NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO:	**1120/Nur20/480D**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**THE DIRECTOR OF PROCEEDINGS**
	Applicant
AND	**MR S,** of X, Registered Nurse
	Practitioner

HEARING held at Wellington on 24-27 August 2020

TRIBUNAL	Ms A Douglass (Chair), Ms L Carlyon, Ms K Marshall, Mr M McIlhone, Ms S Matthews, MNZM (Members)
IN ATTENDANCE	Miss D Gainey, Executive Officer Ms J Kennedy, Stenographer
APPEARANCES	Ms K Eckersley and Ms C McCulloch for the Director of Proceedings Ms M Barnett-Davidson and Ms S Meares for the Practitioner

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DECISION OF THE TRIBUNAL

TUESDAY 27 OCTOBER 2020

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Introduction

[1] [ ] (Mr S), is a registered nurse against whom the Charge, principally involving inappropriate sexual activity with a patient, has been laid. The patient, Ms T, was undergoing medical detoxification, and Mr S was her nurse. The precise Charge is set out in the attached Schedule to this decision. In summary, it is alleged that he:

(a) failed to set and/or maintain appropriate professional boundaries, and

(b) engaged in sexual activity/intimate conduct with the patient.

[2] These events happened, it is also alleged, on the night shift of [ ] 2016 at [ ] (the incident). They are said, by the Director, to constitute professional misconduct, namely, malpractice and/or negligence and/or to be conduct likely to bring discredit on the nursing profession pursuant to s 100(1)(a) and s 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 (the Act).

[3] Mr S has made certain admissions and denials in relation to the particulars of the Charge.

[4] The defended hearing proceeded over four days in Wellington.

Background

[5] In December 2009 Mr S gained a Bachelor of Science in Nursing in [ ]. He immigrated to New Zealand in [ ] and completed his Registered Nurse Bachelor of Nursing and Nursing Competency Assessment programmes. He then became a New Zealand registered nurse in [ ].

[6] Following employment in a rest home for 16 months, Mr S was then employed by [ ] as a registered nurse in [ ]. From [ ] he worked on a medical ward at [ ] hospital.

[7] Following the incident on [ ] 2016 his patient, Ms T made a complaint.

[8] Mr S was contacted by the Nursing Director about the complaint and was placed on special leave. He subsequently resigned from his position at [ ] on [ ] 2016 prior to completion of a disciplinary investigation by [ ].

[9] Due to the seriousness of the allegations, the matter was referred to the Police and Ms T was interviewed by Detective [N] on [ ] 2016.

[10] In [ ] 2017 Mr S appeared in the District Court charged with indecent assault and unlawful sexual connection in relation to the incident with Ms T. On the second day of the trial at the end of Ms T's evidence the criminal charges were dismissed under s 147 of the Criminal Procedures Act 2011.[1] The trial Judge found that there was a risk of an unsafe conviction by a jury due to the complainant, Ms T's inability to consent to the sexual activity.[2]

[11] The complaint was then referred to the Nursing Council who in turn referred the matter to the Health and Disability Commissioner.[3] The Tribunal was advised by the Director that an investigation was carried out by the Commissioner and there were findings that Mr S was in breach of the Code of Health and Disability Consumers' Code of Rights.[4] The Commissioner's opinion was not published to protect the patient's identity, nor was it provided to the Tribunal for the disciplinary proceedings.

[12] On 26 March 2020 the Director of Proceedings laid the Charge of professional misconduct pursuant to s 91 of the Act.

Evidence

[13] This case is unusual because Ms T, the initial complainant in respect of the incident was not called by the Director to give evidence. There were no eyewitnesses to the incident. The only person who gave evidence in respect of what happened was the practitioner himself.

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1 Oral judgment of Judge S B Edwards on 23 August 2017, Agreed Bundle of Documents (ABOD), Tab 7, p 103.

2 Section 128A(4) of the Crimes Act 1961 provides that a person does not consent to sexual activity if the activity occurs while he or she is so affected by alcohol or some other drug that he or she cannot consent or refuse to consent to the activity.

3 Health Practitioners Competence Assurance Act 2003, s 64.

4 Transcipt of Evidence, p 89.

[14] Detective [I] interviewed Mr S on [ ] 2016, in the presence of his lawyer, some 10 days after the alleged incident (the police interview). The police interview was recorded on to a DVD and has been transcribed.

[15] Prior to the hearing, counsel for the practitioner objected to some of the police interview on DVD and the associated transcript. This objection and counter-objections by the Director in respect of some of the practitioner's evidence was determined by a separate Tribunal resulting in parts of the evidence being redacted for the defended hearing.[5]

[16] Detective [I] was the sole witness for the Director. The Director also relies on the documentation in the Agreed Bundle of Documents (ABOD/Bundle) in support of the Charge.

[17] The Bundle included correspondence regarding the complaint to the Nursing Council by the practitioner's employer and also correspondence regarding the complaint from the Nursing Council to the Health and Disability Commissioner.

[18] There are clinical records and notes from Ms T's admission to hospital on [ ] 2016 taken by various staff who were on duty, including clinical notes from Ms T recorded following the incident which occurred in the early hours of [ ] 2016.

[19] Other documentation included the notes of evidence and the decision of Judge S B Edwards following the dismissal of the criminal charges against Mr S.

[20] Dr Caleb Armstrong, consultant psychiatrist provided an expert report and attended the hearing via AVL in relation to his psychiatric assessment of Mr S.

[21] Detective [N] provided an affidavit and gave oral evidence in relation to the application for permanent name suppression. Mr S' wife, Ms S also provided an affidavit in support of that application.

[22] Mr S gave evidence at the hearing and was cross-examined on his police interview and his affidavit. He confirmed that he admits particular 1 of the Charge and that he failed to

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5 Tribunal orders on application by practitioner objecting to evidence dated 5 August 2020.

maintain appropriate professional boundaries with his patient.[6] He further admits particulars 2.5 and 2.6 in that he engaged in sexual and/or intimate contact with his patient.

[23] There are however, three sub-particulars to particular 2 which the practitioner denied. These are: that he hugged his patient;[7] while he admits that he touched the patient's genital area with his hand, he denies he moved his fingers around her genital area;[8] and, he denies that he penetrated his patient's vagina with his finger(s).[9]

[24] We first consider the law that applies to the Charge of professional misconduct.

Relevant law under the HPCA Act

Professional misconduct

[25] Section 100 of the Act provides the grounds on which a health practitioner may be disciplined. The section provides that malpractice and/or negligence (s 100(1)(a)) and conduct likely to bring discredit to the profession can constitute professional misconduct (s 100(1)(b)).[10]

[26] At the forefront of the Tribunal's deliberations is that the primary purpose of its disciplinary powers is the protection of the public and the maintenance of professional standards. There is also a punitive element, although it is accepted that punishment is of secondary importance.[11]

[27] A further purpose is to maintain the integrity of the profession.[12] In *B v Medical Council of* New Zealand,[13] a case decided under previous legislation, Elias J observed:

> The structure of the disciplinary processes set up by the Act, which rely in large part upon judgement by practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical and

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6 Affidavit of Mr S dated 8 July 2020.
7 Particular 2.1.
8 Particular 2.3 (second half).
9 Particular 2.4.
10 Health Practitioners Competence Assurance Act 2003, ss 100(1)(a) and 100(1)(b).
11 *Katamat v PCC* [2012] NZHC 1633 at [53] and *Roberts v Professional Conduct Committee* [2012] NZHC 3354.
12 *Dentice v The Valuers Registration Board* [1992] 1 NZLR 720 per Eichelbaum CJ at 724-725.
13 [2005] 3 NZLR 810.

> responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards.

[28] In relation to establishing malpractice and/or negligence under s 100(1)(a), malpractice is a broader concept than negligence, capable of encompassing neglect but also extending to trespassory conduct in the process of caring for patients that reach the necessary level of gravity such as assaulting a patient or sexual misconduct.

[29] Negligence is conduct which, in the circumstances, falls below the standard of care reasonably expected of a practitioner as judged against the standards applied by competent, ethical and responsible colleagues.[14]

[30] Under s 100(1)(b) of the Act, the Tribunal must consider whether the alleged conduct has or is likely to bring discredit on the medical profession. In *Collie*,[15] Gendall J stated:

> To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with the knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned.

Burden and standard of proof

[31] The burden of proof is on the Director.

[32] The appropriate standard of proof is the civil standard, that is, to the satisfaction of the Tribunal on the balance of probabilities, on the evidence that the events alleged by the Director are more likely than not to have occurred. The degree of satisfaction called for will vary according to the gravity of the allegations. The greater the gravity of the allegations, the

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14 *B v Medical Council of New Zealand*, above at [15] and [17]; and *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [14]; *Collie v Nursing Council of New Zealand* [2000] NZAR 74 (HC), Gendall J at [21] and [23].

15 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [28].

stronger the evidence required to satisfy the burden.[16] In *Z v Dental Complaints Assessment Committee*[17] the Supreme Court held that the threshold for more serious allegations as follows:

> Allowing the civil standard to be applied flexibly has not meant that the degree of probability required to meet the standard changes in serious cases. Rather, the civil standard is flexibly applied because it accommodates serious allegations through the natural tendency to require stronger evidence for being satisfied to the balance of probabilities standard.

Professional misconduct – two-stage test

[33] There is a well-established two-stage test for determining professional misconduct and the threshold is "inevitably one of degree".[18] These two steps are:

(a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area? This requires an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice; negligence; or otherwise bringing or likely to bring, discredit to the profession; and

(b) Secondly, if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protecting the public by maintaining professional standards and/or punishing the health practitioner.

[34] The threshold for justifying a sanction has been described as "not unduly high", as the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected on in penalty.[19] As Moore J observed in *Johns v Director of Proceedings*[20]

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16 *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1.

17 [2009] 1 NZLR 1 at [102].

18 *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA), where the Court of Appeal endorsed the earlier statement of Elias J in *B v Medical Council* (High Court, Auckland 11/96, 8 July 1996) noted at [2005] 3 NZLR 810, as applied for example, in *Johns v Director of Proceedings* [2017] NZHC 2843.

19 *Martin v Director of Proceedings* [2010] NZAR 33, Courtenay J at [32].

20 [2017] NZHC 2843, Moore J at [82]–[83], concurring with Courtney J in *Martin v Director of Proceedings* [2010] NZAR 333 (HC).

> … given the wider range of conduct which might attract sanction in this jurisdiction the threshold should not set [sic] unduly high. It is a threshold to be reached with care having regard to the purposes of the Act and the implications for the practitioner.

Credibility

[35] As Mr S' police interview with Detective [I] and at the hearing is the main evidence relied upon by the Director to prove the Charge, his credibility is of particular importance in this case.

[36] The test for credibility was stated by a Canadian Appellate Court in *Farynia v Chorny*[21] to be that the real test of the truth of the story of a witness must be at harmony with the preponderance of the probabilities which are practical, and which an informed person would readily recognise as reasonable in that place and in those conditions.

[37] As confirmed by the High Court in *Rabih v A Professional Conduct Committee of the Dental Council*, [22] the Tribunal must consider the following factors:

1. The manner and demeanour of the witness when giving evidence;

2. Issues of potential bias, that is, to what extent was evidence given from a position of self-interest;

3. Internal consistency or, in other words, whether the evidence of the witness was consistent throughout, either during the hearing itself, or with regard to previous statements;

4. External consistency or, in other words, was the evidence consistent with that given by other witnesses; and

5. Whether non-advantageous concessions were freely given.

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21 [1952] 2 DLR 354 (BCCA).

22 [2015] NZHC 1110, Brown J at [40], citing. *Farynia v Chorny* [1952] 2 DLR 354 (BCCA)) at 357.

Tribunal's consideration of the Charge

Factual circumstances of the incident

[38] Before making findings on the particulars of the Charge, we summarise the circumstances in which the incident took place.

[39] On the evening in question, [ ] 2016, Mr S was on the night shift starting at 22.45 hours. That night he was working on a medical ward. He was responsible for nine patients, including a medical ward primarily with patients who had had a stroke.

[40] Ms T had been admitted to the ward two days prior in a four-bed room for medical detoxification. Her admission was for the purpose of inpatient detoxification, to enable medical assistance with alcohol withdrawal, prior to her relocation to a rehabilitation retreat. The Tribunal notes that it is unusual for detox patients to be admitted to this medical ward.

[41] On admission Ms T was exhibiting moderate to severe withdrawal symptoms and throughout her stay presented as emotional, highly anxious, agitated and at times experiencing a tremor.

[42] During her admission Ms T was prescribed and administered medication including benzodiazepines. Diazepam was administered in accordance with the CIWA Scale.[23] At times during her admission Ms T was found to be experiencing symptoms of severe withdrawal, and required high doses of Diazepam, (up to 80mg per day).

[43] At approximately 11.40pm, Mr S administered 7.5 milligrams of Zopiclone to Ms T. Although Ms T had requested some Diazepam, Mr S stated (and recorded) that he did not administer Diazepam to her because her last administration was less than four hours prior, at 8.30pm.

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[23] The Clinical Institute Withdrawal Assessment of Alcohol Scale ("CIWA") is an assessment tool to measure a patient's withdrawal symptoms and need for medication. The tool assesses symptoms affecting the patient's physical, cognitive and psychological wellbeing. A score of 0-8 indicates mild withdrawal symptoms, 8-15 moderate withdrawal symptoms, and >15 severe withdrawal symptoms.

[44] At 3.15am Mr S completed a CIWA assessment of Ms T and recorded her CIWA score as 6. Based on Ms T's CIWA score, Mr S again did not administer any Diazepam to her.

[45] During the night Ms T went outside of the ward and met up with a friend in the car park. There were periods of time when she was not under observation.

[46] At approximately 4.30am, Mr S entered Ms T's room to administer an antibiotic (by injection) to the patient in the bed next to Ms T. After he had administered the antibiotic Mr S observed that Ms T was in her bed space and still awake (despite being administered a sleeping tablet, Zopiclone at 11.40pm).

[47] As stated by Mr S in his interview with the Police, he went to Ms T and encouraged her to go to sleep. It was when he was sitting next to her and the interaction that followed that led to the incident as alleged in the Charge, discussed below.

[48] Sometime later, at approximately 6.15am, Mr S returned to Ms T's room in order to check her observations and administer her charted medication that was due. He undertook another CIWA assessment of Ms T and recorded her CIWA score as 10 meaning Ms T was suffering from moderate withdrawal symptoms. Ms T reported an increase in her anxiety from her last CIWA assessment at 3.15am where she reported only mild anxiety. On this occasion Ms T reported feeling moderately anxious or guarded.

