IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2012-404-003916
[2012] NZHC 3354

UNDER	the Health Practitioners Competence Assurance Act 2003
IN THE MATTER OF	an appeal pursuant to s 106(2)(a) and (b) against orders of the New Zealand Health Practitioners Disciplinary Tribunal
BETWEEN	MICHAEL ROBERTS Appellant
AND	A PROFESSIONAL CONDUCT COMMITTEE OF THE NURSING COUNCIL OF NEW ZEALAND Respondent

Hearing: 26 November 2012

Counsel: A H Waalkens QC and K Rose for Appellant
M F McClelland and H de Montalk for Respondent

Judgment: 12 December 2012

In accordance with r 11.5 I direct the Registrar to endorse this judgment with the delivery time of 1.00pm on the 12th day of December 2012.

RESERVED JUDGMENT OF COLLINS J

Introduction

[1] On 15 May 2012 the New Zealand Health Practitioners Disciplinary Tribunal (the Tribunal) suspended Mr Roberts' registration as a nurse. The Tribunal suspended Mr Roberts' registration for three years, the maximum period prescribed by s 101(1)(b) of the Health Practitioners Competence Assurance Act 2003 (the Act). Mr Roberts has appealed the penalty imposed by the Tribunal. His counsel, Mr Waalkens QC submits a three year suspension in the circumstances of this case is excessive and unreasonable. Conversely, the Professional Conduct Committee (the PCC) cross-appeals the order suspending Mr Roberts. Mr McClelland, counsel for the PCC says the Tribunal should have cancelled Mr Roberts' registration as a nurse.

[2] There are two issues which I must address before determining the merits of this appeal and cross-appeal. Those issues are:

(1) Am I required to assess the material considered by the Tribunal and reach my own view on what penalty should be imposed upon Mr Roberts?[1] Or, should I only allow the appeal or cross-appeal if I am satisfied that the Tribunal made an error of principle, considered irrelevant matters, failed to consider relevant matters or was plainly wrong?[2] I will refer to this issue as the "appeal test" question.

(2) The charge was brought after it was discovered that Mr Roberts had engaged in a long-term sexual relationship with a woman (N) whom he met when she was a patient in a ward on which Mr Roberts worked. In these circumstances what factors should be considered

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1 *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141.
2 *May v May* (1982) 1 NZFLR 165 (CA).

when determining what penalty should be imposed? I will refer to this issue as the "penalty factors" question.

Before considering these issues and the merits of the appeal and cross-appeal I will briefly explain the accepted facts and summarise the Tribunal's decisions.

Facts

[3] Ms N was admitted as a patient into Ward 5B of Dunedin Hospital on 22 November 2007. She had been diagnosed with a condition called myasthenia gravis; a neurological condition affecting her muscles. Her symptoms included double vision, droopy eyes, facial paralysis, slurred speech, swallowing difficulties and an inability to hold her head and arms up properly. Ms N was admitted to see if intravenous immunoglobulin would alleviate some of her symptoms.

[4] Ms N was re-admitted into Dunedin Hospital on 4 December 2007 because of rapid progression of her myasthenia gravis.

[5] At the time of her December 2007 re-admission Ms N had been separated from her husband for approximately one year. She was 32 years old and had lost a considerable amount of weight; she weighed only 46 kilograms. She thought she looked horrendous and that no one would ever want to be in a relationship with someone who looked so sick. Ms N described herself as "being extremely vulnerable at that time".

[6] Mr Roberts had been working as a registered nurse on Ward 5B for approximately four months by the time Ms N was re-admitted into the ward on 5 December 2007. When she was re-admitted Mr Roberts completed Ms N's daily care plan, admission assessment and risks screen, fall risk assessment and pressure care risk assessment, all of which are routine assessments completed by nursing staff when a patient is admitted into a ward. Mr Roberts made entries in Ms N's nursing notes on 5 December 2007 and completed two other forms on Ms N's medical file on 5 December 2007.

[7] Ms N remained in Ward 5B until she was discharged on 24 December 2007.

[8] On one occasion during Ms N's December 2007 re-admission Mr Roberts handed her a piece of paper with his first name and cellphone number written on it. When he gave her this note Mr Roberts said to Ms N "this is highly unprofessional".

[9] Later Ms N sent Mr Roberts a text message. They then began exchanging text messages while Ms N was still in hospital.

[10] Ms N enjoyed Mr Roberts' company during her December 2007 re-admission. Mr Roberts would often spend time speaking to Ms N when he was on duty. Ms N was conscious of the fact that she had been diagnosed with an extremely debilitating disease and did not think anyone would be attracted to her. The agreed summary of facts states:

> ... but then along came a nurse who showed an interest in her and did not seem to worry about the "horrible shunt" in her arm. She was not aware that there was anything wrong with a nurse being in a relationship with a patient that they had looked after.

