



Sexual assault of hospital patients

When a patient is a victim of sexual assault, look to administrative negligence when seeking a remedy

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Sexual assault of hospitalized patients is pandemic in a manner similar to that which has recently been exposed in government, entertainment, sports, and business. The healthcare industry has a long-standing history of ignoring complaints of sexual assault, rationalizing patient complaints, and failing to act to prevent additional assaults. This failure is an explicit dereliction of the duty and responsibility of hospital executives to first

and foremost create a safe environment and assure patient safety.

Elder Abuse and Dependent Adult Civil Protection Act

(Welfare and Institutions Code, Division 9, Part 3, Ch. 11.)

It is well understood that when patients are admitted to hospitals they forgo many elements of self-reliance, including the most basic functions that adults manage, such as how and when to medicate, ambulate, toilet, when and what to eat, to name a few. Hospitalized patients tend to be particularly vulnerable, in a weakened fragile state, because of the impact of medications or because of the

underlying disease state that caused hospitalization.

Elderly patients may also be suffering from dementia or other altered mental-state conditions and are particularly vulnerable. As a result, when sexual assaults occur, victims in hospitals are even more vulnerable than victims in other circumstances.

The Elder Abuse and Dependent Adult Civil Protection Act (Article 2, 156.23(b) defines a “dependent adult” as any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility. The Act defines “physical abuse” as including sexual assault, sexual battery, rape, sodomy, oral copulation, sexual penetration, and lewd or lascivious acts.



Respondent superior often fails in sexual-assault cases

The most successful argument that demonstrates corporate negligence for sexual assault is that a sexual assault, a battery on vulnerable hospital patients, is “foreseeable” because the hospital was administratively negligent in failing to establish the safest possible environment by flawed or incomplete hiring, training, supervising, or retaining a questionable employee.

Review of appellate cases demonstrates that, in general, vicarious liability is not an effective plea in sexual-assault cases. To cite two of many sexual-assault cases that reached the appellate courts, “Employer will not be held liable under doctrine of respondent superior for assault or other intentional tort that did not have causal nexus to employee’s work.” (*Lisa M. v. Henry Mayo Newhall Memorial Hospital* (1995) 12 Cal.4th 291.) Also, “Resident’s actions were not in furtherance of the business of hospital, or within the scope of his employment, and thus could not form basis for recovery under doctrine of respondent superior.” (*N.X. v. Cabrini Medical Center*, 2002) 97 N.Y.2d 247, 765 N.E.2d 844.)

Administrative negligence in hiring

The process of protecting patients begins with the Human Resources (HR) department and the pre-employment screening and applicant vetting process. The vast majority of perpetrators are hospital employees, most often caregiving staff (nurses, nurse aides, therapists) and ancillary staff (technicians, transporters), job classifications that allow close proximity and physical interaction with patients. An example of administrative negligence is failure to independently validate all details of the applicant’s qualifications, licensure, and credentials; check references from previous employers; question and reconcile all gaps in employment history; and perform a comprehensive criminal background check.

In *Sparks Regional Medical Center v. Smith* (1998) 63 Ark.App. 131, 976 S.W.2d 396, patient Smith alleged that while she was a patient at the hospital she was sexually assaulted by an employee, Chavez, who had been assigned to bathe her. Smith alleged that the hospital had been negligent in hiring Chavez, because he previously had been discharged by St. Edward Hospital for sexually harassing a patient. Five years after being terminated by St. Edward Hospital, Chavez applied for a position at Sparks Regional Medical Center, omitting his employment at St. Edward Hospital from his employment history, which resulted in a five-year gap in his employment history. The human resource department at Sparks failed to reconcile this obvious five-year gap in Chavez’s employment history. Had they done so, Sparks would have learned of Chavez’s previous employment, and could have found that he was not eligible for re-hire at St. Edward Hospital. Confirmation of eligibility or non-eligibility for re-hire by previous employers is among the critical information for determining whether or not an individual should be hired.

Administrative negligence in supervision

In an unpublished case, an aide who was transporting a patient from the emergency department to a nursing station diverted the patient to an unattended nursing station, closed the door to a vacant patient room, and assaulted a sedated patient repeatedly. The receiving nursing unit had been made aware that a patient would be transferred from the emergency department, but the hospital’s policies did not require specification of the time of transfer. As a result, the receiving unit had no specific expectation as to when the patient would arrive. This hospital also failed to have a policy requiring that patients being transported from one unit to another be accompanied by a nurse in addition to a transporter. The jury found that the hospital had been administratively

negligent by its failure to establish such policies and procedures, and attached liability to the hospital rather than to the perpetrator.

