Physiotherapist, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC16422)

Parties involved

Ms A	Consumer
Mr B	Provider/Physiotherapist/Postgraduate student
Mr C	Provider/Clinics Co-ordinator, School of Physiotherapy
Mr D	Complainant/Dean of School of Physiotherapy,
Dr E	Associate Dean of School of Physiotherapy
Ms F	Consumer's friend

Complaint

On 1 November 2006, the Commissioner received a complaint from Mr D about the services provided to Ms A by a School of Physiotherapy postgraduate student, Mr B. The following issue was identified for investigation:

- *The appropriateness of the care provided by Mr B to Ms A between August and September 2006.*

An investigation was commenced on 26 February 2007. This investigation has taken in excess of twelve months, owing to the need to gather information from a wide variety of sources.

Information reviewed

Information from:
- Ms A
- Mr B
- Mr D
- Dr E, Associate Dean of School of Physiotherapy
- Mr C
- The School of Physiotherapy
- Student Health Services.

Independent expert advice was obtained from Ms Shirley Lamont, a registered physiotherapist.

Information gathered during investigation

Complaint overview
On 28 September, Ms A attended postgraduate physiotherapy student Mr B for routine treatment of a right ankle injury. The consultation occurred outside normal supervised clinic hours at the University's physiotherapy clinic. Ms A complained that Mr B inappropriately touched her breast and nipple during the consultation.

Background
Mr B qualified with a Bachelor of Physiotherapy from a physiotherapy college in his home country in August 2002. Following graduation, he worked there for three and a half years as a physiotherapist in various clinical settings and hospitals. Mr B said that he decided to pursue further training in New Zealand. In 2006, Mr B enrolled in a postgraduate diploma in physiotherapy (the Diploma).

Prior to commencing the Diploma, Mr B had to obtain registration and a practising certificate from the Physiotherapy Board of New Zealand (the Board). This is a requirement for anyone seeking to undertake postgraduate study in physiotherapy who has not obtained their primary physiotherapy degree in New Zealand. In such instances, the Board grants a special purpose scope of practice for a limited time over the duration of the postgraduate course. In 2006, Mr B was registered with the Board with a Special Purpose Registration and Special Purpose Scope of Practice which has since expired. This type of registration is granted for a limited time during which the student completes postgraduate studies at a School of Physiotherapy in New Zealand.

Mr B was also required to meet the minimum standard of English language required by the University as part of the prerequisites for postgraduate study.

The Diploma is designed to advance the physiotherapist's practical and clinical reasoning skills in managing patients with particular disorders. In addition to several theoretical papers, the course involves working in a small group setting under the supervision of qualified physiotherapists at a School of Physiotherapy Clinic.

The University offers physiotherapy services to the public at clinics accredited by the New Zealand Physiotherapy Accreditation Scheme and ACC. The main clinic (the Clinic) is staffed by qualified physiotherapists who supervise undergraduate and postgraduate physiotherapy students. The School's Guidelines for the Clinical Supervision of Students state that the clinical tutor "will either be present with or in close proximity to the patient in order to respond to questions from the student and/or patient, and to assist the student if required". The Guidelines also state:

> "4. The clinical tutor/clinical educator will normally be present for the portion of the time required for an initial assessment and will review the treatment plan with the student. The amount of time the clinical tutor/clinical educator will be present for a follow-up visit will depend on the complexity of the case and the ability of the student.

> 5. The clinical tutor/clinical educator will regularly, within and between sessions, review the student's treatment plans and documentation with the student to ensure patient progress is being made in accordance with best practice."

Mr C, supervisor and Clinics Co-ordinator at the School, supervised Mr B during his clinic sessions two afternoons a week. Mr C described his role as being "to oversee their assessment treatment with their patients to stimulate their clinical reasoning" and to discuss patients with them. There were four students for each supervisor. Mr C noted:

> "Because these are qualified therapists I don't believe I was expected to be in on every patient contact because there's four postgrads and one tutor … Most of the time I tried to get in with new patients and then once I was confident that […] the therapists the postgrad therapists had grasped what was wrong and had a sensible plan of treatment, I would then just either follow up with them after their treatment or I'd pop in to see follow-up treatments now and again as and when I had time considering I am looking after four therapists."

Care provided during August and September 2006
On 30 August 2006, Ms A (a student at the University) attempted to jump over a small creek on a friend's farm. While doing so, she slipped on wet grass and "rolled" her ankle.

The following day, Ms A presented at the Clinic with a right ankle injury. She arrived on crutches and was unable to weight bear on her right foot. Ms A was seen by Mr B and his supervisor, Mr C. An ACC injury claim form was completed and Mr B documented the history and an examination of Ms A's injury in his clinical records. He noted that Ms A was "not weight bearing" and described her pain as "9/10" on 30 August 2006 and "6/10" for 31 August 2006. He also documented "swelling +ve whole ankle" in his notes. Ms A's ankle was strapped[1] and she was advised to obtain an X-ray to exclude the possibility of fractures.

Mr C commented that Ms A reported previous lower back pain. He advised Mr B that he should "keep in the back of his mind" that the lower back may be involved. He also commented that he has "never come across an ankle sprain that involved the thoracic spine". Mr C said that the first appointment was primarily to ask questions about the injury, and treatment was to commence after the injury had settled and X-ray results were received.

On 4 September 2006, Ms A attended her second appointment with Mr B. Mr C was also present periodically during the appointment. It was discussed that Ms A had

[1] Ms A was unable to recall whether her ankle was strapped during the initial appointment, or whether she was just given a pressure bandage.

decided not to have an X-ray as her ankle "seemed to be getting better" and she was able to weight bear. Mr B recorded in his notes that there was reduced pain ("2/10") and swelling in Ms A's right ankle and that she was able to walk.

Mr B recalled that during this appointment he examined Ms A's lumbar and thoracic spine.[2] Mr B said that he advised Ms A that any associated injury to her spine could be contributing to pain in the region of her right ankle. Ms A experienced pain on palpation of her spine but there was no evidence of irritation of the sciatic nerve. Mr B did not document his spinal examination (and acknowledges that he should have), or the discussion about proposed treatment.

Ms A recalls being advised during this consultation that she may have incurred an injury in another region, and that her back was checked. She recalled that Mr C undertook this part of the consultation while Mr B watched and had it explained to him (Ms A recalled that Mr B may have helped a bit with the examination). She lay on her stomach while Mr C checked her back. Mr C advised her that there was no injury to her back and that ongoing treatment would focus on her ankle, particularly on strengthening and stretching out her ankle.

Ms A returned for her third and fourth reviews with Mr B on 8 and 25 September 2006. On both occasions, he was supervised by Mr C, who "popped in and out" of the cubicle where Mr B was treating Ms A. Mr B documented that the swelling had reduced, and demonstrated several exercises to mobilise Ms A's ankle. He strapped Ms A's ankle and gave her a pressure bandage.

