NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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DECISION NO: 742/Mid15/326D

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a Charge laid by the Director of Proceedings designated under the Health and Disability Commissioner Act 1994 pursuant to Section 91(1)(b) of the Health Practitioners Competence Assurance Act 2003 against **Ms Y**, of X, Midwife

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING held in Auckland on 16 September 2015

AMENDED DECISION

TRIBUNAL: Mr D M Carden (Chair)

Dr J Stojanovic, Ms J Thorpe, Ms C Roodt and Ms L Carlyon (Members)

Ms K Davies (Executive Officer)

Ms J Kennedy (Stenographer)

APPEARANCES: Ms N Wills, the Director of Proceedings, Health and Disability Commission

Mr P Le Cren for the practitioner, Ms [ ]

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Background to reconsidered decision

1. The Tribunal issued its decision dated 29 October 2015 following a hearing of the Charge against the practitioner in this matter.

2. That decision included:

   2.1. A finding of fact.

   2.2. An order refusing the practitioner's application for an order for non-publication of her name and identifying details.

   2.3. An indication of other orders that would have been made, had the order refusing non-publication of name and identifying details not been made; that is had an order for non-publication been made. The orders that would have been made in that way were for a fine of $10,000.00 and for a further condition on the practitioner's practice concerning advices to patients for a period. Those orders were not made given that the Tribunal did not grant the application for non-publication of the name and identifying details of the practitioner.

3. The practitioner appealed to the High Court against the first two of those matters, a finding of fact and refusing the order for non-publication of name and identifying details. There was no cross-appeal by the Director, including any cross-appeal in respect of the absence of orders for fine or condition concerning advices to patients as mentioned above.

4. The High Court issued a judgment dated 31 August 2016[1] allowing the practitioner's appeal and directing that the Tribunal reconsider its decision as to certain findings in judgment.

5. Under section 111(3) of the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) where, on an appeal against a decision of the Tribunal, the High Court

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[1] *Ms Y v Director of Proceedings* [2016] NZHC 2054

has directed reconsideration of the decision, the Tribunal must reconsider the decision and, in doing so, must take into account the Court's reasons and give effect to the Court's direction.

6. The Tribunal has had at its request memoranda from counsel for the parties as to how the High Court judgment should be implemented. The parties are agreed on the appropriate course. Counsel for the practitioner advised that the practitioner has abided by conditions that had been directed in the original decision since the date of that decision. The Director submits that the Tribunal has no jurisdiction to review conditions and she was unable to confirm or otherwise compliance with those conditions. The Tribunal is left at having to accept such compliance.

7. This Amended Decision is the Tribunal's reconsideration in accordance with those directions from the High Court in the manner agreed by the parties. Because the original Decision referred, and this Amended Decision refers, to individual particulars of the Charge, the Charge is set out in full in this Decision but that does not change the substance. A draft of the Amended Decision has been submitted to the parties through counsel for submissions on compliance with the High Court judgment; and submissions received have been taken into account. There will also be submitted to the parties through counsel a proposed redacted version of the Amended Decision to ensure that the redactions in the decision also accord with the High Court judgment.

Summary

8. Ms Y was charged with professional misconduct by the Director of Proceedings of the office of the Health and Disability Commissioner under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).

9. The Charge alleged acts or omissions which amounted to malpractice or negligence and/or brought, or were likely to bring, discredit to her profession.

10. The Charge related to Ms Y's having entered into and carried on a sexual or intimate relationship with the partner of her then mother/client when she was providing midwifery services to the client as Lead Maternity Carer (LMC); and failed to terminate her professional relationship as LMC to the mother while carrying on the relationship with the partner.

11. The Charge was admitted by Ms Y and as being of sufficient severity to warrant disciplinary sanction.

12. Having heard the parties and the evidence the Tribunal finds the Charge made out.

13. Having heard further from the parties as to penalty orders and taking into account the directions of the High Court, the Tribunal orders:

    13.1. That Ms Y be censured.

    13.2. That Ms Y be permitted to practise as a midwife only on certain conditions as set out below.

    13.3. That the misconduct warranted a suspension from practice of some 6 – 12 months but, having regard to the time Ms Y has withdrawn from practice and other factors, no order for suspension is made.

    13.4. That Ms Y pay the sum of $11,400.00 as contribution to the costs of the Director of Proceedings and the Tribunal to be divided proportionately between them.

    13.5. That an order for non-publication of the name and identifying details of Ms Y's client and her partner and family and certain specific details concerning them as set out below is made.

    13.6. That there be, as directed by the High Court, an order for non-publication of the name and identifying details of Ms Y, including details of her current

employer and any details that might connect her to the client or the client's family.

13.7. That appropriate publicity be given to this decision as set out in the orders.

The Charge and hearing

14. The Charge read:

> *"…that between June 2013 and January 2014, whilst caring for your client [ ] you, being a registered midwife, acted in such a way that amounted to professional misconduct.*
>
> ***IN PARTICULAR**:*
>
> *1. you entered into, and carried on, a sexual and/or intimate relationship with Mr [ ], the partner of your client Ms [ ], at a time when you were providing midwifery services to Ms [ ] as her Lead Maternity Carer (LMC) for the birth of her third child;*
>
> ***AND/OR***
>
> *2. you failed to terminate your professional relationship as [ ]'s LMC after entering into, and/or while carrying on, a sexual and/or intimate relationship with Mr [ ].*
>
> *The conduct alleged in the above two particulars separately 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 midwifery profession under s 100(1)(a) and/or s 100(1)(b)."*

15. The Charge was heard in Auckland on 16 September 2015 and both parties were represented by counsel. The parties had agreed on a summary of facts and there was produced a bundle of documents on the basis that had been canvassed at an earlier conference namely, that each document in the bundle:

(a) is what it purports to be on its face;

(b) was signed by any purported signatory shown on its face;

(c) was sent by any purported author to, and was received by, any purported addressee on its face;

(d) was produced from the custody of the party indicated in the index;

(e) is admissible evidence; and

(f) is received into evidence as soon as referred to by a witness in evidence, or by counsel in submissions, but not otherwise.

16. The Director did not call evidence in support of the Charge and neither party called evidence in relation to penalty orders. Ms Y produced through counsel a number of statements but none of the authors of those statements, including Ms Y herself, gave evidence in accordance with the statement or were available for cross-examination. Objection was taken by the Director to the content of some of those statements as to relevance and weight. The Tribunal accepted the statements on the basis that it could only give such weight to them as was appropriate given that the authors were not present or available for cross-examination.

