NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

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HPDT No.	890/Mid16/373D
UNDER	the Health Practitioners Competence Assurance Act 2003 (the Act)
IN THE MATTER	of a disciplinary Charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**THE DIRECTOR OF PROCEEDINGS** designated under the Health and Disability Commissioner Act 1994 **Applicant**
AND	**Ms TRACEY GOFF** of Palmerston North, Midwife **Practitioner**

HEARING held at Palmerston North on 2 May 2017

TRIBUNAL:	Mr D M Carden (Chair) Ms J Thorpe, Ms A Foaese, Ms S Bree and Ms L Carlyon (Members) Ms G Fraser (Executive Officer) Ms J Kennedy (Stenographer)
APPEARANCES:	Ms K Eckersley for the Director of Proceedings Ms T Goff, the practitioner, in person

CONTENTS

The Charge and hearing....3

Background 5

The Charge - the parties' position....8

The Charge – discussion....9

Particulars 2 and 4....13

Disciplinary sanction 14

Penalty....15

Penalty -Discussion 16

Costs 20

Non-publication of name and details....21

Result and outcome....22

1. Ms Goff is a midwife who was at all relevant times practising as such in Palmerston North.
2. In [ ] she was the midwife for Ms S (the mother). The mother's baby was born [ ].
3. The Director of Proceedings, designated under the Health and Disability Commissioner Act 1994 (the Director) laid a Charge against Ms Goff concerning the period [ ] and the professional services she rendered to the mother, alleging six particulars of conduct amounting to professional misconduct under section 100(1)(a) and/or (b) of the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).
4. Those particulars referred to alleged failures following blood pressure readings and signs of pre-eclampsia and failures to discuss and recommend consultation with a specialist.
5. The Tribunal has inquired into the Charge and makes findings and orders on it.

The Charge and hearing

6. The Charge against Ms Goff read:

> *"**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 [ ], whilst providing midwifery care to your patient Ms S you, being a registered midwife, acted in such a way that amounted to professional misconduct.*
>
> ***IN PARTICULAR**:*
>
> *1. On [ ], after Ms S's blood pressure (BP) had been taken and recorded as 140/100 and/or despite the presence of other symptoms of pre-eclampsia, including visual disturbance and/or mild oedema and/or a 2kg weight gain over a one week period, you failed to take appropriate steps to assess Ms S for pre-eclampsia including:*
>
> *(i) Re-checking Ms S BP during the appointment and/or later that day; and/or*
>
> *(ii) Arranging a follow-up appointment with Ms S to re-check her BP; and/or*
>
> *(iii) Arranging for Ms S to have blood tests completed; and/or*
>
> *(iv) Arranging for Ms S to have urinalysis completed;*
>
> ***AND/OR***
>
> *2. On [ ], after Ms S BP had been taken and recorded as 140/100 you failed to discuss and/or recommend to Ms S, in accordance with the*

Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines,) that she have a consultation with a specialist;

AND/OR

3. *On [ ], after you received a text message from Ms S where she reported further symptoms of pre-eclampsia, including visual disturbance and/or headaches, you failed to arrange for Ms S to undergo an assessment to check for pre-eclampsia;*

AND/OR

4. *On [ ], at approximately 11.12pm, after Ms S's BP had been taken and recorded as 167/97, you failed to discuss and/or recommend to Ms S, in line with the Referral Guidelines, that she have a consultation with a specialist;*

AND/OR

5. *On [ ], at approximately 11.12pm after Ms S's BP had been taken and recorded as 167/97 and/or despite Ms S's recent history of symptoms of pre-eclampsia including a BP the day prior of 140/100 and/or visual disturbance earlier in the day and/or visual disturbance in the two weeks prior and/or headaches earlier in the day and/or mild oedema recorded the day prior and/or a 2kg weight gain over a one week period, you failed to take appropriate steps to assess Ms S for pre-eclampsia including:*
   - *(i) Questioning Ms S regarding the presence of any other symptoms of pre-eclampsia; and/or*
   - *(ii) Re-checking Ms S's BP within 15 to 30 minutes of the 167/97 reading being taken; and/or*
   - *(iii) Arranging for blood tests to be completed; and/or*
   - *(iv) Arranging for urinalysis to be completed;*

AND/OR

6. *On [ ] between approximately 1.05am and 1.20am and after Ms S's BP had been taken and recorded as 188/106 and/or 170/108 and/or Ms S had been observed to be pale and/or feeling faint, you failed to take appropriate steps including:*
   - *(i) Making a 777 emergency page; and/or*
   - *(ii) Ringing the emergency call bell in the birthing suite.*

The conduct alleged in the above particulars separately and/or cumulatively amounts to professional misconduct. The conduct is alleged to amount to malpractice and/or negligence and/or conduct that has brought or was likely to bring discredit to the midwifery profession under s100(1)(a) and/or s100(1)(b) of the Act."