Booking of unsupervised appointment

Mr B arranged to see Ms A on Thursday 28 September 2006 as the pain in her ankle was not resolving. Ms A's appointment was scheduled for 1pm on 28 September 2006 — during the quiet lunchtime hour before the supervised afternoon sessions recommenced at 1.30pm. Mr B explained that he booked a lunchtime appointment because all the afternoon appointment slots were taken and Ms A was unable to attend a morning appointment. Ms A does not recall receiving any explanation for why the appointment was booked for that time, but recalls some discussion of her availability.

The School's policy states that all scheduling of appointments occurs through the centralised reception office located adjacent to the physiotherapy clinics. Mr B recalls that on this occasion he booked the appointment himself on the School computer rather than through reception staff. He explained that, generally, the students make the appointments themselves if there is time. Otherwise, the appointment is arranged by reception staff.

[2] The lumbar is the lower region of the spine. The thoracic is the middle portion of the spine to which the ribs are attached.

Mr B acknowledged that it was not normal practice to book lunchtime appointments but stated that he had not been specifically told not to do so. He noted that the clinic was not actually closed. Reception staff were present, and other patients were waiting.

Mr C agreed that Mr B may not have been instructed not to book lunchtime appointments, but noted that the requirement for supervision could only be met during clinic hours. Mr D confirmed that lunchtime was quiet and usually reserved for "down time". However, there were generally a few people present in the reception/waiting area.

Supervision requirements
The School's guidelines for the supervision of students state:

> "Postgraduate students will only see patients during their allotted clinic times and when their clinical supervisor is present in the clinic.
>
> The clinical tutor/clinical educator will either be present with or in close proximity to the patient in order to respond to questions from the student and/or patient, and to assist the student if required."

Mr B stated that he was not aware of the relevant guidelines, although he generally knew that he was meant to be supervised.

Associate Dean Dr E commented that the supervisor's role was primarily in relation to clinical skill rather than the standard of ethical behaviour. The School provided written confirmation that Mr B had completed an orientation to the Clinic with the Physiotherapy Clinical Supervisor. Mr B signed the student orientation form on 21 March 2006. In particular, he ticked a box under the heading "Patient/Staff Safety" stating:

> "Policies and procedures manual is explained with instructions to read the manual prior to treating patients in the clinic as well as use it as a reference guide."

Consultation on 28 September
Shortly before 1pm on 28 September 2006, Ms A arrived at the Clinic, and observed that "there was no one around" apart from her and Mr B.

As part of standard procedure, Mr B began the session by asking Ms A about her ankle. Ms A mentioned that she still had some pain which Mr B described as "just immediately after treatment, the pain reduces, but again it comes back later in the day and it keeps on increasing". Mr B proceeded to examine Ms A while she was positioned on a plinth. He stated:

> "[I] [d]id the same kind of thing for the ankle, like just treated the patient I think standing or something, and then gave her exercises, put the bandage on

> and just the routine, just what I was doing, and examining and then treating the patient and trying to change something on the ankle."

Mr B documented under his subjective findings that Ms A had the "same pain" and "feels dodgy ankle". In addition, the ankle felt secure with tape and the pain was reduced. His notes refer to a number of objective tests of Ms A's ankle and ligament showing decreased ankle movement and range of motion, indicating a ligament injury.[3]

Ms A confirmed that Mr B worked on her right ankle "for a while" by applying pressure and then did the "same things" to her leg and thigh. She recalled him checking that the pressure he applied was "OK" as he worked. With regards to "treatment", Mr B documented that he performed mobilisation of Ms A's ankle.

Straight leg raise test

Mr B then moved on to Ms A's right leg and thigh to perform a straight leg raise (SLR) test, described by Mr B as:

> "[T]he patient [lies] on the[ir] back and you hold the leg near the knee and the ankle and you raise the leg straight up and ask for the patient's reaction, whether there is a pain in the leg or in the back, or in the front, or maybe in the ankle."

During an interview with HDC staff Mr B stated that he thought that the SLR test performed on Ms A was negative (no pain elicited on movement) — although he had difficulty recalling the results of the SLR test.[4] He did not document performing the SLR test or the findings and has acknowledged that this should have been done.

Additional examinations

Mr B explained that he decided to re-check Ms A's lumbar and thoracic back region again for "any other problem" because of her ongoing pain. He stated that it is normal not to receive a positive result from a single previous test and therefore he felt it was worthwhile repeating this examination. Examinations were carried out while Ms A lay on her back. Ms A was then positioned on her left side. Mr B stated:

> "To explore any other site of origin for pain and also considering the mode of injury (jumping and falling) her spine (lumbar and thoracic) was examined. She did complain of pain when palpating the spinous process."

Mr C commented that, at this stage, it would have been reasonable for Mr B to check Ms A's lower back region again in case there was an injury to the sciatic nerve that

[3] See Appendix 1 for Mr B's clinical records.

[4] On 6 October 2006, Mr B advised the School of Physiotherapy that he undertook additional examinations because the straight leg raise test was positive. However, he went on to state that the test was not recorded in the treatment notes because it was negative. See Appendix I.

was causing referred pain to her ankle. However, there was no clinical reason to examine any area beyond the lumbar spine. He stated: "Logically, it's very difficult to make a link." He also stated:

> "You would be expecting for him [Mr B] to record every single test that he did on the patient and the result of the test and so that you could logically follow how he was thinking that is the point of the notes …"

Information about additional examinations
Ms A stated that after the straight leg raise test Mr B asked her to roll onto her left side without any explanation of what further treatment or examinations were proposed. Ms A commented that the lack of communication/explanation was an ongoing concern throughout her consultations with Mr B. He was "always nice", but difficult to understand. She commented that Mr B had previously been respectful and checked that she was happy to roll up one pant leg to the knee. On this occasion, she wore a T-shirt dress that extended to her knees.

Mr B acknowledged that he did not reiterate the reasons for the additional back examinations — although he "would have said something", such as asking whether he could examine her back and shoulder region. He noted that his explanation of the rationale for examining Ms A's back occurred during the second or third consultations.

Mr B has ticked boxes on the clinical notes indicating that he explained the treatment and obtained the patient's verbal consent — although no details are recorded. Mr C commented:

> "There is a little box on these patient notes where they have to notate that they have explained their treatment, that they've explained adverse reactions and have gained verbal consent and they have to put their initials and a date, and that is supposed to occur every time they change the modality of treatment."

The School's policy 2.2.3 "Consent for Treatment" states that verbal informed consent will be obtained and documented by the treating physiotherapist when there is a significant change in the treatment plan.

Sterno-costal examination
During an interview with HDC staff, Mr B initially denied examining Ms A's sterno-costal region.[5] He said that this examination is indicated with severe upper back pain, and pain associated with breathing or moving the arms, which was not present. When questioned further, Mr B acknowledged that he had palpated Ms A's sterno-costal joints in the area directly above her breasts as part of the thoracic spine examination.