Background

17. Ms Y and her husband and her client and her partner had been reasonably close friends who shared social and personal occasions together. Ms Y had acted as LMC for her client during the pregnancy and birth [ ]. When the client became pregnant again in early [ ] she asked Ms Y to be her LMC again; and Ms Y discussed with her client the risks of her acting in that capacity and sought advice and support from colleagues to help manage any blurring of personal and professional boundaries.

18. The first professional exchange between Ms Y and her client in relation to the pregnancy was on [ ]; the child was born on [ ]; and the client was discharged from Ms Y's care as LMC on [ ] when the baby was 44 days old. There were 10 clinical appointments during the period between [ ]. No criticism was made as to the quality of midwifery care provided by Ms Y which included abdominal palpation, listening to the foetal heart rate and measuring her client's blood pressure.

19. All appointments between Ms Y and her client were at the client's home and, although there were suggestions of appointments at Ms Y's clinic, the times did not suit the client.

20. The two couples, Ms Y and her husband and the client and her partner, became close friends and socialised together regularly from [ ] onwards. They saw one another more frequently during the client's [ ] pregnancy when Ms Y was acting as her midwife. After midwifery appointments Ms Y would often end up having dinner with her client and her partner with Ms Y's husband ordinarily also attending; and there were also frequent social gatherings between the two families.

21. Ms Y's teenage daughter babysat the children for her client and Ms Y and her husband also engaged the client's partner during [ ].

22. The intimate relationship between Ms Y and the client's partner began in late [ ] when they met while out shopping, had a beer together and engaged in kissing and mutual fondling. This happened on further occasions during the period in question. On or around [ ] they engaged in unprotected sexual intercourse at Ms Y's home.

23. Ms Y's client became suspicious of the relationship and confronted her partner about this but he denied any impropriety in the association with Ms Y.

24. Between [ ] Ms Y and her client's partner engaged in a large number of text communications some of which related to their friendship and [ ] but some of which were of a sexual nature.

25. The Agreed Summary of Facts records that the client became increasingly suspicious of the relationship between her partner and Ms Y towards the end of her pregnancy and during the final two months she said she did not know who to talk to about her concerns. Again on confrontation with her partner he denied any impropriety.

26. The Agreed Summary of Facts further records that Ms Y's client stated "*that she felt as if she was going crazy to be thinking that her midwife … was sleeping with the father of [her] children"*; and that she contemplated changing midwives and recalled being in such a high state of anxiety that when she went into labour she contemplated not calling Ms Y as she did not wish to see her.

27. Ms Y was present throughout the childbirth on [ ] and had a second midwife available but did not request her assistance; and the birth proceeded without complication. Ms Y discharged her client from her care on [ ] and the Agreed Summary of Facts records that the sexual texts between Ms Y and her client's partner continued during that period.

28. There is reference to events after the discharge from care but counsel for Ms Y rightly made the submission that that is outside the period when Ms Y was assisting her client in a professional capacity and therefore outside any consideration of the Charge.

29. The Agreed Summary of Facts further records that Ms Y's client stated that the discovery of the sexual and/or intimate relationship between Ms Y and Ms Y's client's partner had a devastating emotional impact on her (the client) and on her family. The client and her infant [ ] underwent STD testing and the client recalled feeling "*distressed about doing so*". The Agreed Summary of Facts recorded that Ms Y recognised and acknowledged the scale of this emotional impact.

The Charge – Director's position

30. The submissions of the Director included:

    30.1. That the word "*midwife*" has an inherent meaning of being "*with woman*".[2]

    30.2. It is a midwife's job to be with the woman she is caring for and her partner and family throughout her pregnancy, delivery and for a period of time post-partum.

    30.3. The relationship is one of trust where a midwife provides holistic care involving the whole family throughout a significant life event.

    30.4. Reference to the Midwives Handbook for Practice and express references in it.

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[2] Midwives Handbook for Practice NZ College of Midwives Inc 2008 page 5

30.5. That Ms Y's conduct was a severe breach of the trust inherent in her professional relationship with her client and a breach of her duty to the client, her baby and her family.

30.6. That the acts of Ms Y constituted a significant betrayal of the trust that is reposed in a midwife, her client having been in a very vulnerable position as was her client's partner.

31. The Director relied on expert evidence having been obtained from an independent midwifery expert, Ms Billie Bradford, which was recorded as part of the Agreed Summary of Facts and which included:

31.1. That it was acceptable for Ms Y to agree to provide midwifery care for her client who was a close associate.

31.2. That the clinical midwifery care provided by Ms Y was appropriate in terms of frequency and content of assessment and therefore reasonable and in accordance with expected midwifery practice.

31.3. That midwifery care is not limited to the competent execution of normal maternity care assistance and procedures and as such social and relational aspects of care are intrinsic to midwifery.

31.4. That it was not acceptable for Ms Y to engage in a sexual relationship with her client's partner, with that relationship being a new source of potential loss of objectivity for Ms Y which was not disclosed to her client or discussed with Ms Y's colleagues.

31.5. That infidelity is known to put a strain on intimate relationships and for a midwife to engage in an affair with her client's partner undermines the primacy of the midwife's professional relationship with the woman and is not only disempowering but also potentially detrimental to the woman's emotional and psychological wellbeing.

31.6. That it was inappropriate for Ms Y to continue to provide care for her client without disclosing or discussing the potential conflict with the client or with colleagues or taking measures to ensure objectivity.

31.7. That the care provided by Ms Y to her client in this case was inadequate in that it failed in the social and relational aspects of care which are core principles of midwifery.

31.8. That Ms Y's actions contravene the Code of Conduct, the Code of Ethics and the Competencies.

32. The Director referred to the burden and standard of proof and the authorities concerning decisions under the HPCA Act including those relating to disciplinary threshold.

33. It was submitted by the Director that both of the two Particulars Nos 1 and 2 were made out on the facts and in reliance on the principles, standards and authorities mentioned. Having compromised her professional standards by commencing a relationship with her client's partner, it was Ms Y's professional obligation at that point to manage that dual role by terminating her position as her client's LMC.

34. Parallels were drawn with the case of *Re N*[3] where there was a dual relationship of the midwife as LMC and also as prospective grandmother in an adoption to her own daughter.