7. The Charge was heard by the Tribunal for one day in Palmerston North and the Director was represented by counsel, with Ms Goff representing herself.

8. An Agreed Summary of Facts signed by both parties was presented dated 28 February 2017. There was also a bundle of agreed documents produced on the basis that had been directed at a telephone 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.

Background

9. Ms Goff qualified as a midwife in November 2008 and has worked as a registered midwife since 2009. At the time in question she worked in a midwifery group.

10. The mother, who was at that time [ ] years of age, was under Ms Goff's care from [ ] when her original Lead Maternity Carer (LMC) advised she would be on leave on the mother's due date for delivery.

11. The mother attended 12 antenatal appointments with Ms Goff between [ ].

12. On [ ] the mother attended for a routine antenatal check with Ms Goff and also present was a student midwife (Ms Tanner). Symptoms were discussed and blood pressure taken which was 140/100 mmHg, agreed by the parties as "*high and a significant increase from her booking BP of 110/60mmHg*".

13. The parties then discussed the high blood pressure and its symptoms of pre-eclampsia, including headaches and visual disturbance; and Ms Goff advised the mother to contact her immediately if she experienced those symptoms or noticed a decrease in foetal movements. Other advice was given with a proposal for a further consultation on [ ] if the mother was not in labour before then.

14. It was agreed by the parties that the mother did not understand the significance of the information given to her about pre-eclampsia and the seriousness of the symptoms she was experiencing.
15. It was further agreed that Ms Goff did not recommend to the mother or discuss with her at all that she consult with a specialist in the light of the high blood pressure reading.
16. Ms Goff did not take any steps to assess the mother for pre-eclampsia such as arranging for blood tests and further urinalysis or making an appointment to re-check her blood pressure.
17. On [ ] at 9.41 am the mother sent a text message to Ms Goff referring to headaches and a few "*spots in the eyes*" with reference also to "*a few bouts of watery discharge heavier than normal too…*"
18. Despite evidence to the Tribunal that Ms Goff was using her cellphone, she did not immediately respond to the mother's text message.
19. The parties agreed that Ms Goff did not arrange to assess the mother for pre-eclampsia in response to the symptoms reported in the text message.
20. There were other communications between the parties during that day.
21. The mother arrived at the delivery suite at the hospital at approximately 11.00 pm on [ ]. The mother was then in established labour.
22. Although the mother continued to experience headaches and spots in her eyes, she was not asked about any symptoms of pre-eclampsia.
23. At 11.12 pm that day, [ ], a CTG was commenced for the mother and her blood pressure taken at 167/97 mmHg. Ms Goff told the mother that her blood pressure was high and advised her it was "*probably due to being in labour and tired*". Ms Goff did not ask the mother whether she had been experiencing any other symptoms of pre-eclampsia and did not carry out any further assessments in response to the mother's high blood pressure such as asking her to undergo blood testing or to provide a urine sample for testing.
24. Again, Ms Goff did not recommend to the mother or discuss with her at all that she undergo a consultation with a specialist in light of the high blood pressure. Ms Goff did not consult with obstetric services and did not re-check the mother's blood pressure for almost 2 hours.
25. The labour continued through the night and by 1.05 am on [ ] on Ms Goff's return to the delivery suite after admission onto the Computer System the

mother was found to be pale and reported feeling faint. Ms Goff instructed Ms Tanner to attach a blood pressure cuff on an automatic blood pressure machine whilst Ms Goff lowered the mother's bedhead and began to administer oxygen to her.

26. The mother's blood pressure was found to be 188/106 mmHg which Ms Tanner recognised as high. Ms Tanner went to get the manual blood pressure monitor and on return took a reading on the sphygmomanometer of 170/108 mmHg. Ms Goff had not checked the mother's blood pressure at all between 11.12 pm on [ ] when the admission blood pressure was 167/97 mmHg and 1.05 am on [ ] when it was 188/106 mmHg and 170/108 mmHg (depending on the reading method).