[5] The sterno-costal joints are located where the ribs join the sternum (breast-bone).

Mr B makes no reference in his clinical notes to this additional examination and acknowledges that he should have done so.

Ms A stated that Mr B examined her back, the side of her ribs under her arms, and her shoulder and collarbone region. He then placed his right hand between her breasts and "was feeling around" in the region of her cleavage. He then placed his left hand inside her dress, and reached through her bra to under her right breast. According to Ms A the touching occurred for "maybe four or five minutes" during which she felt "very uncomfortable". She stated:

> "I've got his hand inside my dress and inside my bra and he kind of like cupped my right breast and then at one stage his like fingers they actually like stroked my nipple … at the same time he was … feeling around, like, like pushing on things and saying, like is that ok, like um, like pushing pressure points or something."

Ms A is unsure whether Mr B deliberately touched her nipple, and recalled that he "stroked passed it". If this had occurred earlier during the consultation she would have been very concerned but at the time she was trying to "work out" if Mr B had made a mistake. Ms A said that Mr B "only checked one side" and stopped abruptly when other people arrived at the Clinic that afternoon. She advised:

> "… I was just very, very confused and I had no idea what had just happened and couldn't work out like why I was feeling, if what, I mean if the whole situation was … legitimate or … if I just imagined it and it would seem silly or what was going on, so it was just real confusing. I just wanted to get out of there so I could try and work out what had just happened, I was just really uncomfortable."

In contrast, Mr B disputes that any inappropriate touching occurred during his examination and denies touching Ms A's nipples or breasts. He believes that Ms A's complaint was the result of difficulties in communication between them due to English being his second language and consequently not understanding his prior explanations of why he also examined areas of her anatomy other than her ankle. He acknowledges that he did not explain to Ms A the reasons for his sterno-costal examination — which he believes is the reason for the complaint. Mr B commented that Ms A did not appear uncomfortable during these examinations, and arranged a further appointment.

Supervision

Mr C was the clinic supervisor that afternoon and, shortly afterwards, he learnt from the receptionist that Mr B had seen a patient unsupervised. At that stage, Mr B was with his next patient. Mr C reminded reception staff that Mr B required supervision and emphasised that future appointments must be booked during clinic hours. He did not discuss the matter directly with Mr B.

As part of ongoing clinical supervision, the postgraduate physiotherapy students meet together as a group with their clinic supervisor at the end of the day (after the clinic closes). The group session provides an opportunity for the postgraduate students to discuss problems encountered and for the supervisor to provide feedback. Mr B did not mention Ms A's case during the group review session that evening.

Ms A's discussion with her friends

After the appointment, Ms A made a follow-up appointment "because [Mr B] told [her] to". She then "grabbed [her] stuff and walked out" of the Clinic back to university. She left feeling upset and very uncomfortable. She said that she "couldn't work out" if she had not understood and thought maybe Mr B had "just made some errors". It was only after the consultation and a conversation with two friends[6] that she was able to process what had happened and "realised that it was wrong".

Ms A also spoke to her friend Ms F later that day. Ms F stated that Ms A was "extremely shaken" by her treatment that day and felt "violated and vulnerable" and, as a result, required ongoing support from family and friends. She stated:

> "I met up with [Ms A] in the afternoon after her appointment at the Physio School and immediately knew that something had happened, she was not herself. She looked upset and scared. I asked her what was wrong and she said that she had had an appointment with a Physiotherapist at the Physio School and explained that he had touch[ed] her breasts while she received treatment for a back injury.
>
> While she was not crying she seemed visually distressed and confused. I believe she was in shock and was trying to digest the severity of what had just taken place. I continued to ask her questions about exactly what had happened during her treatment. She explained that she had been to see a Physiotherapist and he had fondled her breasts under her bra with his hands without proper consultation.
>
> After I asked her some questions I ascertained that he had not asked for permission to touch her breasts and had not explained why he was touching her breasts as part of the treatment being given. I told her that this was unacceptable, if he needed to touch her breasts as part of treatment that he needed to explain why and he needed to receive her consent before any touching around her breasts began. Because she had trusted the physiotherapist was giving her appropriate care at the time she had not questioned him but the incident had made her feel 'yucky' immediately after."

[6] Ms A provided the names of the two friends to whom she spoke shortly after the consultation with Mr B. However, she was reluctant to provide the contact details for one friend. The other friend is overseas and could not be contacted by this Office.

Subsequent events

On Monday 2 October 2006, Ms A telephoned the Clinic and cancelled her follow-up appointment. The receptionist answered the call and enquired about Ms A's decision to cancel. Ms A then complained about her session with Mr B, and stated that she wanted to meet with his supervisor, Mr C.

Ms A saw a student health general practitioner at her next scheduled appointment on 3 October 2006, and discussed what had occurred. She was offered counselling but decided not to proceed. The medical notes state:

> "Attended a physio for her ankle last [T]hursday. This is the 3rd [appointment] with the same physio … The physio saw her when … she was the only one in the room and he put his hand down her bra. She felt very tearful afterwards. Suggest seeing counsellor and reporting this to the head of physio clinics."

On 4 October 2006, Ms A attended a meeting with Mr C, accompanied by Ms F. Mr C said:

> "When it first came to light I thought maybe it's a misunderstanding because he wasn't so good at explaining what's going on and maybe he brushed her anatomy by mistake doing some procedure or something. I didn't realise at the time that it was [Ms A] and it was the girl with the ankle problem. So I was quite shocked when she and a friend came and saw me for that initial interview. Quite shocked and then I did take it very seriously and I assured her we would do something about it. I actually supplied her with some diagrams so that she could mark out herself where he touched her."

The diagram[7] illustrates that Mr B touched Ms A under the right armpit, under the right breast in the sternum region, and on the right nipple. Mr C commented that an examination of the sternum would be undertaken if there was concern about the way the ribs moved. If this was required, normal practice would be to provide a good explanation together with a chaperone at the examination, or referral to a female physiotherapist.

Following the meeting, Mr C informed Mr D and Dr E of Ms A's complaint.

On 6 October, Ms A met Mr C again and submitted a written complaint.

Also on 6 October 2006, Mr B attended a meeting during which Mr D and Mr C outlined the complaint and invited his response. Apart from stating that he "sometimes had problems with communication", Mr B did not comment on the complaint. The meeting notes state:

[7] See Appendix II.

> "[Mr B] was questioned as [to] the treatment given on 28/9/06, particularly in relation to the examination of the upper thoracic spine, shoulder and chest in a female patient attending for treatment of the ankle. [Mr B] initially insisted that he had only examined and treated the patient's ankle, but when pressed he admitted that he did undertake these examinations, as there was a positive test for SLR. He was then asked why this exam was not in the treatment notes — he responded that it was because the exam was negative. When reminded [that] he had just stated that the SLR was positive, he made no further response."