35. The midwifery profession was, it was submitted, set apart from other professions in the context of a sexual or intimate relationship with a spouse or partner of the client. This was, it was said, because of the obligations on midwives as set out in the relevant standards not to become involved in sexual or emotional relationships with a woman or the partner or a close member of the woman's family and to respect the importance of significant others and whanau in the woman's life; actively to promote and protect

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[3] 213/Mid08/106P

a woman's wellbeing and dignity; and to work in partnership with that woman throughout the maternity process.

36. Ms Y's conduct, it was submitted, is not indicative of the standards promulgated by the wider profession; and it is accordingly important, it was said, that the seriousness of Ms Y's departure from standards be marked in order to signal clearly to the public that this type of conduct will not be condoned.

Ms Y's actions, it was said, clearly amounted to malpractice, negligence and as bringing discredit to the midwifery profession.

Ms Y's position on the Charge

37. Ms Y accepted in the Agreed Summary of Facts that her actions amounted to professional misconduct. She accepted the expert advice set out therein and recorded above and that that advice accords with her own understanding of the relevant standards of the midwifery profession. Ms Y accepted that the Charge warranted a disciplinary finding against her.

The Charge – discussion

38. The onus of proving the Charge is on the Director and the test is one of balance of probabilities with the more serious the allegations, the greater weight of proof.

39. There is professional misconduct under section 100 of the HPCA Act if either there is malpractice or negligence in the scope of practice of the practitioner or acts or omissions which brought, or were likely to bring, discredit to the profession in question.

40. If negligence or malpractice is alleged that 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. Discredit to the profession involves a breach of an objective standard with the question to be asked being 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 in question was lowered by the behaviour of the practitioner.[4]

41. In any case of alleged professional misconduct, even if the Charge is otherwise established, the Tribunal must also consider whether looked at objectively the circumstances require that there be disciplinary sanction.[5]

42. Reference can be had to the standards applicable to the midwifery profession and to the evidence that has been provided by the expert as encapsulated in the Agreed Summary of Facts.

43. Standard 1.2 of the Code of Conduct of the MCNZ reads:

> *"1. Professional relationships*
>
> *Through their conduct, midwives ensure that …*
>
> *1.2 Professional relationships are maintained at all times.*
>
> - *Midwives who choose to provide care to women with whom they have a close personal relationship acknowledge the potential to lose objectivity in decision-making. Midwives in these instances should actively seek collegial support and advice in clinical decision making and ensure they openly discuss the concerns they have with the woman for whom they are providing care.*
>
> - *Midwives and midwifery students must not become involved in a sexual or emotional relationship with a woman in their care, the partner or a close member of the woman's family."*

44. The Midwives Handbook for Practice of the New Zealand College of Midwives Inc 2008 contains:

44.1. First the following Philosophy:

> "*Midwifery care takes place in partnership with women. Continuity of*

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4 *Collie v Nursing Council of New Zealand;* [2000] NZAR 74

5 *McKenzie v Medical Practitioners Disciplinary Tribunal & Anor;* [2004] NZAR 47: *"In summary, the test for whether a disciplinary finding is merited is a two stage test based on first, an objective assessment 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 considerations 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."*

midwifery care enhances and protects the normal process of childbirth.

Midwifery is holistic by nature: combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of women's reproductive health experience; actively promoting and protecting women's wellness; promoting health awareness in women's significant others, enhancing the health status of the baby when the pregnancy is on-going.

Midwifery is: dynamic in its approach; based on an integration of knowledge that is derived from the arts and sciences; tempered by experience and research; collaborative with other health professionals.

Midwifery is a profession concerned with the promotion of women's health. It is centred upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle.

Midwifery care is given in a manner that is flexible, creative, empowering and supportive."

44.2. A Code of Ethics which includes:

"Responsibilities to the woman

…

a) Midwives work in partnership with the woman.

…

f) Midwives respect the importance of others in the woman's life…"

"Responsibilities to colleagues and the profession

…

e) Midwives have a responsibility to uphold the professional standards and avoid compromise just for reasons of personal or institutional expedience."

44.3. Competencies for Entry to the Register of Midwives which include:

"Competency One

The midwife works in partnership with the woman/wahine throughout the maternity experience"

Explanation

The word midwife has an inherent meaning of being "with woman"
The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early parenthood. The midwifery relationship enhances the health and well-being of the woman/wahine, the baby/tamaiti and the family/whanau. The onus is on the midwife to create a functional partnership. The balance of 'power' within the partnership fluctuates but it is always understood that the woman has control over her own experience."

Performance Criteria

The midwife:

1.1 centres the woman/wahine as the focus of care
…

1.6 facilitates, clarifies and encourages the involvement of family/whanau as defined by the woman/wahine."

44.4. The Standards of Midwifery Practice which include:

"*Standard Five*

Midwifery care is planned with the woman."

45. Other decisions of the Tribunal can be helpful in maintaining consistency, but each case must be considered on its own facts. The most helpful case is that relied on by the Director, *Re Ms E.*[6] That case involved a nurse who entered into an intimate and sexual relationship with the husband of a patient at a hospital where Ms E worked who was under her care. The patient had suffered significant brain haemorrhage and was in a wheelchair and required permanent residential care. The Tribunal found that the relationship between the nurse and the husband of the patient was professional misconduct. The decision of the Tribunal includes:

> *"198. What must not be the lost sight of, as has apparently been by Ms E, is the obligations she owes not just to the patient but to the family of the patient. Different family members and different relationships will call for different duties. If this had been a case where Ms S was divorced or separated from Mr S, the position may have been different. Mr and Ms S have two daughters now aged xxx and xxx years. Had those children been significantly younger (or indeed significantly older) the questions may have been different. What the Tribunal is facing is a couple who had an apparently significantly close and loving relationship before Ms S had the subarachnoid haemorrhages. They were working together at a xxx in xxx. They had their two daughters then living with them and apparently there was a compact family unit. No evidence suggested the contrary.*
>
> …
> *203. In considering the ethical duties of a nurse and any other registered health practitioner, the Tribunal has considered the vulnerability of members of the family and the on-going obligations owed by the nurse or health practitioner to*

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[6] 347/Nur10/159P (and penalty 354/Nur10/159P)

