



**NEW ZEALAND HEALTH
PRACTITIONERS
DISCIPLINARY TRIBUNAL**

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HPDT NO 1426/Nur24/606D

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 **DIRECTOR OF PROCEEDINGS** designated under the Health and Disability Commissioner Act 1994

Applicant

AND **JENNIFER SLATER**, Registered Nurse of Masterton

Practitioner

HEARING held in Masterton on 19 July 2024

TRIBUNAL: Ms T Baker (Chair)

Dr B McCulloch, Ms J Molesworth, Ms J Byford-Jones, Ms C Neilson-Hornblow

Ms C Pope, Executive Officer

REPRESENTATION: Ms C McCulloch and Ms K Corbett, Director of Proceedings

Ms S Eglinton for the Practitioner

TRIBUNAL DECISION DATED 9 SEPTEMBER 2024

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Introduction

[1] A panel of the Health Practitioners Disciplinary Tribunal (**the Tribunal**) convened in Masterton on Friday 19 July 2024 to hear a charge of professional misconduct laid by the Director of Proceedings designated under the Health and Disability Commissioner Act 1994 against the practitioner, Ms Jennifer Slater.

[2] The charge concerns Ms Slater's involvement with the administration of clonazepam in the absence of informed consent, some documentation deficits and a failure to inform senior management once informed of the medication administration.

[3] Ms Slater accepted her conduct on the basis of amendments made to the charge and accepted that her conduct amounted to professional misconduct. A full copy of the charge is annexed as Appendix A. Particulars of the charge are reproduced within the summary of the evidence below.

[4] The onus of proof remains with the Director of Proceedings and the standard of proof is on the balance of probabilities.

Summary of findings

[5] The Tribunal upholds the charge of professional misconduct.

[6] The Tribunal orders the following penalty under section 101:

(a) Under section 101(1)(c) there is a condition for a period of two years from the date of this written decision, that RN Slater must disclose a copy of this decision to any current, prospective and/or future employer.

(b) RN Slater is censured under section 101(1)(d).

(c) RN Slater must pay a fine of \$2,500 under section 101(1)(e).

[7] RN Slater is ordered to pay costs of \$13,777.72 under section 101(1)(f).

[8] Under section 95(2)(d) there is an order prohibiting publication of the name and identifying details of [Ms E] and any Healthcare New Zealand staff referred to in the evidence or the decision.

- [9] Under section 157 of the Act the Tribunal directs the Executive Officer:
- (a) To publish this decision and a summary on the Tribunal’s website; and
 - (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 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.

Factual findings

[10] The parties filed an agreed summary of facts and an agreed bundle of documents.

[11] Jennifer Slater qualified as a nurse in 1989 and began working as an enrolled nurse at that time. She graduated with a Bachelor of Nursing from the Universal College of Learning (UCOL) in Masterton and became a registered nurse (“RN”) in 2008. During the time of the events subject to the charge before the Tribunal, RN Slater was registered with the Nursing Council of New Zealand (“NCNZ”) and remains so today.

[12] In 2016, RN Slater began work as a Registered Nurse at Healthcare New Zealand Limited (“HCNZ”)¹ in Masterton. She left this employment briefly in June 2018 but returned in October 2018 and continued to work at HCNZ until the end of June 2020 before resigning in September 2020. During the time of these events, RN Slater was the sole registered nurse for HCNZ in Wairarapa.

[13] Since January 2021, RN Slater has worked at Wairarapa Hospital where she continues to work.

[14] [Ms E], aged [] years old at the time of these events, has [health condition], which significantly affects her daily life. [Ms E] is a vulnerable health consumer who requires an electric wheelchair to move about and is reliant on a high level of support for all aspects of her daily life.

[15] At the time of these events, [Ms E] received 66 hours of support from HCNZ each week, made up of 50 hours of personal care and 16 hours of household management support.

¹ Healthcare New Zealand is a provider of home-based care.

Support workers visited [Ms E] in her home five times a day, seven days a week, with some visits requiring two support workers, to assist with hoist and standing frame transfers.

[16] [Ms E] is reliant on support workers for showering and all aspects of her personal care, medication oversight, monitoring of skin integrity, assisting with exercise, meal preparation, and general cleaning of her home.

[17] [Ms E] was prescribed a number of medications by her general practitioner, including clonazepam,² which she took nightly. [Ms E]'s regular medications were dispensed by the pharmacy in blister packs.

[18] In addition, on 15 April 2020, [Ms E] was prescribed 0.5mg of clonazepam "PO Nocte³/PRN⁴ as a sleeping aid. To be taken in addition to 1.5mg dose if cannot sleep". This was also dispensed in a blister pack.

Particular 1: instructed support worker to administer 0.5mg of clonazepam

[19] The parties agreed that on an unknown date, around 27 May 2020, Support Worker [Ms R] came to see RN Slater at the HCNZ's Masterton office due to concerns she had about [Ms E]'s anxiety during the day. During their conversation [Ms R] advised RN Slater that she wanted to administer [Ms E]'s 0.5mg PRN clonazepam prescription ("the PRN clonazepam") to her during the day.

[20] [Ms R] advised RN Slater that she had suggested this to [Ms E], but that [Ms E] was adamant that she did not want to take the PRN clonazepam. [Ms R] asked RN Slater if she could administer the PRN clonazepam without [Ms E]'s consent, and RN Slater advised that she could. RN Slater and Ms R discussed obtaining consent but thought that Ms E would not give it.

