall or report the incident. Accordingly, the Deputy Health and Disability Commissioner found the nurse in breach of Right 4(1) of the Code.

5. The Deputy Health and Disability Commissioner was critical that two staff members did not report the incident, but was unable to determine whether the culture at the facility at the time of events was such that incidents of this nature were systematically unreported, and expressed concern if this was the case. The Deputy Health and Disability Commissioner noted that the DHB conducted a thorough internal investigation.

Recommendations

6. The Deputy Health and Disability Commissioner recommended that the nurse and the DHB apologise to the man, and that should the nurse wish to obtain a practising certificate, the Nursing Council of New Zealand consider his fitness to practise.

7. The Deputy Health and Disability Commissioner also recommended that the DHB provide evidence of recent training to staff on incident reporting, conduct an audit of incidents reported over the last three months to ensure that incidents have been documented appropriately, and review its protocols for staff who notice adverse practices.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs A[1] about the services provided to her son, Mr C. The following issues were identified for investigation:

- *Whether the district health board provided Mr C with an appropriate standard of care in relation to the alleged incident in 2018 involving RN B.*
- *Whether RN B provided Mr C with an appropriate standard of care in 2018.*

9. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mrs A	Complainant/mother and welfare guardian for Mr C
Registered Nurse (RN) B	Registered nurse
District health board	Provider

11. Information was received from:

Mr C	Consumer
RN D	Registered nurse
Ms E	Mental health assistant
Ms F	Mental health assistant
NZ Police	

12. Also mentioned in this report:

RN G	Charge nurse manager

13. Independent expert advice was obtained from a registered psychiatric nurse, Dr Anthony O'Brien (Appendix A).

Information gathered during investigation

Introduction

14. At the time of these events, Mr C was under the care of the DHB's Intellectual Disability Service and was in his fifties. He was a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and had been a resident at the secure

[1] Mrs A is also the welfare guardian for Mr C.

facility[2] since 2016. Prior to that, Mr C had resided in inpatient wards[3] in the secure units at two other psychiatric hospitals.

15. Mr C has a diagnosis of intellectual disability and has physical health problems that include impaired mobility and balance, chronic lung disease, occasional urinary incontinence, and epilepsy controlled with medication. Mr C uses a walking frame, and his treatment plan states that he has an increased risk of falls.

16. RN B was Mr C's primary nurse at the secure facility from 2016, and was responsible for his care on 26 February 2018. RN B had 30 years' nursing experience and had been employed by the DHB for 10 years. RN B commenced work as a registered nurse in the inpatient ward in 2008, and transferred to the secure facility when it opened in 2012.

17. Mr C's mother raised a number of concerns about the care provided to Mr C at the secure facility, including two alleged assaults by RN B against Mr C in 2018 and concerns that staff witnessed the assaults but took no action. Both alleged assaults were investigated by the DHB and reported to NZ Police.

18. In respect of the first alleged assault on 25 February 2018, the DHB determined that RN B's recollection of the events was the same as another staff member and, as a result, Mr C's allegation was not upheld. NZ Police also investigated the events of 25 February 2018 and, in light of RN B's and another witness's denial of an assault, did not progress the investigation.

19. In respect of the second alleged assault on 26 February 2018, the DHB conducted an investigation[4] and, as a result, RN B's employment was terminated. NZ Police charged RN B with assault, but the charge was later withdrawn.[5] The NZ Police Report Form dated 23 January 2019 states:

> "I have a feeling that there is some sort of revenge here in that [RN B] laid a complaint of assault against [Mr C] for a similar type of incident in 2014 for which [Mr C] was convicted.[6]"

20. In response to the provisional decision, Mr C's family stated to HDC that they refute the above statement. The family stated: "This is inherently unlikely, given he had continued to work with [RN B] for a number of years after the conviction."

21. The alleged assault on 26 February 2018 is the subject of this report.

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[2] A small, secure service for residents with an intellectual disability and associated challenging behaviour and/or mental health issues.

[3] A secure inpatient facility that provides treatment and support to people with a mental illness and/or intellectual disability, who cannot be supported/treated safely in the community.

[4] The internal investigation commenced on 12 March 2018, and RN B's employment was terminated on 25 October 2018 as a result of the investigation.

[5] On 4 June 2019.

[6] This assault occurred in 2014 when RN B was transporting Mr C to visit his family. Neither RN B, nor the DHB, nor Mr C's family have raised the earlier assault as motivation for the assault allegations in 2018.

Complaint to RN D regarding alleged assault on 26 February 2018

22. On 12 March 2018, Mr C told RN D that he had been assaulted by RN B on two occasions. He told RN D that the second assault took place on 26 February 2018 at the secure facility.

23. RN D said that Mr C told her that on 26 February 2018:

> "[RN B] dragged him from the kitchen into the living room, had got him on the ground and sat on him. He then said further that [RN B] sat on his head and thought it was funny … He reported that he has been afraid to lay a complaint because he's scared of what [RN B] would do if he found out."

24. RN D reported this conversation to the Charge Nurse Manager (CNM) RN G immediately.

Mr C's account of events

25. On 13 March 2018, Mr C was interviewed by RN G and the Assistant CNM, and on 12 November 2018 he was interviewed by the NZ Police.[7] In his statements, Mr C said that on 26 February 2018 he was in the kitchen making a drink and something was annoying him, and RN B asked him about it. Mr C stated:

> "[RN B] told me to get into the lounge. I said 'No'. He told me again to get into the lounge and I said I wasn't. He told me he would drag me in. He then pushed me onto the floor and sat on me and then bounced up and down on me. His anus was right beside my mouth."

