Occupational Therapist, Ms B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00895)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the failure of an occupational therapist to maintain professional boundaries with her client.

2. The man sustained a brain injury in June 2017, and subsequently was unable to work. His injury was covered by ACC. In July 2018, ACC referred the man to the rehabilitation service for a 12-week Training for Independence programme. The man was allocated to the occupational therapist for Key Worker and Occupational Therapy services. Within the first several weeks of the programme, the occupational therapist was engaging in text communications of a personal and intimate nature with the man.

3. The occupational therapist and the man's communication escalated to the occupational therapist providing the man with intimate photos. The relationship developed into physical contact approximately four weeks after the first home visit and on several occasions during other appointment times.

Findings

4. The Deputy Commissioner found that the occupational therapist failed to comply with professional, ethical, and other relevant standards, and, accordingly, breached Right 4(2) of the Code.

Recommendations

5. The Deputy Commissioner recommended that the occupational therapist apologise in writing to the man, and undertake further training relating to the management of boundaries, should she reapply for an annual practicing certificate. The Deputy Commissioner recommended that the Occupational Therapy Board consider whether the occupational therapist should undertake a competency review and further training, should the occupational therapist register for an annual practising certificate.

6. The Deputy Commissioner recommended that the rehabilitation service review its Code of Conduct policy to ensure it provides sufficient guidance to managers on supporting staff to manage boundary issues.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a referral from the Occupational Therapy Board of New Zealand in relation to concerns raised by the rehabilitation service about the services provided by a former employee, occupational therapist Ms B, to Mr A. Mr A supported the complaint. The following issue was identified for investigation:

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

8. This report is the opinion of Deputy Commissioner Vanessa Caldwell, and is made subsequent to a provisional report by Deputy Commissioner Kevin Allan and in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Provider/occupational therapist

10. Also mentioned in this report:

Ms C	Manager at the rehabilitation service

11. Further information was received from the rehabilitation service.

Information gathered during investigation

12. This report discusses the development of an intimate relationship between a registered occupational therapist, Ms B (in her forties at the time of events), and Mr A (in his thirties at the time of events), between July and November 2018 while she was providing him with health services.

Background

13. In June 2017, Mr A sustained a brain injury at work. Subsequently, he was unable to work. On 7 July 2017, Mr A was reviewed by a neuropsychologist, who noted that Mr A was experiencing a range of symptoms including depression, frustration, and slowed thinking. Mr A commenced antidepressant medication shortly afterwards owing to a deterioration in his mood and outlook.

14. In October 2017, a psychiatrist noted Mr A's tendency to depression, which pre-existed the injury but had been exacerbated by post-concussion symptoms. Subsequently, Mr A continued to receive care from various providers for his mental health, and was involved in discussions about a gradual return to work.

15. In June 2018, Accident Compensation Corporation (ACC) asked an occupational medicine specialist to review Mr A. His problems at that time included continued daily headaches, pain, and ongoing issues with fatigue, concentration, cognitive function, and mood. It is documented that Mr A lacked self-confidence, and that an occupational therapist would be the most appropriate person to help Mr A to navigate the process of returning to work, and to develop resilience and coping mechanisms. It was noted that Mr A's psychological health needed to be addressed.

Referral to the rehabilitation service

16. In July 2018, Mr A was referred to the rehabilitation service by ACC for a 12-week Training for Independence programme. Mr A was allocated to Ms B for Key Worker and Occupational

Therapy services for the duration of the programme, from 30 July 2018 to 22 November 2018.

17. Ms B is a qualified occupational therapist. She holds a Bachelor of Health Science (Occupational Therapy).[1] Ms B did not know Mr A prior to treating him.

Development of relationship

18. It is documented that between July and November 2018, Ms B and Mr A had 11 appointments together — involving home visits at Mr A's home, and occasionally outings in the community. During this time, an intimate relationship developed.

19. The first appointment occurred on 23 July 2018. Ms B attended Mr A's home for an initial review, with Mr A's sister also in attendance. Mr A told Ms B that he had been experiencing decreased confidence because of the loss of physical strength, sensitivity to noise, increased anxiety, daily headaches, memory issues, fatigue, reduced appetite, decreased motivation, and increased sensitivity to people's comments.