[49] At 6.30am Mr S administered 100 milligrams of Thiamine, Ms T's charted medication which was due, and 10 milligrams of Diazepam in accordance with her CIWA score. In the clinical notes Mr S recorded that Ms T had been "awake all night" but that nil concerns were voiced and it was a "settled night". At approximately 7am Mr S completed handover with the morning nursing shift. He then concluded his shift and left the hospital.

[50] Mr S neither made an incident report nor did he speak to any person about the incident that had occurred between him and Ms T.

[51] At approximately 8am on [ ] 2016 Ms T awoke confused to her whereabouts and upon being orientated began to cry and reported to the nurse an allegation of sexual assault against Mr S.

Credibility findings

[52] In reaching its findings on the evidence the Tribunal is required to take into account the evidence of Mr S weighed with the evidence that is available and documented from Ms T. The Director did not rely upon the evidence of Ms T as presented in the criminal prosecution or any statement that she made to the Police. Instead, the Director's case rested on the admissions given by Mr S at the police interview with Detective [I].

[53] Applying the relevant factors for credibility,[24] the Tribunal finds that Mr S' statement at the police interview held on [ ] 2016 is reliable, and is the most contemporaneous evidence of the incident that occurred four years ago.

[54] The police interview is a plausible account by Mr S that he was unprepared for the encounter and the activity that followed with Ms T.

[55] The police interview was largely against Mr S' own interests because he confessed to the incident, and in particular, to the serious elements of the Charge in relation to masturbation and ejaculation on Ms T (sub-particulars 2.5 and 2.6.). He also denied other aspects of the Charge and did not accept some of Ms T's allegations as put to him by the detective, and in particular, where he is alleged to have moved his hand around her genital area (second half of sub-particular 2.3) and that there was penetration with his finger(s) (sub-particular 2.4).

[56] The Tribunal places particular reliance on the first stage of the police interview as Mr S gave a clear largely uninterrupted account to Detective [I] of his story and the events as they unfolded.[25] The statements made in the first stage of that interview are consistent with his subsequent statement of evidence,[26] and cross-examination by the Director when he gave evidence at the hearing.

[57] During the second stage of the interview Detective [I] then sought to clarify Mr S' admissions and denials. It is at that point of the police interview that there is some confusion expressed by Mr S as to the sequence of the intimate activity following the hug. There follows

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24 *Rabih v A Professional Conduct Committee of the Dental Council* [2015] NZHC 1110, Brown J at [40].
25 Transcript of evidence pp 44-58 of 117 pages.
26 Affidavit of Mr [S] dated 8 July 2020.

a repeated discussion about some of the particulars and it is not entirely clear that Mr S has grasped the police officer's questions.

[58] One example is where Mr S is asked by Detective [I], "So was your hand still on her breast as she was lying down?". And Mr S then replies "Yes, yes". He then contradicts himself and says "Like, ah, not then, like, not when she was lying down."[27]

[59] As English is Mr S' second language, part of the confusion appears to be a language barrier which may have influenced his response to some questions. This confusion is evident when on a number of occasions Detective [I] asks Mr S to spell out some of the words spoken by him in response to questions.

[60] The Tribunal accepts that there are some discrepancies between the statement given by Mr S, particularly in the latter part of the police interview with Detective [I] on [ ] 2016, and his later affidavit and evidence before the Tribunal. The Director submitted that there were examples of Mr S' inconsistent evidence such as, whether he touched Ms T's breast and genitals at the same time, whether he touched her breast more than once, whether he was standing or sitting when he first interacted with Ms T, and with respect to his reaction to Ms T stroking his beard.

[61] Mr S was subject to rigorous cross-examination by the Director at the hearing. However, the Tribunal finds that overall there is internal consistency in Mr S' account of the incident.

[62] The Tribunal is satisfied that Mr S was speaking honestly and truthfully at the police interview. The DVD recording of the interview shows Mr S as calm and co-operative when giving a voluntary statement to the Police in the presence of his lawyer.

[63] The only evidence of Ms T's version of events available to the Tribunal comprised the clinical notes and two entries from nurses who were on duty that morning of [ ] 2016 and the notes of evidence when Ms T gave evidence at the criminal trial.

[64] There are some inconsistent allegations in the clinical records and in the evidence recorded at the trial. At the criminal trial, Ms T is recorded as saying that she did not feel

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[27] Document 3, Brief of Evidence of [I], Transcript of police interview p 85 of 117, lines 7-13.

frightened or in any physical danger, and " I remember feeling like it was a bit yucky. Certainly it wasn't a sexual experience as far as I was concerned. Um, I don't remember him being like violent. And it didn't seem he wanted to hurt me."[28]

[65] The clinical records state that there was kissing and cuddling with her and she was told by Mr S that "I could have extra diazepam if I kissed him".[29] A further report suggests that at 3.30am "Obs done. Nurse trying to undo his pants for her to perform oral sex, to which [Ms T] said no and nurse called away". Yet she then had a shower and upon her return "..he penetrated her from behind".[30]

[66] Ms T's complaint the next morning resulted in Mr S facing criminal charges of indecent assault and sexual violation by unlawful sexual connection. These charges were dismissed following an application based on Ms T lacking capacity to consent or refuse consent due to her alcohol and substance abuse.

[67] A further relevant factor in assessing the evidence is that Ms T was not under observation while she visited her friend in the carpark in the early hours of the morning. The CIWA assessment could not be properly undertaken because firstly, she was absent from the Ward at the time the assessment was due and secondly, it is not possible to be certain about the level of drugs in her body and how this may have affected her recall of events.

[68] From the recorded evidence that is available, Ms T has little recollection of the events despite alleging rape, and the story changed. It is unlikely that she could accurately recall the events in her state of ongoing addiction to drugs and alcohol preceding the incident.

[69] Ms T did not give evidence and her version of events could not be tested in cross-examination. The Tribunal finds that Ms T's evidence is unreliable, and the Tribunal has placed little weight on it.

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28 ABOD, Tab 7 Notes of Evidence Taken before Judge SB Edwards, p 112, lines 31-33.
29 ABOD, Tab 6, Clinical Records, p 37, 15/10/16 8.30am [RN T].
30 ABOD, Tab 6, Clinical Records, p 41 15/10/16 10.15am [RN S].

[70] Taken together with the non-advantageous admissions about the incident made by Mr S, and that led to the disciplinary Charge, the Tribunal finds Mr S' account of the events has probative value and is a credible account of what occurred.

Liability findings

[71] Mr S was working on the overnight shift in a public hospital. He engaged in admitted sexual activity with his assigned patient, including masturbating over her while she lay across a hospital bed and then ejaculating on to her back, wiping it up and returning to work. He later completed an assessment of her medical condition and administered psychotropic medication to her.

[72] The Tribunal is required to consider whether each of the particulars of the Charge are made out and if so, whether discipline is warranted in order to protect the public, maintain high professional standards and to hold Mr S to account, notwithstanding Mr S' acceptance that his behaviour amounted to professional misconduct.

[73] The Tribunal is not required to make a finding in regard to who instigated the sexual activity in order to find the Charge established. Ms T's intentions and/or whether she consented to the practitioner's conduct is irrelevant to the Tribunal's consideration of the Charge.