Mr B commented that he does not recall what was said during this meeting, and was disadvantaged by not having access to Ms A's notes at the time.

Mr B was informed that the School would carry out a fuller investigation of the complaint following which he would be given another opportunity to respond. In the interim, he was suspended from clinical practice.

Audit of Mr B's patients

Between 6 and 9 October 2006 the School conducted an audit of Mr B's past patients. This included reviewing the records of all female patients he treated to ascertain whether there were any particular trends such as patients changing physiotherapists part way through treatment, choosing to stop treatment after a low number of treatments or cancelling appointments without re-presenting at the clinic. Seventeen female patients were contacted for feedback, and some respondents raised concern about Mr B's communication skills and his manner. Mr D stated:

> "[A]s a student they stress the benefit of the doubt, we wondered if this was a communication issue, poor communication. It didn't seem to be. It seemed to be something different and on a limited investigation that we followed up with, it seemed that this behaviour had been exhibited with other patients."

Sequelae

Several days later, on 13 October 2006, Mr D and Mr C discussed the complaint against Mr B with several departmental colleagues. A decision was made to suspend Mr B from treating patients, and to fail him for the clinical component of his course. However, Mr B was permitted to sit two final clinical exams under supervision later that month as he had already completed sufficient clinical hours to fulfil the practical requirements. A decision was also made to lodge a complaint with this Office and the New Zealand Physiotherapy Board.

During a further meeting on 18 October 2006, Mr D and Dr E updated Ms A on the actions taken by the School. Ms A was scheduled to sit her university exams shortly and was advised that the School would support any application she made for impaired performance as a result of the incident.

A week later, on 24 October 2006, Mr B attended a second meeting with Mr D and Mr C during which the findings of the School's investigation were presented. Mr B was given the opportunity to respond but declined to do so. Mr B was informed that the School would be making a complaint to this Office, and that he would receive a zero mark for his most recent clinical placement based on safety/professional concerns.

Responses to provisional opinion

The School of Physiotherapy and Ms A confirmed that they had nothing further to add. Mr B did not respond to the provisional opinion despite various attempts by this Office to contact him.

Independent advice to Commissioner

The following expert advice was obtained from Shirley Lamont, a physiotherapist:

> "August 21, 2007
>
> I, Shirley Mary Lamont, have been asked by the Health and Disability Commissioner's office to provide an opinion to the Commissioner on case number 06/16422.
>
> I am a Registered Physiotherapist in my own private practice at Auckland International Airport. I have been in private practice for 38 years.
>
> I graduated from Otago Physiotherapy School in 1967.
>
> I am a Registered Physiotherapy Acupuncturist.
>
> Past President and Life Member of PAANZ (Physiotherapy Acupuncture Association of NZ) which is a Special Interest Group within the NZ Society of Physiotherapists.
>
> I am currently guest lecturer at AUT western acupuncture postgraduate, under the Faculty of Rehabilitation and Occupational Studies. I have continued to run courses for PAANZ throughout NZ on specific muscle needling.
>
> Other than that association, I have no connection with any teaching institution, so my knowledge of specific school's teaching mechanisms is limited. My strengths are in clinical practice.

[To avoid repetition, the factual summary and questions sent to Ms Lamont have been deleted. The documents sent to her are listed at Appendix III].

…

Standards of Care

The standards questioned in this scenario are procedural, clinical and professional/ethical.

Regarding the appointment time made. It is clearly stated in the school's Student Orientation Guidelines that appointments are made by the receptionists, and [Mr B] has signed that form. Given his explanation of events, it is understandable how he could have justified that new time slot — however he should have notified the receptionist and his supervisor prior to this.

Regarding the clinical standard of care — this is difficult to assess as his note-taking is not clear, and is actually below par. But it seemed from [Ms A's] recollection he was testing for range of movement, swelling and when he performed the squeeze test of the fibula bone, it would have been to check whether there was a fracture higher up the shaft of that bone. However — there is no record of that test in his notes.

Regarding the time-frame of recovery — there are severe ankle sprains that can take up to six weeks to resolve, so that is not an issue for me (from this distance). However — it is obvious that the supervisor was concerned, hence the need to discover another source of possible pain-reference.

Investigations/examinations

It would appear he was doing the correct manual therapy, although it is difficult to read some of his notes.

An X-ray can be sought when the foot is unable to fully weight-bear; however, they can recover quickly once normal alignment of the bones is restored with gentle manual therapy, and correct taping/support. His supervisor had the professional judgment for this at this stage. There are no other radiological or orthopaedic tests of the ankle/lower leg, apart from the X-rays if necessary.

Appropriateness in examining other parts of the body

If the recovery rate is causing concern, and she did fall onto her side as she fell then it is plausible to look for another source of the pain mechanism if he and his supervisor thought her recovery was too slow. This can be referred pain from the back — via the sciatic nerve — to the ankle. It would seem that his clinical supervisor had shown him the spinal tests prior to that date in

question, and obviously discussion had already taken place which I would consider entirely adequate.

However — there are often other neural signs and symptoms associated with this type of event, i.e. altered sensation in the foot/lower leg, weakness of the muscles supplied by that nerve complex.

It is difficult to know whether he was only assessing the lumbo-sacral plexus[8] at this stage as nothing is written in his notes.

Accepting his premise that he was looking for neural pain from her back, in my opinion the patient should initially be examined fully from the upright position to check for symmetry of spinal alignment. Once assessed, then to examine spinal movements to judge which of these refer that familiar ankle pain.

Added to that are the specific neural tests:-

* Checking the reflexes and power in structures supplied by those nerves

* The SLR (Straight Leg Raise test) to judge whether the sciatic nerve was tethering in the back. This is done in supine = lying flat, (which he did do)
* The other neural test which would then be done would be the Slump Test where the patient is seated, the leg straightened while the spine is flexed, and the neural structures will respond in different ways but you will get a picture of neural plasticity — ie how freely the nerves glide in relationship to its surrounding tissues.

Only then would you examine the spine itself.

In my opinion there would <u>not</u> be any need to examine the chest, or the sterno-costal joints, nor would the spine be examined in the supine position — ie lying face-up, or in side lying. I would consider his actions here to be far removed from ethical standard of care, and would view it with moderate – > severe disproval.

Management Plan

The documented management plan was not tailored to her specifically and the documentation was poor for someone who is already a registered physiotherapist.

[8] The lumbar-sacral plexus is the area where the main nerves branch out from the lower region of the spine.

Adequate Supervision

When a physiotherapist has had two years post-graduate experience, it would be expected he would be competent in managing a treatment plan, but it is difficult to know how they do this in [his country] — so maybe a harsh judgment. However, one tutor to four post-graduate physiotherapists sounds to be totally manageable.

Documentation

As noted previously — [Mr B's] documentation is inadequate, as there seems to be no written follow-through showing tests, examinations or actual treatment necessary to have continuity of care. Every test should be documented as to whether positive or negative, especially when these ideas had been discussed with the tutor in this type of learning situation.