26. In his interview with RN G, Mr C said that he was screaming and calling for help. In his statement to the Police, he did not say that he called for help.

27. In his interview with RN G, Mr C stated that he did not report the incident for two weeks because RN B had told him to keep quiet.

RN B's account of events

28. On 13 March 2018, RN B made a verbal statement to RN G regarding the incident. RN B had difficulty recalling the events of 26 February 2018, but stated that he did not assault Mr C or sit on him, and Mr C did not end up on the ground.

29. In a later statement,[8] RN B said that Mr C had been irritable and argumentative that evening. RN B said that Mr C told him that he was concerned about his mother, and that Mr C had agreed to talk about it with RN B in his room. RN B said that he did not drag Mr C out of the kitchen, but rather that he followed Mr C out. RN B said that he did not throw Mr C on the ground, but that Mr C tripped and fell onto the floor. RN B stated that he also tripped and fell, but did not sit on Mr C, and did not touch Mr C. RN B stated:

[7] Mr C's statement to the Police is dated 5 December 2018.
[8] In a letter to HDC dated 24 September 2018.

> "I did not sit on [Mr C], I sat on the couch with my legs over [Mr C] so as to avoid contact with him … I tried to get up from the couch and lost my balance and return[ed] to sitting on the couch with my legs over the top of [Mr C]."

30. RN B said that Mr C did not call out for help.

31. RN B told HDC that Mr C had regular falls, and there was nothing unusual about the fall on 26 February 2018. RN B did not record the fall in the progress notes or on an incident form. He stated: "I did not see it at the time as being a special incident or even noteworthy." RN B also said that he had just returned from [a trip] and was due for a holiday, and that it was an "[o]versight on [his] part".

32. At 9.30pm on the day of the incident, RN B made the following late entry in the progress notes:

> "[Mr C has been] [i]rritable, argumentative, oppositional and generally out of sorts all duty. Loud and obnoxious in his attempts to get attention, not desisting with any interventions. Refused to go to his room to talk at [7pm] but did eventually do so. After some time fitted[9] with further argument, [Mr C] opened up a little and shed some light on what was bothering him."

33. The progress notes record that Mr C was concerned about his mother.

34. Mental health assistants Ms F and Ms E provided statements about the events.[10] However, RN B stated that their accounts are inconsistent and inaccurate, and that they had a restricted view of his position on the couch and Mr C's position when he was on the floor. RN B said that their failure to document the incident indicates that they did not consider it to be serious. He also said that both of the mental health assistants had an ulterior motive for making their statements, and that it would be advantageous for them if he was removed from the secure facility.

35. RN B told HDC that Mr C's family were resistant to Mr C transitioning to the community, and that "[this] has resulted in nurses involved in his care under-reporting inpatient/ward notes for fear of complaint from the family".

Ms F's account of events

36. Ms F works casually at the secure facility as a mental health assistant.[11]

37. Ms F said that Mr C had been "playing up" during the day, and that he had been threatening towards Ms E during the afternoon.

[9] The handwriting for this entry is unclear. This quotation is taken from the transcript provided by RN B on 24 September 2018. The sentence may also read: "After some time, filled with further argument …"
[10] Their statements are discussed below.
[11] Ms F is a Needs Assessor with the Community Mental Health Team, and has looked after people with intellectual disabilities for many years.

38. Ms F said that around 7pm she was sitting in another lounge area with a resident and Ms E and could hear Mr C and RN B talking in the kitchen. Ms F said that she then heard a scuffling noise and went to the lounge to investigate. She stated:

> "I could see [Mr C] on the ground inside the door lying beside the couch. [Mr C] was on his side and appeared to be lying on the ground as though he'd come from the dining room area. [RN B] was sitting on top of [Mr C] around his hip area. I asked [RN B] if everything was alright; [RN B] said it was. [RN B] then got up and I thought he was going to walk away but then he just sat back down on top of [Mr C]. I only saw him sit down once but I believe [Ms E] saw [RN B] do it twice.
>
> I know this behaviour was not ok under any circumstances. [Mr C] didn't appear to be hurt and told [RN B] to get off him and that he would take his PRN medication. [RN B] did not get up straight away, he was probably sitting on [Mr C] for about five seconds, I don't know exactly."

39. Ms F said that she was concerned about the incident but did not document it. She stated that she asked RN B whether he wanted her to stay longer at the end of her shift because of the incident, but he declined the offer. Ms F said that she discussed reporting the incident with Ms E, but Ms E was reluctant and said that she would prefer to wait until RN B was on leave before they reported it.

40. Ms F told HDC that there had been previous incidents involving RN B and residents at the secure facility. She said that staff who had reported incidents had been treated poorly as a result. She said that in this case:

> "Personally, after it being discovered that I had supported the allegation made by [Mr C] I had staff who said they wished they had spoken up about some things they had seen and another staff person who said they couldn't understand why I had supported 'that client'. They said they may have understood if it had been another client."

41. Ms F said that she did not want RN B removed from the secure facility, and stated:

> "I had no ulterior motive for the subsequent events that occurred. I believe that patients have a right to safety and respect within their own homes and particularly from those who are there to provide support."