27. Ms Goff discussed with the mother about consulting with medical staff and then with Ms Tanner as to who should leave the delivery suite to seek the assistance of the on-call obstetrics registrar. It was decided that Ms Tanner would leave for that purpose although she was hesitant to do so because she had little experience in consulting with medical staff.

28. The Agreed Summary of Facts records that Ms Goff did not use the in-room emergency call bell or call the emergency 777 phone line which would have summoned immediate attention.

29. Eventually Ms Tanner located the obstetric registrar who went, accompanied by the senior house officer, immediately to assess the mother. The obstetric registrar was immediately very concerned about the mother who looked very unwell, appearing shaky and pale and reporting feeling faint and nauseous. The obstetric registrar further observed that the mother had marked hyperreflexia, clonus, and a sense of impending doom, all concerning features which indicated impending eclampsia (seizure). The senior house officer was also concerned with how unwell the mother appeared and noted that she was pale and jittery with brisk reflexes.

30. The obstetric registrar checked the mother's clinical records and assessed her and considered her condition to be an obstetric emergency. She, the obstetric registrar, summoned assistance via the emergency bell due to her concerns regarding foetal and maternal welfare. At 1.25 am with assistance from other core midwives, the anaesthetic registrar placed two IV lines, took relevant blood

samples and commenced continuous foetal monitoring via CTG. The mother was managed for severe pre-eclampsia.

31. Planned management for the mother's pre-eclampsia included administering magnesium sulphate for seizure prevention, for an artificial rupture of the membranes to be performed, for attachment of a foetal scalp electrode, and insertion of an indwelling urinary catheter.
32. For the remainder of the labour the mother's pre-eclampsia was closely monitored and throughout this time her blood pressure remained unstable and, despite the management plan, reached 233/144 mmHg at 2.53 am.
33. Labour progressed and the baby was born vaginally at 2.58 am with the assistance of an episiotomy. The baby was well with apgars of 9, 10 and 10.
34. There were further aspects to the attention that the mother received and her physical needs of which details were given to the Tribunal.

The Charge - the parties' position

35. The Director pressed for a finding of misconduct in respect of particulars 1, 3, 5 and 6 taken cumulatively. She argued that there was malpractice or negligence in respect of the allegations made, including in the particulars, and that this was conduct which brought, or was likely to bring, discredit to the midwifery profession. She urged that particulars 2 and 4 be considered separately from the others and from each other but both in the same category, they referring to a failure to recommend discussion or consultation with a specialist which it was argued was also misconduct as malpractice or negligence or conduct bringing, or likely to bring, discredit to the midwifery profession.
36. Reference was made to authorities. It was also submitted that the particulars of a charge when considered in that way warrants disciplinary sanction for the purpose of maintaining standards, protecting the public and punishing the practitioner as necessary. It was submitted that that threshold is not an unduly high one.
37. It was said for the Director that Ms Goff, when presented with clear symptoms of pre-eclampsia, failed to take any appropriate and necessary steps to address those symptoms, namely screening her patient for pre-eclampsia and recommending she have a consultation with a specialist. Emphasis was placed

on the fact that this failure had occurred three times over a 48-hour period and despite the mother's worsening symptoms.

38. It was argued that the failures on Ms Goff's part suggested that she recognised high blood pressure as a symptom of pre-eclampsia but disregarded it as warranting any further action.

39. Reliance was placed on the Midwives Handbook for Practice and, in respect of recommendations, the Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (the MOH Referral Guidelines) expressly referred to in the Charge (particulars 2 and 5).

40. Reliance was placed on the opinion of Ms Mary Wood, a registered midwife. Ms Wood did not give evidence as such but the Agreed Summary of Facts records the expert advice that she provided in the matter and it was acknowledged at the hearing that that advice was correct advice.

41. As to particular 3 the Director produced Ms Goff's cellphone use records which she argued indicated text message use between 9.41 am and 12.30 am on [ ], including text messages from the mother at various times. The Director argued that those records showed use by Ms Goff of her cellphone at those times and further that it was highly likely Ms Goff received text messages from the mother shortly after they had been sent. It was argued that Ms Goff failed to respond to clear and obvious signs which warranted screening for pre-eclampsia and that there were multiple opportunities to correct the initial error.

42. On each occasion, it was said, Ms Goff failed to respond in accordance with mandatory guidelines and that this was not a momentary lapse in judgment but a sustained failure to follow guidelines of midwifery practice.

43. Aggravating features were mentioned which are relevant to the question of any penalty and reference was made to other cases referred to below.