[11] Two days after Ms N was discharged from hospital Mr Roberts visited Ms N at her home. Sexual intercourse took place. The relationship between Ms N and Mr Roberts continued until November 2010. During the last 12 months of this period Mr Roberts and Ms N lived together.

[12] Ms N was admitted into Dunedin Hospital again on 8 September 2008. Mr Roberts again completed the routine admission assessments. Mr Roberts also made one entry in Ms N's progress notes on 9 September 2008.

[13] Ms N was again admitted into Dunedin Hospital on 30 August 2010. Mr Roberts was listed on Ms N's admission forms as an alternative contact person. His address was noted as being the same as Ms N's. Mr Roberts did not nurse Ms N during this particular admission.

[14] The relationship between Mr Roberts and Ms N came to an end on 10 November 2010. On that day Mr Roberts unexpectedly left. Issues arose over

money and items which Mr Roberts had taken from Ms N. Mr Roberts was charged with theft. He was granted a discharge without conviction on 15 November 2010 and returned to the United Kingdom soon thereafter.

[15] Towards the end of November 2010, and by chance, Ms N met the charge nurse manager of Ward 5B. During that meeting Ms N explained to the charge nurse manager the nature of her relationship with Mr Roberts. Shortly thereafter Ms N was encouraged to write a letter of complaint to the Nursing Council of New Zealand. Ms N wrote her letter of complaint on 10 February 2011.

[16] Mr Roberts was charged with professional misconduct. The charge specified that the following matters were either separately or cumulatively acts of professional misconduct:

(1) the "inappropriate and/or sexual relationship" between Mr Roberts and Ms N;

(2) Mr Roberts' misappropriation of money belonging to Ms N when he left her; and

(3) Mr Roberts' misappropriation of items belonging to Ms N at the time he left her.

[17] Mr Roberts, who by the time of the Tribunal hearing was working as a registered nurse in England, returned to New Zealand to appear before the Tribunal. He admitted that his relationship with Ms N constituted professional misconduct but contended that the issues of misappropriation of money and items belonging to Ms N were domestic rather than professional issues. Mr Roberts gave evidence before the Tribunal during which he appears to have accepted that he gave misleading information to the Nursing and Midwifery Council of the United Kingdom and his employer in England about the nature of the complaint against him.

The Tribunal's decisions

[18] On 15 May 2012, the day the hearing concluded, the Tribunal gave an oral decision in which it explained the penalties it imposed on Mr Roberts. On 12 June 2012 the Tribunal gave a written decision in relation to its findings on both liability and penalties.

[19] In its oral decision the Tribunal:

(1) recorded that it found Mr Roberts guilty of professional misconduct in relation to the charge concerning his relationship with Ms N, but not in relation to the allegations concerning the misappropriation of money and items belonging to Ms N;

(2) said it would not cancel Mr Roberts' registration as a nurse because of the need to rehabilitate Mr Roberts. Instead, the Tribunal ordered that Mr Roberts' registration as a nurse be suspended for three years;

(3) said "pursuant to s 101(1)(c) [of the Act] Mr Roberts undertake an appropriate course to be approved by the Nursing Council of New Zealand in professional ethics and boundaries";

(4) directed that a copy of the Tribunal's decision be sent to the Nursing and Midwifery Council of the United Kingdom;

(5) ordered that Mr Roberts be censured;

(6) ordered that Mr Roberts pay $10,000 as a contribution towards the costs of the PCC and the Tribunal; and

(7) ordered that Mr Roberts' name be published on the Tribunal's website and such other publications that the Tribunal would identify in its written decision.

[20] In its written decision the Tribunal:

(1) recorded that by the time of the hearing Mr Roberts had accepted that his relationship with Ms N involved a breach of professional boundaries;

(2) noted that Mr Roberts had sought and obtained some assistance from the Clinic for Boundaries Studies in London and had been recommended for acceptance into their three day programme;

(3) mentioned that Mr Roberts had told the Nursing and Midwifery Council of the United Kingdom that he was the subject of a complaint in New Zealand and that:

(a) Ms N had never been a patient of his; and

(b) their relationship started when they met in a café.

The Tribunal noted that these statements were not accurate.