Particular 1 – failure to set and/or maintain professional boundaries

[74] In the recorded police interview, Mr S, under caution and with legal counsel present, admits that sexual activity took place between himself and his patient. Counsel for the practitioner submitted that Mr S accepted that he had failed to set and/or maintain professional boundaries.

[75] In Mr S' evidence he stated that he was unable to remove himself from the situation and records that his "brain froze" and he "couldn't do anything", as Ms T was holding onto his trouser pockets on both sides and he could not run away. And he thought if he ran away and told other staff what had happened, he would then be accused by Ms T of assault.

[76] Mr S further acknowledged that training he received as a nurse was that in situations such as that occurred, he should have removed himself and told some other staff. He also admits that his behaviour was contrary to his professional ethics.

[77] Mr S accepted that it was his responsibility to set and maintain boundaries, and that no matter what is accepted and denied it was his responsibility to act in an appropriate manner and he should have walked away from the situation.[31] He further accepted that his conduct could harm the nursing profession, and that it did cause harm to his patient.[32]

[78] In respect of Particular 1 of the Charge the Tribunal is satisfied that Mr S failed to maintain appropriate professional boundaries with Ms T and this particular is established. There was ample opportunity for Mr S to extract himself from the encounter. As he has acknowledged himself, he should have done this to maintain the professional boundaries.

Particular 2

[79] For the reasons we have set out above, the Tribunal is satisfied on the balance of probabilities that Mr S' recall of the events as explained in the first part of the police interview is the most accurate account of the incident and the specific allegations against him.

[80] Mr S accepts that he engaged in sexual and/or intimate contact with his patient. He further admits particulars 2.5 and 2.6 in that he engaged in sexual and/or intimate contact with his patient. The parties agreed that there were four factual issues identified in this case. These are: firstly, whether Mr S hugged his patient (sub-particular 2.1); secondly, whether Mr S immediately removed his hand from his patient's breast (sub-particular 2.2); thirdly, whether Mr S moved his fingers around his patient's genital area; (sub-particular 2.3); and fourthly, whether he penetrated his patient's vagina with his finger(s) (sub-particular 2.4).

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31 Transcript of evidence, p72, lines 9-14.

32 Transcript of evidence, p 71, lines32-34.

Sub-particular 2.1 - Hugged your patient

[81] Mr S denies that he hugged Ms T. He describes that when he was sitting next to her on the bed she just turned to him and gave him a hug. He says that Ms T hugged him and he patted her shoulder because she was stressed.

[82] The Tribunal finds that it is more probable than not that Mr S did not engage in a sexual or intimate hug with his patient. In the circumstances that arose, the Tribunal accepts that the patient initiated the hug, Mr S patted her on the shoulder and then she hugged him.

[83] The Tribunal observes that it is not uncommon for patients and staff to hug or make some form of physical contact in the context of the therapeutic relationship. We accept the patient initiated the hug, however the situation then escalated thereafter. This sub-particular is not established.

Sub-particular 2.2 - Touching breast

[84] The Tribunal accepts Mr S' account that Ms T then pulled up her top and placed his hand on her breast. Mr S admits that she placed his left hand on her right breast. His evidence is that she pulled up her T-shirt and grabbed his hand and put it on her breast. He denies he did not remove his hand immediately.

[85] The Tribunal is satisfied on the balance of probabilities that Mr S did move his hand away quickly from Ms T's breast.

[86] This sub-particular is not established.

Sub-particular 2.3 - Hand in genital area

[87] The Director alleged that Mr S did not immediately remove his hand from Ms T's breast, or genital area, but rather, at a certain point he had one hand on her breast and one hand on her genitals at the same time.

[88] Mr S' evidence is that Ms T then lay down on the bed and pulled down her trousers and took his hand and put it on her genital area. He denies that he moved his hand there and he states he removed his hand straight away.

[89] The Tribunal finds on the balance of probabilities that Ms T placed Mr S' hand on her genital area and that he then pulled his hand away. This sub-particular is not established.

Sub-particular 2.4 - Penetration of vagina with finger(s)

[90] It is further alleged that with respect to Ms T's genital area, Mr S moved his fingers around and penetrated her vagina with his finger(s).

[91] His evidence is that she unzipped his fly and stood up, turned and leaned over the bed face down and physically pulled his trousers urging him to have sex with her. He denies that he penetrated Ms T's vagina with his fingers.

[92] The Tribunal is satisfied on the balance of probabilities that Mr S did not penetrate Ms T's vagina with his finger(s).

[93] This sub-particular is not established.

Sub-particulars 2.5 and 2.6 - Masturbated and ejaculated onto his patient.

[94] Mr S then masturbated over Ms T and ejaculated onto her lower back. After Mr S had wiped this up he left Ms T's room and returned to work.

[95] Mr S admits these sub-particulars and the Tribunal is satisfied that this sub-particular has been established.

Liability decision

[96] The Tribunal finds that particular 1 and sub-particulars 2.5 and 2.6 are established. Each of these particulars and sub-particulars is separately established and of such a serious nature to both separately and cumulatively warrant disciplinary action. Undoubtedly, particular 1 and sub-particulars 2.5 and 2.6 are malpractice and negligence and were likely and have brought discredit to the nursing profession. Such sexual misconduct must be regarded as the most serious and merit condemnation by the Tribunal.

[97] The Tribunal finds that the conduct, alleged in this case in respect of those particulars, is established, and cumulatively, amounts to professional misconduct warranting disciplinary sanction.

[98] Mr S' conduct is in breach of the relevant professional standards. These include the Code of Conduct for Nurses (June 2012) and the Guidelines Professional Boundaries – A Nurses Guide to the Importance of Appropriate Professional Boundaries (June 2012). These professional standards recognise that nurses have greater power than health consumers because of their authority and influence as a health professional, their specialised knowledge, and access to privileged information about the health consumer when receiving care.[33]

[99] As acknowledged by Mr S, and stated in the applicable guidelines on professional boundaries, health consumers may read more into a therapeutic relationship with a nurse and seek to have personal or sexual needs met. These Guidelines state:

> It is the nurse's responsibility when this occurs to maintain the appropriate professional boundary of the relationship. A nurse has the responsibility of knowing what constitutes appropriate professional practice and to maintain his or her professional and personal boundaries … it is the responsibility of the nurse to assist health consumers to understand the appropriate professional relationship. There is a professional onus on the nurse to maintain a relationship based on care plans and goals that are therapeutic in intent and outcome.

[100] Mr S should not have engaged in sexual or intimate behaviour with his patient. Ms T was particularly vulnerable given her admission due to substance and alcohol abuse and detoxification. She was heavily sedated at the time, in a state of anxiety and distress and Mr S should have been alert to the circumstances as they unfolded and taken appropriate actions.

[101] Mr S' conduct departs from acceptable professional standards. Sexual or intimate behaviour with a health consumer is prohibited due to the inherent power imbalance and the vulnerability in the patient/nurse relationship, and the potential for real harm to be caused to the health consumer by that behaviour.

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[33] Guidelines: Professional Boundaries – A Nurses Guide to the Importance of Appropriate Professional Boundaries, ABOD, Tab 9, p 237.

[102] Mr S has acknowledged that he was aware of what his nursing education required him to do – leave the situation and/or involve another staff member – and yet he failed to follow that training.