Abuse often occurs post-operatively while the patient is emerging from anesthesia or sedation. It is at this time that patients may be least lucid and least able to defend themselves. However, patients tend to have explicit memories when grossly inappropriate behavior occurs, notwithstanding their temporary cognitive limitations. Abuse also occurs when caregivers are assisting patients with showering, bed-baths, or toileting, or exposing genitalia for wound care.

Joint Commission Standard LD.03.01.01 requires that hospital leaders create and maintain a culture of safety and quality. It is left to individual hospitals to establish policies and procedures that comply with this standard.

For example, policies could include a requirement that two staff members are present whenever a patient is examined or bathed. At the very least, patients should be informed that a chaperone is available. A more proactive policy would allow patients to refuse the presence of a chaperone rather than be advised that one is available upon request. When a hospital ignores the foreseeability of patient abuse in this circumstance it is in effect failing to establish a protocol that prioritizes a culture of safety.

Administrative negligence in retention

Hospitals often respond to allegations of sexual abuse by denying and rationalizing patient complaints of sexual assault. Patient complaints of abuse often are dismissed as hallucinatory post-anesthesia or medication-induced events, or the patient’s misinterpretation of routine patient care because nursing staff hasn’t adequately explained to the patient what is or will be occurring in the caregiving process.

The default priority of hospital administrators and senior staff is to protect the reputation of the facility, which may shield the predator, effectively enabling



serial predators to continue to abuse patients, even when multiple complaints are received by administrators and senior staff. Continuity of concern regarding an individual predator is often disrupted when supervisors change jobs, leave the facility, produce poor documentation or fail to review prior complaints, while the predator remains in place. In these circumstances new supervisors, when faced with a complaint of sexual assault, absent specific staff records to the contrary and having no historical context or knowledge of previous complaints, presume that the alleged predator has a clean record and will give the employee the benefit of the doubt.

Patients rarely are believed

Hospitals rarely report allegations to law enforcement because patients rarely are believed. Bedside caregivers usually report patient complaints to a nursing supervisor, who assumes that the patient was dreaming or hallucinating because of the effect of medication. Typically, the supervisor who interviews the patient has been given no investigative training by the hospital. The Human Resources representative who interviews the accused staff member rarely has any training for investigating a complaint of assault. All too often the patient complaint is considered “resolved” and no further action is taken. A report of the complaint and resolution may be placed in the employee’s personnel file. When another complaint about the same employee is made at a later date there may be a new supervisor who has no knowledge of the initial complaint. At that point the interview and resolution begins again; thus, a serial predator has been created as a result of hospital negligence.

In a large number of litigated cases the fact pattern reflects a series of similar allegations about assaults occurring in the same manner on the same nursing unit. Too often, for reasons noted

above, hospital leadership dismisses the complaint out of hand and fails to give any credence to the allegation. As a result, the allegations are not investigated, thereby enabling the serial predator the ongoing opportunity to continue to assault additional patients until an incident occurs wherein the allegations are irrefutable and cannot be ignored. In these cases it is clear in retrospect that the hospital had early notice of a sexual predator but failed to act. When this fact pattern is demonstrated, the hospital is exposed to punitive damages because hospital leaders knew or should have known of the prior instances had they been properly investigated.

In *Rosenberg v. Encino Tarzana Medical Center et al.*, Superior Court of California, County of Los Angeles, BC364189, the jury awarded \$65 million in punitive damages, citing the hospital’s failure to act upon its notice of a series of sexual assault allegations about a specific employee, prior to his assault on patient Rosenberg. This case is a classic example of systemic failures ranging from front-line nursing supervisors to the Chief Executive Officer, demonstrating administrative negligence in protecting patients from serial predators.

In-hospital assault by outsiders

Review of appellate cases demonstrates that in general, premises liability is not an effective plea in cases of sexual assault by outsiders. “Generally, a person has no duty to control the conduct of a third person to prevent injury to another.” (*Delgado v. Lohmar*, 289 N.W.2d 479 (Minn. 1979).)

Exposure to patient abuse by visitors and intruders occurs when hospitals fail to establish and implement visitor containment policies and concurrently sensitize nursing staff to the possibility of safety issues with legitimate visitors and unauthorized intruders. For example, although many hospitals require visitors to register, visitors are rarely asked for the

name of the patient they are visiting. As a result, when visitors arrive on a nursing unit it is possible for almost anyone to simply walk past the nursing station and enter any room.