> *those members. That duty of care impacts not only on those family members but on the patient herself and Ms S in this case could have been significantly distressed if she had learned that family members were being disquieted by the relationship her husband was having with Ms E.*
>
> *204. It is the Tribunal's view that Ms E's experience should have led her to conclude of her own initiative that any relationship with the husband of Ms S, her patient at X Hospital and under her care, was inappropriate and a breach of ethical standards. The fact that it occurred to her and she says she took advice on it only serves to underline that she was aware that there were ethical issues involved.*
>
> *205. The Tribunal does not accept that the Nursing Council Code of Conduct, the Nursing Council Competencies for Registered Nurses or the NZNO Code of Ethics give no guidance on this issue. Although there may not be express reference to spouses, partners or other family members of a patient, the principles of care from those documents are clear. The nurse must take into account the total family unit. The nurse must weigh up the bonds of family links that there are and must be sensitive to the different family dynamics. Each case will vary. Codes of this kind cannot prescribe for every eventuality."*

46. There was no case directly involving a midwife having a relationship with the partner of the woman under her care; but the principles applicable to nurses as stated by the Tribunal in the *Re Ms E* case also apply to midwives. It may even be said that there is greater application of those principles, given that the relationship between the midwife and the woman and the principles encapsulated in the Handbook referred to above which encompass the total family unit. This inevitably includes the partner of the woman.

47. The Tribunal has no hesitation in saying that in establishing an intimate and then sexual relationship with the partner of her client in this case, Ms Y has breached the standards applicable and has let the family unit down. The partner required support and Ms Y had to bring to that, her professional responsibilities and objectivity which was no longer possible when the relationship developed. On the one hand she should not have commenced the personal relationship given that there was the professional relationship; and on the other hand there is the continuity of the professional responsibilities once the personal relationship had commenced. Those distinctions are encapsulated in the two Particulars of the Charge.

48. It may be said that the personal relationship between Ms Y and her husband and the client and her partner may have been a factor which led more easily into the relationship between Ms Y and her client's partner developing. In normal life circumstances that does occur and cannot be the subject of any disciplinary proceeding before this Tribunal.

49. In this case, however, Ms Y had already undertaken professional responsibilities to her client before the intimate relationship commenced and she should have not embarked upon the behaviour and activity with the partner which has led to this Charge being brought. Her professional commitment to her client, the woman, dictated that she refrain from any such intimate behaviour with her client's partner.

50. That having occurred, however, there is then the continuation of the professional relationship with the woman despite the personal relationship that Ms Y had entered into with the woman's partner. That is the circumstance to which Particular 2 refers.

51. The obligation then was for Ms Y to see that her objectivity and professionalism were compromised and that she was then unable properly to discharge her responsibilities to her client, the woman in question. She had the further obligation then to withdraw from giving professional assistance and ensure that continuity of care during the pregnancy and after were given by someone else. It did not need any admission to the relationship but there did need to be a withdrawal from the professional relationship.

52. The consequences of her failing to do so can be seen by the agreed facts recording the reaction of the woman to the circumstances. When the woman became suspicious that something was afoot she faced the period of uncertainty not knowing to whom she should speak about her concerns. (This was exacerbated by the denial by her partner of any impropriety).

53. At the time, as the Agreed Summary of Facts records, the woman was working and managing [ ] other small children. She said that she "*felt as if she was going crazy*"

in contemplating the possibility of the relationship between her partner and Ms Y. She says that she contemplated changing midwives and recalls a high state of anxiety such that when she went into labour she did not wish to see Ms Y as her midwife.

54. The Agreed Summary of Facts refers to the devastating emotional impact that the intimate relationship between Ms Y and her client's partner have had on her and her family; although that may include the normal reaction of a spouse or partner to infidelity on the part of the other.

55. She did however, feel distressed about the necessity for testing for sexually transmitted diseases and Ms Y has, to her credit, recognised and acknowledged the scale of the emotional impact on her client.

56. All that serves to underline how improper the continuation by Ms Y of her professional relationship with her client, the mother, was once the personal intimate relationship with the client's partner had commenced. It serves to underline how important it was that Ms Y then withdraw from further professional involvement with the woman.

57. The Tribunal accordingly finds that there is misconduct on the part of Ms Y in relation to each and both of the separate Particulars of the Charge. This is malpractice on her part in both cases and there are acts which bring discredit to the midwifery profession.

58. Ms Y's acts in this matter in relation to each and both of the two Particulars are such as to warrant disciplinary sanction. This is for the purpose of maintaining standards in the profession and protecting the public. Midwives need to know of the impropriety that there is in contemplating, let alone having, any intimate relationship with the partner of a woman to whom professional services are to be rendered or are being rendered. They need to know that it is a breach of the standards and professionalism expected of them to have that relationship, and then to continue with the provision of professional services despite the relationship. In this way standards will be maintained in the profession.

59. Likewise, the public need to be protected from the consequences of a midwife's acting in this way. Such consequences are encapsulated in the reactions which Ms Y's client had to her suspicions and then in due course to her discovery of the relationship. It is only by imposing a sanction on Ms Y that other midwives will learn of their obligations in this manner and so the public will be protected. There will be inevitable penal consequences to Ms Y as a consequence from the decision of the Tribunal; but that is not the main thrust at this stage in deciding that disciplinary sanction is warranted.

Penalty

60. The Director presented very carefully considered submissions as to the penalty which she was seeking in relation to this matter; and the Tribunal appreciates the careful and balanced way in which the Director has considered all the conflicting considerations and given a balanced and thoughtful submission to the Tribunal.

61. The Director accepted that it was not necessary to make any order removing Ms Y's name from the register and she gave the reasons that there was remorse shown and efforts undertaken by Ms Y to rehabilitate herself.

62. The Director submitted that normally a suspension of around 9-12 months would be warranted; but in this case Ms Y had removed herself from practice and so imposed a suspension on herself of some five months when Ms Y was working on rehabilitative steps and a gradual return to work. Although this was shorter than the normal suspension that the Director would have sought, she said that in all the circumstances that should suffice as a period of removal from practice for those rehabilitative steps and return to work.

63. The Director sought an order for censure, that conditions be imposed on practice by Ms Y as a midwife, a fine and costs. The conditions are discussed below.

64. The Director's submissions helpfully referred to the general principles and the protection of the public and deterrence of similar conduct.

65. The Director submitted:

65.1. That Ms Y had shown a significant and on-going lack of professional judgement in a core aspect of midwifery care which strikes at the very heart of the midwifery philosophy.