44. For her part, Ms Goff, who was not represented by counsel, accepted, as she had done in the Agreed Summary of Facts that the conduct on her part amounted to professional misconduct under section 100 of the HPCA Act. She did not argue to the contrary.

The Charge – discussion

45. The Tribunal has no hesitation in finding the Charge made out on the basis that is argued by the Director. Considering particulars 1, 3, 5 and 6 cumulatively as

has been requested, these are found (subject to the discussion concerning the individual sub-particulars below) to be malpractice and negligence on Ms Goff's part and conduct bringing discredit to the midwifery profession.

46. The facts that have been presented to the Tribunal and agreed to by Ms Goff which appear above partially in summary established to the Tribunal that there were clear signs from the high blood pressure readings, that there was a significant risk of pre-eclampsia for the mother.

47. Ms Wood in her advice said:

    47.1. That pre-eclampsia is a condition that complicates around 8% of pregnancies, can be subtle initially, but can worsen very quickly as occurred in this case.

    47.2. That pre-eclampsia is a potentially life threatening disorder that can have serious effects on both mother and child and is the reason that blood pressure and urine are checked at every antenatal check, especially after 20 weeks of pregnancy.

    47.3. That on [ ] when the mother's blood pressure was 140/100 mmHg urgent blood tests and urine PCR were indicated as well as consultation with the local obstetrics service.

    47.4. That a plan for follow-up specifically to recheck the blood pressure for the mother was also indicated.

    47.5. That not taking these steps was a "*moderate departure from accepted standards*".

    47.6. That whilst Ms Goff was aware of the possibility of pre-eclampsia and discussed this possibility with the mother, without any diagnostic tests such as bloods and PCR (urine testing), clinical judgment is very limited and any clinical decisions would be made "*without a full picture*".

    47.7. That, while oedema is a common feature of a normal pregnancy, rapid development of generalised oedema is a warning sign and should alert to screen for pre-eclampsia.

    47.8. Given the significant increase in blood pressure on [ ] the presence of the symptoms described in the 9.41 am text message on [ ] "*warranted an urgent assessment*".

47.9. That failure to respond to the text message with a phone call to arrange an urgent review of pre-eclampsia was a "*serious departure from expected standards of care*".

47.10. That urgent bloods should have been taken after the mother's admission blood pressure had been taken and obstetric services should have been consulted.

47.11. That whilst blood pressure can increase during labour, in light of the fact that the mother's blood pressure had been significantly raised the day before, at the very least the mother's blood pressure should have been rechecked within 15 - 30 minutes.

47.12. That in the circumstance where the admission blood pressure was 167/97 mmHg there should have been an assessment about the presence of other symptoms such as headaches, epigastric pain or visual disturbances but there was no record of this having occurred.

48. While those agreed aspects of advice from Ms Wood are helpful to the Tribunal, it would have been more help had there been a more comprehensive analysis of the situation by way of an expect report produced by consent discussing the 6 particulars of the Charge and the individual sub-particulars referred to in it. To an extent that has occurred and some aspects are canvassed by Ms Wood, but otherwise not.

49. What the Tribunal has had to do therefore is apply its own expertise in assessing the standards and the extent to which the facts as admitted indicate malpractice or negligence or conduct bringing discredit to the profession in the context of the specific particulars. It does so mindful that Ms Goff has accepted that these do constitute misconduct in this way.

50. The Tribunal does not wish to come to any express finding on any of the individual sub-particulars of the particulars of the Charge. It is satisfied that particulars 1, 3, 5 and 6 cumulatively amount to malpractice as stated above in the more generalised allegation of failure to take appropriate steps for pre-eclampsia despite the presence of symptoms of this.

51. Exactly what a midwife would do when confronted with symptoms of pre-eclampsia in the circumstances referred to in particulars 1, 3 5, and 6 is a matter of judgement and call at the time. The Tribunal is not prepared, particularly in the absence of express evidence, to make any express findings that there should

have been a re-check of blood pressure, arrangements for follow-up appointment, arrangements for blood tests, arrangements for urinalysis, assessment for re-check for pre-eclampsia, an assessment of the presence of other symptoms of pre-eclampsia, re-checking blood pressure within a specific period, arranging for blood tests or urine analysis at different times. These are matters which in general terms a midwife should consider, given symptoms of pre-eclampsia.