(4) mentioned that Mr Roberts had also not been entirely accurate when he had at one point said he had told his current employer about Ms N's complaint before he was employed. It transpires he told them of this matter after he was employed;

(5) restated its earlier conclusion that Mr Roberts' relationship with Ms N constituted professional misconduct on his part;

(6) stated that:

> forming a sexual relationship with a patient is recognised as being an abuse of power by the nurse against a patient who relies upon their care. As a patient, Ms N was vulnerable. She was very unwell and met and came to know Mr Roberts when he cared for her in hospital.

The Tribunal said Mr Roberts' conduct in this regard "clearly amounts to professional misconduct".[3]

(7) reaffirmed its earlier finding that the misappropriation of money and items by Mr Roberts did not amount to professional misconduct;

(8) confirmed the principles of "sentencing" in a professional disciplinary context required the Tribunal to:

(a) protect the public;

(b) maintain professional standards;

(c) punish the practitioner;

(d) where appropriate, consider rehabilitation of the practitioner.

(9) in deciding to impose the maximum period of suspension the Tribunal said Mr Roberts:

> (a) failed to recognise that he was in breach of professional boundaries right up until his guilty plea.[4]
>
> (b) had come back to New Zealand to answer the charges and had taken significant steps to evaluate for himself, why he had fallen into the error that he did.[5]
>
> (c) needed to receive "the least punitive penalty which also maintains standards and protects the public".[6]
>
> (d) had not been truthful in his communications with the Nursing and Midwifery Council of the United Kingdom, or in the evidence he had given to the Tribunal. The Tribunal said this "... illustrated how far he has to go in recognition of the impact of the relationship on Ms N and his responsibility for this."[7]

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3 *Professional Conduct Committee v Roberts* HPDT 459/Nur12/202P, 12 June 2012 at [24].
4 At [32].
5 At [33].
6 At [34].
7 At [35].

(10) reiterated the penalties that it had ordered in its oral decision except for the requirement that the Tribunal said had been made under s 101(1)(c) of the Act, namely that Mr Roberts undertake an appropriate course to be approved by the Nursing Council on professional ethics and boundaries.

[21] The Tribunal's decision was forwarded to the Nursing and Midwifery Council of the United Kingdom. As a consequence Mr Roberts has been suspended as a nurse in the United Kingdom since July 2012.

Appeal test

[22] Both Mr Waalkens and Mr McClelland respectfully expressed a level of frustration that conflicting decisions of the High Court have created uncertainty over what test is to be applied by the High Court when considering appeals from penalty decisions of the Tribunal.

[23] The conflict in approach in the judgments of the High Court arises in the following way:

(1) There are High Court judgments which apply the test articulated by the Supreme Court in *Austin, Nichols & Co Inc v Stichting Lodestar* when considering appeals from penalty decisions of the Tribunal. That case involving an appeal to the High Court by way of rehearing from a decision of the Trade Marks Commissioner. The Supreme Court said:[8]

> Those exercising general rights of appeal are entitled to judgment in accordance with the opinion of the appellate court, even where that opinion is an assessment of fact and degree and entails a value judgment. If the appellate court's opinion is different from the conclusion of the tribunal appealed from, then the decision under appeal is wrong in the only sense that matters, even if it was a conclusion on which minds might reasonably differ. In such circumstances it is an error for the High Court to defer to the lower Court's

[8] *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141 at [16].

> assessment of the acceptability and weight to be accorded to the evidence, rather than forming its own opinion.

This is referred to as the *Austin, Nichols* approach.

(2) There are conflicting High Court authorities which hold that a penalty decision of the Tribunal should not be overturned on appeal unless it can be demonstrated that the Tribunal made an error of principle, considered irrelevant matters, failed to consider relevant matters or was plainly wrong. This approach is based on the reasoning that a penalty decision of the Tribunal involves the Tribunal making a judgement that involves the exercise of discretion. In *May v May*[9] the Court of Appeal held that decisions of lower courts that involve the exercise of discretion should not be overturned unless the criteria referred to earlier in this subparagraph are satisfied. This threshold is usually referred to as the *May v May* test.

The conflicting High Court judgments

The Austin, Nichols approach

[24] In *A v Professional Conduct Committee*,[10] Keane J applied *Austin, Nichols* in the context of a medical practitioner's appeal against a penalty imposed by the Tribunal. In referring to *Austin, Nichols* Keane J said:[11]

> An appellant still must show, the Supreme Court said, why the court appealed to should differ from the tribunal whose decision is under appeal. Unless the appellant can show that the tribunal appealed from was wrong, the court on appeal is not entitled to interfere ... The court on appeal will still recognise any advantage that the tribunal appealed from enjoys, like expertise or the ability to assess witnesses first hand, where these are important ... But otherwise no deference is called for ...