Ms E's account of events

42. Ms E is a mental health assistant at the secure facility, and has worked at the psychiatric hospital since 2010.[12]

43. Ms E said that on the afternoon of 26 February 2018, Mr C had been playing up and had been abusive towards her.

[12] The secure facility is located within the psychiatric hospital at the DHB.

44. Ms E stated that she had seen Mr C and RN B talking in the kitchen, and that she was sitting in another lounge with Ms F and a resident when she heard a bang. Ms E said that she and Ms F got up to investigate. Ms E stated:

> "I could see [Mr C] lying on his side beside a couch. [Mr C] was on the floor and his feet were closest to the lounge door as though he'd gone through from the dining room area into the lounge and fallen to the floor in some way. [RN B] was also sitting on top of [Mr C] and he appeared to be sitting just above his hip area.
>
> Like I say, we were only a couple of metres from [Mr C] and [RN B]. I heard [Mr C] yelling for [RN B] to get off him, saying 'Get off me, [RN B]'. I can't recall what side [Mr C] was lying on. I thought [RN B] was going to get off [Mr C] as he went to stand up but then he plonked himself right back down on top of [Mr C]. I saw him do this twice."

45. Ms E said that Ms F asked RN B whether they were all right, and he replied that they were. She stated that while RN B was sitting on Mr C she heard Mr C say that he would take his PRN medication.

46. Ms E did not document the incident, and said that she thought that RN B would do this.

47. Ms E stated that she considered reporting the incident but did not do so. She said that approximately four to five years earlier she had reported an incident involving RN B and a resident, and stated:

> "I went to senior management at the time [and] was told that it was my word against his [RN B's] and that he was an RN and I'm just an MHA. I then felt that I did not have a voice, and needed to have a witness if I ever saw or heard anything. I did not go to management sooner as in between all this my mother-in-law passed away and [I] was off on bereavement leave. Also I wanted to talk to [Ms F] and do it together so I would have a witness."

Subsequent events

48. Following this incident, the DHB conducted an investigation and, as a result, RN B's employment was terminated. RN B told HDC that he has let his nursing registration lapse and he does not intend to work as a mental health nurse again.

49. The incident was also investigated by NZ Police. RN B was charged with assault but the charges were later withdrawn.

The DHB's policy

50. The Incident Management Policy (District) states:

> "An identified incident or near miss must be reported immediately to the line manager or person in charge and an incident form is to be completed as soon as practicable before the end of the working day."

51. An incident is described as "an unplanned or unexpected event resulting in, or having the potential for harm, ill health, damage, loss or disruption to service delivery".

52. In the Restraint Minimisation and Safe Practices Policy (District)[13] (the Restraint Policy), restraint is defined as "the use of any intervention by a service provider that limits a consumer's normal freedom of movement". A restraint episode is defined as follows:

> "For the purposes of restraint documentation and evaluation, a restraint episode refers to a single restraint event or, where restraint is used as a planned regular intervention and is identified in the patient's service delivery plan, may refer to a grouping of restraint events."

Further information from the DHB

53. The DHB told HDC that RN B's conduct on 26 February 2018 was unacceptable and does not reflect the usual high standard of care provided to service users.

54. The DHB stated:

> "[The DHB] treats all allegations of mistreatment or misconduct very seriously and endeavours to respond to such as soon as they are brought to the attention of staff and/or managers. This is especially the case in services such as [the DHB's] Intellectual Disability (ID) Service due to the vulnerability of the clients it provides for. The ID Service has undergone significant changes in the management over the last 24 month period. The current manager is very clear on his responsibility to address any service user or staff complaint/allegation as soon as they are brought to his attention. In relation to the event being investigated [RN G] acted immediately to [Mr C's] allegation against [RN B]."

55. The DHB said that no other allegations or complaints of a similar nature have been made by Mr C about RN B. The DHB also said that it was aware of Mr C's conviction for an assault on a staff member in 2014, but was not aware that it was RN B who was assaulted.

56. In response to the provisional opinion, the DHB stated that it reviewed Mr C's files and ascertained that RN B was assaulted by Mr C on a flight in 2014. The DHB said that the other staff member who was on the flight, a nurse, completed the progress notes and incident report. The DHB stated:

> "It has also been established that the charges relating to this event were added to an existing court process on an unrelated matter which occurred in January 2014 resulting in this particular incident not being readily identifiable in the clinical record. [The DHB] apologises for the error in initially reporting that no record could be found of the conviction of assault against [RN B]."

57. In response to the provisional opinion, Mr C's family stated that they were concerned that RN B was assigned to Mr C as his primary nurse after the assault in 2014.

[13] Released on 23 September 2015.

58. The DHB told HDC:

> "[RN B] had known and nursed [Mr C] for several years. [RN B's] designation as primary nurse for [Mr C], was at the time, based on the therapeutic relationship they had developed over this time. [Mr C] has always responded in a more favourable manner to mature staff members."

59. The DHB said that neither Ms F nor Ms E have reported any previous incidents to management. The DHB told HDC that "any reluctance to report incidents as suggested by Ms E or Ms F was and is not collectively shared by the wider [Intellectual Disability] Service team". The DHB said that at the time of the incident, and at present, there was a relatively stable and well-functioning team of registered nurses, enrolled nurses, occupational therapists, and medical staff at the secure facility. The DHB stated: "At the time of the events, [the DHB] does not feel that there were any negative culture issues within the secure facility."