[103] While Mr S accepted that there were multiple opportunities to leave the situation, he also suggested that he had "no choice" but to masturbate over his patient's back. The Tribunal accepts the Director submission that despite an escalating situation with numerous opportunities to remove himself, Mr S chose not to leave but instead followed through with the sexual activity in that he masturbated over his patient as she lay prone across the hospital bed. Having ejaculated onto his patient's back, Mr S simply wiped up his ejaculate and left.

[104] Mr S took advantage of a situation that presented itself, and instead of following through on his training which indicates he should leave the situation and seek assistance, he instead engaged further in the sexual activity and in so doing, grossly breached the patient/nurse practitioner relationship.

[105] Despite the accepted professional standards, and Mr S' understanding of his training, there has been a serious departure from acceptable professional standards by engaging in sexual activity with a patient.

[106] The Tribunal is satisfied that Mr S' conduct, as it finds established, departed from standards to a degree that warrants disciplinary sanction. Mr S was a registered nurse working in a public hospital. He was entrusted with the care of patients who are vulnerable. Ms T's vulnerability was particularly evident as she was undertaking detoxification due to a history of alcohol overuse disorder and serious drug dependency. As Mr S noted himself, the first thing that is required for detox patients is for nurses to try to "reduce their stress and give them much more personal attention".[34]

[107] There are numerous cases where the Tribunal has acknowledged that sexual relationships of any kind with a patient is conduct that must be regarded as the most serious and merits condemnation by the Tribunal.[35] The purpose of the prohibition on health

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34 Transcript p 39, lines 17-21.

35 For example: *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC).

practitioners who may enter into any sexual encounter or sexual relationship with patients is the existence of the professional relationship blurs and undermines consent.[36]

[108] The Tribunal emphasises that whether Mr S or Ms T instigated the sexual activity or whether it was consensual is irrelevant for the purposes of establishing the disciplinary charge of professional misconduct and the seriousness of it. Mr S' conduct is malpractice, negligence, and has brought or is likely to bring discredit to the nursing profession pursuant to s 100(1)(a) and (b) of the Act. The Charge is established and it warrants disciplinary sanction.

Penalty decision

Legal principles

[109] Having found the Charge, particular 1 and sub-particulars 2.5 and 2.6 established, the Tribunal turns to make orders in relation to penalty. The Tribunal has already acknowledged the seriousness of the Charge and the completely inappropriate response to the patient's actions by Mr S. This was a gross breach of professional boundaries and standards by the practitioner.

[110] The available penalties under s 101 of the Act are: cancellation of registration; suspension for a period not exceeding three years; a fine not exceeding $30,000, imposition of conditions on practice for a period not exceeding three years; and censure.[37]

[111] The Tribunal's role is to determine the appropriate penalty, given the nature of the conduct, to ensure that both the public interest and the integrity of the profession are maintained. The principles for imposition of a penalty are well established. In *Roberts v PCC,* Collins J set out the relevant principles and a summary is as follows: [38]

(a) The first consideration requires the Tribunal to assess the penalty that most appropriately protects the public.

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36 *Mr R* 842/Nur16/349D at [45].
37 Health Practitioners Competence Assurance Act 2003, s 101(1).
38 [2012] NZHC 3354 per Collins J at [44]-[51].

(b) The Tribunal must be mindful of the fact that it plays an important role in setting professional standards.

(c) The penalties imposed by the Tribunal may have a punitive function, although protection of the public and setting professional standards are the most important factors.

(d) Where appropriate, the Tribunal must give consideration to rehabilitating health professionals.

(e) The Tribunal should strive to ensure that any penalty it imposes is comparable to other penalties imposed in similar circumstances.

(f) The Tribunal must assess the health professional's behaviour against the spectrum of the sentencing options available.

(g) The Tribunal should endeavour to impose the penalty that is the least restrictive that can reasonably be imposed in the circumstances.

(h) The Tribunal must assess whether the penalty imposed is fair, reasonable and proportionate in the circumstances.

[112] In *A v Professional Conduct Committee*,[39] the Court discussed carefully the range of sanctions available to the Tribunal, particularly cancellation and suspension. The Court observed that four points could be expressly, and a fifth impliedly, derived from the authorities:[40]

> [81] First, the primary purpose of cancelling or suspending registration is to protect the public, but that 'inevitably imports some punitive element'. Secondly, to cancel is more punitive than to suspend and the choice between the two turns on what is proportionate. Thirdly, to suspend implies the conclusion that cancellation would have been disproportionate. Fourthly, suspension is most apt where there is 'some condition affecting the practitioner's fitness to practise which may or may not be amendable to cure'. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish.
>
> [82] Finally, the Tribunal cannot ignore the rehabilitation of the practitioner: *B v B* (HC Auckland, HC 4/92, 6 April 1993) Blanchard J. Moreover, as was said in *Giele v The General Medical Council* [2005] EWHC 2143, though '… the maintenance of public confidence…must outweigh the interests of the individual doctor', that is not absolute –'the existence of the public interest in not ending the career of a competent doctor will play a part.'

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39 *A v Professional Conduct Committee* [2008] NZHC 1387.

40 [2008] NZHC 1387 and (HC Auckland, CIV-2008-404-2927), 5 September 2008, per Keane J at [81]-[82].

[113] In *Katamat v Professional Conduct Committee,*[41] the High Court confirmed that the primary factor in determining a penalty will be what penalty is required to protect the public and to deter similar conduct. The overall decision is ultimately one involving an exercise of discretion.

Penalty Submissions

[114] The Director sought cancellation of Mr S' registration, censure and costs. In addition, the Director sought orders under s 102(1) of the Act that should Mr S seek to resume practice in the future he must at his own expense comply with two conditions that relate to a course of instruction on professional boundaries and ethics and for a period of 24 months following re-registration be under regular and structured supervision as approved by the Nursing Council. The Director also sought recommendations that Mr S be required to advise his employer of the Tribunal's decision in this matter for a period of three years and that Mr S only work for an employer that has been approved by the Nursing Council.

[115] The Director submitted that there are a number of aggravating features to Mr S' conduct. These include:

(a) The conduct occurred in the hospital where Ms T was an inpatient, and where she was entitled to receive ethical and professional nursing care;

(b) At the time Mr S had nursing responsibilities to not only Ms T but to eight other patients. In addition, the sexual misconduct took place in Ms T's bed space and while three of Mr S' other patients were in the room asleep;

(c) At the time, and as Mr S was well aware, Ms T was a very vulnerable patient while undergoing medical detoxification from alcohol and serious drug dependency. Ms T was medicated for this with high doses of diazepam and was suffering from the effects of withdrawal (at times to a severe level);

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41 [2012] NZHC 1633 at [53].

(d) There was an inherent power imbalance between Mr S and Ms T as there is between all nurses and their patients;

(e) There was "ample opportunity" for Mr S to extract himself from the encounter in the course of its escalation. However, Mr S chose not to extract himself and instead further escalated the sexual contact by masturbating and ejaculating over his patient. This was because, in his words "there was no other option"; and

(f) Immediately following the events Mr S did not report the sexual misconduct, but returned to work as though nothing had happened and continued to provide nursing care to Ms T (including the administration of her medication) and failed to report the incident prior to leaving the ward.