[25] The *Austin, Nichols* approach was considered to be the appropriate test by Woodhouse J in *L v Director of Proceedings*.[12] That case concerned an appeal by a

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9 *May v May* (1982) 1 NZFLR 165 (CA).
10 *A v Professional Conduct Committee* HC Auckland CIV-2008-404-2927, 5 September 2008.
11 At [65].
12 *L v Director of Proceedings* HC Auckland CIV-2008-404-2268, 25 March 2009.

nurse from a decision of the Tribunal in which the Tribunal found the nurse had formed an inappropriate relationship with a patient. The Tribunal cancelled the nurse's registration and imposed conditions which the nurse needed to comply with before she applied for re-registration. In commenting on the test that applied when considering an appeal from a penalty decision of the Tribunal, Woodhouse J thought the law was clear. He said, citing *Austin, Nichols*, that he "had to make [his] own assessment".

[26] The approach taken by Keane and Woodhouse JJ was also taken by Allan J in *O v Professional Conduct Committee*.[13] That case concerned an appeal from a decision in which the Tribunal suspended the registration of a nurse for six months for having a sexual relationship with the spouse of a patient. Nurse O appealed against the finding that she was guilty of professional misconduct and the penalty that was imposed. When considering the test he needed to apply when considering an appeal from the penalty decision of the Tribunal, Allan J cited *Austin, Nichols* and concluded that he must review the evidence and come to his own view.[14]

[27] More recently, in *Vohora v Professional Conduct Committee*,[15] Whata J determined an appeal from the Tribunal, in which the Tribunal had found a pharmacist guilty of professional misconduct because he had:

(1) allowed an unqualified person to dispense prescription medicines; and

(2) failed to document standard operating procedures, including maintaining a controlled drugs register.

The Tribunal cancelled Mr Vohora's registration as a pharmacist and imposed conditions that Mr Vohora would need to satisfy before applying for re-registration.

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13 *O v Professional Conduct Committee* [2011] NZAR 565 (HC).
14 At [7].
15 *Vohora v Professional Conduct Committee* [2012] NZHC 507, [2012] 2 NZLR 668.

[28] The appeal which Whata J determined involved an appeal against the Tribunal's finding that Mr Vohora was guilty of professional misconduct, and the penalty which the Tribunal imposed.

[29] Whata J recognised that there were divergent High Court approaches as to whether the requirements of *Austin, Nichols* applied to appeals against penalties imposed by the Tribunal. His Honour concluded the correct course was to follow the *Austin, Nichols* approach because:

(1) there was nothing in the relevant provisions of the Act that distinguished between appeals against penalty and appeals against findings of liability;

(2) the penalty decision imposed by the Tribunal was more akin to the issues in *Blackstone v Blackstone*,[16] which involved an appeal against a parenting order, and not an appeal against the exercise of discretion;

(3) *May v May* involved a very different type of decision from the Tribunal's decisions which were the subject of appeal.

[30] There are other cases in which High Court Judges have applied *Austin, Nichols* when considering appeals against penalty imposed by the Tribunal. *MacDonald v Professional Conduct Committee*[17] and *N v Professional Conduct Committee*[18] are examples. However, in both those cases it appears to have been assumed that the *Austin, Nichols* test applied. There is no record of the Court in those cases having been asked to decide between *Austin, Nichols* and *May v May*.

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16 *Blackstone v Blackstone* (2008) 19 PRNZ 40 (CA).

17 *MacDonald v Professional Conduct Committee* HC Auckland CIV-2009-404-1516, 10 July 2009.

18 *N v Professional Conduct Committee* HC Wellington CIV-2009-485-2342, 19 March 2010.

The May v May approach

[31] The approach taken by Keane, Allan, Woodhouse and Whata JJ can be contrasted with other High Court authorities where the *May v May* approach has been followed when considering penalty decisions of the Tribunal.

[32] In *L v Professional Conduct Committee of the New Zealand Psychologists Board*[19] Andrews J, when considering an appeal against a penalty imposed upon a psychologist, concluded that *Austin, Nichols* did not apply to appeals from penalty decisions of the Tribunal. Her Honour concluded that an appeal from the Tribunal's decision on penalty was governed by the principles in *May v May* because it involved an appeal from the Tribunal's exercise of its discretion.

[33] The approach taken by Andrews J was taken by Venning J in *GS v A Professional Conduct Committee*.[20] That case concerned an appeal against part of the penalty imposed by the Tribunal upon a psychologist for practising without a current practising certificate. Venning J considered whether he should follow the *Austin, Nichols* or the *May v May* approach and concluded:[21]

> ... an appeal under s 106 of the Act as to the penalty imposed by the Tribunal is an appeal against a discretion. The principles in *May v May* apply. It is for the appellant to show that the Tribunal made an error of principle, considered irrelevant matters, failed to consider relevant matters or was plainly wrong.