52. The Tribunal does not wish to make any finding that any individual separate allegation of proper response is made out as misconduct. It is sufficient for the present decision to take all allegations in those 4 particulars cumulatively and make the finding that there was misconduct.

53. Further, so far as particular 6 is concerned, the Tribunal does not need to make separate findings on what express steps Ms Goff should have taken when the blood pressure was recorded at 188/106 mmHg or 170/108 mmHg. The making of the 777 emergency page or the ringing of the emergency call bell in the birthing suite were certainly available options.

54. The course taken by Ms Goff did not achieve the objectives. She sent Ms Tanner, the trainee midwife, who was unfamiliar with dealing with specialists, in a situation which required an urgent response. That was not an appropriate way in which to deal with the matter. The emergency page or the emergency call bell were certainly better options as did indeed prove to be the case when used by the obstetric registrar.

55. There were many occasions on which Ms Goff could have helped the mother in the circumstances she was in better than what was in fact done; and Ms Goff's failure to address and confront the conditions she found the mother in cumulatively amount to malpractice and negligence and conduct bringing discredit.

56. Symptoms of possible pre-eclampsia call for prompt and urgent action. As Ms Wood said, pre-eclampsia is a disorder that can worsen very quickly and is a potentially life threatening disorder that can have serious effects on both mother and child. The risk of pre-eclampsia is, Ms Wood said, the reason high blood pressure and urine are checked at every antenatal check especially after 20 weeks of pregnancy.

57. Those warning signs were present on [ ] for this mother; they were repeated in the text message sent on [ ]; blood pressure was increasing by [ ] at 11.12 pm; and the blood pressure had further increased and there were other signs of pre-eclampsia in the early morning of [ ].
58. The Tribunal accepts the Director's submission that it was particularly concerning that failure by Ms Goff to respond occurred three times over a 48-hour period and despite the mother's worsening symptoms.
59. Ms Goff should have done better than she did and it was misconduct for her not to do so.
60. As to the individual sub-particulars of these respective particulars of the Charge, the Tribunal does not make any finding of misconduct in respect of them each separately or cumulatively but rather finds that they exemplified what could have been considered and done by Ms Goff.
61. Accordingly, the Tribunal amends the Charge by:
    61.1. Deleting from particulars 1 and 6 the word "*including*" in each case and replacing with the words "*for example*".
    61.2. Adding to particular 5 after the word "*including*" the expression "*(but not exclusively)*".

Particulars 2 and 4

62. These individual particulars refer specifically to the MOH Referral Guidelines. The Charge in respect of each is that, when the high blood pressure readings were taken (140/100 mmHg on [ ] and 167/97 mmHg at 11.12 pm on [ ]) Ms Goff had failed to discuss with the mother or recommend to her that she have a consultation with a specialist.
63. The Purpose section of the MOH Referral Guidelines is expressed to include the promotion and support of co-ordination of care across providers. The Guiding Principles include that the transfer of clinical responsibility is a negotiated three-way process involving the woman, her Lead Maternity Carer and the practitioner to whom clinical responsibility is to be transferred. There are four categories of referral, namely primary, consultation, transfer and emergency. The tables in the Conditions and Referral Categories chapter include that the condition of gestational hypertension, described as "*new hypertension presenting after 20 weeks with no significant proteinuria*" is in the consultation

referral category. That consultation referral category requires as consequent action that the Lead Maternity Carer "*must recommend*" to the woman "*that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition*".

64. Standard Six of the Midwives Handbook for Practice (2008 version) requires that midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk; with the criteria including that the midwife identify deviations from the normal and, after discussion with the woman, consult and refer as appropriate.
65. The Tribunal accepts the Director's submission that in her actions or lack thereof on [ ], Ms Goff breached the obligations referred to in those authorities and that such breach in each case amounted to malpractice and negligence and conduct bringing discredit to her profession.
66. The high blood pressure on [ ] called for this; and by 12.00 pm on [ ], especially after there had been the earlier text message and with worsening blood pressure, there was certainly the call for recommendation for consultation with the specialist.
67. The Tribunal finds each and both of these particulars established as misconduct both separately and cumulatively and warrant disciplinary sanction.

Disciplinary sanction

68. In any charge of misconduct the Tribunal is required to decide whether, even if the facts indicate misconduct, it is of sufficient severity to warrant disciplinary sanction to maintain standards in the profession, protect the public, or, to the extent necessary, punish the practitioner.
69. The Tribunal does find that this Charge crosses that threshold. It accepts the Director's submission:
    69.1. That there were multiple opportunities for Ms Goff to correct the initial error of not inappropriately screening or recommending a consultation with a specialist.
    69.2. That this was not a momentary lapse in judgment but a sustained failure to follow core guidelines.
    69.3. That there were the aggravating features for the conduct all calling for disciplinary sanctions.