65.2. That the conduct was on-going with persistence in the relationship for some five months while care was being provided to the woman.

65.3. That an appropriate penalty would send a clear message to the public and other midwives that such conduct cannot be sanctioned and that it is important that prospective clients become aware of previous conduct before engaging Ms Y as their midwife.

65.4. That conditions should address the risk for the future that Ms Y will not adequately manage boundaries and in particular boundaries with friends or family; and secondly the underlying cause of the conduct where Ms Y herself, in a statement which was submitted, referred to pressures that have taken a toll over a long period, and that she was suffering severe burn out, physical exhaustion, anxiety and depression.

65.5. That any consideration of penalty should also take into account Ms Y's "*journey to rehabilitation*" which should be permitted but in a way which ensures protection of the public.

65.6. That, instead of supporting and enhancing the woman and her family in this case, Ms Y made the experience worse for her.

66. The Director outlined what she said were the aggravating and mitigating factors and referred to other decisions of the Tribunal noted below. The Director accepted that Ms Y had made serious and concerted efforts to rehabilitate herself, having handed in

her Practising Certificate for a period of approximately five months and having accepted the recommendations of the Health and Disability Commissioner to enter into a mentoring relationship, with counselling and various courses to attempt to obtain insights into her behaviour.

67. In the context of fine and costs submissions were made about the inadequacy of information about the means of Ms Y to meet these.

Penalty – Ms Y's position

68. The carefully presented submissions for Ms Y included reference to the principles and then to other cases noted below. Those submissions emphasised that the relationship between Ms Y and her client's partner had occurred in the context of longstanding friendship and a close and highly connected relationship between the families (although some of what was said was not supported by any evidence).

69. Regret was expressed that Ms Y did not disclose to a trusted colleague the intimate nature of her relationship with her client's partner but she was, it was said in submissions, conscious of the potential for compromise and conflict of interest in providing midwifery care to a close friend.

70. The submissions referred to:

    70.1. The "*very significant and genuine remorse*" experienced by Ms Y as a result of the incident.

    70.2. That Ms Y has in no way attempted to justify her actions but has been willing to accept both professional and personal consequences.

    70.3. That Ms Y has suffered significant depression and anxiety as a consequence and reference was made to a statement from a registered counsellor who had been assisting.

    70.4. That Ms Y had expressed her remorse and willingness to address professional shortcomings by:

70.4.1. Her attempt to apologise to her client including writing a letter of apology.

70.4.2. Acceptance of the breach of the Code of Health and Disability Services Consumers' Rights and the Health and Disability Commissioners' recommendations.

70.4.3. Resignation of her position as a Midwifery Standards Reviewer and Midwifery First Year in Practice Programme Reviewer with the New Zealand College of Midwives.

70.4.4. Transfer of her entire patient load to colleagues in April 2014 and relinquishment of her Annual Practising Certificate in April 2014 in recognition, it was said, that her depression and anxiety potentially impact upon her ability.

70.4.5. Re-application for an Annual Practising Certificate and taking up employment as a bureau midwife with the [ ] District Health Board (xDHB) in September 2014.

70.4.6. Transparency about the complaint with the xDHB maternity services management team and not providing continuity of care or working on weekends.

70.4.7. Undergoing a Midwifery Standards Review by the NZ College of Midwives in November 2014.

70.4.8. Undergoing mandated mentoring under the MCNZ continuing until April 2016.

70.4.9. Researching of ethical obligations and discussing research with her supervisor.

71. After having referred to the financial consequences and information provided concerning that, submissions on Ms Y's behalf were:

71.1. To accept that censure should be ordered.

71.2. That there was nothing to suggest cancellation of registration is necessary or that suspension was necessary and appropriate having regard to the voluntary cessation of practice for five months.

71.3. That Ms Y did not, it was said, impose a risk to the public.

71.4. That Ms Y's rehabilitation would be significantly compromised by any period of suspension.

71.5. That Ms Y should be given the opportunity to demonstrate that she can comply with difficult standards.

72. The submission was that Ms Y did not believe that conditions were necessary "*to ensure her safety*" but some conditions were proposed should that not be found to be the case. It was said that a fine was neither necessary nor appropriate given the "*significant and on-going financial burden*" on Ms Y and her family.

73. There was produced by counsel a bundle of written statements. These have been accepted by the Tribunal under clause 6, Schedule 1, of the HPCA Act but objection was taken by the Director, which the Tribunal accepts, that none of the authors of the statements, which were all unsworn, was called to read them or be cross-examined on them. The Director also objected to some of the content of those statements which were not accepted by the Director.

74. The Tribunal views statements of this kind, particularly from the practitioner herself, with some hesitation. Any statement which the Tribunal is asked to take into account and which is not able to be challenged by questioning or cross-examination, does not carry the same weight. Practitioners who choose to tender statements of this kind without "*fronting up*" to cross-examination must realise that the Tribunal cannot give the same weight to what they say. So far as references and professional opinions from qualified experts are concerned, the Tribunal accepts that there can be convenience

considerations in requiring the authors to be present and that is taken into account in giving weight to what is said. If there were controversial professional comment or assessment made, then it is more likely that the Tribunal would be assisted by the presence of the author for cross-examination.

75. The statements tendered for Ms Y included:

75.1. A statement from Ms Y herself. Although she was present at the hearing, counsel on her behalf said she did not wish to read the statement or be questioned about it. That statement refers to

75.1.1. "*[A] number of sexual encounters*" with her client's partner in this case.

75.1.2. The acknowledgement of the significance of the breach of trust in this case.

75.1.3. The acknowledgement of the devastating effects of her actions on her client and family and the breach of her trust, deceit and unprofessional conduct.

75.1.4. The breach of the trust central to her role as her client's midwife's with the acknowledgement that "*my actions means that the special memories and intense emotions associated with the births of [the client's] babies have been for ever spoiled*".

75.1.5. Her attempts to see the client and communicate but the refusal by the client to read a letter of apology or listen to words of remorse.

75.1.6. Her embarrassment and shame at her "*very bad lapse in judgment*".

75.1.7. The time she has been thinking about and analysing the events and the counselling that she is receiving which are helping to "*identify and address the severe burn out, physical exhaustion, anxiety and depression that [she was] experiencing by early 2014*".

75.1.8. The resultant reorganisation of the structure of her life, re-evaluation of her priorities and that she had stopped drinking alcohol.

