

- Do you think chaperone conditions are an effective measure to protect patients, and why?

I would first like to have an agreed, clear and simple definition of 'chaperone'. Google has it as: A person who accompanies and looks after another person or group of people.

I think that is a good starting point to work from.

To respond to the question, yes. Yes, I do think chaperone conditions are an effective measure to protect patients. Do I hold a belief that this will guarantee a patient with a chaperone will never come to harm? No, I do not. There are no guarantees in life with any person to person interaction.

My position that I think it is a good idea is that it acknowledges in a practical way that the issue exists. It is like putting locks on the doors of our homes. When we have a door with a lock and we choose to lock the door we have taken all the reasonable steps to safeguard ourselves. The chaperone is the lock that has had the key turned.

- If chaperone conditions are appropriate in some circumstances, what steps do you think need to be taken to ensure patients are protected and adequately informed?

The first question I would need answered was why? Who thought a chaperone was necessary? The patient? The hospital? The medical practice? A religious group? A cultural issue?

I would need to know for what purpose was the chaperone to be introduced as patient support. Was it even for patient support? Was that something the patient wanted? Was the chaperone to the patient requested to protect the medical person from false allegations?

At the foot I have made self-disclosures. In part it is my current work with the Family Court and children. At times there can be accusations of fear by the child in being in the company with the non-custodial parent. However, there is in place a Court Order that supervised visits take place. The child is our client. We want the visit to go ahead and we want the child to feel safe and be safe. We can ensure the child is safe, making the child *feel* safe is another matter. We say to the child, the supervisor will be with you. We go into other issues. We can give the child a 'safe word'. We tell the child if you become frightened say the safe word and we will immediately remove you for the visit. The word has to be something that will protect the child from any potential disapproval of the visiting parent. A safe word could be 'Can I have a drink of water.' Or, 'I need to go to the toilet.' I will not take time to go into what happens then. However, my point is that we do not suggest having a safe word with every child. This is because we do not want to introduce a level of mistrust at the outset between the child and the visiting parent. I would be cautious around the use of a chaperone. The why would be important to me.

- In what circumstances do you think chaperone conditions are not appropriate, and why?

When there was no risk to the safety of the patient. I am of the view that chaperones are useful but should be used only when appropriate. Appropriate being guided by the why. Is the chaperone there because there is a high risk of patient harm? Then the focus needs to be not on the patient but what the potential harm may come.

Is the need of the chaperone due to the high anxiety of the patient? In my paid professional role we see a number of people with high levels of anxiety. The pivotal point is the concern based in reality, or the reality imagined by the person in question. In those cases where the anxiety is the person's projection of possible harm we often find that we work in reverse and are there to protect the reputation of the person who is accused.

Is the chaperone there as a support person for the patient. To be a second person who the patient will be able to talk over the events with. Or is it cultural. A traditional aboriginal person, male or female, who needs to have the chaperone there to bridge the cultural gap.

A case for not having the chaperone would be when any of the above, or some other valid reason, did not satisfy the why. It could be that issues of the patient's privacy could be at risk by having the chaperone present. A woman who is pregnant, or who wants to discuss a termination, or any gender with a STD. It may be just overweight but is excruciatingly embarrassing to the patient. Then no chaperone. What does the patient want?

Can you suggest an alternative regulatory measure to protect patients while allegations of sexual misconduct are investigated?

I would recommend what we use in the Family Court. 2 people were in a relationship that has ended. A child or children are involved. One party refuses to let the other parent see the child. They cannot go the Court and say, I don't like person Y any more so he/she is not going to see the child. That would not get to Court. The person withholding the child has to put a serious allegation of why the other parent cannot see the child. This then is exactly the situation of an unproven allegation of misconduct has to be investigated and what happens to the child and that child's relationship to the other parent. The Court orders supervised visits with a chaperone. In fact the terminology is not chaperone. The matter goes to a children's contact service to conduct the supervised visits, as though they were chaperones.

I would say, maintain the chaperone system, but become clear why and for what purpose it is functioning. There can be situations when the patient is a high risk of harm and other situations when the chaperone is as a support person.

Do you have any general comments for the review to consider?

I wish to self-disclose as I have a vested interest in the issue. I am Brian Stafford, a Patient for Patient Safety Champion with WHO (World Health Organisation). I have had experience when a sitting member of a board of a health consumer group we had to deal with an allegation by a patient of sexual abuse against the chaperone. Some years ago as a community representative I held Qualified Privilege to sit on a committee to hear issues of medical error and on a few occasions accusations from patients of sexual misconduct. I am currently the Director of Patient Affairs with the Swiss based NGO, ISCOM. While speaking at a public forum in Switzerland I became aware of the second injury sustained to patients when misconduct occurred, either intentionally or unintentionally. The negative outcome to the patient was the same. In my professional employment I provide services to the Family Court in cases of unresolved conflict where children are involved.

Brian Stafford

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