70. The Director referred to other cases which were, it was said, relevant to the question and submitted that the test is an objective one with subjective factors not relevant to the decision on disciplinary threshold.
71. Those submissions are accepted by the Tribunal and Ms Goff, to her credit, did not argue otherwise.
72. Accordingly, the Tribunal finds the Charge in respect of particulars 1, 3, 5 and 6 cumulatively and 2 and 4 separately and cumulatively to amount to misconduct.

Penalty

73. The hearing then proceeded to consider penalty questions. The Director's submissions drew attention to that fact that after the events to which this Charge refers the mother had complained to the Health and Disability Commissioner which resulted in the Midwifery Council requiring that Ms Goff undergo a Competency Review. That took place on 20 April 2015 and concluded that Ms Goff:
    73.1. Had not been practising midwifery to the standard of competency reasonably to be expected of a midwife.
    73.2. Is a serious risk to the public, and
    73.3. Appears to have no understanding of pre-eclampsia.
74. On 14 May 2015, the Midwifery Council ordered that Ms Goff be suspended from practice pending successful completion of:
    74.1. A "full formal assessment against the Competencies for Entry to the Register of Midwives".
    74.2. A "suitable remedial programme of education".
75. In light of those restrictions on Ms Goff's practice in place, the Director sought orders for censure and conditions on Ms Goff's practice namely:
    75.1. That she comply with all conditions imposed by the Midwifery Council should she succeed in having the suspension lifted.
    75.2. That she be subject to supervision for 18 months.
76. Emphasis was placed by the Director on the aggravating features and in mitigation that Ms Goff had acknowledged her failure to provide an acceptable standard of care and had agreed that this amounted to professional misconduct and that Ms Goff had been co-operative and helpful to the Director.

77. The Director's submissions referred to certain cases and the relevance of rehabilitation in any order made. While criteria concerning an order for fine were mentioned by the Director, this was not pressed as a penalty that should be ordered.

78. In her submissions, Ms Goff expressed her regret that the events had occurred as outlined in this Charge and the facts. She acknowledged that she did not have adequate understanding of pre-eclampsia or of gestational diabetes and that she needed training and education in these areas. She expressed her relief that the outcome for the mother and baby was positive, but also expressed her remorse that it could have been otherwise.

79. Ms Goff referred to her personal family situation and her finances. She referred to an earlier employment situation where there had been, she said, a conflict between her and other midwives concerning vitamin K administration. That led to a Competence Review and there had been a further Competence Review following the complaint by the mother in this case.

80. Ms Goff spoke of her aspirations to be a midwife and referred to the training courses that she needed to complete under the current regime.

Penalty -Discussion

81. The available penalties for the Tribunal are:[1]

    81.1. That registration be cancelled.

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

    81.3. 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.

    81.4. Censure.

    81.5. 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).

    81.6. Costs.

[1] Section 101 of the HPCA Act

82. The eight factors normally taken into account on the basis of authorities[2] are:

82.1. What penalty most appropriately protects the public

82.2. The important role of setting professional standards.

82.3. A punitive function.

82.4. Rehabilitation of the health professional.

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

82.6. 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.

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

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

83. While each case must be considered on its own merits, there should also be consistency in the Tribunal's decisions and the Tribunal has taken into account the other cases referred to by counsel for the Director. Those cases include:

Director of Proceedings v Robertson,[3] a case concerning failure by a midwife to respond appropriately by ensuring a CTG was undertaken and interpreted by a registered midwife. The Tribunal considered in that case that in the circumstances a CTG was required to assess adequately foetal wellbeing, especially given the mother's obstetric history and other concerns regarding reduced foetal movements. While the events were considered by the Tribunal to be apparently isolated there was need for conditions for supervision for a term of two years, for undertaking no more than four midwifery cases per month for a period of 12 months and for undertaking a New Zealand College of Midwives Midwifery Standards Review. The midwife was censured and fined $2,080.00.

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2 *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])

3 130/Mid07/63D

Director of Proceedings v Naidu,[4] a case concerning failure to record blood pressure and assessment of pulse and pain. This was provision of suboptimal care which compromised patient and public safety and conditions were ordered by the Tribunal for undergoing training and limiting of caseload; and she was censured and fined $5,000.00.