20. Shortly after meeting, Mr A and Ms B began to communicate via text message. Ms B told HDC that it was approximately two to three weeks following the start of Mr A's programme that Mr A began to text her[2]. Ms B also confirmed that their relationship and messaging did not extend beyond the treatment period.

21. HDC received photographs of a portion of these text messages, which had been provided to the rehabilitation service by Mr A. The messages do not contain clear date or time stamps.[3] However, Ms B has provided HDC with an approximate timeline of when the messages occurred.

22. Ms B said that she responded to Mr A's text messages, and that they began to communicate regularly, mostly in the evenings. The contents of the conversations varied between occupational therapy and personal discussions.

23. On 30 July 2018, Ms B attended a home visit with Mr A. Ms B documented that they reviewed Mr A's goals, and Mr A agreed to attend a physiotherapy gym with a view to transitioning to a sports club. Ms B emailed Mr A's ACC case manager recommending physiotherapy input into Mr A's programme to help improve his low self-esteem, sleep, mood, and activity tolerance. She also requested transport assistance for Mr A to attend physiotherapy. Mr A's case manager agreed to this.

[1] Owing to a gap in her registration with the Occupational Therapy Board of New Zealand, Ms B was required to complete a number of modules, and had a six-month condition of scope on her practice. The condition required Ms B to participate in fortnightly supervision. This condition was completed and removed from her scope of practice in September 2018.

[2] Mr A has not responded to the allegation that he initiated communication with Ms B.

[3] Ms B and the rehabilitation service were unable to provide HDC with screenshots of all messages with clear dates and times, as these had been deleted.

24. In photographs of the text messages provided to HDC of an unknown date, Ms B told Mr A that she would be bringing her daughter to the next home visit because she was having a busy week.

25. In August 2018, Ms B texted Mr A and asked how his weekend had been, and told him that she had booked him in for a visit the next day. Ms B told HDC that this occurred in mid-August. The conversation continued, and was of a personal nature. The conversation ended with Ms B telling Mr A that she looked forward to "catching up" the next day.

28 August 2018

26. On 28 August 2018, Ms B attended a home visit with Mr A. The documentation shows that this was the only appointment between Ms B and Mr A in August 2018. Although there are no clinical notes from this visit, Ms B documented on 27 August 2018 that she was preparing for a home visit planned for the next day.

27. As discussed above, photographs of text messages have been provided to HDC. In the messages, identified as having occurred following their appointment on 28 August 2018,[4] Ms B apologised to Mr A for overstepping professional boundaries, stated that he was a lovely person, physically attractive, and that she didn't want to lose her job. Ms B asked Mr A if she could see him the next day to discuss what had happened. Ms B stated that she had been an occupational therapist for almost 20 years, and had never kissed a client before.

28. The messages continued and were of a sexual nature. In this conversation, Ms B told Mr A that they would have to wait until November (when his programme ended) to engage in sexual intercourse. She told Mr A that she was "worth the wait" and that they had to "make a plan that involve[d] [her] not getting fired". Ms B told Mr A that this was not just about sex for her, and that she liked Mr A.

29. Ms B told HDC that following an appointment in August 2018, Mr A kissed her after she had told him that he "can't do that"[5]. This was not reported to the rehabilitation service.

30. On 20 July 2020, Ms B stated that approximately three to four weeks following the start of Mr A's programme (i.e., in approximately late August 2018), "the relationship progressed physically ... with kissing and cuddling". At this time, Ms B had attended two previous appointments with Mr A.

Continuation of relationship — September to November 2018

31. Ms B and Mr A kept in contact, sending intimate text messages to each other as well as having occupational therapy sessions. There were approximately eight appointments in this time — on 3 September, 17 September, 8 October, 16 October, 18 October, 29 October, 5 November, and 15 November 2018. The majority of these were home visits.

32. In September 2018, Ms B contacted Mr A and asked whether he was available for her to drop off occupational therapy equipment. Initially he declined, saying that he was not

[4] Ms B informed HDC that these messages were sent in August 2018. The only documented appointment that occurred in August 2018 was on 28 August 2018.
[5] Ms B subsequently advised HDC that she considered this to be sexual assault.

feeling well. Ms B responded that she did not mind if he looked "like shit" and that his personality had won her over, and she commented on Mr A's genitalia. Mr A agreed for Ms B to visit his house.