60. The DHB said that in respect of the witnesses' failure to report the incident:

> "It is understood that any delay in reporting of incidents or misconduct is undesirable, and it is acknowledged that both witnesses to the event on 26 February should have reported any concerns straight away. Both parties discussed the event amongst themselves in the days following it occurring, with a plan to bring their concerns to the attention of management."

61. The DHB told HDC that its Orientation Booklet highlights staff responsibilities for incident reporting. The Safe Practice Effective Communication (SPEC) Handbook includes a section on staff and patient rights and responsibilities, which states: "[W]e must speak up, for ourselves and for those who cannot do so for themselves."

62. The DHB stated that at the time of these events, incident training was incorporated into the Mental Health Personal Restraint Training, and that Ms F attended training in 2012, 2014, 2015, and August 2018. Ms E attended training in 2010, several trainings in 2011, and in 2012, 2014, 2015, and 2016.

63. The DHB said that RN B completed a three-day Mental Health Personal Restraint training course in 2008, and revalidated his training in 2009, 2010, 2011, 2013, and 2015. He also attended a four-day SPEC training in November 2017.

Responses to provisional opinion

Mr C's family

64. Mr C's family was given an opportunity to comment on the provisional opinion. Where relevant, their response has been incorporated into the "information gathered" section above.

65. The family also noted that Ms F and Ms E were reluctant to report the events of 26 February 2018, and expressed concern that unacceptable behaviour by staff was not being

reported or acted upon. The family stated that a review of the culture at the secure facility is appropriate.

RN B

66. RN B was given an opportunity to comment on the provisional opinion. He again denied that the assault took place, and noted that the witnesses to these events had not been cross-examined. He also said that he had instituted proceedings with the Employment Relations Authority.

The DHB

67. The DHB was given an opportunity to comment on the provisional opinion. The DHB advised HDC that it supported the findings in relation to RN B. Where relevant, the DHB's response has been incorporated into this report.

68. The DHB said that it welcomed the opportunity to reflect on the culture at the secure facility. It stated:

> "[The DHB] would like to note that an Associate Charge Nurse role has been established, commencing in July 2020, to support staff and clinical practice in the secure facility, and that systems exist to support staff working in clinical areas (robust clinical leadership including charge nurse manager, associate charge nurse and clinical nurse specialist roles, training, clinical supervision, and staff forums)."

Opinion: General comment

69. Mr C is a particularly vulnerable consumer. He has an intellectual disability and physical health concerns, and is a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mr C's family have been closely involved with his care and have been strong advocates for him. However, the family do not live in the region, and therefore are not in a position to monitor his day-to-day care. For that reason, it is critical for the DHB to ensure that Mr C is safe in the facility, and that any concerns regarding his care are addressed immediately and appropriately.

70. Mrs A raised a number of issues about the care provided to Mr C at the secure facility, including that RN B had assaulted Mr C twice and that staff witnessed the assaults but took no action.

71. In light of the NZ Police and the DHB investigations into the alleged assault on 25 February 2018, I have not considered the incident that occurred on this date. This report is concerned solely with the events of 26 February 2018.

Opinion: RN B — breach

The fall

72. Mr C says that RN B dragged him from the kitchen and pushed him onto the floor in the lounge. RN B says that Mr C tripped and fell onto the floor and that he (RN B) then fell on top of Mr C.

73. There were no witnesses to the fall and no contemporaneous documentation of the fall. As a result, I am not able to prefer one account over the other, and I do not make a finding on whether Mr C tripped or was pushed.

74. Mr C said that when he was lying on the floor, RN B sat near his head and bounced up and down on him. Ms F said that RN B was sitting on Mr C's body and that she watched RN B get up and sit back down on Mr C and that he remained sitting on Mr C for about five seconds. Ms E said that RN B was sitting on Mr C's body and that he bounced on Mr C twice.

75. On the other hand, RN B said that he did not sit on Mr C. RN B said that he was sitting on the couch and when he tried to get up he lost his balance and returned to the couch with his legs over Mr C.

76. Mr C's, Ms F's, and Ms E's account of the events after the fall are consistent and, as a result, I find that it is more likely than not that RN B sat on Mr C's body while he was on the floor, and that he remained sitting on Mr C and bounced on him.

77. My independent expert advisor, Dr Anthony O'Brien, referred to the standards applicable to registered nurses, and advised:

> "What these standards have in common is that consumers are treated with the skill and care expected of a registered nurse, in particular that they are not subject to any unreasonable restraint or other actions that could be construed as abusive. This would clearly include not subjecting a consumer to the indignity of sitting on them as has been alleged."

78. RN B does not submit, and nor do I find, that this incident was an intentional intervention to limit Mr C's normal freedom of movement, as provided for in the Restraint Policy. In fact, RN B denies touching Mr C. However, based on the statements provided by two witnesses to the incident, together with Mr C's statement, I am satisfied that it is more likely than not that RN B unreasonably restrained Mr C by sitting on his body, bouncing on him, and then not removing himself immediately. RN B's conduct is wholly unacceptable, especially in the case of such a vulnerable consumer, and I am critical of his actions.

Documentation

79. The progress notes, completed later that evening by RN B, record that Mr C was argumentative, that he refused to go to his room at 7pm, and that he discussed his

concerns about his family with RN B when he had retired to his room. However, RN B did not document the fall in the progress notes.