Liability may attach to the hospital based upon its administrative failure to establish and enforce policies and procedures designed to protect patients from intruders. It is the responsibility of the patient care staff to be aware of outsiders on the unit and to challenge anyone whose identity is unknown. According to Joint Commission Standard LD.01.03.01, the governing body is ultimately responsible for the safety and quality of care, treatment and services provided to patients. Joint Commission Standard EC.02.01.01, Elements of Performance, specifically requires that hospitals identify all individuals entering the facility.

When hospitals fail to limit access to patient rooms, and nursing staff fail to challenge and oversee visitors, this failure creates an opportunity for outside predators to assault vulnerable patients. Policies and procedures should include sign-in sheets and stick-on name badges for visitors, specifically noting the room number and the name of the patient the visitor is authorized to visit. Limiting access to nursing units in this manner, and requiring nursing staff to respectfully engage every person who enters the unit, by acknowledging their presence and verifying their destination, demonstrates a sense of priority to maximizing patient privacy and protection.

Administrative failure to train

Hospitals typically require staff to sign an acknowledgement of the institution’s policy regarding sexual abuse and harassment. Other than addressing the issue in new staff orientation, hospitals rarely if ever follow through with annual in-service education sessions devoted to this topic. A proper curriculum should address reviewing and enforcing policies and procedures for responding to complaints of sexual assault, as well as policies



related to hiring and reporting. When hospitals negligently fail to create a sense of priority and fail to sensitize staff to the possibility of patients being sexually assaulted, sexual predators are enabled to assault patients.

Reporting requirements

Licensed staff, as well as supervisors and administrators working in hospitals, are considered “mandated reporters” under the California Elder Abuse and Dependent Adult Civil Protection Act. When a mandated reporter has observed or has knowledge of an incident that reasonably appears to be abuse, the incident must be reported to the Department of Health. However, hospital policies often conflict with this requirement, and instead direct that allegations of sexual assaults be handled through the hospital incident-reporting mechanism. Because an allegation of sexual assault is an allegation of a crime, hospitals should establish policies to ensure that there is timely involvement of law enforcement so that allegations can be professionally investigated. The alleged perpetrator must be placed on suspension and isolated from all patient interaction until the investigation is complete.

Although there is always a first time for each predator, most preventable instances of sexual abuse are committed by serial predators. In order to create a culture that is sensitive to preventing sexual abuse, hospitals must recognize this fact and incorporate it into the overall goal of creating and overseeing a safe environment. A climate that encourages sexual assaults is created when nurses and nursing supervisors do not fully understand their reporting responsibilities when receiving a complaint alleging sexual assault.

Elements of discovery in sexual-abuse cases

- The perpetrator’s employment application;
- The perpetrator’s personnel file maintained in Human Resources redacted as

to information considered confidential, such as social security number, pay rates, dependents, health insurance;

- The perpetrator’s file maintained in the department in which he works;
- The Human Resource department’s policies and procedures related to employment interviews, documentation of employment interviews, hiring, criminal background checks, employment reference checks, documentation of employment reference checks;
- Incident reports involving the perpetrator;
- Incident reports involving this patient/this case;
- Notes of investigation carried out by hospital with regard to this incident;
- All patient allegations of sexual assault occurring within the past three years, redacted as to patient name. These may be maintained in a variety of departments, usually Risk Management or Patient Relations; possibly, though less likely, in the Nursing Administration office;
- Notes from investigations of all allegations of sexual assault occurring within the past three years, redacted as to patient name;
- Copies of reports made to Department of Health, OIG, Adult Protective Services, police, or other agencies with regard to allegations of sexual assault over the past three years, including this incident;
- Policies and procedures for responding to patient allegation of sexual assault;
- Records demonstrating training of relevant staff with regard to responding to patient allegation of sexual assault;
- Orientation curriculum and in-service curriculum regarding sexual assault;
- Annual licensure surveys conducted by the Department of Health for two years prior to this incident, the year of this incident, and one year subsequent to this incident;
- Complaint surveys conducted by the Department of Health for two years prior to this incident, the year of this incident, and one year subsequent to this incident;
- Depositions of individuals involved in this investigation;

- Depositions of individuals involved in investigations of allegations of sexual assaults;
- Depositions of percipient witnesses, Nursing Director of the unit where the incident occurred, Risk Manager, Chief Nursing Officer, and Chief Executive Officer;
- All hospital marketing materials;
- Corporate bylaws;
- Job descriptions of all deponents.

Conclusion

Sexual assault of hospitalized patients is a significant foreseeable problem. Although hospitals cannot protect patients from every conceivable risk, hospital Chief Executive Officers (CEOs) should be actively involved in taking prudent management actions to address a patient’s right to freedom from sexual abuse. Attorneys should recognize that the hospital, rather than the perpetrator, may be liable for sexual assault when it has failed to meet administrative community standards that address patient safety.



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