[34] The issue was considered in the context of appeals from the New Zealand Lawyers and Conveyancers Disciplinary Tribunal by Wylie J in *Auckland Standards Committee 1 v Fendall*.[22] In that case a lawyer appealed a penalty decision of the New Zealand Lawyers and Conveyancers Disciplinary Tribunal. Wylie J reviewed the recent cases, including *Vohora v Professional Conduct Committee* and *O v Professional Conduct Committee* and concluded that the preferred approach was that taken in *Bhanabhai v Auckland District Law Society*[23] where it was held that where

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19 *L v Professional Conduct Committee of the New Zealand Psychologists Board* (2009) 20 PRNZ 92 (HC).
20 *GS v A Professional Conduct Committee* [2010] NZAR 417 (HC).
21 At [14].
22 *Auckland Standards Committee 1 v Fendall* [2012] NZHC 1825.
23 *Bhanabhai v Auckland District Law Society* [2009] NZAR 282 (HC).

an appeal relates to a penalty decision imposed by a disciplinary tribunal, the decision in question is a discretionary decision and that in these circumstances the more limited approach to appeals set out in *May v May* is to be preferred.

[35] Thus, as my brief summary of New Zealand High Court decisions demonstrates, there are two opposing approaches as to what test governs my consideration of both the appeal and cross-appeal in this case from the penalty imposed by the Tribunal.

Which approach should I follow?

[36] I start with the Act and in doing so note:

(1) The decision of the Tribunal involved the imposition of a penalty and was made pursuant to s 101(1)(b) of the Act.

(2) Section 106(2)(b) confers on Mr Roberts a right of appeal to the High Court against the whole or any part of the Tribunal's penalty order made under s 101 of the Act.

(3) Section 106(3) confers on the PCC a right of appeal to the High Court against "a finding or decision or order of the Tribunal" that relates to the charge laid by the PCC against Mr Roberts.

(4) Section 109(2) and (3) of the Act specifies that an appeal to the High Court is conducted "by way of rehearing". On appeal the Court:

(a) may confirm, review, or modify the decision or order appealed against; and

(b) make any other decision or order that the person or body that made the decision or order appealed against could have made.

[37] Thus, the statutory framework which regulates appeals from the Tribunal provides that all appeals, whether they be from findings that a practitioner is guilty

of a disciplinary offence and/or a penalty decision are to be conducted by way of rehearing. The legislature has not distinguished between findings of liability and penalty decisions.

[38] However, the issue becomes more complicated when I have regard to authorities that bind me.

[39] In *Austin, Nichols* the Supreme Court noted that where an appeal is conducted by way of rehearing, the appeal must be dismissed if the appellant fails to demonstrate that the Tribunal's decision was wrong. The Supreme Court said:[24]

> ... the appellant bears an onus of satisfying the appeal court that it should differ from the decision under appeal. It is only if the appellate court considers that the appealed decision is wrong that it is justified in interfering with it.

[40] However, the Supreme Court also cautioned that a different approach may be justified when the decision under appeal involves the exercise of discretion.[25] Where the decision involves an exercise of discretion it appears that the more limited criteria for allowing an appeal articulated in *May v May* applies. Two types of case illustrate this principle:

(1) *Bail appeals*

Appeals against bail decisions are, by virtue of s 41 of the Bail Act 2000 conducted by rehearing. It has now been made clear by the Court of Appeal that appeals on bail decisions are governed by the *May v May* test. In *Dodd v R*[26] the Court of Appeal confirmed that those who appeal bail decisions face the difficulty that they are challenging a Judge's exercise of their discretion. In *Dodd* the Court of Appeal adopted earlier authority which said:[27]

> The appellant must therefore establish that the refusal of bail was contrary to principle, or that the Judge failed to consider

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24 *Austin, Nichols & Co Inc v Stichting Lodestar* [2007] NZSC 103, [2008] 2 NZLR 141 at [4].
25 At [17].
26 *Dodd v R* [2011] NZCA 490.
27 Citing *B v Police (No 2)* [2000] 1 NZLR 31 (CA).

> all relevant matters or took into account irrelevant matters, or that the decision was plainly wrong.