80. RN B offered a number of reasons why he did not record the fall, including that he considered it to have been minor in nature and not noteworthy. However, he acknowledged that it was an oversight on his part. I note that in November 2017 RN B had attended a SPEC training course, which included incident reporting and personal restraint training. In addition, the Incident Management Policy (District) requires staff to report incidents to the person in charge and to complete an incident report before the end of the working day.

81. Dr O'Brien advised:

> "The primary responsibility for documentation in this case falls to [RN B] as the registered nurse in charge of the facility at the time, and as the nurse involved in the incident. I note that [Mr C] had had other falls during his time with the DHB. Even accepting [RN B's] statement that [Mr C] fell, it remains his responsibility to report that fall either in the nursing notes or as a special incident. [RN B's] explanation that he was tired from a recent trip [away] and was anticipating annual leave does not excuse this departure from the expected standard. I believe the lack of documentation by [RN B] to be a moderate departure from the expected standard of care."

82. I am concerned that RN B considered this incident to be so minor that it did not warrant documentation, or that he was too tired to complete an incident form.

83. Dr O'Brien advised:

> "Documentation is a core requirement of nursing practice ... Any untoward or significant event should be reported in the written nursing notes, with an incident report if the event is considered serious."

84. I agree that documentation is the cornerstone of good nursing practice, and I am critical that RN B did not document the fall.

Conclusion

85. The care provided by RN B to Mr C fell well below the accepted level of care in these circumstances. I am critical of RN B's conduct in the following respects:

- When Mr C fell, RN B sat on Mr C's body, bounced on him, and did not remove himself promptly from this position. These actions amount to an unreasonable restraint.
- RN B did not document Mr C's fall or report the incident.

86. As a result, I find that RN B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

[14] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Opinion: District health board — adverse comment

87. The DHB is responsible for the care of a group of particularly vulnerable consumers. As such, it is critical that the DHB has policies and practices in place to ensure that consumers are safe and that its services are provided in accordance with the Code.

88. I note that in 2014 Mr C was convicted of an assault against RN B. After the assault in 2014, RN B was Mr C's primary nurse from 2016 until the events in 2018, and the DHB said that a therapeutic relationship had developed.

89. Mr C's family expressed concern that RN B was Mr C's primary nurse after the 2014 assault. However, if the 2014 assault had been of concern to RN B, Mr C, or the DHB, I would have expected that to be evident. My expert advisor considers that there is no evidence to suggest that the assignment was inappropriate, and I accept my expert's advice.

90. The DHB provided HDC with a copy of a number of policies. Dr O'Brien reviewed the policies and concluded that they were fit for purpose. I accept this advice.

91. I note that the Incident Management Policy (District) requires staff to report incidents to the person in charge and to complete an incident report before the end of the working day.

92. Neither Ms F nor Ms E reported this incident or completed an incident report, although it appears that they were both aware of the requirement to do so. I note that both Ms F and Ms E attended training courses that included incident reporting and personal restraint training in 2015 and 2016 respectively. The reason given by Ms E for the failure to report the incident was that she felt that she would not be listened to. Ms F said that in the past, staff had been treated poorly when they reported incidents of a similar nature.

93. The DHB stated that there were no negative culture issues at the time of these events. Given the passage of time, it is not possible for me to determine whether the culture at the secure facility at the time of these events was such that incidents of this nature were systematically unreported. I would be very concerned if staff felt unable or unwilling to report incidents of this nature. Dr O'Brien stated that this is an opportunity for the DHB to ensure that there are adequate procedures in place to support staff to come forward with matters of concern, especially when staff are not in a position to address the matter of concern directly. I agree with this advice and have included a recommendation in this report to that effect.

94. I note that the DHB conducted a thorough investigation into this event and co-operated with the NZ Police investigation.

95. I also note Dr O'Brien's comment on the DHB's internal review: "My sense is that the investigation, although it has taken a long time, has been thorough and careful."

96. I am satisfied that RN B's actions were an individual failure on his part and were not part of a suboptimal pattern of care. However, I am critical that in this case two staff members did

not comply with policy and report an incident immediately, and did not complete an incident form. I would be very concerned if the reason for this was that staff at the secure facility felt unable to raise concerns with clinical staff or management. I agree with my expert that this is an opportunity for the DHB to reflect on the culture at the secure facility and ensure that there are adequate systems in place for staff to report their concerns, especially if they are unable to address the concerns directly.

Recommendations

97. I note that RN B was dismissed from the DHB and that he no longer holds a practising certificate. I recommend that should RN B wish to obtain a practising certificate, the Nursing Council of New Zealand consider his fitness to practise in light of this report.

98. I recommend that RN B provide a written apology to Mr C for the departures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

99. I recommend that the DHB provide evidence of recent training to staff at the secure facility on the policy relating to incident reporting, within three months of the date of this report.

100. I recommend that the DHB conduct an audit of incidents reported over the last three months to ensure that the incidents have been documented appropriately. The DHB is to provide the results of the audit to HDC within three months of the date of this report.

101. I recommend that the DHB review the protocols that are in place for staff who notice adverse practices but are not in a position to address them. A copy of the protocols, and evidence of training provided to staff, should be provided to HDC within three months of the date of this report.