[21] RN Slater instructed Ms R to administer the PRN clonazepam to [Ms E] on two non-consecutive days (being 27 and 29 May 2020), and to advise [Ms E] subsequently what had occurred.

² A benzodiazepine used to treat epilepsy primarily, and sometimes anxiety. It is also used as a sleep aid.

³ By mouth at night.

⁴ Pro re nata – for use when necessary.

[22] RN Slater did not attempt to contact [Ms E] to discuss the administration of the PRN clonazepam with her, or to obtain her consent to administer it.

[23] [Ms E] states that she did not want to use clonazepam during the day as she considered it a risk to her safety, and that it might impair her ability to operate her electric wheelchair safely.

[24] On the mornings of 27 and 29 May 2020, [Ms R] and [Ms N] provided support to [Ms E] at her home.

[25] During the morning shifts on these days, acting on RN Slater's instructions, [Ms R] administered the PRN clonazepam (0.5mg) to [Ms E] without her knowledge or informed consent.

[26] RN Slater accepted that she instructed [Ms R] to administer 0.5mg of clonazepam to [Ms E] in the morning on or around 27 and/or 29 May 2020 without [Ms E]'s knowledge, when she knew:

- she had not obtained [Ms E]'s informed consent;
- [Ms E] had told support workers, including [Ms R], that she did not want to take her prescribed PRN clonazepam during the daytime; and/or
- Ms R had sought advice as to whether clonazepam could be given to [Ms E] without her knowledge.

[27] RN Slater also accepted that she failed to discuss with [Ms E]:

- the proposed administration of clonazepam during the daytime; her preferences and concerns around taking clonazepam during the daytime;
- the benefits and/or risks of administering clonazepam to her during the daytime; and/or
- the alternatives to treatment by clonazepam, and their risks and/or benefits.

[28] All aspects of Particular 1 are established.

Particulars 2 and 3: documentation

[29] RN Slater did not make any record of her conversation with [Ms R], or her instructions to [Ms R] to administer the PRN clonazepam on the mornings of 27 and/or 29 May 2020.

[30] RN Slater did not make any record of the administration of medication to [Ms E] on these occasions or instruct [Ms R] to record the administration of this medication. [Ms R] did not record the administration of this medication in [Ms E]'s medication record either. Consequently, there is no record of the PRN clonazepam being administered to [Ms E] on 27 or 29 May 2020. Particulars 2 and 3 are established.

Particular 4: inadequate response to notification

[31] On the morning of 1 June 2020, [Ms R] and [Ms N] provided support to [Ms E] at her home.

[32] During the course of the morning, [Ms N] asked [Ms E] if she felt any 'different' or 'funny' that week. When [Ms E] advised that she did not, [Ms N] advised that [Ms R] had administered clonazepam to her the previous week, with her morning medication.

[33] [Ms E] states she was very upset when she learned that she had been given the additional medication without her knowledge. She advised the support workers that she did not believe this was the right thing to do, and that it could be dangerous.

[34] [Ms R] subsequently reported to RN Slater that while initially upset, [Ms E] confirmed she felt good, believed she had benefited from it, and agreed to its continued use.

[35] At RN Slater's request, [Ms N] recorded in [Ms E]'s communication book:

please include PRN medication – (1/2 clonazepam [sp] in [Ms Es] [sp] breakfast medication. This is the blister pack medication labelled 'As Required Medication.' Dosage is ½ tablet, so each one can be broken in half. This is being trialled at Jenni's (RN) request. Please contact Jenni if any concerns / clarification. [Ms A].

[36] [Ms E] felt betrayed and shocked and did not want to take clonazepam in the mornings. [Ms E] is adamant that she did not find this beneficial and did not agree to continue using clonazepam during the day.

[37] On the morning of 2 June 2020, support workers [Ms D] and [Ms L] provided support to [Ms E] at her home.

[38] When they arrived at her home, [Ms E] told [Ms D] and [Ms L] that [Ms R] and [Ms N] had given her clonazepam without her knowledge or consent.

[39] [Ms L] and [Ms D] recorded in [Ms E]'s communication book:

[Ms E] refused ½ Clonazepam. – [Ms L].

It has also not been verified with me officially by Jenni to give it. [Ms L] / [Ms D].

[40] [Ms E] states she had not agreed to any trial and did not want to take the medication.

[41] [Ms L] took a photograph of the messages left in the communication book on 1 and 2 June 2020.

[42] At 8.43am, with [Ms E]'s permission, [Ms L] telephoned HCNZ and spoke to Service Co-ordinator, [Ms T]. [Ms L] advised [Ms T] that Ms [Ms E] had been given clonazepam without her consent.

[43] At 8.45am, [Ms T] recorded in the Client Event Notes Report:

Subject: sw [Ms L]

Notes: rang and is irate that client was given extra half tab of diazapan [sp] ? without clients knowledge on wed/fri. advised I will pass on to the nurse.

[44] In line with the usual escalation processes, the concern was escalated to the registered nurse responsible for the client, which was RN Slater.

[45] At 8.46am, [Ms T] emailed RN Slater and advised her:

Morning [Ms L] rang in a flap as she angry that [Ms E] had been given half a diazepam? Without [Ms Es] knowledge. I advised I will pass on to you.

[46] RN Slater was not at work on 2 June 2020.

[47] There is no record that RN Slater took any action as a response to this complaint being escalated to her by [Ms T].

[48] RN Slater accepts that at this time, she did not inform her manager, or anyone in management at HCNZ, that she had instructed a support worker to administer clonazepam to [Ms E] without her knowledge or consent, or that [Ms L] had reported and complained that this had occurred. Particular 4 is established.

Subsequent events

[49] On 4 June 2020, [Ms E] advised a practitioner at her local medical centre that her caregivers were recommending clonazepam in the morning to help with anxiety.

[50] On 9 June 2020, [Ms E] contacted HCNZ and requested a meeting with the regional coordinator of HCNZ services, due to concerns about her care plan and current care.

[51] On an unknown date shortly before 22 June 2020, RN Slater telephoned [Ms E] to discuss the events which are subject to this Charge and apologised.

[52] On 22 June 2020, [Ms E], RN Slater, and [health condition] Community Advisor, [Ms B], met at [Ms E]'s home to discuss [Ms E]'s concerns, including that she had been given the PRN clonazepam without her consent. During this meeting, when they discussed that [Ms E] had been given the PRN clonazepam without her consent, RN Slater again apologised to [Ms E].

[53] On 23 June 2020, [Ms L] and [Ms D] submitted a list of concerns to HCNZ, relating to RN Slater, [Ms R], and [Ms N]. This list included that [Ms E] had been given clonazepam without her consent, and this had not been recorded on her medication sheet.

[54] On 29 June 2020, RN Slater met with RN [Ms S], the locality manager. During this meeting, RN Slater advised that she had instructed [Ms R] to administer clonazepam to [Ms E] without her consent. At RN [Ms S]'s request, RN Slater provided an account of what had occurred in writing, via email the same day.

[55] RN [Ms S] escalated the matter to the regional manager and the Director of Allied Health, and an investigation was launched immediately. In her email to RN [Ms S], RN Slater advised that she had spoken to [Ms E] and had "offered her to make a complaint on two occasions", but that [Ms E] had declined. RN Slater also stated she had verbally apologised to [Ms E].

[56] [Ms E] states that she did not receive any information about making a complaint and did not decline to make a complaint.

[57] [Ms E] states that while RN Slater did call and subsequently came to her home to apologise, it was not straight after the events, but sometime later. There is no record of RN Slater calling [Ms E], providing her with documentation, or visiting her in relation to these events.

[58] At the end of June 2020, an investigation into the events was launched and RN Slater was suspended during this time.

[59] During this investigation, RN Slater accepted her part in the unconsented administration of the PRN clonazepam to [Ms E]. RN Slater subsequently resigned from her position.

Impact on [Ms E]

[60] [Ms E] states that she was absolutely horrified to learn that she had been medicated without her knowledge. She felt betrayed and was lost for words when she was told by her support workers that they had given her medication without her knowledge. [Ms E] considers that receiving this medication, particularly without her knowledge, could have been very dangerous for her.

[61] These events have caused [Ms E] to lose faith in those who care for her. [Ms E] worries that similar things might be happening to other vulnerable people.

Professional misconduct

[62] The factual allegations of the charge are established.

[63] The practitioner accepts that her conduct amounts to professional misconduct. Nonetheless, the Tribunal must be satisfied that it reaches that threshold.

[64] The Tribunal's grounds for discipline of a health practitioner are found in section 100 of the Act which includes two types of professional misconduct:

100 Grounds on which health practitioner may be disciplined

- (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—

- (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
- (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or

[65] Determining professional misconduct is approached in a two-step test:⁵

- (a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession;
- (b) The second requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

[66] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct",⁶ and as:

*1. Law. Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer ... 2. Gen. A criminal or illegal action: wrong doing, misconduct.*⁷

[67] A finding of negligence requires the Tribunal to determine:⁸

Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal.

⁵ *F v Medical Practitioners Disciplinary Tribunal* [2005] 3NZLR 774, subsequently confirmed in the High Court on appeals from the Health Practitioners Disciplinary Tribunal, see for example *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [16].

⁶ *Collins English Dictionary* 2nd Edition. Definition accepted in many cases, including *Leach* 389/Nur11/179P and *Rodrigues* 384/Ost11/173P.

⁷ *New Shorter Oxford English Dictionary* (1993 edition). See paragraph 34 of *Jackson* (Decision No. 35/Nur35/20P).

⁸ *Cole v Professional Conduct Committee* [2017] NZHC at [41].

[68] Negligence or malpractice must be established as behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error or oversight or even carelessness.⁹

[69] More recently the position has been summarised in *Williams*,¹⁰ where the following conclusion was reached:

...The Tribunal must assess whether the departure from acceptable standards has been significant enough to warrant a finding of professional misconduct against the practitioner. It should bear in mind that a finding of professional misconduct carries considerable stigma. It sends a very strong message about the practitioner's failure to properly discharge his or her professional responsibilities. An adverse finding will likely be keenly felt by the practitioner, and it will inevitably be noted by his or her peers. A finding of professional misconduct is a significant matter, which is reserved only for serious conduct.¹¹

[70] And in *PCC v R*,¹² a decision issued a week after *Williams*, Powell J in overturning a Tribunal decision observed:

It is after all a threshold rather than a substantive hurdle, and it is not necessary to show that the respondent's conduct was as serious as that of others that have received penalties. I note in particular that in addition to protecting the public and punishing the practitioner, a penalty can provide clarity to the profession and assist the practitioner through the imposition of conditions on practice.

[71] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:¹³

... whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the [profession] was lowered by the behaviour of the [practitioner] concerned.

⁹ *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [21].

¹⁰ *Williams v Professional Conduct Committee* [2018] NZHC 2472 at [36].

¹¹ Footnotes included in the original: *Collie v Nursing Council of New Zealand* [2001] NZAR 74; *Martin v Director of Proceedings* [2010] NZAR 333 (HC) at [30]–[31]. *Vatsyayann v Professional Conduct Committee* HC Wellington CIV-2009-485-259, 14 August 2009 at [8]; and *Johns v Director of Proceedings* [2017] NZHC 2843 at [69]. *Cole v Professional Conduct Committee of the Nursing Council of New Zealand* [2017] NZHC 1178 at [45].

¹² *PCC v R* [2018] NZHC 2531 at [31].

¹³ Above at [28].

[72] The High Court has also observed that:

The legislature has entrusted the Tribunal, comprising in large part health practitioners, with bringing their collective judgment to bear on individual fact situations, and in determining whether or not conduct by a health practitioner is likely to bring discredit on the medical profession. The decision in this regard essentially calls for a value judgment. The Tribunal acts in a representative capacity, formulating standards which of themselves are representative. **It is an expert body, well placed to assess and evaluate the seriousness of a practitioner's conduct. Deference is appropriate in respect of the Tribunal's judgment on such matters.** [Emphasis added]

[73] As to the second step of the test for professional misconduct, the High Court has endorsed the earlier statement of Elias J in *B v Medical Council* [2005] 3 NZLR 810 that “the threshold is inevitably one of degree”. This was further discussed in *Martin, HRE v Director of Proceedings* where the High Court said:¹⁴

... While the criteria of “significant enough to warrant sanction” connotes a notable departure from acceptable standards, it does not carry any implication as to the degree of seriousness. Given the wide range of conduct that might attract sanction, from relatively low-level misconduct to misconduct of the most reprehensible kind, the threshold should not be regarded as unduly high. It is certainly a threshold to be reached with care, having regard to both the purpose of the HPCAA and the implications for the practitioner, but the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected in penalty. The degree of seriousness does not form part of the Tribunal's enquiry at the second stage of the two-step process.

[74] This two-step test has been adopted by this Tribunal since its first decision, *Nuttall 8/Med04/03P* issued in 2005 and endorsed by the High Court in many decisions.¹⁵ The second step is a “threshold” rather than a “substantive hurdle”.¹⁶

[75] In determining whether the disciplinary threshold has been met, there is no room for subjective considerations of the practitioner's circumstances when it comes to the second step. As Venning J said in *McKenzie v Medical Practitioners Disciplinary Tribunal*:¹⁷

¹⁴ *Martin v Director of Proceedings* [2010] NZAR 333 at [32].

¹⁵ *Martin v Director of Proceedings*, above note 24, *Johns v Director of Proceedings* [2017] NZHC 2843 [85]; *H v Director of Proceedings* [2018] NZHC 2175.

¹⁶ *PCC v R* [2018] NZHC 2531.

¹⁷ *McKenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47 (HC) at [71].

In summary, the test for whether a disciplinary finding is merited is a two stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a **consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner**. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner. (Emphasis added)

Director submissions

[76] The Director of Proceedings submitted that RN Slater's actions were contrary to several aspects of the Nursing Council of New Zealand's *Code of Conduct for Nurses*, which outlines the standards of ethical conduct set by the Council under section 118(i) of the Act:

- (a) Principle 1: Respect the dignity and individuality of health consumers, including by listening to them, asking for, and respecting their views about their health.¹⁸
- (b) Principle 3: Work in partnership with health consumers to promote their wellbeing and respect their right to participate in decisions about their care.¹⁹
- (c) Principle 4: Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.²⁰
- (d) Principle 6: Work respectfully with colleagues to best meet health consumers' needs, including working with colleagues to maintain the safety of those in your care.²¹
- (e) Principle 8: Maintain public trust and confidence in the nursing profession.

[77] The Director also submitted that the principle of informed consent is at the heart of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (**the HDC Code**).

¹⁸ Principle 1.3.

¹⁹ Principle 3.2.

²⁰ Principle 4.1.

²¹ Principle 6.6.

Discussion

[78] According to the introduction to the Nursing Council Code of Conduct:

The Code of Conduct for nurses is a set of standards defined by the Council describing the behaviour or conduct that nurses are expected to uphold. The Code of Conduct provides guidance on appropriate behaviour for all nurses and can be used by health consumers, nurses, employers, the Nursing Council and other bodies to evaluate the behaviour of nurses. Failure to uphold these standards of behaviour could lead to a disciplinary investigation.

[79] It further states:

While mandatory language such as 'must', 'shall' and 'will' has restricted use throughout this Code, it is important for nurses to understand there is an expectation that they will adhere to these standards.

[80] RN Slater not only instructed the administration of Clonazepam without obtaining informed consent but did so knowing that it was contrary to [Ms E]'s wishes.

[81] Under the HDC Code, it is the right of every consumer of health or disability services to effective communication,²² to be fully informed before giving consent,²³ to receive services only if they give informed consent, and to refuse services or withdraw consent to services.²⁴ RN Slater's actions amount to a flagrant disregard for one of [Ms E]'s fundamental rights.

[82] Furthermore, the administration of the medication was in fact contrary to the prescriber's instructions which were that the PRN prescription was for night-time use.

[83] The Tribunal finds that RN Slater's conduct as found in particular 1 is a significant departure from expected standards of a nurse in her position and amounts to negligence. It was also unethical and therefore amounts to malpractice. Finally, it is also conduct that is likely to bring discredit to the profession. Members of the public need to be able to trust that nurses will comply with prescriber directions, communicate with their patients and not

²² Right 5.

²³ Right 6.

²⁴ Right 7 (except where any enactment, or the common law, or any other provision of this Code provides otherwise).

provide medication to a patient without her knowledge and consent. This is a very serious matter and is sufficiently serious to warrant a disciplinary sanction.

[84] The Nursing Council has also issued guidance for nurses' delegation to health care assistants.²⁵ The Director referred to the following entry:

Processes for seeking contact and support with the registered nurse must be clearly documented and communicated within the nursing setting.

[85] That appears to refer to the need for a protocol to be well disseminated within a team providing care, rather than stipulating a requirement to record the interaction between registered nurse and health care assistant. Nevertheless, the Tribunal agrees that RN Slater needed to document her instructions to administer 0.5mg of clonazepam to [Ms E] in the morning. This was an important part of the care being provided to [Ms E]. The health care team needed to be aware of it so that the care could be reviewed and evaluated. The Tribunal finds that this failure amounts to negligence in RN Slater's scope of practice.

[86] The situation is the same with the administration of the clonazepam in the morning. RN Slater did not instruct support worker, [Ms R], to record the morning administration of 0.5mg of clonazepam to [Ms E]. Again, members of the team needed to know what medications had been administered. This is a fundamental part of appropriate care and a failure to do so amounts to negligence. Together, these particulars also amount to malpractice.

[87] Finally, once the staff had raised concerns, RN Slater's failure to inform senior management at HCNZ that she had instructed support worker, [Ms R], to administer 0.5mg of clonazepam to [Ms E] without her knowledge was negligent.

[88] Cumulatively, all particulars amount to professional misconduct under sections 100(1)(a) and (b) and are sufficiently serious to warrant a disciplinary sanction.

²⁵ Nursing Council of New Zealand *Guideline: delegation of care by a registered nurse to a health care assistant* May 2011.

Penalty

[89] Having found the charge under section 100(1) established, the Tribunal may consider whether the conduct requires a disciplinary sanction for the purposes of protecting the public and maintaining professional standards.

[90] The Tribunal heard evidence from RN Slater about her personal circumstances at the time of this conduct, the intervening events and her current personal and professional situation. Her current manager gave evidence as outlined below.

[91] RN Slater explained that at the time of the relevant events, the country was dealing with COVID-19 pandemic and working through lockdowns. In addition to her fulltime role as an RN with responsibility for up to 20 clients, she was responsible for organising and distributing PPE gear. She had to field a lot of enquiries from staff and families of patients who were all very concerned during a time of uncertainty. The PPE was also difficult to source. Once some were obtained, they needed to be distributed carefully because they were in short supply and so RN Slater had to drive between towns in the Wairarapa to give the support workers enough masks for one week.

[92] In addition, during the last month of the COVID-19 Alert Level 4 lockdown, RN Slater had found out that her husband had cancer. Following the lockdown, there were delays in accessing the specialist, all contributing to the family's state of distress. It was difficult for her to focus on her work.

[93] RN Slater's husband began radiation treatment at Wellington Hospital for two weeks. While RN Slater was off work to support him, she was stood down. Since approximately February 2021 her husband has been free of cancer but still undergoes annual monitoring.

[94] After resigning in September 2021, RN Slater took some time to recoup before applying for a casual health care assistant position at Wairarapa Hospital. At her interview for this position, the duty nurse manager persuaded her to apply for a casual RN position instead, which she started in January 2021.

[95] In May 2021, RN Slater accepted a permanent part-time (0.6FTE) RN role in the rehabilitation ward (now known as the Assessment Treatment and Rehabilitation Unit – AT&R) where she is still working.

[96] Around a month or two later, RN Slater received an email from the HDC confirming they were assessing the complaint by [Ms E] and therefore she advised both her Charge Nurse Manager (CNM) at the time, Sally Fahey, and the Director of Nursing.

[97] Around 15 months ago RN Slater's current CNM, Stephen Downie-Fribbens, asked if she would like to take on the role of rostering for the AT&R in addition to her RN role, which she agreed to. This role is four hours per fortnight. RN Slater completes the weekly rosters for the RNs and HCAs to ensure there is a good skill mix on each shift.

[98] Since September 2023, RN Slater has also been the pressure injury resource nurse for the AT&R. This role, which is for eight hours per fortnight, involves auditing patient notes, checking and closing pressure injury squares (which are reports made when someone discovers a pressure injury) and teaching patients and staff about prevention and treatment of pressure injuries.

[99] Along with other senior nurses, RN Slater provides cover when CNM Downie-Fribbens is on leave.

[100] Since commencing this role at the Wairarapa Hospital, RN Slater has completed the following Te Whatu Ora training on medications:

- (a) Ko Awatea – Medication Certification WrDHB – 4 hours – completed 9 April 2021;
- (b) Ko Awatea – Oral Medication Administration (National Course) – 30 minutes – completed 4 May 2021;
- (c) Ko Awatea – Medication Safety National Course – 1 Hour – completed 22 October 2021.

[101] RN Slater has also completed the following training modules at the request of HDC:

- (a) Module 1: How the code of rights improves health and disability services;

- (b) Module 2: What you need to know about informed consent;
- (c) Module 3: Complaints management and early resolution.

[102] RN Slater also said that she has undergone a considerable amount of reflection. She said she has mentally beaten herself up for directing [Ms R] to administer PRN medication when she knew that [Ms E] did not want to take the medication during the day.