33. On the morning of 6 September 2018, Mr A missed an appointment with his physiotherapist. In images of the text messages provided to HDC, Ms B told Mr A not to worry and that they could reschedule the appointment, and then asked Mr A whether he wanted to "catch up" that week. Mr A did not respond.

34. Ms B messaged Mr A again asking if he was ok and saying that she was "getting a bit worried and starting to feel like a stalker". Mr A did not respond. Ms B told Mr A that she would send him a picture of her naked if he responded. Mr A responded and told her that he had had no credit on his phone to message her. Ms B then sent Mr A two intimate photographs — of herself in her underwear and covering her breasts with her arm accompanied by an intimate comment. On an unknown date, Ms B also sent Mr A a photograph of her cleavage while wearing a bra. Ms B advised that this latter image was sent at the end of September.

35. In a photograph of a text message provided to HDC, Ms B expressed to Mr A that she really wanted to have sexual intercourse with him. She submitted to HDC that she sent this text even though she had no intention of having sex with Mr A, and felt that this was what was expected of her.

36. Ms B told HDC that following home sessions with Mr A, they would sometimes "kiss and cuddle", and she would write notes and complete emails and reports in the evenings to make up for time they had spent together that was not part of therapy sessions.

37. Ms B said that towards the end of the programme when she and Mr A got closer, she felt that she liked Mr A more than he liked her. She said that she noticed that Mr A became less affectionate and replied less to her communications.

38. Ms B said that during the last month of the programme, Mr A began to cancel appointments, and told her that this was because of an increase in his symptoms. Ms B stated:

> "[Upon reflection, I wonder whether [Mr A] was feeling uncomfortable seeing me, and was] unsure of how to end the relationship because of the power dynamic between therapist and client. At the time I did not see this but I have since reflected on how difficult it must have been for [Mr A] given the balance of power in favour of myself as the therapist."

39. Ms B continued to provide services to Mr A until the completion of his programme on 22 November 2018. Ms B said that after the programme finished, she did not see Mr A or have any contact with him.

40. In summary, Ms B first met Mr A at the time of his first home visit on 23 July 2018. Ms B attended a second session with Mr A at his home on 30 July 2018. Shortly after the second home visit, Ms B began engaging in personal communication with Mr A via text message. Ms B engaged in physical sexual interactions with Mr A during the third appointment on 28 August 2018 and on several subsequent home occupational therapy appointments.

Following their third appointment on 28 August 2018, their communication continued in a personal and intimate manner, which were on occasion, of a sexual nature. During September 2018, when Ms B was providing occupational therapy services to Mr A, she sent him explicit intimate photographs of herself.

Ms B's account

41. Ms B told HDC that Mr A had requested intimate photographs, and initially she declined the requests. She said that eventually she agreed, but hid her face in the photographs because she was worried that he might share them or post them online. She said that despite her concerns, she sent them because she wanted Mr A to like her, and to make him happy. Ms B also submitted that Mr A sent photographs of himself, and he was pressuring her to send him naked photographs.

42. Ms B said that she and Mr A did not spend time together outside of the programme. Ms B recalls attempting to spend time with Mr A outside of the programme, but said that this did not occur as Mr A cancelled because of other commitments.

43. Ms B stated that she did not engage in sexual intercourse with Mr A, as her understanding was that she could not do so until she had stopped providing him with health services.

44. Ms B said that she contemplated telling her colleagues on many occasions, but feared the consequences.

Subsequent events

45. The rehabilitation service told HDC that it was first made aware of the allegations in May 2020 by an employee. On 14 May 2020, Mr A was visited at home by a rehabilitation service social worker during the course of another Training for Independence programme. During the visit, Mr A told the social worker about his relationship with Ms B, and showed the social worker text messages between himself and Ms B. Mr A indicated that he wished to make a complaint.

46. The social worker reported this to the rehabilitation service regional lead, Ms C, immediately following the appointment, and emailed photographs of the text messages to Ms C the next day.

47. On 18 May 2020, Ms B attended a meeting with the rehabilitation service management and Human Resources, and they provided her with a notice of suspension for alleged serious misconduct, pending investigation. Ms B resigned on 19 May 2020, and her resignation was accepted on the same day. The rehabilitation service notified the Occupational Therapy Board of New Zealand of the allegations on 20 May 2020.