102. I recommend that the DHB provide a written apology to Mr C for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

103. RN B 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.

104. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

105. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Director of Mental Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

106. The Director of Proceedings declined to file proceedings against the provider. Instead, a restorative justice option was facilitated between the Director, the provider and the consumer's welfare guardian, and the matter was settled by negotiated agreement.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Anthony O'Brien:

"May 21, 2020

Report prepared by Anthony O'Brien, RN, PhD, FNZCMHN

Preamble I have been asked by the Commissioner to provide expert advice on case number C18HDC01604. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualification I qualified as a registered nurse in in 1977 and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Maramatanga, the New Zealand College of Mental Health Nurses. I have been recently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and currently as Associate Professor in Mental Health Nursing with the University of Waikato. My recent clinical experience involves assessment and care of people in acute mental health crisis, and advising on care of people with mental health or behavioural issues in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. I have previously acted as an external advisor to mental health services following critical incidents, and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided by [RN B] to [Mr C] at [the DHB] on February 26th 2018.

I do not have any personal or professional conflict of interest in this case.

Instructions of the Commissioner are:

Please provide comment on:

1. If [Mr C's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.
2. If [RN B's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.
3. If the MHAs' account of the event is accepted, whether [RN B's] conduct was appropriate.
4. The adequacy of the reporting and documentation of the incident by [RN B] and other staff.

5. Any concerns that you might have about the appropriateness of [the DHB's] placing [RN B] and [Mr C] closely together following [Mr C's] earlier assault conviction against [RN B].
6. The adequacy of relevant policies.
7. Any other matters in this case that you consider warrant comment.

In relation to the above issues I have been asked to advise on:

a. What is the standard of care/accepted practice;
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in the future

I have had the following documents available to me for the purpose of writing this report:

1. Letter from [the CEO of the DHB], 11 September 2019
2. Nursing notes 18.2.18 to 7.3.18.
3. Letter from [RN G], Charge Nurse Manager, to [RN B], 19.3.2018.
4. Letter from [Nurse Director] to [lawyer] 3.9.18.
5. Letter from [Nurse Director] to [lawyer] 25.10.18.
6. A document dated 5.9.18 which lists some points of clarification of an earlier interview with [RN B].
7. Notes from a meeting at which issues related to this complaint were discussed; attendees identified by initials only 19.10.18 (includes two photographs of xx Ward and a sketch drawn of the ward floor plan by [RN B]).
8. [RN B's] statement of response to material provided in investigation of 23.3.18.
9. Copy of handwritten notes in a notebook, dated 13.3.18 to 3.4.18.
10. Summary of an investigation into events of 26 February, 2018, no author noted, together with various written statements and copies of emails. 20.3.18.
11. Statement to [the] Police, by [Ms F], 1.10.18.
12. Letter from [Acting Charge Nurse] ID service, to [RN B] advising of a complaint 13.1.16.
13. Letter from [Acting Charge Nurse] ID service, to [RN B] inviting to a meeting to discuss a complaint 22.1.16.
14. Letter from [the CEO of the DHB], to the Commissioner, 5.10.18.
15. Letter from [lawyer], to the Commissioner, 24.9.18.
16. Statement of [RN B], 4.9.18.
17. [DHB] Plans of Care, updated 17.5.18; 29.5.18

18. [DHB] Restraint minimisation and safe practice policy, version …
19. [DHB] Restraint minimisation and seclusion policy, version …
20. Letter from [the DHB's CEO] to the Commissioner, 14.1.19.
21. [DHB] Intellectual Disability Service Orientation Book.
22. [DHB] Mandatory Training Policy.
23. [DHB] Health Record Documentation Standards [DHB] Restraint Minimisation and Safe Practice Policy [DHB] Consumer Complaints Policy.

In addition there are other documents provided in composite electronic files.

Background

[Mr C] is a [consumer in his fifties] with [the DHB's] Intellectual Disability Service. He is a resident of a DHB staffed facility [the secure facility]. At the time of the events discussed in this report he was [in his fifties], and was a compulsory patient under the Mental Health (Compulsory Assessment and Treatment (Act (1992). He has a diagnosis of intellectual disability and has been a consumer with [the DHB] for 13 years. Prior to that he lived at [two other psychiatric hospitals]. His clinical notes indicate that [Mr C] has multiple physical health problems. He is semi-independent in his activities of daily living, but needs a high level of guidance from staff. His family oppose any plan of transition to community care because of concerns about past behaviours which have led to police involvement. Nevertheless his family remain closely involved.

On 28 August 2018 a complaint was received by the Commissioner alleging two assaults on [Mr C] by registered nurse [RN B], one on February 25th 2018 and the other on February 26 2018. The complaint was communicated by [a] law firm, on behalf of [Mrs A] who is [Mr C's] mother and welfare guardian. The allegation related to February 25th was not upheld on investigation by [the DHB] and the current opinion relates to the second allegation. The second allegation is that on 26th February 2018 [RN B] dragged [Mr C] from the kitchen of his residence at [the secure facility], pushed him to the floor then sat on him. Two [DHB] mental health assistants have given statements that they witnessed [RN B] sitting on [Mr C], although they did not witness the events immediately prior. [RN B] has made a statement that [Mr C] tripped and fell and that he ([RN B]) then tripped over [Mr C]. [RN B] denies sitting on [Mr C] and states that instead he was sitting on the couch. The incident was not recorded in clinical notes at the time.

The incident that is subject to the assault allegation was reported to Charge Nurse Manager [RN G] on March 12th 2018. The allegation was initially made to [RN D] who informed [RN G]. [The DHB] initiated an investigation on March 13th, the final result of which was that the allegation of assault was upheld and [RN B] was found to have breached the [DHB] Code of Conduct and Integrity and was dismissed on October 25th 2018.