75.1.9. Her withdrawal from practice in early 2014 and the voluntary handing in of her Annual Practising Certificate.

75.1.10. Consequences of the whole matter for her husband and family.

75.1.11. Her return to practice in June/July 2014 and commencement of work in September 2014 at the xDHB as a bureau midwife.

75.1.12. The support she says she has had from xDHB; and supporting statements from staff there were produced to the Tribunal.

75.1.13. The Midwifery Standards Review that she underwent in November 2014.

75.1.14. Her current practice as a bureau midwife at [ ] Hospital and what this involves.

75.1.15. Her acceptance of a recommendation from the Health and Disability Commissioner's opinion that she enter into a mentoring relationship with a senior colleague and what she has done in response to that; with mentoring continuing until April 2016; and a report from her mentor dated 27 April 2015 produced to the Tribunal.

75.1.16. The research she says she has carried out on ethical issues, the relational dynamics and strategies for managing the risk associated with these.

75.1.17. Her genuine belief that there is absolutely no prospect she will breach the trust of a woman in her care again and her learning from this experience.

75.1.18. Her resignation as the Midwifery Standards Reviewer and Midwifery First Year in Practice Reviewer that she had earlier been involved in.

Annexures to Ms Y's statement included reference to the outcome of a Health Committee consideration by the MCNZ; extensive consumer feedback forms, all of which speak of Ms Y's capacity as a midwife; the advice of the MCNZ concerning mentoring and the mentoring report dated 27 April 2015.

75.2. A statement from Ms Y's husband dated 15 August 2015. This includes reference to:

75.2.1. "*[The] stress and immense responsibility*" that Ms Y has experienced as an LMC which he described as "*a bit like living in a war zone*".

75.2.2. Periods for Ms Y when she was "*extremely tired, underslept, and overworked*".

75.2.3. Aspects of the relationship so far as it affected Ms Y's husband and his responses to it and matters concerning consequences for the children.

75.2.4. A calculation of what he said was the total financial loss to the family of $160,000.00 based on a reduction of income for three years for Ms Y, the cost of counselling and legal and associated costs.

75.3. A statement dated 20 June 2015 from a registered counsellor who had seen Ms Y weekly since 15 April 2014. She described the counselling process that had occurred between them and her report includes that Ms Y "*came to a place of deep remorse*" and that she "*is currently displaying classic symptoms of being under threat*".

76. The Tribunal has read carefully the various other references and statements from individuals as tendered to it and has taken these into account in the context referred to above.

Penalty – discussion

77. The available penalties for the Tribunal are:[7]

77.1. That registration be cancelled.

77.2. That registration be suspended for a period not exceeding 3 years.

77.3. That the health practitioner be required, after commencing practice following the date of the order, for a period not exceeding 3 years, to practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise specified.

77.4. Censure.

77.5. A fine of up to $30,000.00 (but not if he or she has been convicted of a relevant offence or damages have been awarded against him or her – not the case here).

77.6. Costs.

78. The eight factors normally taken into account on the basis of authorities[8] are:

78.1. What penalty most appropriately protects the public

78.2. The important role of setting professional standards.

78.3. A punitive function.

78.4. Rehabilitation of the health professional.

78.5. That any penalty imposed is comparable to other penalties imposed upon health professionals in similar circumstances.

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7 Section 101 of the HPCA Act

8 *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand*[2012] NZHC 3354; *Katamat v PCC* [2012] NZHC 1633 at paragraph 49 and *Joseph v PCC;* [2013] NZHC 1131 at [65] – [66]; *Singh v Director of Proceedings*, [2014] NZHC 2848 (esp. paragraphs [56] – [60] and [66])

78.6. Assessing the health practitioner's behaviour against the spectrum of sentencing options that are available and trying to ensure that the maximum penalties are reserved for the worst offenders.

78.7. An endeavour to impose a penalty that is the least restrictive that can reasonably be imposed in the circumstances.

78.8. Whether the penalty proposed is fair, reasonable and proportionate in the circumstances presented.

79. Other cases are helpful to maintain consistency but each must be decided on its own facts. The case of *Re Ms E* referred to above is the most helpful to the Tribunal and in that case, in the circumstances mentioned, the Tribunal censured the nurse and suspended her from practice for a period of six months; but with the further order that that suspension was itself suspended for another 12 months. More recent judicial decision means that such a course is not available to the Tribunal but it does indicate that the Tribunal in that case considered that rehabilitation would be assisted more by the practitioner, a nurse, not being removed from practice by any order for suspension.

80. The Tribunal accepts the submission for Ms Y that in the *E* case an aggravating factor was her refusal to accept that she had breached professional standards:[9]

> *"The protection of the public is required because Ms E is in on-going denial of breaches of obligations. She needs to have the sanction of a penalty in this case so that she realises clearly that she has breached standards and does not continue in a state of denial about that."*

81. The Tribunal also accepts what was said as to fine namely:[10]

> *"The Tribunal is of the view that Ms E has already suffered significantly both from a professional nursing career viewpoint and also from a costs viewpoint. She has had income disruptions; she has incurred her own legal costs; and there are the costs which the Tribunal orders against her as set out below. Costs are not in themselves a penalty but the Tribunal is mindful that there has been significant financial ramifications for Ms E."*

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[9] 347/Nur10/159P at paragraph 236

[10] Penalty decision 354/Nur10/159P at paragraph 46

82. Counsel for Ms Y also referred to *O v The Professional Conduct Committee*.[11] In that case the High Court reversed a decision of the Tribunal that there had been discredit to the nursing profession in the circumstances of the case. It is therefore unhelpful in the present case where discredit is found by the Tribunal (and acknowledged by Ms Y). What was emphasised by submissions for Ms Y, which the Tribunal has taken into account, was the distinction between the husband's vulnerability in the *E* case but not so in the *O* case by virtue of her professional role.

83. Important features in this case include:

83.1. The relationship between Ms Y and her clients.

83.2. The vulnerability of her client both physically and emotionally in the environment of her pregnancy and delivery of her baby.

83.3. The vulnerability of her client's partner in this life situation.

83.4. The significant breach of trust in this intimate and personal relationship.

83.5. The period of time over which the relationship continued, particularly in relation to the sequence of, and periods of, the pregnancy and delivery of the baby.