Overall his documentation was very inadequate.

Summary

It is difficult to be specific as to whether his clinical competence and skill was adequate — only the clinical supervisor would know that, but I believe the major departure from 'adequate professional care' here is in the circumstances around the examination of distal body areas [regions not proximate to the ankle]. In this instance I viewed his actions with grave concern, and if found to be true, would consider this to be a major failure of professional standards."

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable to this complaint:

RIGHT 2

Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 4

Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 6

Right to be Fully Informed

…

(2) Before making a choice or giving consent, every consumer has a right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Other relevant standards

The Physiotherapy Board of New Zealand's *The Standards of Ethical Conduct 2006*:

"Physiotherapists should at all times:
1. Act in the best interests of their patients.
2. Practise in accordance with acceptable professional standards.

…

3. Respect the rights and dignities of individuals.

…

1.1 The relationship between the physiotherapist and their patient is one of trust.

...

1.3 The relationship of trust must never be abused. This includes not entering into a sexual relationship with a current patient.

…

3.4 Ensure that comprehensive, accurate and up-to-date clinical records are kept.

…

4.1 Patients have the right to

… be free from discrimination, coercion, harassment and sexual, financial or other exploitation. ”

The New Zealand Society of Physiotherapists Incorporated *Policy on Professional Sexual Boundaries 2003*:

“… Physiotherapists, like a number of other professionals, are involved in relationships in which there is a potential imbalance of power. The physiotherapist to patient relationship is not one of equality. In seeking assistance, guidance and treatment the patient is vulnerable. Sexual exploitation of the patient is an abuse of power. ...

The term “sexual relationship” is not restricted to sexual intercourse but may include any conduct which has as its purpose some form of sexual gratification, or may be reasonably construed by the patient as having that purpose.

…

3. Breaking Professional Sexual Boundaries

Varying degrees of sexual harassment may occur which break professional boundaries. Such behaviour can be grouped into the following three categories:

- Sexual impropriety
- Sexual transgression
- Sexual violation

Sexual impropriety means any behaviour such as gestures or expressions that are sexually demeaning to a patient, or which demonstrate a lack of respect for the patient’s privacy, including but not exclusively:

…

- Examining the patient intimately without the patient’s informed consent.

…

Sexual transgression includes any inappropriate touching of a patient that is of a sexual nature, short of sexual violation, including but not exclusively:

- Touching of breasts or genitals except for the purpose of physical examination or treatment.

…

- ***Sexual violation*** means physiotherapist/patient sexual activity whether or not initiated by the physiotherapist.

…

5. Safety and protection

To avoid misunderstandings or inappropriate conduct the physiotherapist should employ the following safeguards:

…

- Provide adequate information and explanation which helps to avoid misunderstandings and misinterpretation.

…

- Offer and encourage the presence of chaperone/whanau/friend during intimate examinations."

Opinion

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

Opinion: Breach — Mr B

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) Ms A had the right to services provided in accordance with professional and ethical standards. Right 2 of the Code provides that Ms A had the right to be free from exploitation, including sexual exploitation. Right 7 of the Code gave Ms A the right to make an informed choice and give informed consent, and Right 6(2) entitled her to the information necessary to provide informed consent.

In my opinion, Mr B breached Rights 2 and 4(2) of the Code by unnecessarily examining Ms A's chest and sterno-costal region, and by inappropriately touching her breast. He did not explain the purpose of this examination or obtain Ms A's consent and therefore breached Rights 6(2) and 7 of the Code. He also breached Right 4(2) in relation to the standard of his clinical documentation. The reasons for my decision are set out below.

Informed consent
On 31 August 2006 Ms A attended the Clinic for treatment of her right ankle injury. An initial assessment was undertaken by Mr B and his supervisor, Mr C. During the next appointment Ms A's lumbar and thoracic region were checked owing to concern that she may have injured another part of her body. Ms A recalls that this was discussed with her. Mr C performed the examination while she was lying on her stomach, and Mr B watched and assisted (Mr C did not consider that examination of the thoracic region was clinically relevant). On examination there was no evidence of spinal or back injury. Accordingly, it was explained to Ms A that treatment would focus on her ankle injury.

Although not adequately documented, I am satisfied that appropriate information was provided about the initial treatment and the reasons for the examination of Ms A's spine, and that she consented to the examination. According to the School's policy, it was not necessary to explain the treatment again at subsequent consultations unless the treatment was different from that which had already been discussed and agreed upon.

Treatment proceeded as discussed during consultations on 8 and 25 September 2006. However, on 28 September Mr B decided to re-examine Ms A's spine. Mr B did not advise Ms A of his intention to re-examine her spine or the reasons for the re-examination. The additional tests on Ms A's back and chest area included the thoracic

spine and sterno-costal joints and were clearly an extension of the previous examination of her lumbar spine undertaken by Mr C during her second appointment.

Mr B should have explained to Ms A the reasons for the spinal examination prior to performing those examinations, particularly as Ms A had already been told that she did not have a spinal injury. It was not adequate simply to ask whether he could examine her back and shoulder region — if this did indeed occur — and assume that Ms A would deduce the reasons for repeating and extending the previous examinations. Most significantly, Mr B has acknowledged that he did not explain to Ms A the reasons for the sterno-costal examination — and believes this is the reason for the entire complaint. This examination, given the close proximity to the breast region, should not have been undertaken without a full explanation together with the offer of a chaperone or referral to a female physiotherapist.

I am not convinced that Mr B's failure to explain the sterno-costal examination is the sole reason for Ms A's complaint (see below). Furthermore, while Ms A commented that she had generally found Mr B to be difficult to understand — no doubt in part because English is not his first language — this is no excuse for not providing adequate information. In this case, the failure to provide information and obtain consent to this examination was a significant departure from the standard expected. The School's policy for informed consent requires documentation of informed consent when there is a significant change in the treatment plan. Quite clearly, the policy was not complied with.

Overall, I consider that Mr B did not adequately explain to Ms A the examination of her thoracic spine and sterno-costal region, and did not obtain her consent to perform the examination. Accordingly, Mr B breached Rights 6(2) and 7 of the Code.

Examination 28 September
On 28 September, Ms A expected Mr B to continue with routine treatment to her ankle. This included a number of objective tests followed by mobilisation of the ankle. My expert advisor, physiotherapist Ms Shirley Lamont, considered that, generally, Mr B provided appropriate manual therapy to Ms A's ankle. However, Ms Lamont believes that the additional examinations he performed were clinically inappropriate. Most significantly, there was no reason to examine the chest or sterno-costal joints.

Ms Lamont considered that it was reasonable for Mr B to consider whether there was a source of pain other than the ankle, given the relatively slow recovery time. Ms Lamont noted that when checking for neural pain from the back, a patient should initially be examined fully from the upright position to check for symmetry of the spine. Mr B did not do this. Furthermore, it is appropriate to do a number of specific neural tests prior to a spinal examination — including the straight leg raise. The straight leg raise is a standard test for ascertaining whether there is any neural tension present indicating a possible spinal injury. Once assessed, it is appropriate to examine spinal movements to judge whether there is referred ankle pain.

Mr B did perform a straight leg raise test, although this was not documented. He found it difficult to recall the results of the straight leg raise test, although believes that it was negative (having initially advised the School that it was positive). Mr B's limited recall of the results of the straight leg raise test is perhaps understandable. However, given that it appears most likely that the straight leg test was negative there was no particular reason to proceed further with any spinal examinations.

I accept that it was reasonable to consider other sources for Ms A's ankle pain. However, there was no clinical reason to perform a chest or sterno-costal examination, or even to ask Ms A to lie on her side to facilitate examination of the spine or shoulder region. There no plausible reason to explore these regions when seeking to treat an ankle injury. I accept Ms Lamont's advice that Mr B's unnecessary examination of Ms A's chest and sterno-costal area was a moderate to severe departure from an ethical and professional standard of care. Accordingly, in my view Mr B breached Right 4(2) of the Code.

Inappropriate touching
Ms A complained that during the chest and sterno-costal examination, Mr B put his hand inside her bra and reached through to under her right breast. Mr B acknowledged performing a sterno-costal examination without obtaining informed consent, but disputes that he touched Ms A's breast region or nipples.

Although we have been unable to follow up with two of Ms A's friends, immediately after the consultation Ms A told three friends about what had occurred. Ms F clearly recalls being advised by Ms A that her breast had been touched, and stated that Ms A was "upset and scared". On 3 October, Ms A advised a general practitioner that Mr B had "touched her breasts", and was offered counselling. On 4 October, Ms A clearly identified to Mr C on a diagram the areas where she had been touched. This included her sterno-costal and breast region.

Mr B has found it difficult to recall precisely what occurred on 28 September — at one point he even denied undertaking a sterno-costal examination. He also explained that sterno-costal examinations are undertaken with severe upper back pain or pain on breathing or moving the arms. He has not asserted that these symptoms were present on 28 September.

I prefer the evidence of Ms A on this matter. Her recall of events is consistent and her concerns about Mr B touching her breast were raised with numerous parties almost immediately following the event and in the days following. Her communications with Ms F and her general practitioner corroborate her version of events. I am persuaded on the balance of probabilities that Mr B touched Ms A's breast as she described.

Mr B's actions were clearly contrary to the professional and ethical standards that apply to physiotherapists. Principle 1.1 of the Physiotherapy Board of New Zealand's *Standards of Ethical Conduct 2006* states that the relationship between a physiotherapist and his or her patient is one of trust. Principle 1.3 states that the

relationship of trust must never be abused. Trust is a fundamental cornerstone of the physiotherapist–patient relationship. As noted in the New Zealand Society of Physiotherapists Inc. *NZSP Policy on Professional Sexual Boundaries* (2003), the relationship is not equal. In seeking assistance, guidance, and treatment, patients are vulnerable. In addition, the principle of trust is integral to the often intimate physical contract required for physiotherapy treatment.

Mr B's conduct in touching Ms A's chest and breasts during a clinically unnecessary examination was a serious departure from the professional and ethical standards applying to a physiotherapist.[9] The NZSP *Policy on Professional Sexual Boundaries* sets clear parameters around acts of sexual impropriety and sexual transgressions. Mr B's actions amount to both sexual impropriety (behaviour that is sexually demeaning to a patient) and sexual transgression (inappropriate touching of a patient that is of a sexual nature).

In conclusion, I share Ms Lamont's grave concern about Mr B's actions. Mr B's actions in touching Ms A's breast are a severe departure from the acceptable standard of professional and ethical behaviour, and a breach of Right 4(2) of the Code.

Furthermore, the Code states that any abuse of a position of trust amounts to exploitation. Mr B's actions were an abuse of his power in the physiotherapist–patient relationship, and of the trust that Ms A placed in him as her physiotherapist. Accordingly, Mr B's conduct amounts to exploitation, and a breach of Right 2 of the Code. It is not clear why Mr B conducted the sterno-costal examination and touched Ms A's breast. In the absence of any clinical indication for the examination, he runs a clear risk of having his actions viewed as being for the purposes of his own sexual gratification.

Documentation
Ms Lamont found it difficult to assess the standard of care provided by Mr B based on his documentation. She stated:

> "[Mr B's] documentation is inadequate, as there seems to be no written follow-through showing tests, examinations or actual treatment necessary to have continuity of care. Every test should be documented as to whether positive or negative, especially when these ideas had been discussed with the tutor in this type of learning situation."

With regards to the consultation of 28 September, Mr B's notes make no reference to the additional examinations he performed. Nor did he fully document the standard investigations, such as the straight leg raise.

[9] While Mr B was not fully registered as a physiotherapist, the principles of the *Standards of Ethical Conduct* apply to his conduct with respect to his special purpose registration.

Principle 3 of the *Standards of Ethical Conduct 2006* requires a physiotherapist to apply best practice of physiotherapy to his or her professional activities. Principle 3.4 requires comprehensive and accurate clinical records. I share Ms Lamont's concern about the adequacy of the documentation for someone who is already a registered physiotherapist. Adequate record-keeping is important for many reasons. An accurate and proper clinical record is essential for continuity of care and for communicating with other health professionals. Furthermore, as is evidenced by this case, a comprehensive and accurate clinical record is integral for reviewing patient care and audit when questions are raised about the adequacy of care provided.

Overall, I consider that Mr B did not document his care of Ms A in accordance with professional standards and breached Right 4(2) of the Code.

Opinion: No breach — University

Vicarious liability
Under section 72(3) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for the acts or omissions of an agent. Therefore, consideration must be given to whether the University is vicariously liable for Mr B's breaches of the Code.

In his letter of complaint, Mr D stated that Mr B was an employee of the University. It was subsequently clarified that at no stage was Mr B an employee of the University. Rather, he provided services in the clinic in his capacity as a student undertaking postgraduate clinical experience, having been granted special purpose registration by the Physiotherapy Board of New Zealand.

The issue is whether, by providing services in this capacity, Mr B was acting as an agent of the University. A key element in that assessment is whether it appears that Mr B was acting on behalf of the University, and what a consumer's perception of the situation would be (including the consumer's understanding/impression/awareness of the nature of the relationship).