Director of Proceedings v Dale,[5] a case involving a nurse found to have failed adequately to assess and respond to changing blood glucose levels. It was incumbent on the nurse to discuss with caregivers an appropriate course of action and a fundamental step would have been to test the urine. Although the Director in that case sought cancellation of registration or alternatively suspension, the Tribunal ordered conditions for supervision for three years.

84. This is not a case which calls for an order cancelling Ms Goff's registration as a midwife. Such an order should be avoided if there are other ways in which the matter can be effectively dealt with while maintaining standards in the profession, protecting the public, and giving the practitioner the opportunity for adequate rehabilitation.

85. This may have been a case calling for suspension had there not already been in place the outcome of the Competence Review conducted by the Midwifery Council. This had resulted, as noted above, in suspension of Ms Goff until successful completion of a full formal assessment against the Competencies for Entry to the Register of Midwives and a suitable remedial programme of education.

86. The outcome of that process remains in place. It occurred as the consequence of the events to which this Charge refers. What is sought of the Tribunal is therefore what is additionally required.

87. The Tribunal accepts the Director's submission that censure and conditions are also required and these are ordered below.

88. The background to the conditions are:

    88.1. That Ms Goff will need to complete the formal assessment and suitable remedial programme of education before her suspension by the Midwifery Council is lifted.

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4 165/Mid08/82D
5 20/Nur05/09D

88.2. At that time, the Midwifery Council may impose any further appropriate conditions on Ms Goff's practice and the Tribunal is satisfied that compliance with these should be ordered.

88.3. That there is a need for supervision after Ms Goff recommences practice as a midwife. The Director had sought that this be for 18 months, at Ms Goff's cost and by a supervisor approved by the Midwifery Council. The Tribunal is of the view that a longer period should be fixed with the discretion on the Midwifery Council to reduce this to not less than 18 months should circumstances warrant that. The supervisor should report to the Midwifery Council on the outcome of supervision. As to the intervals at which Ms Goff should meet with her supervisor and the supervisor report to the Midwifery Council, this should be as fixed by the Midwifery Council after consultation with the supervisor.

88.4. The Tribunal is further of the view that for the period of three years after return to practice as a midwife, Ms Goff work only in an employment position or, if she does work in sole practice, that she limit her case load to the number fixed by the Midwifery Council in consultation with her supervisor. During the period between when supervision concludes and the condition ends, that number is to be fixed by the Midwifery Council on its own.

89. This is a case calling for an order for censure of Ms Goff. This is not a formality but expresses the Tribunal's significant disquiet at the events which have led to the Charge being laid and how these reflect on Ms Goff's practice and fitness to practise as a midwife.

90. In the circumstances of the information given by Ms Goff as to her means and taking into account the financial implications that the orders and conditions of the Tribunal will impose on Ms Goff, the Tribunal is of the view that in this case no order for fine is required.

91. The Tribunal is of the view that Ms Goff would benefit from having formal counselling and, while this is not ordered, the Tribunal recommends that she do so and take the advantage of any advice and assistance that may be given to her.

Costs

92. The Director sought an order for costs referring to relevant cases and principles. It was said that costs for the Director were estimated to be $10,845.00. Costs for the Tribunal were estimated at $19,401.00. This gives a total in excess of $30,000.00. The Director sought an order for contribution from Ms Goff of 30%.

93. The normal starting position in respect of an order for costs is 50% of the costs reasonably incurred by the prosecutor and by the Tribunal. There can be adjustment upwards or downwards depending on particular factors. These include:

    93.1. The means of the practitioner. In that regard, accurate information (preferably supported by a statutory declaration and other relevant material) about those means is helpful to the Tribunal. Without that information, the Tribunal cannot speculate on whether or not the practitioner is able to comply with any order.

    93.2. The extent to which costs have been added to or reduced by steps taken or not taken by the practitioner. A co-operative and constructive contribution to the disposal of a charge by the Tribunal certainly helps to keep costs down. Although in turn that means that costs are in any event likely to be lower, allowance can be made to a practitioner for any such co-operation. Conversely, if a hearing is protracted by a practitioner's conduct in relation to a charge, the effect of this may justify a greater contribution to costs. Again, account must be taken that that extra time is likely to be reflected in the monetary amounts involved. This is not to say that a practitioner is in any way to be discouraged from defending a charge brought against him or her as is that practitioner's right.

    93.3. To the extent that the practitioner is not ordered to contribute to costs, these must be met by professional colleagues.

94. Having regard to the financial information given and those principles in the cases, the Tribunal is of the view that a contribution of $9,000.00 (which is approximately 30%) should be ordered to be divided between the Director and the Tribunal in the same proportions as the costs amounts.

Non-publication of name and details

95. A permanent order for suppression of the name and identifying details of the mother had already been made.

96. Ms Goff sought to have an order for permanent name suppression and this was resisted by the Director.

97. Section 95 of the HPCA Act includes:

> "***95 Hearings to be public unless Tribunal otherwise orders***
>
> *(1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.*
>
> *(2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:*
>
> *...*
>
> *(d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person*."

98. The presumption in section 95(1) of the Act that the Tribunal's hearings shall be in public are the primary principle and endorse the principle of open justice; but section 95(2) does give the Tribunal discretion to make the orders mentioned.

99. The test is whether it is "*desirable*" to prohibit the publication of the name or any particulars of the affairs of the person in question and the Tribunal must consider both:

    99.1.1. The interest of any person and

    99.1.2. The public interest.

100. Public interest factors include:

    100.1. Openness and transparency of disciplinary proceedings.

    100.2. Accountability of the disciplinary process.

    100.3. Public interest in knowing the identity of a health practitioner charged with a disciplinary offence.

    100.4. Unfairly impugning other practitioners.

101. In support of her application, Ms Goff referred to her family position and particularly concerning individuals. She emphasised the stress that they have all been under as a consequence of the events surrounding this Charge and enquiries into it, including by the Health and Disability Commissioner. She

spoke of her earnest desire to protect them by there being no further publicity. She did not advance any medical reasons or supporting material.

102. The Director resisted any order for non-publication of Ms Goff's name. She said that information of that kind has been held not to be sufficient to justify an order.

103. The Tribunal upholds that submission. For there to be taken into account factors relating to the private interests of the practitioner or others related to, or known to, her, there needs to be more objective information provided to the Tribunal. Publicity concerning charges heard by the Tribunal and the individuals involved are common to all charges brought.

104. The Tribunal finds that the private interests advanced by Ms Goff in support of her application are outweighed by the other public interest factors identified above. The application is declined.

Result and outcome

105. The Charge as amended and its individual particulars are found to be made out as misconduct under section 100(1)(a) and (b) of the HPCA Act. Particulars 1, 3, 5 and 6 are so found cumulatively but without individual findings on the sub-particulars alleged in the Charge. These are treated as examples of steps that might have been taken by Ms Goff in relation to the matters referred to (and the Charge was amended accordingly as noted above). Particulars 2 and 4 are separately and cumulatively found as misconduct. All are found to warrant disciplinary sanction.

106. Ms Goff is censured.

107. After commencing practice for a period of 3 years, Ms Goff is to practise her profession as midwife only in accordance with the following conditions:

    107.1. That at her own cost, Ms Goff is to comply with any and all conditions imposed by the Midwifery Council on her practice should she succeed in having her suspension lifted.

    107.2. That at her own cost, Ms Goff has supervision in her practice as a midwife for a period of 24 months after resumption of practice (or such lesser period but no less than 18 months as is fixed by the Midwifery Council) by a supervisor approved, and at intervals fixed, by the Midwifery Council after consultation with the supervisor; with the

supervisor reporting to the Midwifery Council on the supervision at such times as is fixed by that Council.

107.3. That for a period of 36 months after resumption of practice, Ms Goff work in an employment position or, if she works in sole practice, she limit her caseload to the number of mothers fixed by the Midwifery Council (after consultation, if appropriate and applicable, with the person giving her supervision).

108. The Tribunal recommends that Ms Goff have at her cost formal counselling and take the advantage of any advice and assistance that may be given to her.

109. Ms Goff is ordered to pay the sum of $9,000.00 towards the cost of the Director and the Tribunal to be divided between them as to $3,227.00 to the Director and $5,773.00 to the Tribunal.

110. The application for non-publication of the name or identifying details of the practitioner, Ms Goff, is declined.

111. The Tribunal directs the Executive Officer:

111.1. To publish this decision, and a summary, on the Tribunal's website;

111.2. To request the Midwifery Council to publish either a summary of, or a reference to, the Tribunal's decision on its website and in its next available publication to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Auckland this 30th day of May 2017

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David M Carden
Chairperson
Health Practitioners Disciplinary Tribunal