[116] The Director also acknowledged that there were mitigating factors regarding Mr S' evidence that this complaint is the first that has been made against him while he has been practising as a nurse in New Zealand. He has also undertaken a two-hour course in relation to the Nursing Council's Code of Conduct and attended a session of EAP counselling. The Director acknowledged that Mr S has offered an apology to Ms T in his brief of evidence and in his evidence before the Tribunal.

[117] For the practitioner, Ms Barnett-Davidson acknowledged the aggravating features of the conduct for the Tribunal to consider and that the sexual conduct was serious. Mr S did not report what happened, although he recognised that it was wrong.

[118] Counsel for the practitioner submitted that the following mitigating factors for consideration of penalty were relevant to addressing public safety and setting professional standards are as follows:

(a) Mr S did not instigate the sexual conduct with his patient. He was taken by surprise and he froze in his reaction;

(b) It was a one-off sudden situation;

(c) Subsequent evidence prior to the criminal trial in 2017 showed that the patient had a motivation and a purpose for initiating sexual conduct with Mr S;

(d) This misconduct was not repeated and no patient relationship was formed despite Ms T saying to Mr S she wanted them to repeat the sexual contact the next night; and

(e) Mr S has not been involved in any patient complaint before this incident;

(f) Mr S acknowledged to his manager that sexual contact had occurred on [ ] 2016 when asked by his manager the next day following Ms T' complaint.

(g) Mr S attended a Police interview on [ ] 2016 and gave a statement admitting the incident. He has accepted that he has been suspended from practice as a registered nurse through the criminal trial in [ ] 2017. He was then resuspended in [ ] 2017 after the criminal charges were dismissed. He gave evidence again to the HDC investigation from March 2018 to March 2019. In March 2019 the HDC referred him to the Office of the Director of Proceedings.

(h) Mr S has been fully compliant with the proceedings as filed by the Director in the Tribunal on 30 March 2020.

[119] Dr Armstrong, consultant psychiatrist, gave expert evidence in relation to Mr S' conduct. Dr Armstrong concluded that Mr S has no substance misuse problem, no psychiatric illness, no personality disorder and no previous incidents to suggest an elevated risk of recurrent behaviour. Dr Armstrong did note that it is difficult to predict the risk of recurrent behaviour but in his opinion, there was an absence of typical risk factors that might lead to concern about re-offending.[42] Now that Mr S has been charged this could be a factor to consider, however this comment was based on overall historical combined statistics as opposed to Mr S' individual situation.

[42] Transcript of evidence, p 165, lines 20-34.

[120] It was submitted for Mr S that Dr Armstrong had recorded that Mr S has a good relationship with his wife, good social support and a desire to return to the nursing profession which Dr Armstrong noted Mr S held in high regard.

[121] Dr Armstrong also noted that Mr S had no attitudes supportive of sexual contact with his patients. He noted that he was acutely aware of his wrongfulness of his actions, and that he had experienced significant losses as a result of his actions.

[122] Mr S has been suspended from practice for almost four years. He has returned to care for patients as a healthcare assistant in the last three years since the criminal charge was dismissed. It is submitted on his behalf that he has continued to progress his life constructively. Character references were provided by Ms [B] who had known him previously for over a year as a registered nurse, and again while suspended she had employed him as a healthcare assistant for the last three years.

Comparable cases

[123] In its assessment of an appropriate penalty the Tribunal considers the penalties imposed in other similar cases in order to achieve consistency where possible, accepting that particular facts and circumstances of each case are different.

[124] In the comparison of other cases, the majority of Tribunal cases referred to by the Director involved ongoing sexual relationships with a patient or inappropriate sexual contact with a patient that resulted in cancellation of the practitioner's registrations.

[125] In *Director of Proceedings v Mete,*[43] Nurse Mete developed a relationship with a mental health inpatient he cared for. The sexual relationship occurred after the patient's discharge, and lasted over seven months, and he initially denied it. He was censured and his registration cancelled and conditions imposed upon any application for re-registration.

[126] *In Director of Proceedings v R*[44] Mr R was a nurse who breached professional boundaries by engaging in sexual intercourse with a patient of a community mental health service at

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43 191/Nur08/104D.

44 842/Nur16/349D.

which the practitioner worked, and whose care the practitioner had limited involvement with. The sexual contact took place at the patient's place of residence rather than the hospital/clinical setting as in the present case. The practitioner also supplied the patient with alcohol despite knowing she was experiencing alcohol-related health issues. The events took place over the course of one day.

[127] In relation to the issue of the consensual sexual relationships the Tribunal stated:

> We hasten to say that there is no evidence at all suggesting that the practitioner forced himself on patient A in any physical sense. But the whole point of the prohibition on health practitioners entering into romantic or sexual relationships with patients or former patients is that the existence of the professional relationship blurs and undermines consent.[45]

[128] Mr R accepted his conduct amounted to professional misconduct and proceeded by way of an Agreed Summary of Facts. The Tribunal concluded that the case was a serious one, albeit not at the most serious end of the scale, and cancelled Mr R's registration.

[129] In the *Director of Proceedings v McMillan,*[46] the practitioner had established a relationship with a mental health inpatient whilst a mental health nurse. The inappropriate relationship while the patient was admitted lasted for nearly two months. It became sexual after the patient was discharged from acute inpatient care, and the sexual relationship continued for over six months. His registration was subsequently cancelled.

[130] In *PCC v Gulliver,*[47] the practitioner formed an inappropriate relationship with a patient he cared for in the community as a mental health nurse. After discharge it became a sexual relationship for approximately eight months, and an inappropriate relationship continued for six months after that. He failed to see the impact of his relationship on his patient's care and his registration was subsequently cancelled. He was censured and fined.

[131] The above cases differ from this case in a number of ways. In contrast to the above cases resulting in cancellation, the following two cases involve suspension and different factual circumstances that involved brief sexual encounters.

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45 *Director of Proceedings v R* at [45].
46 634/Nur14/274D.
47 61/Nur06/35P.

[132] In *Director of Proceedings v Harypursat*[48] a GP, it was considered a serious case of professional misconduct whereby, while the doctor and the patient did not enter into a sexual relationship, the practitioner sent a number of text messages to the patient and he persisted with his attentions despite the patient expressly pointing out he was acting unprofessionally. The Tribunal imposed a nine month suspension with conditions on his practice. He was censured in particular in relation to the power imbalance with his patient and his lack of insight into his conduct and the risk to his patient.

[133] In *Director of Proceedings v Y*[49] Dr Y a medical practitioner was found guilty of professional misconduct in that he transgressed sexually in one breach of professional boundaries with his patient who was also a health practitioner when he gave her a hug after she consented to his offer of a hug. In a second particular, Dr Y was found to have sexually violated his patient where in a brief encounter his patient was persuaded to perform oral sex on Dr Y, which conduct was considered to be completely inappropriate. Dr Y was fined the sum of $25,000 and conditions were imposed on his practice for a period of three years in relation to chaperoning when treating female patients and to notify any prospective employer of this requirement. There was an order of censure.

Penalty decision

[134] The Tribunal is satisfied that the case law suggests that a penalty less than cancellation can be considered with relevant conditions placed on practice where the sexual contact has some degree of consent and/or is less than a relationship involving a prolonged sexual relationship. The significant power imbalance will always be present in these circumstances.