Rehabilitation service investigation

48. The rehabilitation service carried out an investigation into the events. As part of this, it asked Ms B a series of questions, which were provided to HDC. Ms B told the rehabilitation service that Mr A had leaned into her car and kissed her, but that she did not inform the rehabilitation service because the situation was complicated by the communication that

they had been having. It was noted that Ms B decided to continue to treat Mr A, and, in addition, had "coffee sessions" with him.

49. Ms B told the rehabilitation service that her "top had come off" on three occasions during physical interactions, but that she and Mr A did not have sexual intercourse. She said that the relationship began approximately four weeks into Mr A's programme, and lasted about eight weeks in total.

50. The investigation documentation indicates that Ms B informed the rehabilitation service that she was aware of its Code of Conduct standards, as well as the Occupational Therapy Code of Conduct standards.

51. The rehabilitation service told HDC that Ms B's induction and training had included review of policies and procedures pertaining to its Code of Conduct, working with ACC and the specific contract guidelines, and standard operating procedures. The rehabilitation service also advised that Ms B had fortnightly supervision, as well as incidental oversight during working hours, and that no staff members who had worked regularly in the past or who currently work with Mr A have had any concerns about the care provided to Mr A by Ms B.

Further information

Statement from Ms B

52. Ms B said that she deeply regrets her behaviour, and she should have maintained professional boundaries no matter what Mr A's actions were, or how she felt about him. She advised that at the time, she was under "enormous emotional stress and not thinking clearly". She apologises to Mr A for any negative consequences that her actions may have caused him.

53. In relation to the text messages, Ms B submitted that Mr A initiated text messaging her outside of work hours; that the record provided was not a complete or accurate record of the communications — mainly showing only Ms B's responses and not Mr A's; that earlier messages showing how the relationship was completely non-physical and professional have not been supplied; and that the messages were provided in a "deliberately altered order" with messages missing, and "cherry picked and packaged in a way designed to cause maximum embarrassment and maximum damage to [Ms B] by [Mr A]".

54. Ms B also submitted that prior to starting Mr A's treatment she was concerned about seeing him alone at his home, and raised this with her manager, who reassured her that it was fine.

Statement from the rehabilitation service

55. In response to Ms B's statement, the rehabilitation service told HDC that there were no risk factors or care indicators identified during Mr A's triage or allocation process that raised concerns. The rehabilitation service said that it was appropriate to allocate Mr A's referral to Ms B because she was an experienced occupational therapist with approximately 15 years of experience, and previously had been an ACC Case Manager, so had appropriate experience with this type of work, and injuries. The rehabilitation service said that previously Mr A had participated in two rehabilitation programmes with female providers,

and no concerns were raised about his behaviour that would have required additional risk mitigation.

56. The rehabilitation service said that approximately four weeks into Mr A's programme, Ms B informed Ms C that Mr A had touched her leg and commented on her tights. The rehabilitation service said that Ms B was informed that they could report this to Mr A's ACC Case Manager and lodge an incident report. The rehabilitation service stated that Ms C also discussed with Ms B the option of having another rehabilitation provider assigned to Mr A, or always having another provider present during appointments, and that Ms C offered support to Ms B. The rehabilitation service told HDC that Ms B said that she did not want to make an issue about it, and declined to take the matter further, have another provider allocated to Mr A, or have another provider present during appointments.

57. The rehabilitation service said that at this time Ms C did not discuss with Ms B the need to talk with Mr A about the importance of therapeutic boundaries. Ms C said that this was because Ms B was an experienced practitioner and this was expected.

58. The rehabilitation service said that it would be considered normal process in this situation to identify, discuss, and review therapeutic boundaries with the clinician and provide support to ensure that the employee was comfortable having this discussion with the client. The rehabilitation service said that if the employee was not comfortable, another provider would be allocated to the client.

59. The rehabilitation service said that it takes no responsibility for the actions of Ms B. It stated that Ms B is an experienced clinician who is aware of the Occupational Therapy Board of New Zealand's Code of Ethics and the Code of Conduct, which she is bound to uphold. The rehabilitation service said that Ms B had multiple support mechanisms in place that she could have accessed, but, to its knowledge, did not.