Related to this alleged incident, [Mr C's] family have commented that in their view there was a lack of intervention by staff who witnessed this incident, and there is a general lack of reporting of [Mr C's] behaviour.

The following sections of this report respond to the Commissioner's questions.

1. If [Mr C's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.
2. If [RN B's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.
3. If the MHAs' account of the event is accepted, whether [RN B's] conduct was appropriate.

After reading the documents provided I have accepted the MHAs' account of the events. This is not to say that [Mr C's] account is not correct, but the part of that account that relates to [Mr C's] allegation that [RN B] dragged [Mr C] into the lounge area prior to sitting on him was not witnessed.

What is the standard of care/accepted practice?

In relation to the general care of consumers in inpatient services the standard of care is governed by many standards and guidelines, including the Nursing Council of New Zealand Competencies for Registered Nurses, the Nursing Council of New Zealand Code of Conduct for Nurses. The DHB also has a specific standard for Restraint Minimisation and Safe Practice. In addition there are standards that apply to all professionals such as the Health and Disability Commissioner Code of Consumers' Rights. What these standards have in common is that consumers are treated with the skill and care expected of a registered nurse, in particular that they are not subject to any unreasonable restraint or other actions that could be construed as abusive. This would clearly include not subjecting a consumer to the indignity of sitting on them as has been alleged.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

The allegation relating to [RN B's] actions have been extensively investigated by [the DHB], with ample opportunity for [RN B] to explain his actions and to contest the accounts provided by the two witnesses, mental health assistants [Ms F] and [Ms E]. The DHB investigation found the allegation to be substantiated and I have not found any reason to disagree with that conclusion. The accounts of MHAs [Ms F] and [Ms E] are consistent (save for minor differences in wording) especially in the key aspect that both observed [RN B] to have sat on [Mr C]. I could find nothing in [RN B's] accounts to lead me to any other conclusion. My opinion is that [RN B's] actions represent a severe departure from the expected standard.

How would it be viewed by your peers?

In my opinion my peers would also view [RN B's] actions as a severe departure from the expected standard.

Recommendations for improvement that may help to prevent a similar occurrence in the future.

As a result of this incident [RN B] was dismissed from his employment, and I understand he no longer holds a practising certificate, so there is no recommendation to make in regard to his practice. I understand that [the DHB] have notified the Nursing Council of New Zealand of this allegation and their actions, and expect that the Council will also be notified of the findings of this inquiry so that can be considered if [RN B] were to apply for re-entry to the nursing register. I did not see evidence of any wider issue within the service that would need to be subject to any other recommendation.

4. The adequacy of the reporting and documentation of the incident by [RN B] and other staff.

(The comments below pertain to [RN B]. Comments related to the two MHAs are provided below.)

What is the standard of care/accepted practice?

Documentation is a core requirement of nursing practice, covered by the standards noted above. Any untoward or significant event should be reported in the written nursing notes, with an incident report if the event is considered serious.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

The primary responsibility for documentation in this case falls to [RN B] as the registered nurse in charge of the facility at the time, and as the nurse involved in the incident. I note that [Mr C] had had other falls during his time with [the DHB]. Even accepting [RN B's] statement that [Mr C] fell, it remains his responsibility to report that fall either in the nursing notes or as a special incident. [RN B's] explanation that he was tired from a recent trip [away] and was anticipating annual leave does not excuse this departure from the expected standard. I believe the lack of documentation by [RN B] to be a moderate departure from the expected standard of care.

How would it be viewed by your peers?

I believe my peers would view this as a moderate departure from the expected standard of care.

Recommendations for improvement that may help to prevent a similar occurrence in the future.

My comments in relation to questions 1–3 (above) apply here. [RN B] is no longer employed by [the DHB], and is no longer registered as a nurse so there is no recommendation to make regarding prevention of similar occurrences. I have made some additional comments below.

Comments related to other staff (MHAs [Ms F] and [Ms E])

The DHB investigation noted that this incident should have been reported at the time by [RN B]. The DHB investigation also noted that MHAs [Ms F] and [Ms E] should have communicated their concerns to the Charge Nurse Manager soon after the event, rather than after another nurse had expressed concern. There is some evidence that MHAs [Ms F] and [Ms E] felt their reports would not be listened to, and that to report this incident would have risked some sort of retaliation from [RN B]. However this was a serious incident and all staff, including MHAs, have a responsibility to report. In saying this I note that both MHAs readily came forward when the incident was reported by [RN D]. Based on these observations my recommendation is that [the DHB] ensure that there are adequate procedures in place to support staff, especially those who may feel vulnerable as unregistered or junior staff, to come forward with issues of concern.

Any concerns that you might have about the appropriateness of [the DHB's] placing [RN B] and [Mr C] closely together following [Mr C's] earlier assault conviction against [RN B].

I don't feel able to comment on the appropriateness of [RN B] being assigned to care for [Mr C]. I noted that in a 2016 disciplinary hearing [RN B] was noted to be considered a good nurse and in the documentation available to me there is no evidence that this was an inappropriate assignment.

The adequacy of relevant policies.

I have reviewed the policies listed above and believe they are fit for purpose.

Any other matters in this case that you consider warrant comment.