83.6. The failure of Ms Y to withdraw her services for her client once the personal relationship had commenced.

84. Mitigating features include:

84.1. That Ms Y has admitted her conduct.

84.2. That Ms Y has attempted to apologise direct to her client.

84.3. That Ms Y voluntarily ceased practice as an LMC and indeed as a midwife and handed in her Practising Certificate for a period of some 4 – 5 months.

84.4. That Ms Y has co-operated with the investigation by the Health and Disability Commissioner.

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[11] [2011] NZAR 565

84.5. That Ms Y has also co-operated in the prosecution process with Ms Y attending the hearing and, although she did not give evidence, her participation in the hearing process. This is always of help to the Tribunal.

85. An important factor is the rehabilitation of Ms Y into the profession. This has, to Ms Y's credit, commenced already by her having undertaken the period of self-suspension and the steps that she has for mentoring and increasing her awareness of her responsibilities.

86. What must be taken into account is the apparent stress that she was under at the time, a matter referred to graphically by her husband in his written statement. Any rehabilitation must address this issue. The Tribunal is of the view that that can be done by appropriate conditions imposed.

87. Questions of whether Ms Y's rehabilitation would be restricted or compromised by publication of her name and identifying details do not arise because there is an order for non-publication of name and identifying details.

88. Having weighed these issues carefully, the Tribunal has formed the view that there need be no order for removal of Ms Y's name from the register; as this would be an excessive response to the circumstances which can be dealt with otherwise.

89. The Tribunal has also formed the view that there is no need for any order for suspension. It accepts the Director's submission that an appropriate suspension might have been considered as between 6 and 12 months. Midwives must realise that if there is any behaviour of this kind in their professional capacity, there is the risk of a suspension of that period. The public must know that the Tribunal is concerned to maintain standards in the profession and protect the public by being prepared to suspend a midwife for a period of time.

90. Against that in this case, however, is the voluntary suspension for some 4 - 5 months that Ms Y has undertaken, the steps that she has taken already to rehabilitate herself, and the conditions that the Tribunal orders in this decision. These are sufficient to outweigh the need for imposition of a suspension order in this case; and that outcome is consistent with what occurred in the *Re Ms E* case referred to above.

91. There needs to be an order for censure from the Tribunal expressing its disquiet about the offending and the circumstances of the case and an order is made below.

92. The Tribunal considered carefully the question of imposition of a fine and is of the view that a monetary penalty is appropriate given the circumstances of the case and given that there is no suspension of the practitioner, Ms Y.

93. There was little information given to the Tribunal about Ms Y's means to meet a fine. The statement from her husband referred to his calculation of their financial losses as a consequence but the Tribunal finds this to be exaggerated. For one thing it refers to Ms Y's not practising as a LMC for three years and the consequential loss of income; but in fact this decision of the Tribunal does not deprive her of that opportunity and there will be the availability of work for her should she choose to do that.

94. Other than the calculation of their losses, there is no information about Ms Y's means to pay a fine.

95. In its original decision the Tribunal found that it would have imposed a fine of $10,000.00 in all the circumstances, had there been an order for non-publication of Ms Y's name and identifying details; but in the circumstances outlined in the Background to this revised decision, there is no order for fine.

96. The conditions proposed by the Director appear to the Tribunal to be appropriate. The detail is set out below but these are summarised as:

96.1. A prohibition on providing midwifery care to a friend or family member except in an emergency for a period of 18 months from 29 October 2015 (being the date from which this condition was imposed).

96.2. The continuation of the mentoring arrangement that she currently has with her mentor or another senior colleague as approved by the MCNZ for a period of 18 months from 29 October 2015 (being the date from which this condition was imposed).with regular reporting to the MCNZ. Mentoring is a useful process for Ms Y and the Tribunal is of the view that this should continue.

96.3. Personal counselling at Ms Y's own cost at a minimum of monthly intervals for a period of 12 months from 29 October 2015 (being the date from which this condition was imposed). The Tribunal is of the view that, despite the Director's submission that this should be for a period of 18 months, the period of 12 months as an **obligatory** continuation of counselling is sufficient. Counselling inevitably involves a measure of voluntary input and the Tribunal can only order counselling that may be effective. It is the Tribunal's view that, despite the period ordered against Ms Y, she should **voluntarily** continue with counselling for such longer period as is necessary to meet her needs.

96.4. If Ms Y practises as an LMC at any time within 24 months from 29 October 2015 (being the date from which this condition was imposed), she limit the number of her clients to 36 clients per annum. That is not to try to limit her practice as a midwife but rather to limit that practice to a realistic number, given the evidence there was before the Tribunal of the stress and pressure causative factors said to be behind her offending. The Tribunal is of the view that for that period a limitation of that kind will enable Ms Y to regularise her practice as an LMC so that there is not undue stress and pressure but still

maintaining a reasonable workflow. That number is approximately 80% of the recommended maximum and this is, in the Tribunal's view, an appropriate percentage. Indeed the Tribunal recommends that, because of those stressor factors and the professional responsibilities involved in proper discharge of her midwifery functions, after that period of 24 months Ms Y limits her clientele number to the maximum that is recommended.

97. The Director also sought conditions:

97.1. Prohibiting Ms Y from practising in a role that provides continuity of care to a woman either as LMC or employed midwife for a period of 12 months from the date of the original decision 29 October 2015. The Tribunal does not consider that further condition is necessary given the limitation on the number of clients as an LMC. There are the stressor factors mentioned which will need to be addressed if Ms Y is to discharge her responsibilities as a midwife professionally, but the Tribunal is of the view that that will be covered by the mentoring and counselling conditions referred to above.

97.2. That Ms Y inform any woman as soon as practicable to whom she is giving continuity of care as a midwife that she has been censured by this Tribunal for having a sexual and/or intimate relationship with the partner of a woman under her care for a period of 18 months from the date of the decision. The Tribunal in its original decision did not consider this necessary given that there was then no order for non-publication of Ms Y's name or identifying details and that would have been available for any person to research should they wish. In the event that, following the High Court judgment there is now an order from non-publication of Ms Y's name or identifying details, the situation could have been different; but, in the circumstances outlined in the Background to this decision above, there is no order made for such condition.