The Court of Appeal was reassured by a leave decision of the Supreme Court in which it was said that bail decisions involve the exercise of discretion.[28]

(2) *Name suppression appeals*

In *Rowley v Commissioner of Inland Revenue*[29] the Supreme Court declined leave to appeal in a case concerning a refusal to grant name suppression. The Supreme Court confirmed that a decision concerning the declining or granting of name suppression involved the exercise of discretion and should not be overturned on appeal unless the lower court decision was shown to be "plainly wrong".[30]

[41] Thus, it appears to be presently settled law that even where the legislative framework prescribes that appeals are to be by way of rehearing, where the issue under appeal involves the exercise of a discretion by the court or tribunal appealed from, the obligation on an appellant is to establish that the decision appealed from is "plainly wrong". I would interpolate that the concept of "plainly wrong" also includes reaching a decision on a wrong principle, applying irrelevant considerations or failing to apply relevant considerations.

[42] I accept that issue could be taken with the epithet "plainly". There is logic in the suggestion that a decision should be able to be appealed if it is wrong. A wrong decision is a wrong decision regardless of the obviousness of the error. However, the authorities which bind me appear to make it clear that a decision which involves the exercise of a discretion can only be overturned on appeal if the *May v May* criteria are satisfied.

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28 *Wong v R* [2009] NZSC 64.
29 *Rowley v Commissioner of Inland Revenue* [2011] NZSC 76, (2011) 25 NZTC 25,438.
30 At [5].

Is the Tribunal's penalty decision an exercise of discretion?

[43] The distinction between an appeal from the exercise of discretion, and a general appeal is not always clear.[31] However, in my assessment the penalty decision in this case involved the exercise of discretion by the Tribunal. I have reached this conclusion because, when deciding what penalty to impose the Tribunal evaluated a wide range of factors, including the penalty options that were available. The process of evaluating penalty options and deciding what penalty to impose involved an exercise of discretion by the Tribunal in the same way that a decision about bail or name suppression also involves the exercise of discretion by judicial officers. All involve the careful evaluation of options and the choosing of the most suitable option that is available. In this respect, the Tribunal's penalty decision can be distinguished from its role when interpreting the law, deciding facts and/or applying the law to established facts when determining if a practitioner has committed a disciplinary offence. That aspect of the Tribunal's role does not involve the exercise of discretion.

Penalty factors

[44] The Tribunal's first consideration requires it to assess what penalty most appropriately protects the public. This factor is identified in s 3 of the Act where it is said that the principal purpose of the Act is:

> to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

Part of the function of protecting the public involves the Tribunal setting penalties that will deter other health professionals from offending in a similar way.

[45] Secondly, when assessing what penalty to impose the Tribunal must be mindful of the fact that it plays an important role in setting professional standards.

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[31] *Kacem v Bashir* [2010] NZSC 112, [2011] 2 NZLR 1 at [42].

This point was made in the following way by Eichelbaum CJ in *Dentice v Valuers Registration Board*:[32]

> [Disciplinary hearings] exist to enforce a high standard of propriety and professional conduct; to ensure that no person unfitted because of his or her conduct should be allowed to practise the profession in question; to protect both the public and the profession itself against persons unfit to practise; and to enable the profession or calling, as a body, to ensure that the conduct of members conforms to the standards generally expected of them ...

[46] Thirdly, it is also important to recognise that penalties imposed by the Tribunal may have a punitive function.[33] I accept that punishment is often viewed as a by-product of the penalties imposed by the Tribunal and that protecting the public and setting professional standards are the most important factors for the Tribunal to bear in mind when setting a penalty. However, where the Tribunal imposes a fine or censure it normally does so in order to punish the health professional.

[47] Fourthly, where it is appropriate, the Tribunal must give consideration to rehabilitating health professionals. This point was made by Blanchard J in *B v B*.[34] A reason why rehabilitation may be an important consideration is that health professionals and society as a whole make considerable investments in the training and development of health practitioners. Where appropriate, the Tribunal should endeavour to ensure these investments are not permanently lost, provided of course the practitioner is truly capable of being rehabilitated and reintegrated into the profession.

[48] Fifthly, the Tribunal should strive to ensure that any penalty it imposes is comparable to other penalties imposed upon health professionals in similar circumstances. In stating this objective I recognise that each case will require a careful assessment of its own facts and circumstances. Rarely will two cases be identical. Nevertheless, it is important for the Tribunal to try and ensure a degree of equity between those health professionals who appear before the Tribunal. Importantly, in cases involving sexual misconduct, there is no logical reason why

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32 *Dentice v Valuers Registration Board* [1992] 1 NZLR 720 (HC) at 724.