I am satisfied that Mr B was acting as an agent of the University in providing physiotherapy services to Ms A at the Clinic. The Clinic at the School of Physiotherapy clearly holds itself out as providing physiotherapy services to university students and the wider community by supervised physiotherapy students. The Clinic is accredited by the New Zealand Physiotherapy Accreditation Scheme and is recognised by ACC. Mr B provided supervised treatment to patients who presented to the Clinic for treatment. Appointments for his services were booked through the Clinic, and consultations took place at the Clinic within the School of Physiotherapy. In conclusion, having considered the outward appearance of Mr B's relationship with the University to his patients, I am satisfied that the University allowed him to appear as

its agent, and Ms A and other patients of the Clinic would legitimately perceive that through these arrangements there was an agent relationship between Mr B and the University. Consequently, I consider that Mr B was an implied agent of the University for the purposes of section 72(3) of the Act and was acting within the scope of his authority when he provided physiotherapy services to Ms A.

Vicarious liability does not arise under section 72(3) if the acts or omissions of an agent took place without the express or implied authority of the employing authority. In addition, under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the acts or omissions leading to an employee's breach of the Code. The defence in section 72(5) is also available in relation to the acts or omissions of agents (and members).

The University had comprehensive policies in place, including in relation to the supervision of postgraduate students and informed consent. The University provided documentation to confirm that Mr B had been orientated to the clinic and the policies and procedures manuals. While Mr B booked the appointment for 28 September outside clinic hours (see discussion below), he was certainly aware of the requirement for supervision.

Mr B breached Rights 2, 4(2), 6(2) and 7 of the Code. Having considered the policies in place and the nature of Mr B's breach of the Code, I conclude that the University took reasonable steps to prevent the acts and omissions in question, and that Mr B's acts took place without the express or implied authority of the University. Overall, I consider that Mr B was adequately supervised — although I have been left with some reservations about his consistently poor standard of documentation (see below). I also consider that the University took prompt and appropriate steps in response to Ms A's complaint. In addition, appropriate support appears to have been provided to Ms A.

In the circumstances I consider that the University is not vicariously liable for Mr B's breaches of the Code.

Other comment

Booking of appointments
The School's policy documents state that appointments are to be booked through reception staff — although Mr B has indicated that students make these bookings themselves if they have time.

Mr B apparently booked Ms A's appointment on 28 September during the lunchtime to cater for her availability. In light of the important requirement of supervision, a lunchtime appointment should not have been scheduled, notwithstanding any possible inconvenience to Ms A.

I note that when Mr C became aware that an appointment had been arranged outside clinic hours, he reminded reception staff to book appointments only during clinic hours. In the circumstances, I recommend that the School remind its students that appointments must be booked only through reception staff, and must be made only during clinic hours.

Supervision/documentation
As noted above, Mr B's documentation was consistently poor. I acknowledge that the requirements of supervision are variable. It certainly appears that Mr B was well supervised from a clinical perspective during the initial consultations. Treatment then proceeded as planned (until 28 September) with Mr C available if required during supervised clinic sessions. However, even during the initial consultations Mr B did not document his spinal examination.

I recommend that the University consider whether any further measures should be taken in relation to the supervision of postgraduate students' documentation, such as whether patient notes should be signed off by the clinical supervisor.

Actions taken

Following receipt of Ms A's complaint, Mr B was suspended from clinical practice, and the University audited Mr B's recent female patients. Mr B received a zero mark for the clinical component of this aspect of his course. However, he was able to sit his final clinical exams as he had already completed sufficient clinical hours.

Recommendations

I recommend that Mr B provide a written apology to Ms A for breaching the Code of Health and Disability Services Consumers' Rights. The apology is to be sent to this Office and will be forwarded to Ms A.

Follow-up actions

- Mr 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 will be sent to the Physiotherapy Board of New Zealand.

- A copy of this report, with details identifying the parties removed, except the name of Mr B, will be sent to the New Zealand Society of Physiotherapists Incorporated and the association of physiotherapists from Mr B's home country.
- 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

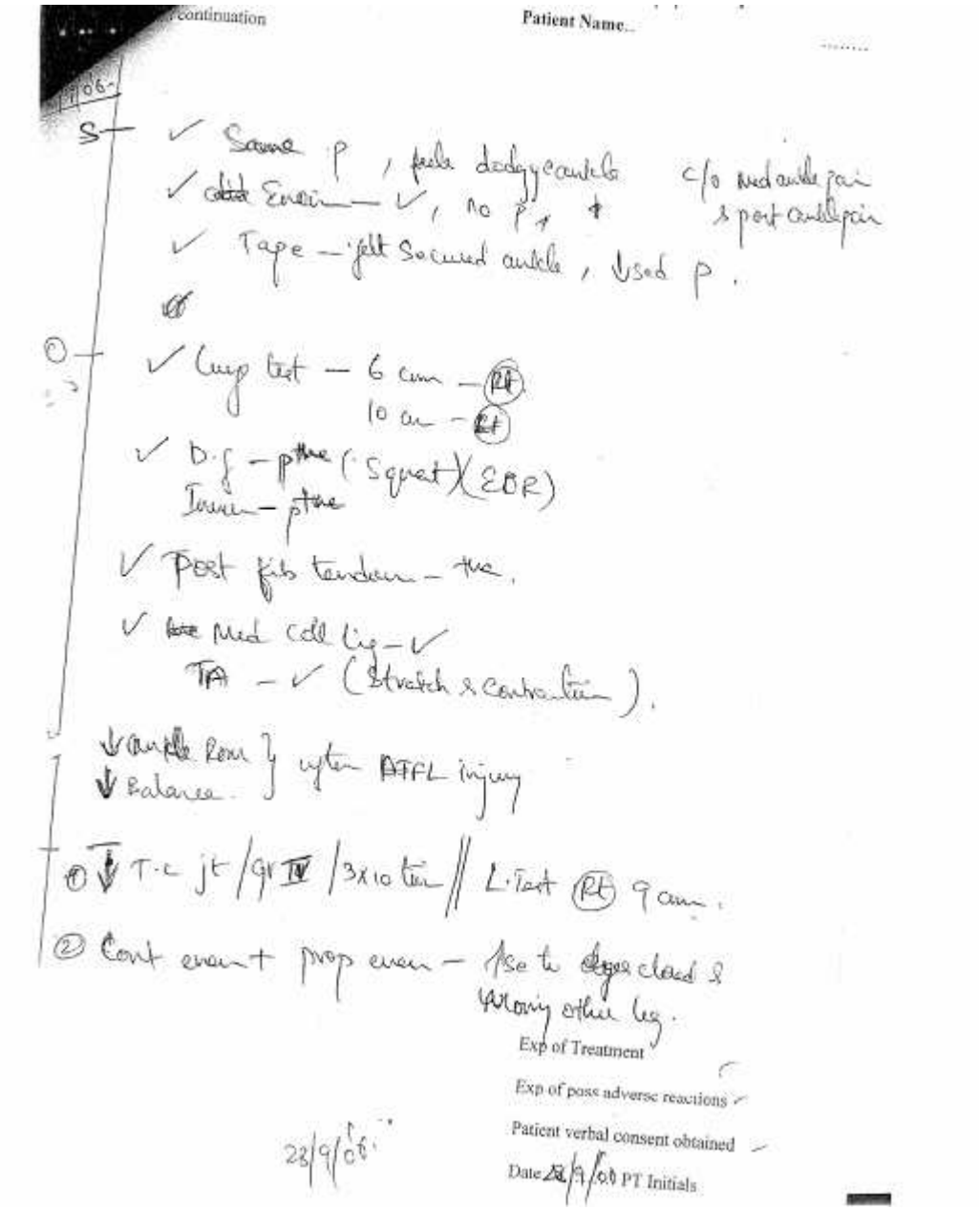
On 8 July 2008 the Health Practitioners Disciplinary Tribunal upheld a charge of professional misconduct against Mr B. Because Mr B was not currently registered in New Zealand, the Tribunal was not able to cancel or suspend his registration. Should he apply for registration in New Zealand, he must at his own cost, undertake a psychological assessment to assess what risk, if any, he poses to public safety, and complete training in ethics and professional boundaries, including personal and patient safety to the satisfaction of the Physiotherapy Board of New Zealand.

In the event that Mr B meets those conditions and re-registers, he is to undertake a mentoring programme. The Tribunal recommended that the programme should include education as to professional boundaries, personal safety and patient safety.

Mr B was censured and fined $2,000.

Appendix I

Clinical records for 28 September


Continuation

Patient Name...

9/06

S ✓ Same P, feels dodgy ankle c/o med ankle pain
✓ ~~did~~ Exam — ✓, no P, + & post ankle pain
✓ Tape — felt secured ankle, used P.

O ✓ Grip test — 6 cm — (Rt)
10 cm — (Lt)
✓ D.F — P^the (Squat)(EBR)
Invers — P^the
✓ Post fib tenderness — the.
✓ ~~Lat~~ Med calf leg — ✓
TA — ✓ (Stretch & Contraction).

↓ ~~Ankle~~ Rom } ? ATFL injury
↓ Balance.

A ↓ T-L jt / gr IV / 3x10 ten // L-Tart (Rt) 9 cm.

P ② Cont exercise + prop exercise — Use to ~~keep~~ closed & Weaning other leg.

Exp of Treatment

Exp of poss adverse reactions ✓

Patient verbal consent obtained ✓

28/9/06

Date 28/9/06 PT Initials

[redacted]

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix II

Diagram illustrating regions where Ms A stated that Mr B had touched her.

[redacted] continuation Patient Name

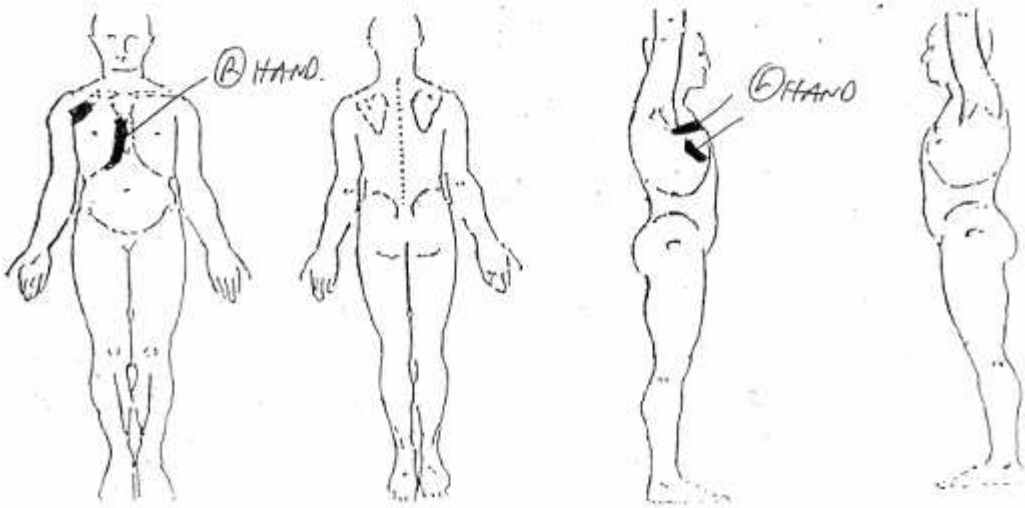
School of Physiotherapy Clinics

Patient name:

Measurable Goals:	Date goal met:

Date ...4./..10./..06

PATIENT INDICATED ON THE DIAGRAM BELOW, WHERE THE THERAPIST PLACED HIS HANDS



Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix III

Supporting Information

1. Copy of Ms A's complaint submitted through the School of Physiotherapy, marked 'A' (Pages 1–5).
2. Copy of notes of meetings held in the School of Physiotherapy in October 2006 regarding the complaint, marked 'B' (Pages 6–13).
3. Copy of notes of telephone discussion between Ms A and the HDC investigator on 14 February 2007 marked 'C' (Page 14).
4. Copy of HDC's notification letter of 26 February 2007 to Mr B, marked 'D' (Pages 15–16).
5. Copy of Mr B's response to HDC of 4 April 2007, marked 'E' (Pages 17–18).
6. Copy of enclosed documents regarding Mr B's Physiotherapy registration and training, marked 'F' (Pages 19–25).
7. Copy of notes of telephone discussion between Mr B and the HDC investigator on 11 April 2007, marked 'G' (Page 26).
8. Copy of HDC's notification letter of 26 February 2007 addressed to the University marked 'H' (Pages 27–28).
9. Copy of the University's response to HDC of 20 March 2007, marked 'I' (Pages 29–30), with copies of the following enclosures:—Confirmation of Mr B's enrolment, marked 'II" (Page 31).
10. Masters/Postgraduate [Diploma in Physiotherapy] Manual 2006, marked 'I2' (Pages 32–39).
11. Clinical records of Ms A's consultations with Mr B between August and September 2006, marked 'I3' (Pages 40–46).
12. Guidelines for Clinical Supervision of Students in the School of Physiotherapy Clinic, marked 'I4' (Pages 47–49).
13. School of Physiotherapy Orientation document, marked 'I5' (Pages 50–55).
14. School of Physiotherapy orientation form signed by Mr B, marked 'I6' (Pages 56–57).
15. School of Physiotherapy Accreditation Manual, marked 'I7' (Pages 58–63).
16. Copy of transcript of interview with Ms A on 15 May 2007, marked 'J' (Pages 64–80).
17. Copy of transcript of interview with Mr B on 14 June 2007, marked 'K' (Pages 81–103).
18. Copy of transcript of interview with Mr D, Dean of School of Physiotherapy on 14 June 2007, marked 'L' (Pages 104–113).
19. Copy of transcript of interview with Mr C on 14 June 2007, marked 'M' (Pages 114–122).
20. Copy of HDC's letter of 30 May 2007 requesting information from the University's Student Health Services, marked 'N' (Page 123).
21. Copy of response dated 8 June 2007 from the University's Student Health Services, marked 'O' (Pages 124–125).