[135] Counsel for the practitioner submitted that Mr S' sexual conduct with Ms T was sudden and brief, not relationship forming and was instigated by the patient for a purpose. It was consensual as in the category of less serious in terms of penalty, where suspension and conditions should be considered by the Tribunal as an option. Specifically, the conduct penalised in *Harypursat* and *Dr Y* are more serious than the conduct in Mr S' case.

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48 729/Med15/316D.

49 591/Med/13/258P.

[136] The Tribunal notes the aggravating features of this case as outlined above by the Director. While Mr S' conduct was at the high end of breach of professional boundaries, it was a "one-off incident". From the outset Mr S made an early admission of two of the serious elements of the offence, namely that during the incident he masturbated and ejaculated over Ms T.

[137] As confirmed by Dr Armstrong, Mr S has insight into his actions and the risk of Mr S re-offending is low.

[138] Mr S did not form an ongoing inappropriate relationship with this patient, nor was it premeditated, rather he inappropriately responded to the circumstances that presented and did not remove himself from this situation.

[139] Mr S has cooperated fully with responses to an HDC investigation of over a year, followed by the process of his referral to the Director of Proceedings whereby a further year passed before a Charge was filed before the Tribunal. From the outset, Mr S has accepted that he had sexual contact with his patient and he did not respond appropriately to his patient's actions. In proving the disciplinary Charge as established, the Director has been reliant upon Mr S' own admissions at the police interview.

[140] The Tribunal has given due consideration to imposing cancellation of the practitioner's registration given the seriousness of the conduct. Cancellation of his registration would be disproportionate and overly punitive in view of the mitigating factors.

[141] The Tribunal is satisfied that suspension together with rigorous conditions of practice and a censure to mark the strong disapproval by the Tribunal for such a serious breach of professional boundaries is an appropriate penalty. Applying the principles in *Roberts*[50]suspension of Mr S' practice will allow for rehabilitation and is less restrictive, fair and proportionate.

[142] In view of the seriousness of the breach of professional boundaries, the starting point for a penalty to be imposed is three years' suspension from practice, the maximum available,

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50 *Roberts v PCC* [2012] NZHC 3354 per Collins J at [44]-[51].

to reflect the seriousness of the professional misconduct and the disapprobation of the profession.

[143] As this matter has taken just under four years to reach a penalty hearing before the Tribunal, a discount should apply for imposing suspension from Mr S' practice. The maximum term of suspension is to be discounted by two and a half years, taking into account that Mr S has, in effect, been suspended by the Nursing Council for a period of approximately four years as at the date of this decision.

[144] Mr S will be expected to comply with conditions upon resuming practice, including the requirement to undertake regular and structured professional supervision. Mr S is expected to identify and meet monthly with a senior male registered nurse (as a mentor) for a two-year period to enable him to reorient safely back into nursing practice. Working with a senior male registered nurse will assist Mr S to develop strategies and a reflective practise for nursing practice, particularly working with women. The many facets presented to the Tribunal underpin our decision to take a rehabilitative approach to the penalty to be imposed as the Tribunal considers that Mr S is motivated to make a positive contribution to nursing in the future.

Costs

[145] When considering the appropriate quantum of costs, the Tribunal must take into account the need for the practitioner to make a proper contribution towards costs. In doing so it takes 50% of the total reasonable costs as a starting point which can be reduced or increased depending on the circumstances, in accordance with the principles in *Cooray v Preliminary Proceedings Committee*.[51]

[146] Ms Barnett-Davidson submitted that Mr S' defence of the Charge can be characterised as only ever seeking to clarify the ambiguities in the Charge regarding the fact that the patient initiated the contact, disproving Particulars in which there was no evidence – these matters

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[51] *Cooray v Preliminary Proceedings Committee* (unreported) AP 23/94 Wellington High Court, 14 September 1995, Doogue J at [9]; *Vatsyayann v PCC* [2012] NZHC 1138, Priestly J at [34].

have been important findings of fact by the Tribunal at the liability stage, and are facts that are significant and relevant to penalty.

[147] Mr S has cooperated throughout and has always been accepting as to his failures and the consequences of his actions.

[148] Mr S' financial circumstances reflect his modest income. He has purchased a house with his wife, and he has been working on a healthcare assistant's salary for the last three years and prior to that as a vegetable picker. He has lost four years of professional salary as a registered nurse.

[149] Counsel for the practitioner submitted that costs should be in the order of a 25% contribution.

[150] The Director submitted that it is appropriate and in the public interest that Mr S make a reasonable contribution to the costs involved in the disciplinary process. As Mr S has been successful in his defence of some of the particulars of the Charge, the Director submitted that an order for 30% would be appropriate.

[151] The Tribunal's costs are estimated at $62,206.55.[52] and the Director of Proceedings' costs are estimated to be $44,379.05,[53] a total of $106,585.60.

[152] Balancing all of these factors, including the early admissions, the severity of the disciplinary Charge and Mr S' financial circumstances, the Tribunal considers that an order for Mr S to contribute 25% of all costs is fair and reasonable. The amount of costs will be fixed at $26,000 to be shared equally between the Director of Proceedings and the Tribunal.

Name suppression

[153] Interim name suppression was initially granted for both Mr S and Ms T.

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52 Document 20, HPDT Estimate of costs expended in relation to the disciplianary action.

53 Document 19, Health and Disability Comissioner Breakdown of costs, .

[154] An application for permanent name suppression for Ms T and continuing name suppression for Mr S was made on 24 April 2020.

[155] At the hearing a further application for permanent suppression of the practitioner's name and identifying details was made. Several affidavits were filed in support of the application.

[156] Mr S seeks an order for permanent non-publication of his name and identifying details under s 95(2)(d) of the Act. An order was sought prohibiting publication of his name and any particulars of his affairs and the name of his wife based on an affidavit filed by him and the affidavit of his wife, Ms S.

[157] The Director submitted that Mr S should not be granted permanent name suppression and the Tribunal should not depart from the principles of open justice.

Legal principles

[158] Section 95(1) of the Act states that every hearing of the Tribunal must be held in public. Notwithstanding the presumption of openness, the Tribunal has discretion under s 95(2) to make non-publication orders if it is satisfied that it is "desirable" to order name suppression having regard to competing interests, including (but not limited to) the public interest and the legitimate private interests of the practitioner.

[159] The following public interest considerations are relevant when evaluating an application for permanent name suppression in respect of a medical practitioner[54] (and these considerations apply to all health practitioners). These include:

(a) Openness and transparency of the disciplinary process;

(b) Accountability of the disciplinary process;

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54 *Tonga* 18/Med04/01D.

(c) The public interest in knowing the name of the doctor charged with a disciplinary offence;

(d) The importance of freedom of speech and the right enshrined in s 14 of the New Zealand Bill of Rights Act 1990; and

(e) The extent to which other doctors may be unfairly impugned if the practitioner's application is granted.

Permanent name suppression order

[160] The Tribunal has carefully considered the relevant factors in favour and those against, publication of Mr S' name and identifying details and those of his wife, Ms S.

[161] When addressing the public safety measures, we are satisfied that the conditions on practice imposed will adequately address these concerns and mitigate against the risk of re-offending. We have also taken into account the accountability of the disciplinary process to both the public and the profession, as well as the public interest in knowing the identity of a practitioner against whom a Charge is established.

[162] It is important that Mr S and other nurses understand that one of the consequences of serious misconduct such as in this case is that the public and professional peers become aware of that misconduct given the seriousness of the misconduct involved.