Responses to provisional opinion

Mr A

60. Mr A was provided with the "information gathered" section of the provisional opinion. However, HDC has had no further contact from him.

Ms B

61. Ms B was provided with the sections of the provisional opinion that relate to her. She advised that she does not recall having informed the rehabilitation service that Mr A had touched her leg and commented on her clothing. Ms B said that if this did occur, then the rehabilitation service continued to send her to a client alone, after that client had made unwanted physical contact with her. Ms B noted that the rehabilitation service did not take steps to mitigate risk to her.

62. However, Ms B said that this does not absolve her of her responsibility for what occurred, and she accepts the provisional opinion and recommendations.

63. Ms B stated that since leaving the rehabilitation service she has not practised as an occupational therapist, nor does she hold an annual practising certificate. She said that she feels too ashamed of the way that she interacted with Mr A to return to this field of work.

Rehabilitation service

64. The rehabilitation service was provided with the provisional opinion. The rehabilitation service responded that it does not wish to provide any further comment, and it accepted the recommendations set out below.

Opinion: Ms B — breach

Introduction

65. Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mr A had the right to have services provided to him that complied with professional, ethical, and other relevant standards. At the time of events, Ms B was required to comply with the the rehabilitation service's Code of Conduct, as well as the Occupational Therapy Board of New Zealand's Code of Ethics (April 2015), which also references the "Professional Boundaries Guide" (2016) (see Appendix A).

66. The Code of Ethics states that occupational therapists shall not enter into, or continue with, any personal or professional relationships with clients that will, or have the potential to, exploit or harm the client and/or others.

67. The maintenance of professional boundaries is an integral part of the provision of health services. I consider that Ms B's conduct, specifically sending inappropriate text message communications, entering into an intimate relationship, and engaging in sexual acts with her client, Mr A, while providing him with services, breached professional boundaries and ethical standards.

Inappropriate communication and development of relationship

68. Between July and November 2018, Mr A was receiving health services from Ms B in her capacity as an occupational therapist. It is not disputed that during this time Ms B entered into an intimate and sexual relationship with Mr A. This is accepted by Ms B and is evident in the multitude of inappropriate electronic communications outlined above.

Power imbalance

69. When Ms B and Mr A entered into a therapeutic relationship, Ms B was aware that Mr A had experienced a head injury resulting in post-concussion symptoms, and that he was not working at the time. During their first appointment, Mr A informed Ms B, in her capacity as his occupational therapist, that he had been experiencing decreased confidence and increased sensitivity since his injury. He outlined to Ms B the symptoms that he was experiencing as a result of his head injury. Mr A did not know any personal information about Ms B.

70. The Occupational Therapy Board of New Zealand's "Professional Boundaries Guide" states:

> "Occupational therapists must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers and those close to them when receiving care. The health consumer does not have access to the same degree of information about the occupational therapist which increases the power imbalance."

71. In my opinion, there was a clear power imbalance, with Ms B having access to, and being able to access further information about Mr A in her capacity as an occupational therapist. Ms B had authority and influence over Mr A in her capacity as his occupational therapist, and was aware that Mr A had been experiencing difficulties in his life. The difficulties that Mr A was experiencing, as well as physical and mental health concerns, increased his vulnerability.

Text messages

72. Ms B has submitted that the text messages were not complete and not in order, and did not include the non-physical and professional communications that occurred. She also submitted that Mr A initiated the text messages, and certain conversations occurred with pressure from Mr A.

73. The Occupational Therapy Board of New Zealand's Code of Ethics states that occupational therapists shall:

> "Not enter into or continue with any personal or professional relationships with clients or their carers that will, or have the potential to, exploit or harm the client and/or others."

74. The Occupational Therapy Board of New Zealand's "Professional Boundary Guide" states:

> "Occupational therapists must be aware of professional boundaries and ensure communication via text is not misinterpreted by the health consumer or used to build or pursue personal relationships."

75. In my view, the content of the messages between Ms B and Mr A alone contravenes the above standards, and the timeline or completeness of the communications in these circumstances are not relevant. Furthermore, regardless of whether Mr A was the initiator of the text messaging, and instigator of certain conversations, it was Ms B's responsibility as a healthcare provider to maintain the professional boundary, stop — and certainly not respond to — these communications, and advise her manager in accordance with the Occupational Therapy Board of New Zealand's "Code of Ethics" and "Professional Boundaries Guide".

Reducing risk of boundary transgressions

76. Ms B said that she contemplated telling her colleagues on many occasions, but feared the consequences. The Occupational Therapy Board of New Zealand's "Professional Boundaries

Guide" states that occupational therapists can reduce the risk of boundary transgressions by:

> "Consulting with colleagues and/or the manager in any situation where it is unclear whether behaviour may cross a boundary of the professional relationship …
>
> …
>
> Raising concerns with a colleague if the occupational therapist has reason to believe that they may be getting close to crossing the boundary or that they have crossed a boundary."

77. Ms B clearly failed to recognise the significance of treating patients at home, where boundary transgressions could be more likely to occur. Ms B also failed to take steps to reduce the risk of boundary transgressions between herself and Mr A. When Ms B and Mr A began to communicate via text message, this would have been an opportune moment for her to inform her supervisor and manager at the rehabilitation service to prevent any further transgressions occurring.

Physical relationship

78. Ms B has acknowledged that her relationship with Mr A escalated to physical contact with "kissing and cuddling", and also that she took off her top on three occasions. Their physical relationship is further evidenced by the sexually explicit matters that were discussed via text message. Ms B said that she enjoyed the attention and kindness that Mr A showed her.

79. Ms B confirmed that the relationship occurred during the 12-week programme, with no further communications subsequently, and therefore the relationship and occupational therapy services overlapped entirely. In addition, she said that they did not meet outside the programme, and therefore the physical relationship was conducted during treatment sessions.

80. The Occupational Therapy Board of New Zealand's "Professional Boundaries Guide" states:

> "There is a professional onus on occupational therapists to maintain a relationship based on care plans and goals that are therapeutic in intent and outcome.
>
> …
>
> Occupational therapists shall not enter into or continue with any personal or professional relationships with clients or their carers that will, or have the potential to, exploit or harm the client and/or others. (Please also refer to Guideline of Professional Boundaries for Occupational Therapists …)
>
> ...
>
> Sexual relationships with current health consumers are inappropriate. They are unacceptable because they can cause significant and enduring harm to health consumers, damage the health consumer's trust in the occupational therapist and the public trust in occupational therapists, impair professional judgment and influence

> decisions about care and treatment to the detriment of the health consumer's well-being. However consensual the relationship appears to be, there is a power imbalance that will always mean that there is the potential for abuse of the occupational therapists professional position and harm to the health consumer."

81. Ms B has submitted that she had personal stressors and her own vulnerabilities at the time. However, in my opinion this does not excuse her contravening the ethical and professional standards expected of her. It was the responsibility of Ms B, the healthcare professional, to set and maintain the professional boundary, and to inform her manager, supervisor, or colleague, when the transgression first occurred. She failed to do this.

Concerns about the rehabilitation service

82. Ms B said that she was concerned about attending Mr A's home alone, and raised this with her manager prior to commencing treatment. Ms B submitted that her employer must take some responsibility for the situation in which she was placed.

83. The rehabilitation service's "Code of Conduct" states:

> "[Make] sure you manage your personal and workplace relationships appropriately, so they do not adversely affect the way you do your work.
>
> …
>
> [Behave] in a manner that will not bring the rehabilitation service into disrepute."

84. The Occupational Therapy Board of New Zealand's "Professional Boundaries Guide" envisages that rural and remote locations, including a person's home, are places where there could be a risk of boundary transgressions, and places responsibility on the occupational therapist to recognise these situations.

85. I do not accept that Ms B's concerns which she states she made to her employer about visiting Mr A and the subsequent development of an intimate relationship are associated. The rehabilitation service had clear Code of Conduct expectations that Ms B would not engage in an inappropriate relationship with Mr A, and this appears consistent with Ms B's professional obligations. Therefore, I do not accept that the rehabilitation service is responsible for the development of a relationship between Ms B and Mr A. I note that Ms C offered Ms B the option of lodging an incident report and assigning another therapist to Mr A, but Ms B refused this.

Conclusion

86. In summary, I consider that by sending inappropriate text message communications, entering into an intimate relationship, and engaging in physical sexual contact with Mr A, while providing him with occupational therapy services, Ms B failed to maintain appropriate professional boundaries and failed to comply with the ethical standards set out in the the rehabilitation service Code of Conduct and the Occupational Therapy Board of New Zealand's Code of Ethics and Professional Boundaries Guide. Accordingly, I find that Ms B breached Right 4(2) of the Code.

Opinion: Rehabilitation service — other comment

87. Prior to the development of the inappropriate communication and relationship between Ms B and Mr A, Ms B informed her supervisor and manager at the rehabilitation service, Ms C, that Mr A had touched her and made a comment about her clothing in an inappropriate manner.

88. Ms C discussed with Ms B possible options they could take in response to this behaviour. However, Ms C did not tell Ms B to discuss with Mr A the importance of therapeutic boundaries, or provide her with support to do so. I acknowledge the rehabilitation service's statement that Ms B declined to take the matter further, and had multiple support mechanisms in place that she could have accessed, including the rehabilitation service's employee assistance programme and Ms B's professional body.

89. Whilst I acknowledge that Ms B is an experienced occupational therapist, was aware of her professional obligations, and was well aware that her subsequent actions with Mr A were inappropriate, I consider that it was Ms C's and the rehabilitation service's responsibility at this time to provide adequate supervision and support to Ms B, to enable her to set therapeutic boundaries with Mr A and ensure a safe working environment. I note that the rehabilitation service has told HDC that in this situation it considers that its normal process would have been for Ms C to identify, discuss, and review therapeutic boundaries with Ms B and provide support to ensure that Ms B was comfortable having a discussion about boundaries with Mr A. Had Ms B not been comfortable, another therapist would have been allocated to Mr A. However, these expectations are not clear in the "Additional Expectations for Managers" section of the rehabilitation service's Code of Conduct.

90. In addition to my below recommendations, I invite the rehabilitation service to reflect on what further actions could have been taken at this time to provide Ms B with additional support to manage this situation.

Recommendations

91. I recommend that Ms B:

a) Apologise in writing to Mr A for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A;

b) Undertake training relating to boundaries management, should she apply for an annual practicing certificate. Ms B is to notify HDC should she apply for an annual practicing certificate and provide confirmation that she has completed the necessary training.

92. Should Ms B apply for an annual practising certificate, I recommend that the Occupational Therapy Board of New Zealand consider assessing Ms B's competence and whether any further training is warranted, and inform HDC of the outcome of the consideration.

93. I recommend that the rehabilitation service review its Code of Conduct to ensure that it provides sufficient guidance to managers about supervising staff that manage boundaries with clients. Evidence of this is to be provided to HDC within three months of the date of this report.

Follow-up actions

94. A copy of this report with details identifying the parties removed will be sent to the Occupational Therapy Board of New Zealand, and it will be advised of Ms B's name.

95. A copy of this report with details identifying the parties removed will be sent to ACC and Occupational Therapy New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

96. Due to the nature and seriousness of the Breach, a referral to the Director of Proceedings was considered. However, noting that Ms B immediately left the profession and has indicated she will not reapply to practice, together with some extenuating circumstances personal to Ms B, on balance I am satisfied that, in this particular case, a referral is not required.

Appendix A: Relevant standards and rehabilitation service policies

Professional and Ethical Standards

[Rehabilitation Service] Code of Conduct

The Code of Conduct that Ms B was expected and required to adhere to in the performance of her duties at the time of these events stated:

> "You are expected to exercise good judgement to determine what action to take in a given situation. Your actions need to be able to withstand scrutiny from internal and external parties. Our behaviour and actions must be seen fair, impartial, responsible and trustworthy at all times.
>
> …
>
> 1. Respect the rights of others by:
>
> - Treating others fairly, respectfully and without discrimination or harassment.
> - Being respectful of and responsive to all cultures, values and beliefs.
> - Upholding the rights of clients.
>
> 2. Be honest and act with integrity in all aspects of your employment (e.g. in your work with clients, with regard to work attendance …)
>
> 3. Perform your duties to the best of your ability by:
>
> - …
> - Complying with all policies and processes.
> - Complying with the Code of any professional body that you are registered or affiliated with, where this impacts upon your work with [the rehabilitation service].
> - …
> - Making sure you manage your personal and workplace relationships appropriately, so they do not adversely affect the way you do your work.
>
> 4. Uphold the reputation and standing of [the rehabilitation service] by:
>
> - Behaving in a manner that will not bring [the rehabilitation service] into disrepute."
>
> …"

Occupational Therapy Board of New Zealand "Code of Ethics for Occupational Therapists"

The Code of Ethics that Ms B was expected and required to adhere to in the performance of her duties at the time of these events stated:

> "1.2 Occupational therapists shall ensure that people receiving their services feel safe, accepted, and are not threatened by actions, omissions or attitudes of the therapist.

> Occupational therapists shall:
>
> …
>
> 1.2.3 Not enter into or continue with any personal or professional relationships with clients or their carers that will, or have the potential to, exploit or harm the client and/or others. (Please also refer to Guideline of Professional Boundaries for Occupational Therapists …)."

Occupational Therapy Board of New Zealand "Professional Boundaries" guide
The professional boundaries guideline states:

> "Occupational therapists must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers and those close to them when receiving care. The health consumer does not have access to the same degree of information about the occupational therapist which increases the power imbalance. The occupational therapist may also have a professional relationship with the health consumer's family and others close to that person that may increase the health consumer's vulnerability.
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> The power imbalance is increased when the health consumer has limited knowledge, is made vulnerable by their health circumstances or is part of a vulnerable or marginalised group. Some particularly vulnerable consumers are children, frail older people, and those with mental illness or disability. Health consumers must be able to trust occupational therapists to protect them from harm and to promote their interests. Occupational therapists must take care to ensure that their own personal, sexual, or financial needs are not influencing interactions between themselves and a health consumer. They must also recognise that health consumers may read more into a therapeutic relationship with the occupational therapist and seek to have personal or sexual needs met. It is the occupational therapists responsibility if this occurs to maintain the appropriate professional boundary of the relationship.
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> The occupational therapist has the responsibility of knowing what constitutes appropriate professional practice and to maintain his or her professional and personal boundaries. The health consumer is in an unfamiliar situation and may be unaware of the boundaries of a professional relationship. It is the responsibility of the professional to assist health consumers to understand the appropriate professional relationship. There is a professional onus on occupational therapists to maintain a relationship based on care plans and goals that are therapeutic in intent and outcome.
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> Text messaging may be an appropriate form of communication, e.g. reminding health consumers about appointments. Occupational therapists must be aware of professional boundaries and ensure communication via text is not misinterpreted by the health consumer or used to build or pursue personal relationships.
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All messages should be documented.

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Occupational therapists can reduce the risk of boundary transgressions by:

- Maintaining the appropriate boundaries of the occupational therapist — health consumer relationship, and helping health consumers understand when their requests are beyond the limits of the professional relationship

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- Recognising that there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings e.g. rural and remote locations. For example, when care is provided in a person's home, occupational therapists may become involved in the family's private life and need to recognise when his or her behaviour is crossing the boundaries of the professional relationship.

- Using supervision to discuss potential boundary issues.

- Consulting with colleagues and/or the manager in any situation where it is unclear whether behaviour may cross a boundary of the professional relationship, especially circumstances that include self-disclosure or giving a gift to or accepting a gift from a health consumer.

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- Raising concerns with a colleague if the occupational therapist has reason to believe that they may be getting close to crossing the boundary or that they have crossed a boundary. Sometimes a newly registered occupational therapist may not be aware that his/her actions have crossed a boundary.

- Discussing the nature of a therapeutic relationship with a health consumer if they believe that the health consumer is communicating or behaving in a way that indicates they want more than a professional relationship with the occupational therapist.

- Consulting with colleagues or the manager where another colleague appears to have transgressed boundaries or a health consumer is behaving in an inappropriate manner towards an occupational therapist.

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Sexual relationships with current health consumers are inappropriate. They are unacceptable because they can cause significant and enduring harm to health consumers, damage the health consumer's trust in the occupational therapist and the public trust in occupational therapists, impair professional judgment and influence decisions about care and treatment to the detriment of the health consumer's well-being. However consensual the relationship appears to be, there is a power imbalance that will always mean that there is the potential for abuse of the occupational therapists professional position and harm to the health consumer."