[103] RN Slater said that she now understands just how serious the impact of what she did has been on [Ms E]. She expressed deep remorse at having caused [Ms E] such distress and betrayal.

[104] As a consequence of the training and reflection RN Slater has undergone, she has become extremely vigilant when checking and administering medication, to ensure that the patient has provided informed consent to the medication prescribed. She is also very particular when instructing new staff members and students to ensure that all care is given in accordance with the HDC Code of Rights, and they know how important it is to make sure the patient has provided informed consent.

[105] RN Slater is also now fully aware of how stress can affect her performance at work and therefore how important it is to manage it well. She is much better equipped to manage her stress, which would include taking time off work if necessary.

[106] In answer to questions, RN Slater said that she now has a lot of colleagues who support each other, and she said she has a good manager.

[107] The Tribunal also heard from Stephen Downie-Fribbens, who is the Charge Nurse Manager of the ATR at Wairarapa Hospital. He is RN Slater's direct manager. If she has a dilemma or a problem, there are lots of people she can speak with, and she and her colleagues often discuss small issues throughout the day.

[108] RN Downie-Fribbens was a Duty Nurse Manager when RN Slater started working in the casual pool in January 2021, and observed that RN Slater was professional in manner, kind and compassionate and was a staunch advocate for both patients and staff.

[109] Since becoming RN Slater’s manager, RN Downie-Fribbens observed and consulted with her, discussing among others, best practice guidelines for medication administration. From his observations, she is able to guide both junior and senior RNs on the ward and is a real asset at MDT meetings. RN Slater provided 1:1 support to a newly graduated nurse who was having performance issues, as a result of struggling with their professional obligations, including multiple issues in relation to medications. RN Slater’s approach to nursing is to have the patient and their whānau at the centre of her practice, while being mindful of what it is the patient wants and consents to.

[110] Section 101 provides for the following penalties:

- (a) Cancellation of registration.
- (b) Suspension of registration for a period not exceeding three years.
- (c) Conditions imposed on practising certificate.
- (d) Censure.
- (e) Payment of costs of the Tribunal and/or Director of Proceedings.

[111] In *Roberts v Professional Conduct Committee*,²⁶ His Honour Justice Collins discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have been summarised in the decision of *Katamat v Professional Conduct Committee*:²⁷

- (a) Most appropriately protects the public and deters others;
- (b) Facilitates the Tribunal’s “important” role in setting professional standards;
- (c) Punishes the practitioner;
- (d) Allows for the rehabilitation of the health practitioner;
- (e) Promotes consistency with penalties in similar cases;
- (f) Reflects the seriousness of the misconduct;
- (g) Is the least restrictive penalty appropriate in the circumstances; and

²⁶ [2012] NZHC 3354 at [44] to [51].

²⁷ [2012] NZHC 1633.

- (h) Looked at overall, is a penalty which is “fair, reasonable and proportionate in the circumstances”.

[112] The following guidance was also given in *Katamat*:²⁸

In summary, the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect the public and to maintain professional standards, are more intuitive in their application. Others, such as the seriousness of the offending and consistency with past cases, are more concrete and capable of precise evaluation. Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct. The need to punish the practitioner can be considered, but is of secondary importance. The objective seriousness of the misconduct, the need for consistency with past cases, the likelihood of rehabilitation and the need to impose the least restrictive penalty that is appropriate will all be relevant to the inquiry. It bears repeating however, that the overall decision is ultimately one involving an exercise of discretion.

Similar cases

[113] The parties referred to the following Tribunal decision with similar facts.

[114] *Buckley*²⁹ concerned a registered nurse who administered and directed a healthcare assistant to administer unprescribed Lorazepam to three different residents when not clinically indicated. She also falsified the signature of another nurse. Again, the Tribunal imposed some conditions for further education and disclosure of the Tribunal’s decision to any employer. She was censured and ordered to contribute 35% of the costs of the hearing.

[115] The case of *Draper*³⁰ also involved a nurse. She administered medicines without any prescription, failed to undertake appropriate assessments before the administration and then failed to report the error. The Tribunal ordered censure, conditions that she undertake certain educational courses and for a period of 6 months to practice under supervision for the administration of drugs and pharmacology. She was also ordered to pay \$12,000. The Tribunal recorded that it would have ordered suspension, but the nurse had been unemployed as a nurse and had not sought re-employment as a nurse for over 2 years.

²⁸ Above, at [53].

²⁹ 1254/Nur21/527P.

³⁰ 534/Nur12/227D.

[116] In *Jackson*³¹ a nurse administered unprescribed medications to 7 patients over a period of 2 weeks. The Tribunal imposed conditions and ordered costs of \$10,000.

[117] A medical practitioner in *Shehata*³² was suspended for the insertion of an IUD without patient consent. Conditions, censure and fine were also imposed along with an order to pay 40% costs. His appeal to the High Court was unsuccessful.

[118] In *Bakker*³³ a self-employed midwife instructed a student midwife to administer saline solution instead of pethidine during a woman's labour without telling the patient and despite a pain relief plan being in place. The midwife also failed to document what had been administered. The Tribunal placed conditions on her practice, including annual reviews of her practice, censure, fine of \$3,500 and costs of 30%, which came to \$10,000.

[119] In *Casey*³⁴ a midwife's registration was cancelled, on the basis of findings of professional misconduct in six charges involving different episodes of care and various mothers. One particular involved the misleading antenatal discussion with a mother as to the safety of a water birth. The evidence included an expert opinion that Ms Casey was obliged to provide the mother with accurate and current information about water birth. The Tribunal noted that had this been the only charge before the Tribunal, there would have been an order of suspension.³⁵

Director's submissions

[120] The Director sought a penalty of:

- (a) Suspension.
- (b) Conditions on practice.
- (c) Censure.
- (d) Fine.

³¹ 35/Nur05/20P.

³² 958/Med17/396D.

³³ 1199/Mid21/508D.

³⁴ 334/10/144P.

³⁵ At [313].

[121] On behalf of the Director, Ms Corbett submitted that although it has been some time since the events, the Tribunal ordered that a term of suspension “underlines the message that this type of behaviour will not be tolerated.”³⁶ Further a period of suspension allows an opportunity for reflection, and it is necessary for deterrent purposes.

[122] It was further submitted that RN Slater should be directed to undertake some form of mentoring, supervision, or training, directed at addressing the identification and management of stressors, ensuring they do not impact on RN Slater’s work and decision-making in the future.

[123] Finally, it was submitted that the imposition of a fine would mark the seriousness of RN Slater’s misconduct and a censure would signal to the profession and the wider public the serious nature of the professional misconduct in this case.

The practitioner

[124] For the practitioner, Ms Eglington submitted that an appropriate penalty is censure.

[125] Ms Eglington submitted that the Tribunal should take into account the stress RN Slater was under at the time of the events, that this was a one-off incident and that RN Slater has co-operated willingly with the investigation by her employer, the HDC and the Director of Proceedings. This process had taken four years and has already punished her. Since the events RN Slater has had time for personal reflection, growth and development, has completed further professional development, has been practising well in her new role, and has apologised on a number of occasions. It was submitted that no further education is required.

Discussion

[126] The Tribunal acknowledges the significant distress this episode has caused the patient, [Ms E]. Such conduct erodes the trust that she must place in the nursing profession, while she is very dependent on others for her daily needs. She is in a vulnerable position.

[127] The Tribunal’s disapproval of RN Slater’s conduct is reflected in the finding of professional misconduct.

³⁶ Dr L, 1176/Med20/489P, at [54].

[128] In determining whether suspension is required, the Tribunal has considered the decision of *A v Professional Conduct Committee*³⁷ where the High Court cited, with approval, the decision in *Taylor v The General Medical Council*³⁸ and said that four points could be expressly and a fifth impliedly derived from the authorities namely:

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 amenable to cure'. Fifthly, and perhaps only implicitly, suspension ought not to be imposed simply to punish.

[129] In *Draper*³⁹ a further five similar cases were summarised.⁴⁰ Suspension was not ordered in any of them. The Tribunal concludes that although suspension has been ordered in matters involving informed consent, in many cases, that has not been the penalty,

[130] In the present case, the Tribunal decided that a suspension is not necessary for the purposes of protecting the public. It is relevant that:

- (a) The events took place approximately four years ago;
- (b) RN Slater's personal circumstances have changed;
- (c) RN Slater's professional circumstances have changed. She is in a collegial environment where she takes advantage of the opportunities for peer-to-peer consultation;
- (d) Although serious, this was one confined episode of poor conduct.

[131] The Tribunal considers that the intervening four years have provided ample opportunity for reflection. RN Slater has been investigated by the Health and Disability Commissioner who

³⁷ Auckland HC; CIV 2008-404-2927; 5/9/08; Keane J

³⁸ [1990] 2 All ER 263

³⁹ Above, note

⁴⁰ Ms A 3/Nur05/18D; *Cruzada* 34/Nur0517D; *Jackson* 35/Nur05/20P; *Harbrow* 217/Nur08/92P; *Curry* 421/Nur11/189P

has made a formal finding that she breached the HDC Code of Rights. She has now faced a disciplinary procedure.

[132] The Tribunal considered whether to impose a condition requiring some form of intervention in relation to stress management, but the Tribunal accepts that there were two significant factors which may have affected RN Slater's judgement at the time of these events. The first was her husband's health and the second was the impact of the COVID-19 pandemic. Those matters were not and could not have been offered as an excuse, but the Tribunal acknowledges that in May 2020 New Zealand was in a state of flux as we adjusted to the risks, uncertainties and requirements of living with a global pandemic. This was particularly so for those working in the provision of health services and for users of health services. A diagnosis of cancer is always very distressing, but in the environment of the time no doubt caused more anxiety.

[133] Given the time that has passed since the events, the stability of RN Slater's husband's health, the further education RN Slater has undertaken, and the supportive collegial environment in which she is currently working, the Tribunal does not consider that there is a risk of harm to the public that requires her to attend any counselling or further education at this stage. It is expected that should there be any stressful events in her life she will recognise that she may need to seek support and help.

[134] The Tribunal decided that in order to meet the penalty principles of maintaining standards for the profession, and deterrence of others, a censure under section 101(1)(d) and a fine of \$2,500 under section 101(1)(e) are appropriate penalties. In addition, and in order to provide some protection to the public, the Tribunal imposes a condition under section 101(1)(c) for a period of two years from the date of this written decision, that RN Slater must disclose a copy of this decision to any current, prospective and/or future employer.

Costs

[135] Under section 101(1)(f) of the Act, the Tribunal may order that the practitioner pay part or all of the costs and expenses of and incidental to any or all of the investigation or inquiry into the subject matter or the charge, the prosecution of the charge and the hearing by the Tribunal.

[136] The general principles to be taken into account are:

- (a) The fact that professional groups ought not to be expected to fund all the costs of a disciplinary regime; and members of the profession who come before disciplinary bodies must be expected to make a proper contribution towards the costs of the inquiry and hearing.⁴¹
- (b) Costs are not in the nature of a penalty or to punish.⁴²
- (c) Means, if known, are to be taken into account.⁴³
- (d) A practitioner has a right to defend himself or herself.⁴⁴
- (e) The level of costs should not deter other practitioners from defending a charge.⁴⁵

[137] The PCC referred to the High Court decision of *PCC v Brown*⁴⁶ where the costs of 40% was upheld. LaHood J concluded:

A reduction of 10% to reflect co-operation provides the necessary incentive for practitioners to cooperate while still balancing other factors, such as the need to ensure that the costs of disciplinary proceedings do not fall disproportionately upon the profession.

[138] For the practitioner, Ms Eglinton submitted that a contribution of 30% would be appropriate and consistent with comparable cases where the orders were in the region of 30 to 35%.

[139] The Tribunal did not have the benefit of any evidence of RN Slater's financial circumstances.

[140] Because the hearing did not take as long as predicted, some reduction was made to the estimates of costs provided by the Director and the Executive Officer for the Tribunal. The

⁴¹ *G v New Zealand Psychologists Board* (Gendall J, 5 April 2004, HC Wellington, CIV-2003-485-2175) and *Vasan v Medical Council of New Zealand* (18 December 1991, AP43/91 at page 15).

⁴² *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 at 195.

⁴³ *Kaye v Auckland District Law Society* [1988] 1 NZLR 151.

⁴⁴ *Vasan*, above note 19.

⁴⁵ *Gurusinghe*, above, note 20.

⁴⁶ [2024] NZHC 990.

Director's costs were reduced to \$22,364.90 and the Tribunal's costs to \$17,000, making a total of \$39,364.90.

[141] The Tribunal has decided that a contribution of 35% is reasonable and orders RN Slater to pay a total of \$13,777.72.

Name suppression

[142] There was no opposition to the order for non-publication of the name of the patient, [Ms E] being made final. The Tribunal is satisfied that public interest factors are outweighed by the patient's personal interests and makes a final order for non-publication of her name and identifying details under section 95(2) of the Act.

[143] By consent the Tribunal also orders non-publication of the names of any of the Healthcare New Zealand staff mentioned in the evidence and decision.

[144] RN Slater did not seek permanent name suppression. The Tribunal's interim order will lapse when the written decision is issued.

Dated at Feilding this 9th day of September 2024

A handwritten signature in blue ink, appearing to read "A. Woodcock".

Chair
Health Practitioners Disciplinary Tribunal

Appendix A

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 between May and July 2020 you, being a registered nurse, in your dealings with your patient, [Ms E], acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

1. On or around 27 May 2020, you instructed support worker, [Ms R], to administer 0.5mg of clonazepam to [Ms E] in the morning on or around 27 and/or 29 May 2020 without [Ms E]'s knowledge, in circumstances where you knew or ought to have known that you had not obtained [Ms E]'s informed consent. In particular, you:
 - (a) knew or ought to have known that [Ms E] had told support workers, including [Ms R], that she did not want to take her prescribed PRN⁴⁷ clonazepam during the daytime; and/or
 - (b) knew or ought to have known that support worker, [Ms R], had sought your advice as to whether clonazepam could be given to [Ms E] without her knowledge; and/or
 - (c) failed to discuss with [Ms E] the proposed administration of clonazepam during the daytime; and/or
 - (d) failed to discuss with [Ms E] her preferences and/or concerns around taking clonazepam during the daytime; and/or
 - (e) failed to discuss with [Ms E] the benefits and/or risks of administering clonazepam to her during the daytime; and/or
 - (f) failed to discuss with [Ms E] the alternatives to treatment by clonazepam, and their risks and/or benefits;

⁴⁷ Pro re nata – for use when necessary.

AND/OR

2. On or around 27 May 2020, you failed to document your conversation with support worker, [Ms R], about [Ms E] and/or your instructions to administer 0.5mg of clonazepam to [Ms E] in the morning on or around 27 and/or 29 May 2020;

AND/OR

3. On or around 27 and/or 29 May 2020, you failed to record the morning administration of 0.5mg of clonazepam to [Ms E], or to instruct support worker, [Ms R], to record the morning administration of 0.5mg of clonazepam to [Ms E];

AND/OR

4. On or around 2 June 2020, when a report made by support worker [Ms L] to your employer, Health Care New Zealand ("HCNZ"), (advising that [Ms E] had been given clonazepam without her knowledge) was escalated to you as the registered nurse responsible for [Ms E], you failed to respond appropriately to the report when you failed to inform senior management at HCNZ that you had instructed support worker, [Ms R], to administer 0.5mg of clonazepam to [Ms E] without her knowledge.

AND/OR

5. On an unknown date, but around the end of June or beginning of July 2020, in a discussion with [Ms E] you misled [Ms E] as to the circumstances that had led to her receiving 0.5mg of clonazepam in the morning on or around 27 and/or 29 May 2020. In particular, you:
 - (a) Told [Ms E] she had been administered the 0.5mg of clonazepam without her consent due to a misunderstanding by her support workers; and/or
 - (b) Failed to advise [Ms E] that you had directed the administration of the medication.

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 brings discredit to the nursing profession under s100(1)(a) and s100(1)(b).