It is worth noting that the service investigated this event promptly and supported staff, including [RN B], to make statements and to engage their own supports, and thus to gain a full understanding of the circumstances. My sense is that the investigation, although it has taken a long time, has been thorough and careful. Any event of this severity gives the professionals involved cause to reflect on what could be done differently in the future. I have mentioned above that this event offers the opportunity to review supports available to whistleblowers, those staff who notice adverse practices and are in a position to act on it. [Mr C] is an especially [vulnerable] consumer, something noted by [the DHB] in responding to [RN B's] lawyer. He is subject to a guardianship order but his guardian is not in a position to monitor his day to day care. Responsibility for [Mr C's] welfare therefore falls to [the DHB] and its staff. In my opinion it appears that this responsibility is understood and taken seriously. There is no question that [Mr C's] allegations, when notified to senior staff, were investigated quickly and thoroughly. But if there is something to take from this event it might be to consider strengthening supports available to whistleblowers. I'm struck that [Mr C] is living a long way from his home, and from his closest natural supports, apparently because there is no suitable alternative closer to his home. I note that there have been some difficulties in reaching agreement with [Mr C's] family about care in a community setting. While respecting [Mrs A's] concerns about how

[Mr C's] welfare can be ensured in a community setting this is something that should still be pursued.

Anthony O'Brien RN, PhD, FNZCMHN"

The following further advice was obtained from Dr O'Brien:

"June 8, 2020

Report prepared by Anthony O'Brien, RN, PhD, FNZCMHN

I have been asked by the Commissioner to provide further advice on case number C18HDC01604. This follows my initial advice on May 21 2020. Specifically I have been asked:

1. If [Mr C's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.
2. If [RN B's] account of the events is accepted, whether [RN B] provided [Mr C] with an acceptable standard of care.

The incident took place on February 26th 2018. I have read over my initial advice and referred, where necessary, to the original documents provided.

[Mr C's] account.

[Mr C] first made his complaint to [RN D] on March 12th, approximately two weeks after the events in question. An account of [Mr C's] complaint was provided by [RN D] to Charge Nurse Manager [RN G] on March 12th. In an email on that date [RN D] reported that in the course of an informal activity at [the secure facility], [Mr C] had stated that on February 26th [RN B] had dragged him from the kitchen to the living room, got him on the ground and sat on his head. [Mr C] gave a further account when interviewed by [RN G] and [the ACNM] on March 13th. At that interview [Mr C] again stated that [RN B] had dragged him from the kitchen and sat on his head, adding that [RN B] had his anus on [Mr C's] face and a smile on his face. During this time [Mr C] reported 'screaming and calling "help me"'.

I have outlined the appropriate standard of care in my initial report. If [Mr C's] account is accepted this would be a severe breach of the accepted standard of care. In expressing that opinion I consider, based on [Mr C's] account alone, that [RN B's] actions were not simply negligent, but actively abusive.

[RN B's] account.

[RN B's] account is given in several documents and statements given in the course of investigations since the incident, including nursing notes, statements made to [the DHB] staff, and statements made through [RN B's] lawyer. The nursing notes of 26th March, written by [RN B], record that [Mr C] was 'irritable, argumentative, oppositional and generally out of sorts all duty. Loud and obnoxious.' The notes make no mention of [Mr C] falling. In his initial statement to [RN G] on March 13th [RN B] is

reported to have struggled to recall details of the events of February 26th. He stated that [Mr C] had been angry, but denied having assaulted [Mr C]. He specifically denied that [Mr C] had ended up on the floor, and that he ([RN B]) had sat on him. [RN B] stated that he would need to read the nursing notes of February 26th to recall what had occurred. On September 4th 2018 [RN B] again denied having dragged [Mr C] from the kitchen or throwing him on the floor, or sitting on his head. Also on September 4th 2018 [RN B] added that [Mr C] 'must have tripped' and this caused [RN B] to trip over him. He states that he ended up on the couch with his legs over [Mr C] to avoid contact with him, although he could not recall how [Mr C] was lying on the ground. [RN B] denies that [Mr C] was calling for help. Notes of a meeting with [the DHB] staff on September 5th record [RN B] stating that he ([RN B]) had not fallen. In the statement made through [his lawyer] to the Health and Disability Commissioner on September 24th 2018 (paragraph 22) [RN B] again stated that [Mr C] tripped on the couch, landed briefly on the couch, then slid to the floor. In that statement [RN B] stated that he tripped over [Mr C] and landed on the couch with his legs in the air above [Mr C] to avoid touching [Mr C]. In the same statement [RN B] denies touching [Mr C] throughout the incident and states that there was no intentional application of force. On September 25th in a letter to the Director of Nursing [the DHB], through [his lawyer], [RN B] stated that 'he *thinks* the patient tripped … and somehow he either tripped or fell over the patient as well' (paragraph 23 — my italics).

Accepting [RN B's] account that [Mr C] tripped and fell, and that he ([RN B]) then tripped over him but otherwise avoided any physical contact, this would not involve a departure from the accepted standard of care as far as [Mr C's] fall and [RN B's] subsequent fall are concerned. If the incident occurred as described by [RN B] it was an accident. However there is still the question of [RN B's] subsequent actions in investigating the fall and recording it in the nursing notes. There is no record of the incident in the notes, and no record of any inquiry by [RN B] as to whether [Mr C] was injured. I have given advice on the issue of documentation as part of my initial advice. My opinion remains that this represents a moderate departure from the accepted standard.

Anthony O'Brien RN, PhD, FNZCMHN"