Costs

98. The principles applicable to costs are these. The normal approach for the Tribunal based on the authorities[12] is to start with a 50% contribution. That, however, is a starting point and other factors may be taken into account to reduce or mitigate that proportion. The balance of costs of the prosecution after the orders for costs must be met by the profession itself. As was said in *O'Connor v Preliminary Proceedings Committee*:[13]

> *"It is a notorious fact that prosecutions in the hands of professional bodies, usually pursuant to statutory powers, are very costly and time consuming to those bodies and such knowledge is widespread within the professions so controlled. So as to alleviate the burden of the costs on the professional members as a whole the legislature had empowered the different bodies to impose orders for costs."*

99. In Winefield[14] the Tribunal held that costs of some 30% of actual costs were appropriate having regard to:

99.1. The hearing being able to proceed on an agreed statement of facts.

99.2. Co-operation of Mr Winefield.

99.3. The attendance of Mr Winefield at the hearing.

99.4. Consistency with the level of costs in previous decisions.

99.5. Costs not paid by Mr Winefield would fall on the profession as a whole.

100. The Director sought a reasonable contribution to costs and said this was appropriate and in the public interest. She acknowledged that Ms Y had accepted the Charge and that the facts prove the Charge. She sought an order for contribution of 30% plus disbursements and produced an estimate of the costs of the Director totalling $16,901.00. The Tribunal's costs must also be considered and these were estimated to total $21,122.57. This makes a total of approximately $38,023.00.

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[12] Including *Cooray v Preliminary Proceedings Committee*; Wellington HC: AP 23/94; 14/9/95; Doogue J
[13] Wellington HC; AP 280/89; 23/8/90; Jeffries J
[14] 83/Phar06/30P

101. For Ms Y it was suggested that there should be "*a small costs award*" as appropriate and reference was made to the co-operation by Ms Y with both the Health and Disability Commissioner and the Director from the outset; and her facilitation of a timely and efficient consideration of the matter before the Tribunal by not contesting the Charge and agreeing to a summary of facts.

102. As noted above, there was no significant evidence from Ms Y about her means to afford an order for costs or otherwise. She made no reference to it in her unsworn statement and neither did her husband other than referring to what he had estimated as being the cost to Ms Y and the family from this whole affair which, as noted above, the Tribunal treats as being an excessive estimate.

103. On the basis of the authorities and in light of the submissions the Tribunal has determined that a fair contribution would be approximately 30% to the total cost of the Director and the Tribunal, $38,023.00, that is the sum of $11,407.00 and this is ordered accordingly.

Name suppression

104. The Director sought suppression of the name and identifying details of Ms Y's client and her partner and family members. This was effectively accepted by Ms Y and the Agreed Summary of Facts contains a consent signed by her for appropriate orders.

105. In addition, the Director sought appropriate orders in respect of the children of that family and any detail leading to their identity and this is also appropriate. Six specific items were sought to be suppressed and these effectively identify the client and her partner and family namely:

105.1. The number of children they have.

105.2. Any connection they may have to [ ].

105.3. The fact that the client's partner was contracted to carry out [ ] work for Ms Y.

105.4. Details of the current state of the client and her partner's relationship (and there was really no evidence given about this; the Director made some reference to this in submissions but this was not supported by evidence and is discounted by the Tribunal in any event).

105.5. The fact that Ms Y was the client's midwife for her [ ] child.

105.6. Any details that could lead to identification of the dates of the client's pregnancy and birth of her [ ] child.

106. Although some of these are encompassed in the order concerning the client and her partner and family, the Tribunal accepts that those can be expressly ordered. There is an order accordingly set out below.

107. Ms Y also sought a permanent order for non-publication of her name and identifying details, submitting that in all circumstances such an order was appropriate.

108. The question of whether an order prohibiting publication of the name or identifying details of Ms Y should be made was addressed by the High Court in its judgment. The Court has directed that there should be such an order and the Tribunal orders accordingly. That order extends, as directed by the Court, to Ms Y's current employer and to any detail that may connect Ms Y to the client or the client's family.

Result and orders

109. The Charge is made out in respect of both Particulars separately and cumulatively.

110. Ms Y is censured pursuant to section 101(1)(d) of the HPCA Act.

111. The Tribunal orders pursuant to section 101(1)(c) of the HPCA Act that on resumption of practice by Ms Y as a midwife following the date of the original decision 29 October 2015 this is to be on the following conditions:

111.1. That for a period of 18 months from 29 October 2015 (being the date from which this condition was imposed) Ms Y is prohibited from providing midwifery care to a friend or family member (except in an emergency).

111.2. That for 18 months from 29 October 2015 (being the date from which this condition was imposed) Ms Y will, at her own cost, continue in a mentoring relationship with the current mentor or another senior colleague approved by the MCNZ, with that person to provide reports to the MCNZ regularly as directed by it.

111.3. That for a period of 12 months from 29 October 2015 (being the date from which this condition was imposed) Ms Y will, at her own cost, continue with counselling (at a minimum of monthly intervals) and the Tribunal encourages Ms Y to continue with that counselling after that period has concluded.

111.4. That for a period of 24 months from 29 October 2015 (being the date from which this condition was imposed) whenever Ms Y is practising as an LMC, she is to limit the number of her clients to 36 clients per annum and the Tribunal recommends that even thereafter she limit to 100% of the recommended maximum.

112. Ms Y is ordered pursuant to section 101(1)(f) of the HPCA Act to pay towards costs the sum of $11,400.00 divided as to $5,067.00 to the Director and $6,303.00 to the Tribunal.

113. The Tribunal orders pursuant to section 95 of the HPCA Act permanent non-publication of the name and identifying details of:

113.1. Ms Y's client, her partner, and family members including in particular the following details:

113.1.1. The number of children they have.

113.1.2. Any connection they may have to [ ].

113.1.3. The fact that the client's partner was contracted to carry out [ ] work for Ms Y.

113.1.4. Details of the current state of the client and her partner's relationship.

113.1.5. The fact that Ms Y was the client's midwife for her [ ] child.

113.1.6. Any details that could lead to identification of the dates of the client's pregnancy and birth of her [ ] child.

113.2. Ms Y and Ms Y's employer both current and at the time of the original decision, 29 October 2015, and any details that might connect Ms Y to the client or the client's family in this case.

114. The Tribunal directs the Executive Officer to publish a copy of this decision and a summary on the Tribunal's website. The Tribunal further directs the Executive Officer to publish a notice stating the effect of the Tribunal's decision be published in the Midwifery Council Newsletter "Midpoint" and the Midwifery Council of New Zealand's Annual Report. (Section 157 of the HPCA Act).

DATED at Auckland this 23rd day of December 2016

David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal