Registered Nurse, Mr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 13HDC01357)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

Introduction

1. Mr B is a registered nurse (RN). He was employed by a district health board (the DHB) working in the Community Mental Health Service (MHS) as a full-time community forensic mental health nurse. His role included court liaison, which involved working with alleged offenders who might require the assistance of MHS. Ms A had been a client of the MHS, on and off since the early nineties. Her medical history included major depressive disorder and associated anxiety and panic attacks. She also had a history of suicidal ideation, which increased when stressful situations arose. More recently, she had also developed alcohol related issues.

2. Ms A and RN B lived in the same town and had intermittent social contact. During June and early July 2013, RN B became directly involved in Ms A's clinical care. The DHB said that RN B's involvement in the care of Ms A "was centred on responding to requests from her case manager for assistance with communication from the Courts and transportation, and … assistance in locating emergency accommodation and respite".

Sexual relationship

3. On 16 September 2013 Ms A divulged to her MHS case manager, Ms C, that she had sexual intercourse with RN B on 6 September 2013.

4. Ms A told Ms C that on Friday 6 September 2013 she bumped into RN B in town and that he asked whether she still lived across the road, and said that "he might pop in later". Ms A advised that she did not think this unusual as he had been involved with her care. Ms A told Ms C: "I thought he was just coming to see how I was."

5. At about 4.30pm RN B arrived at Ms A's residence in a DHB car. He pulled out a bottle of wine, which he said was for her. He then said: "I wonder if there's something you could do for me … he got his penis out." RN B produced a condom and they had sexual intercourse, and soon after this he left.

6. Ms A told Ms C that RN B returned later that day and they had sexual intercourse again. RN B told Ms A that he would "return on Monday with more wine and that he … had always fancied her".

7. Ms A told Ms C that she texted RN B on 8 September 2013 (Sunday) telling him not to return on the Monday. Ms A also told Ms C that she had since considered "overdosing on her pills", and she felt "yuck about it".

The DHB's response to the complaint

Meeting with Ms A

8. On 19 September 2013 DHB staff met with Ms A. Ms A was asked whether the sex was consensual. Ms A stated that "she felt coerced at the beginning but once he said things weren't great at home her soft side took over and she gave in". She said that she did not start to feel uncomfortable again until later.

Meeting with RN B

9. DHB staff met with RN B. RN B advised at this meeting that his initial interaction with Ms A in the street was purely coincidental. He said that he then asked to come to see her "to tell her she was making poor choices around driving". He further advised, however, that he did not feel that he was seeing her as a nurse. He acknowledged that he gave her a bottle of wine and that they had sex, and that he returned later that day and they had sex again.

10. During the meeting, RN B offered his resignation, which was accepted.

Findings

RN B

11. By having sexual intercourse with Ms A while knowing she was a patient of the MHS team, and after he had recently been involved in her care, RN B departed from the Nursing Council of New Zealand *Guidelines: Professional Boundaries.* He also failed to follow the DHB's Code of conduct. RN B failed to comply with professional and ethical standards and, accordingly, breached Right 4(2)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

12. RN B had been involved in Ms A's care two months prior to having sexual intercourse with her. He knew at the time the sexual incidents occurred that Ms A was still a patient of the DHB. Having recently been involved in her care, RN B was also aware that Ms A was a vulnerable consumer with several mental health issues including issues with alcohol, yet he had sexual intercourse with her on two occasions, provided her with alcohol, and offered to bring more alcohol. RN B's conduct was sexually exploitative and, therefore, he breached Right 2[2] of the Code.

The DHB

13. The DHB was not found to be vicariously liable for RN B's breaches of the Code.

Complaint and investigation

14. The Commissioner received a complaint from Ms A about the services provided to her by RN B at the DHB.

15. The following issues were identified for investigation:

- *The appropriateness of the services provided by RN B to Ms A.*
- *The appropriateness of RN B's relationship with Ms A.*
- *The appropriateness of the care provided to Ms A by the DHB, including the appropriateness of its response to her complaint about RN B.*

[1] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[2] Right 2 of the Code states: "Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation."

16. An investigation was commenced on 23 January 2014.

17. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
RN B	Provider/registered nurse
District Health Board	Provider

18. Information was also reviewed from the Nursing Council of New Zealand.

Information gathered during investigation

RN B

19. RN B is a registered nurse. At the relevant time, RN B was employed by the DHB working in the MHS as a full-time community forensic mental health nurse. His role included court liaison, which involved working with alleged offenders who might require the assistance of the MHS.

Ms A

20. Ms A (aged 48 years at the time of events) had been a client of the MHS on and off since the early nineties. Her medical history included major depressive disorder and associated anxiety and panic attacks. She also had a history of suicidal ideation, which increased when stressful situations arose. In 2013 she also developed alcohol related issues.

RN B's professional contact with Ms A

21. Ms A and RN B had known each other personally for many years. They both lived in the same town and had had intermittent social contact.

22. RN B became directly involved in Ms A's clinical care during June and early July 2013. The DHB advised this Office that RN B's involvement in the care of Ms A "was centred on responding to requests from her case manager for assistance with communication from the Courts and transportation, and requests from the TACT[3] team for assistance in locating emergency accommodation and respite".

23. On 12 June 2013 Ms A's clinical notes record that she underwent day surgery at a hospital, and that afterwards RN B transported her back home.

24. From 24 June 2013 until 1 July 2013 Ms A's usual case manager at MHS, Ms C, was on leave. Ms C assigned Ms D as Ms A's relieving case manager for that period. Ms D asked RN B to assist with Ms A during that time.

[3] TACT (Triage, Assessment, Crisis and Treatment Team) is a 24-hour, 7 days a week service for people in the acute phase of a psychiatric illness, or at risk of an acute episode, who may require assessment and short-term follow-up.

25. On 24 June 2013 Ms A presented at the MHS after being asked to leave her accommodation. RN B supported Ms A to find temporary accommodation. Accommodation was found and RN B drove Ms A to the accommodation.

26. On 25 June 2013 the Acting Manager of the MHS, assigned RN B to check Ms A's bail conditions with the court.

27. On 26 June 2013 Ms D arranged respite accommodation for Ms A at a residential facility in another town and requested that RN B liaise with the court to organise bail to that facility. Ms D also arranged for RN B to drive Ms A to the facility, which he did on 28 June 2013.

28. On 1 July 2013 RN B and Ms D discussed Ms A with two DHB psychiatrists. RN B discussed Ms A's accommodation situation with Ms A and a staff member at the residential facility, and then RN B passed on this information to Ms C, on her return from leave, and to the TACT team.

29. On 2 and 3 July 2013 RN B and Ms C discussed Ms A and her accommodation and bail arrangements. After that, RN B had no further involvement in Ms A's care.

Relationship divulged

30. On 16 September 2013 at about 2pm Ms C noticed Ms A sitting outside a shop when she was driving past. Ms C stopped and talked to Ms A. Ms C made notes after this encounter, which Ms A signed as being correct on 19 September 2013. Ms A advised HDC that the contents of the statement are correct.

31. It is recorded that Ms A told Ms C: "I need to tell you something; I need to get it off my chest. I feel yuck about it." Ms A then divulged that she had had sexual intercourse with RN B on 6 September 2013. Ms C talked briefly to Ms A about this, and arrangements were made to talk about it in more detail later that day.

32. At 3.30pm Ms A met Ms C at Ms C's office at the MHS. Ms C informed Ms A that she would need more information so that the "complaint could be investigated". Ms C also explained to Ms A the implications for nurses who cross professional boundaries.

Ms A's account

33. Ms A told Ms C that on Friday 6 September 2013 she bumped into RN B in town (around 1.30pm) and that he asked whether she still resided across the road, and said that "he might pop in later". Ms A advised that she did not think this unusual as he had been involved with her care while Ms C had been on leave. Ms A told Ms C: "I thought he was just coming to see how I was."

34. At about 4.30pm RN B arrived at the place where Ms A was staying, in a DHB car. Ms A told Ms C that she was sitting outside in the sun having a smoke, and RN B asked her what she had been up to. Ms A told Ms C that RN B said, "I've got something for you, come in here" (meaning into her unit). Ms A stated to Ms C that RN B pulled out a bottle of wine, which he said was for her. He then said, "I wonder if there's something you could do for me" and he "got his penis out". Ms A stated that she said to him, "You're married" and that he said, "Don't let that worry you, you

understand" and she replied, "I do understand". RN B produced a condom and they had sexual intercourse, and soon after that he left.

35. Ms A told Ms C that RN B returned later that day, and they had sexual intercourse again. Ms A also said that RN B told her that he would "return on Monday with more wine", and that he had "always fancied her".

36. Ms A told Ms C that she texted RN B on 8 September 2013 (Sunday) telling him not to return on the Monday. Ms A also told Ms C that she had considered "overdosing on her pills" the evening after the sexual encounters occurred, and that she felt "yuck about it". HDC was provided with a copy of the text message sent by Ms A to RN B on 8 September. RN B did not respond to the text.

37. RN B and Ms A have not met since these events.

Information provided to the DHB

Meeting with Ms A

38. On 19 September 2013, the MHS Operations Manager, the DHB's HR Advisor, and Ms C met with Ms A. HDC was provided with the notes from the meeting.

39. Ms A read over the notes Ms C had made following their initial encounter and meeting on 16 September, and agreed that they were correct. Ms A signed the notes as a true record of what had occurred. Ms A advised at that meeting that she was "looking for someone to be in her life and though[t] it might be [RN B] but now she feels it was just sex".

40. Ms A was asked whether the sex was consensual. The notes record that Ms A stated that "she felt coerced at the beginning but once he said things weren't great at home her soft side took over and she gave in. She didn't start to feel uncomfortable again until later". The DHB did not ask Ms A any further questions in relation to her advising that "she felt coerced at the beginning". At the end of the meeting, Ms C encouraged Ms A to refrain from discussing the sexual encounters with anyone, and to "keep this matter quiet".

Meeting with RN B

41. The Acting General Manager Mental Health, asked RN B to attend a meeting with regard to Ms A's complaint. The Acting General Manager provided RN B with a full copy of Ms A's complaint (as documented by Ms C following her discussions with Ms A on 16 September 2013 and signed as a correct record by Ms A on 19 September 2013), and the notes made at the meeting with Ms A on 19 September 2013.

42. RN B and his solicitor met with the Acting General Manager Mental Health, the MHS Operations Manager, and the HR Advisor. RN B admitted the sexual encounter and stated that Ms A's account "is accurate although not entirely accurate". However, he said that he did not wish to dispute the complaint or challenge it.

43. Notes from this meeting record that RN B advised that his interaction with Ms A was "purely coincidental not planned". He said that he was attending to another client across the road, and that he saw her car and knew she was a disqualified driver. He

had seen her and the car in town and made "the poor clinical decision to stop and talk to her". He said that he asked to come to see her "to tell her she was making poor choices around driving". He further advised that the bulk of the conversation was about Ms A's historic personal issues, and that she had no money. He advised that he "stepped out of his role as a nurse" and "didn't feel he was seeing her as a nurse". It is recorded in the notes of the meeting that RN B described it as having been "him and [Ms A] as they used to be".

44. RN B advised that he "shared some of the stresses in his life" with Ms A and it was "a weak moment". He said that he gave her a bottle of wine and that she was appreciative, he cuddled her and they then had sex, which he believes was mutually initiated.

45. RN B advised that he offered to come back (that day) and take Ms A to town so she could check the money machine. He said that when he returned at 4.30pm Ms A had had a couple of glasses of wine. Ms A had checked her bank balance on her tablet, so she did not require RN B to take her to town. RN B stated that Ms A said, "Do you want some more?" and that they had sex again.

46. RN B advised that he knew he had crossed a boundary, that he had made a serious error of judgement, and that he was entirely at fault. He further stated that he had been alcohol dependent for a long time, under stress, and could not continue to practise nursing. He said he knew that he really needed help with dependency, and that he was not fit to be a nurse at that time.

47. During the meeting, RN B offered his resignation, which was accepted.

RN B's response to HDC

48. RN B advised HDC that his professional contact with Ms A started on 25 June 2013. However, Ms A's case notes record that he was also involved with her care on two earlier occasions (12 June 2013 and 24 June 2013, as stated above). RN B said that throughout this period (from 12 June until 3 July 2013) he did not have any formal involvement in Ms A's court proceedings, and he did not register Ms A under his forensic caseload.

49. RN B stated that on 16 September 2013 at around 11am, he observed Ms A driving in her car. He saw her again about half an hour later walking close to her car, and approached her and asked whether she would be at her residence later, as he would like to see her if agreeable. He said that he made reference to her driving at this time as she was disqualified from driving.

50. RN B advised that he went to Ms A's residence after work and, after some conversation, including her driving without a licence, her current circumstances of financial hardship, and some family catching up, he offered Ms A a bottle of wine. He said that at this time they hugged and he "became aroused", and they engaged in consensual sexual intercourse.

51. RN B said that he returned about an hour later because "she had sent me a text message enquiring if I might be of assistance to her over the weekend", and that they had sexual intercourse again.

52. RN B advised that at the meeting with DHB staff relating to these events, he offered his resignation as he did not believe that he could practise in a professional manner because of his actions. He acknowledged that he was "for a limited period, a likely significant additional member of the mental health team from Ms A's perspective providing care", and that he knows he "failed to maintain a professional boundary which must exist, despite any mitigating circumstances".

53. RN B advised that he has since consulted his general practitioner (GP) and has engaged in professional counselling through a Primary Health Organisation referral. He further advised that he is not using alcohol, and that he resumed nursing approximately eight weeks after resigning. He now practises on a casual basis in aged care and dementia.

54. RN B said that he has practised for 32 years in virtually all domains of mental health nursing care and that, prior to this incident, he did not bring the "profession into disrepute".

DHB referral of complaint to Nursing Council

55. On 3 October 2013 the DHB notified the New Zealand Nursing Council (the Nursing Council) of the incident. The DHB advised the Nursing Council that RN B's resignation was accepted on the basis of "his awareness of his current inability to practise safely, his willingness to seek and accept rehabilitation, and his previous exemplary employment record and professional practice". The Nursing Council referred the complaint to HDC on 14 October 2013, and advised that it had not placed any conditions on RN B's practice.

The DHB's response to HDC

56. The DHB advised HDC that prior to RN B having any involvement with Ms A's care, he informed Ms C (in her capacity as Ms A's case manager) that he knew Ms A socially. The DHB advised that it was not aware that RN B had visited Ms A on the date the sexual encounter occurred, nor that a sexual encounter had taken place on that date, until Ms A disclosed it to Ms C.

57. The DHB provided its Code of Conduct For Staff (version No. 6). Code 1.04 states: "With respect to their duty of care, all [DHB] staff members will at all times: … not enter into sexual or inappropriate relationships with a patient/client." The DHB advised that at the time of the sexual encounter RN B was not directly involved in Ms A's care, but that he was aware that she was still a current client of the service.

Training

58. The DHB was asked what training RN B had received on professional boundaries. The DHB advised that during 2010 and 2011 RN B participated in two sessions of a Mental Health In-Service Programme, which included two one-hour relevant sessions focusing on boundaries.

59. The DHB further advised that all mental health staff were individually provided with copies of the updated Nursing Council Guidelines on Professional Boundaries and Code of Conduct in 2012.

60. The DHB advised this Office that over the last three years it has hosted Nursing Council and New Zealand Nursing Organisation presentations that focused on both professional boundaries and the nursing code of conduct. It advised, however, that RN B did not attend any of these sessions.

Responses to provisional opinion

61. Ms A, RN B and the DHB were given the opportunity to respond to relevant sections of my provisional opinion.

62. Ms A's response has been incorporated into the report where relevant.

63. The DHB accepted the findings and advised that it noted the proposed recommendation I made relating to it (see below).

64. RN B accepted the proposed recommendations, and advised "I sincerely regret the harm I have caused [Ms A]".

Other relevant standards

65. The Nursing Council of New Zealand *Code of Conduct for Nurses* (June 2012) includes the following:

> "7.14 Do not engage in sexual or intimate behaviour or relationships with health consumers in your care or with those close to them."

66. Further information is provided to nurses in the Nursing Council of New Zealand *Guidelines: Professional Boundaries* (June 2012), which state the following:

> "***Sexual relationships with current health consumers/Relationships with former health consumers and their families***
>
> Sexual relationships with former health consumers may be inappropriate however long ago the professional relationship ceased. There is no arbitrary time limit that makes it safe for a nurse to have an intimate or sexual relationship with a health consumer who was formerly in their professional care. The reason for this is that the sexual relationship may be influenced by the previous therapeutic relationship where there was a clear imbalance of power. There is also potential for the health consumer to be harmed by this relationship.

In considering whether a relationship could be appropriate the nurse must consider:

- how long the professional relationship lasted (the longer the relationship lasts, the less appropriate a personal relationship becomes). Assisting a health consumer with a temporary problem e.g. a broken limb is different from providing long-term care for a chronic condition;
- the nature of that relationship in terms of whether there was a significant power imbalance and whether the nurse could be perceived as using their previous influence to begin a relationship;
- the vulnerability of the health consumer at the time of the professional relationship and whether they are still vulnerable (including the health consumer's psychological, physical and character traits);
- whether they may be exploiting the knowledge they hold about the health consumer because of the previous professional relationship; and
- whether they may be caring for the health consumer or his or her family members in the future.

Where the relationship was a psychotherapeutic one or involved emotional support, where the nurse was privy to personal information that could compromise the health consumer person if used out of a professional setting, or if the health consumer was previously a mental health consumer or has an intellectual disability, it may never be appropriate for a sexual or intimate relationship to develop."

Opinion: RN B — Breach

Introduction

67. Under Right 4(2) of the Code, Ms A had the right to have services provided that complied with professional and ethical standards. She also had the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation (Right 2 of the Code). I consider that RN B's conduct was unprofessional and unethical. I also consider that his behaviour was sexually exploitative.

Relationship between RN B and Ms A

Professional relationship

68. RN B, at the time of these events, was employed by the DHB, working in the MHS as a full-time community forensic mental health nurse. His role included court liaison, which involved working with alleged offenders who might require the assistance of MHS.

69. RN B said that his professional contact with Ms A started on 25 June 2013. However, Ms A's case notes record that, during the relevant period, RN B first had professional contact with Ms A on 12 June 2013.

70. RN B and the DHB said that RN B did not have any formal involvement in Ms A's court proceedings, he was not involved in providing any mental health services to the court on her behalf, and that Ms A was not registered under his forensic caseload. Nonetheless, I am satisfied that there was a professional relationship between RN B and Ms A. In particular, in his professional capacity as a registered nurse employed by the DHB, RN B provided help to Ms A with transportation, checking bail conditions with the court, and organising bail to suitable accommodation. RN B was also involved with discussing Ms A's current situation at the time with psychiatrists and other staff members.

71. Based on the evidence before me, I accept that a direct professional relationship was in place from 12 June 2013 until 3 July 2013.

72. RN B referred to his previous social contact with Ms A. In my view, once a professional relationship existed, RN B had an obligation to comply with professional and ethical standards regardless of any previous social relationship.

Sexual relationship

73. RN B accepts that he had sexual intercourse with Ms A. However, there are differing accounts between RN B and Ms A regarding when the sexual encounters occurred.

74. Ms A advised that on 6 September 2013 she bumped into RN B in town (around 1.30pm) and that after establishing that she was still residing across the road, he said "he might pop in later". She advised that she did not think this unusual as he had been involved with her care in June, and that she thought he was just coming to see how she was.

75. Ms A said that RN B arrived later about 4.30pm in a DHB car with a bottle of wine which he said was for her, and said, "I wonder if there's something you could do for me". She said that RN B "got his penis out", produced a condom and they then had sexual intercourse. He left soon afterwards, only to return later that day and have sexual intercourse with her again. Initial plans were made for RN B to return on Monday with more wine, and he told Ms A that he had "always fancied her". Ms A later texted RN B telling him not to return on the Monday.

76. On 16 September 2013 Ms A divulged the sexual encounters to Ms C. Ms A advised Ms C that later that evening she had considered "overdosing on her pills". She said that she felt "yuck about it".

77. RN B advised this Office that the sexual encounters took place on 16 September 2013, and provided some different times as to when the events occurred, compared with Ms A's account.

78. Both Ms A and RN B acknowledge that the sexual encounters occurred on only one day. Ms A divulged the sexual encounters to Ms C at 2pm on 16 September 2013, and

said that the encounters took place on 6 September 2013. RN B advised that the sexual encounters occurred around 4.30pm on 16 September 2013. Based on the evidence before me I accept that the sexual encounters occurred on 6 September 2013, and that RN B is mistaken as to the timing of events.

Professional standards

79. I note that RN B advised the DHB that his initial interaction with Ms A (on 6 September 2013) was "purely coincidental not planned". He advised that initially his reason for stopping to talk to Ms A was to tell her that she was making poor choices around driving. He also advised that during this interaction he stepped out of his role as a nurse, and did not believe he was seeing Ms A as a nurse. He told the DHB that he saw it as "him and [Ms A] as they used to be".

80. In my opinion, the professional boundary was clearly becoming blurred at that stage; RN B acknowledged that he was "for a limited period, a likely significant additional member of the mental health team from [Ms A's] perspective providing care". It is not surprising, therefore, that Ms A felt that this initial interaction, and RN B's offer to come to see her, was not unusual, as he had been involved with her care. Ms A stated: "I thought he was just coming to see how I was."

81. RN B has acknowledged that he "crossed a serious boundary" by having sexual intercourse with Ms A, and has admitted that it was unprofessional. He stated that he had been alcohol dependent for a long time, and under stress. He has since consulted with his GP and has engaged in professional counselling through a Primary Health Organisation referral, and advised that he no longer drinks alcohol. He admitted that he could not practise at that time and offered his resignation.[4]

82. RN B acknowledged that he "failed to maintain a professional boundary which must exist, despite any mitigating circumstances".

83. While I acknowledge that RN B was not involved in Ms A's care at the time the sexual encounters occurred, he had, however, been directly involved in Ms A's clinical care only two months previously, and knew that she was a vulnerable consumer and still a client of the MHS.

84. The importance of maintaining professional boundaries in such situations is clearly set out in the Nursing Council of New Zealand *Guidelines: Professional Boundaries* (as set out above). It is a responsibility of a registered nurse to maintain professional boundaries and ethical standards.

85. This Office has previously stated that "[p]ersonal relationships between nurses and patients with whom they have previously had a professional relationship are almost always inappropriate".[5] The Nursing Council of New Zealand's *Code of Conduct for Nurses* states that entering into a sexual or inappropriate intimate relationship with a

[4] I note that eight weeks later he resumed nursing and now practises on a casual basis in aged care and dementia at a rest home facility, and in the hospital ward of a rest home.
[5] Opinion 12HDC00027 (12 December 2013) available at www.hdc.org.nz.

client or ex-client is an example of unethical behaviour that could be considered to be a basis for a finding of professional misconduct.

86. By having sexual intercourse with Ms A while knowing that she was a patient of the MHS team, and after he had recently been involved in her care, RN B departed from the Nursing Council's Guidelines. RN B also failed to follow the DHB's Code of Conduct, which states at Code 1.04 that DHB staff members are not to enter into sexual or inappropriate relationships with patients or clients of the service. In these circumstances, I find that RN B failed to comply with professional and ethical standards and, accordingly, breached Right 4(2) of the Code.

Sexual exploitation

87. The time that had elapsed between RN B's professional relationship with Ms A and the sexual encounters — about two months — is also relevant. RN B knew at the time that the sexual encounters occurred that Ms A was still a patient of the DHB. Having recently been involved in her care, RN B was aware of Ms A's personal and medical issues.

88. This matter has been highlighted in previous reports from this Office.[6] In 06HDC06218, HDC's expert advisor, registered psychiatric nurse Clarissa Broderick, stated:

> "[The] nurse has the responsibility to recognise the significant power imbalance that exists within the therapeutic relationship. The dynamics of a relationship that involves disclosure on the client's part, and empathy and understanding from the nurse, can arouse strong emotions for the client and feelings of dependence. To take advantage of these emotions, to form a 'friendship', intentionally or not, is unethical and exploitative …"

89. Ms A was a vulnerable consumer with several mental health issues. She had a history of major depressive disorder, anxiety and panic attacks, with episodes of suicidal ideation and, more recently, problems with alcohol. RN B arrived in a DHB car and provided her with alcohol and, as he advised the DHB, Ms A "was appreciative". RN B said that he cuddled Ms A and then they had sex. I consider that the provision of alcohol to a patient with alcohol issues was seriously sub-optimal and, in the context of the sexual intercourse that subsequently occurred, amounted to exploitation of Ms A's vulnerability. Furthermore, RN B returned soon afterwards and they had sexual intercourse again. RN B also offered to return and bring more alcohol.

90. Right 2 of the Code provides that every consumer has the right to be free from exploitation. Ms A assumed that RN B was arranging to visit her as he had been involved in her care. By arriving in a DHB car, with alcohol, and having sexual intercourse with Ms A on two occasions, and by arranging to visit with alcohol again, RN B exploited Ms A and, accordingly, breached Right 2 of the Code.

[6] For example, Opinion 12HDC00027 (12 December 2013) available at www.hdc.org.nz..

Opinion: The District Health Board — No Breach

91. The DHB had an obligation to provide Ms A with appropriate and safe care. As RN B's employer at the time of these events, the DHB is also vicariously liable for RN B's breaches of the Code unless it can show that it took reasonable steps to prevent these breaches from occurring.[7]

92. RN B and Ms A had had intermittent social contact, due to both living in the same town, and from having known each other for many years. Prior to RN B becoming involved in Ms A's care he had disclosed this social relationship to the DHB. I acknowledge that RN B and Ms A lived in a small community and that, as advised by the DHB, "the reality is that most clients are known to the staff in the [local] community mental health team prior to their entry to the service". In these circumstances, I accept that it was reasonable for the DHB to assign RN B to be involved in Ms A's care in the way in which he was.

93. I am also satisfied that the DHB responded promptly once it became aware of the sexual encounters between Ms A and RN B. It interviewed both Ms A and RN B soon after the relationship was divulged, and it alerted the Nursing Council promptly.

94. The DHB carried out an in-service programme that included sessions focusing on boundaries, which RN B attended in 2010 and 2011. The DHB also hosted workshops delivered by the Nursing Council and the New Zealand Nurses Organisation in relation to professional boundaries and the code of conduct. The DHB advised that RN B had not attended any of these sessions, but I acknowledge that RN B was bound by the Nursing Council's Code of Conduct for Nurses and its competencies for registered nurses, and that the DHB had a reasonable expectation that RN B would comply with these in respect of his obligation to maintain professional boundaries. Taking these factors into account, I do not find the DHB vicariously liable for RN B's breaches of the Code.

Recommendations

95. I recommend that RN B:

a) provide a written apology to Ms A, which is to be sent to this Office within three weeks of the date of this report, for forwarding on; and

b) undertake training on professional boundaries, and report to HDC within six months of the date of this report with evidence of this training.

96. I recommend that the Nursing Council of New Zealand consider undertaking a competence review of RN B.

[7] Section 72, Health and Disability Commissioner Act 1994.

97. I recommend that the DHB consider whether compulsory annual up-skilling for staff on professional boundaries is required, given the small size of the community, and report to HDC within three months of the date of this report on the outcome of this consideration.

Follow-up actions

98.
- 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.
- A copy of this report, with details identifying the parties removed, will be sent to the Nursing Council of New Zealand, and the Council will be advised of RN B's name.
- A copy of this report with details identifying the parties removed will be sent to the New Zealand Nurses Organisation.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

99. The Director of Proceedings filed a charge before the Health Practitioners Disciplinary Tribunal. Professional Misconduct was made out and RN B's nursing registration was cancelled.