[163] The public considerations have to be balanced with the private considerations of the practitioner.

[164] Rehabilitation is an important objective in this case, an objective that will be compromised if name suppression is not granted and Mr S is not given the opportunity to maintain his commitment to his profession.

[165] Mr S is well motivated and has consistently had the support of his employers through the disciplinary process. In this respect the Tribunal received an affidavit from Ms [B] his employer at the rest home where he has been working as a healthcare assistant since [ ] 2017.

Ms [B] had also been Mr S' manager when he was employed from [ ] 2013 to [ ] 2013 prior to the events in 2016 at another rest home as a registered nurse.

[166] Ms [B] gave a character reference to confirm that she had no doubt about Mr S' honesty, integrity or ability to provide care for the vulnerable residents at the rest home. Importantly she confirmed that Mr S has reflected on all the circumstances and actions over the four years demonstrating insight that he had learnt from what has occurred and taken responsibility in relation to what has happened.

[167] The Tribunal observes that publication of Mr S' name is likely to adversely affect his employer and related work settings in the town where he and his wife live and work.

[168] Other factors to which the Tribunal places weight is the impact on family members and in this case, the impact on his wife and her professional circumstances and employment should his name be published.

[169] The Tribunal places less weight on Mr S' professional standing and that within his community and that such reputation would be harmed by publication. This is an inevitable consequence in practically all cases that come before the Tribunal where a Charge is made out. It is not a factor which is entitled to significant weight, where the misconduct is serious.

[170] Counsel for the practitioner called Detective [N], the police detective who took a statement[55] from Ms T at the time of the initial complaint to the Police while she was a patient at [ ] Hospital. That statement was not signed and was not provided to the Tribunal. There were concerns at the time of the incident due to threats made by Ms T regarding an associate of hers to the personal safety of Mr S. Even though the likelihood was somewhat reduced with the passage of time, there still remained a possibility in Mr S' mind that this threat would be enacted.

[171] The Tribunal considers that this evidence has little probative value and is speculative. We accept Mr S may have had personal safety concerns at the time, however there are currently no imminent threats of harm to himself and family.

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55 Document 15, Affidavit of [N] dated 13 August 2020.

[172] In hearing this matter, given the practitioner's early admission to the allegations and Charge as made out. These events occurred nearly four years ago. He has been subject to a criminal trial and an investigation by the Health and Disability Commissioner. The resulting delay in the matter being prosecuted in a disciplinary jurisdiction is a factor which we consider is entitled to be given some weight to non-publication.

[173] Standing back, these factors that make up the private considerations in this case, on their own, would not be sufficient to outweigh the public interest in publication. The Tribunal is satisfied however, that on balance, it is desirable for an order for permanent name suppression be made pursuant to s 95 of the Act.

[174] Importantly, granting name suppression to Mr S further protects the identification of Ms T when she may seek to access future healthcare from the hospital or health services in the community. The Tribunal was also advised that one of the reasons for not publishing the Commissioner's opinion was to protect the patient, Ms T.[56] Similarly, there is less risk of Ms T being identified if the practitioner is not identified.

[175] The Tribunal's overall assessment is that non-publication of both Ms T and Mr S' name and identifying details is a proportionate response to the established Charge and the circumstances of this case.

Result and orders

[176] The Tribunal finds that the Charge has been established. The practitioner's conduct by engaging in inappropriate sexual activity with the patient amounts to professional misconduct and is a serious departure from professional standards. Separately and cumulatively the particulars as proved amount to malpractice and negligence and has brought or is likely to bring discredit to the profession. This conduct is sufficiently serious to warrant disciplinary sanction.

[177] In respect of the penalty, the Tribunal makes the following orders:

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[56] Transcript of Evidence p 204, line 16.

(a) The registration of the practitioner will be suspended for a period of six months from the date of this decision pursuant to s 101(b) of the Act.

(b) The following conditions pursuant to s 101(c) are to be imposed after Mr S recommences practice. These are:

(i) That the practitioner undertake regular and structured professional supervision with a senior and experienced male nurse for mentoring, as approved by the Nursing Council; these sessions should include (but not be limited to) professional boundaries, appropriate behaviour when working with women, strategies for dealing with manipulative patients and the importance of honest and timely documentation.

(ii) That the practitioner, under the guidance of the supervisor as set out in Condition (i) above, successfully complete a course of instruction approved by the Nursing Council in professional boundaries and ethics;

(iii) That the practitioner is required to advise any employer of the Tribunal's decision in this matter for a period of three years; and

(iv) The practitioner may only work for an employer that has been approved by the Nursing Council for a period of three years.

(v) All of the above conditions are to be complied with at the practitioner's own cost.

(c) There will be an order for censure pursuant to s 101(d) to express the Tribunal's disapproval and condemnation of the serious breach of professional boundaries that occurred.

(d) A 25% contribution to the total costs of the Tribunal and the Director fixed at $26,000 to be shared equally between the Director of Proceedings and the Tribunal.

[178] There will be an order for permanent non-publication of the practitioner's name and identifying details pursuant to s 95 of the Act as follows:

(a) Mr S' name;

(b) Location of hospital to be described in the Lower North Island, and any staff at the hospital;

(c) Mr S' ethnicity;

(d) Place of work;

(e) Name and identifying details of his wife, her profession and place of work.

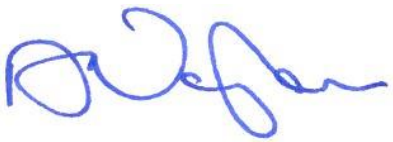
[179] There will also be permanent non-publication of Ms T's name and her identifying details including any association she has with [ ]. This order is made under s 98 pursuant to section 157 of the Act and subject to the suppression orders made above, the

[180] Tribunal directs the Executive Officer:

(a) To publish this decision and a summary, on the Tribunal's website.

(b) To request the Nursing Council of New Zealand to publish either a summary of, or a reference to, the Tribunal's decision in its principal professional publications to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Dunedin this 27th day of October 2020



A J Douglass
Chair of the Tribunal

SCHEDULE

NOTICE OF CHARGE

TAKE NOTICE that pursuant to sections 91 and 100(1)(a) and 100(1)(b) of the Health Practitioners Competence Assurance Act 2003, the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that on [ ] 2016 whilst caring for your patient, Ms T, at [ ] Hospital you, being a registered nurse, acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

1. You failed to set and/or maintain appropriate professional boundaries with your patient;

AND/OR

2. You engaged in sexual and/or intimate contact with your patient in that you:

    2.1 hugged your patient; and/or

    2.2 touched your patient's breast with your hand and/or did not immediately remove your hand from your patient's breast; and/or

    2.3 touched your patient's genital area with your hand and/or moved your fingers around your patient's genital area; and/or

    2.4 penetrated your patient's vagina with your finger(s); and/or

    2.5 masturbated over your patient while your patient was lying face down across the hospital bed; and/or

    2.6 ejaculated onto your patient's lower back and wiped it up.

The conduct alleged in the above particulars separately and/or cumulatively amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that has brought or was likely to bring discredit to the nursing profession under section 100(1)(a) and/or section 100(1)(b) of the Health Practitioners Competence Assurance Act 2003.

DATED at Wellington this 26th day of March 2020

Kerrin Eckersley Director of Proceedings