33 See, for example, *A v Professional Conduct Committee* HC Auckland CIV-2008-404-2927, 5 September 2008 at [81], applying the decision of the House of Lords in *Taylor v General Medical Council* [1990] 2 All ER 263 (HL).

34 *B v B* HC Auckland HC4/92, 6 April 1993.

different categories of health professional should be treated differently. The establishment of a single Tribunal to determine disciplinary charges against all 20 categories of registered health professionals is a clear signal that Parliament intended that health professionals be treated in a similar way where their circumstances are comparable. This point was recognised by the Tribunal in *Professional Complaints Committee v O*[35] where it endeavoured to impose a penalty on a nurse who engaged in an inappropriate relationship with a patient that was consistent with the type of penalty that would be imposed upon a doctor or other health professional.

[49] Sixthly, it is important for the Tribunal to assess the health practitioner's behaviour against the spectrum of sentencing options that are available. In doing so the Tribunal must try to ensure that the maximum penalties are reserved for the worst offenders.

[50] Seventhly, the Tribunal should endeavour to impose a penalty that is the least restrictive that can reasonably be imposed in the circumstances. This point was made in the following way by Randerson J in *Patel v Dentists Disciplinary Tribunal* when he said that the Tribunal must consider "alternatives available to it ... and to explain why lesser options have not been adopted in the circumstances of the case".[36]

[51] Finally, it is important for the Tribunal to assess whether or not the penalty it is proposing to impose is fair, reasonable and proportionate in the circumstances presented to the Tribunal. Imposing a penalty involves issues of finely balanced judgement. It is not a formulaic exercise.

Did the Tribunal properly consider all penalty factors?

[52] It is clear from the Tribunal's decision that it considered the following penalty factors:

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35 *Professional Conduct Committee v O* HPDT 47/Nur05/25P, 6 July 2006.

36 *Patel v Dentists Disciplinary Tribunal* HC Auckland AP77/02, 8 October 2002 at [31].

(1) The need to protect the public;[37]

(2) Maintenance of professional standards;[38]

(3) The role of punishment;[39]

(4) Rehabilitation;[40]

(5) "Previous case law";[41] and

(6) The need to impose "the least punitive penalty".[42]

[53] However, while the Tribunal did address most of the factors that should be weighed when considering what penalty to impose, there are three aspects of the Tribunal's decision that require careful consideration. Those matters are:

(1) the need to rehabilitate Mr Roberts;

(2) the comparisons which the Tribunal made with the penalties that have been imposed on other health professionals in similar circumstances; and

(3) the extent to which there was an overall assessment of the appropriateness of the penalty that the Tribunal was proposing to impose.

Rehabilitation

[54] In this case the Tribunal imposed the maximum period of suspension that was available to it. In doing so the Tribunal removed Mr Roberts from the nursing profession for at least three years. Mr Waalkens submitted that a three years'

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37 *Professional Conduct Committee v Roberts* HPDT 459/Nur12/202P, 12 June 2012 at [28](a).
38 At [28](b)-[29].
39 At [28](c).
40 At [28](d), [34] and [36].
41 At [34].
42 At [34].

suspension was likely to be "a game breaker". By this Mr Waalkens suggested that the period of suspension was so long that Mr Roberts was unlikely to resume his career as a nurse.

[55] In explaining the imposition of a three year period of suspension the Tribunal said that:

> The length of suspension will enable [Mr Roberts] to take every opportunity to rehabilitate himself and to learn more about boundaries in nursing.[43]

[56] However, Mr Waalkens is correct when he submits that the Tribunal did not explain why a three year suspension was necessary to ensure that Mr Roberts received appropriate training on professional boundary issues. I also note that in its written decision the Tribunal abandoned its earlier requirement that Mr Roberts undergo courses approved by the Nursing Council of New Zealand in relation to professional ethics and boundaries.

[57] In my assessment the Tribunal did not adequately explain its reasons for imposing the maximum period of suspension in this case. In the circumstances of this case, it was incumbent on the Tribunal to give reasons which adequately explained to Mr Roberts why the Tribunal thought it was necessary to suspend him for the maximum period that was available, and to enable this Court to fully evaluate the merits of Mr Roberts' appeal. The Tribunal's failure to do so constituted an error of both law and principle.[44]

Parity with other health professionals

[58] New Zealand courts have recognised that there is a "legitimate debate" as to whether it is permissible for a health professional, who has terminated a professional relationship with a patient, to engage thereafter in an intimate relationship with his or

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43 At [36].

44 See *Chief Executive of the Department of Labour v Taito* [2006] NZAR 420 (CA) at [24], *A v X* [2005] 1 NZLR 123 (HC) at [74], *Wilfred v Chief Executive of the Department of Labour* [2007] NZAR 237 (HC) at [108].

her former patient.[45] I need not, however, concern myself with whether or not it is a disciplinary offence for a nurse to engage in a sexual relationship with a patient either during, or immediately after the cessation of a therapeutic relationship. Mr Roberts has accepted the charge of professional misconduct by commencing a relationship with Ms N when she was an in-patient in the ward where he worked, and to commencing a sexual relationship with her, two days after she was discharged from that ward.

[59] My primary concern is whether, in suspending Mr Roberts the Tribunal endeavoured to achieve consistency between Mr Roberts' penalty and penalties that have been imposed on other health professionals in similar circumstances. In deciding to impose a three year suspension the Tribunal said that it had considered "previous case law" but did not explain which cases it had considered.

[60] During the course of his oral submissions Mr Waalkens informed me that considerable disparity has evolved between the penalties which the Tribunal imposes on nurses who form sexual relationships with patients or former patients and doctors who offend in a similar way. Mr Waalkens submitted that there has been a discernible trend of nurses being treated more severely than doctors for this type of offending.

[61] An examination of the Tribunal's summaries of its decisions on its website reveals that since the Tribunal was established on 18 September 2004 ten nurses have been disciplined for sexual misconduct or forming a sexual relationship with a patient or former patient. Of those ten cases one received a three month suspension. The Tribunal cancelled the registration of the other nine nurses. However, on appeal, one of those nine cases resulted in the nurse being suspended for one year. During the same period six doctors have been disciplined by the Tribunal for similar offending. Of those six doctors, one was suspended for nine months, one was suspended for 18 months, one was suspended for two years and three had their registration cancelled.

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[45] *P v Nursing Council of New Zealand* HC Wellington AP124/01, 27 August 2001 at [51] per Wild J and *Director of Proceedings v Medical Practitioners Disciplinary Tribunal* [2003] NZAR 250 (HC) at 50 per Ellen France J.

[62] There is therefore statistical support for Mr Waalkens' submission. It appears the Tribunal has cancelled the registration of nurses in 90 per cent of the cases it has considered involving sexual misconduct or forming a sexual relationship with a patient or former patient. Only 50 per cent of the doctors who have appeared before the Tribunal on similar charges have had their registration cancelled. However, I immediately caution against placing too much weight on these statistics. The facts and circumstances of each case must be carefully considered and weighed. More meaningful information is gained by examining the cases to see if the penalty imposed on Mr Roberts was more severe than the penalties imposed on other health professionals in similar circumstances.

[63] Counsel have referred me to a number of cases involving health professionals who have been disciplined by the Tribunal or its predecessors for engaging in a sexual relationship with a patient or former patient. I have found the following cases particularly useful:

(1) *Professional Conduct Committee v K*.[46]

This case involved a doctor who embarked upon a relationship with a patient whom he treated for a very significant and intensive medical condition. The patient is described as being "very vulnerable". The relationship was highly emotional and sexualised. Dr K was aware that the relationship was inappropriate. The relationship caused harm to the patient and her family. Dr K was censured, had conditions imposed upon his practice, fined and directed to contribute towards costs.

(2) *MacDonald v Professional Conduct Committee*.[47]

This case concerned a doctor who entered into a sexual relationship with a patient who also worked with her. Dr MacDonald was highly criticised, not only for the sexual relationship but also her inadequate

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[46] *Professional Conduct Committee v K* HPDT 349/Med10/157P, 17 January 2011.

[47] *MacDonald v Professional Conduct Committee* HC Auckland CIV-2009-404-1516, 10 July 2009.

medical management. The Tribunal suspended Dr MacDonald for nine months but on appeal this was reduced to five months.

(3) *Professional Conduct Committee v Gray*.[48]

Dr Gray entered into a sexual relationship with an existing patient whom he continued to treat. The Medical Practitioners Disciplinary Tribunal considered Dr Gray lacked insight and overall judgement. He was censured, fined and directed to pay a contribution towards costs. He was suspended for six months although that suspension in itself was also suspended.

(4) *Professional Conduct Committee v Patel*.[49]

Dr Patel engaged in a sexual relationship with a significantly impaired psychiatric patient whom he had referred to specialist psychiatric care. The doctor's relationship with his patient caused the patient and her family significant harm. Dr Patel continued to treat not only the patient but also the patient's husband and daughter. The Tribunal suspended the doctor for two years with conditions.

(5) *Professional Conduct Committee v O*.[50]

This case concerned a nurse who entered into an inappropriate relationship with a prison inmate and patient of the prison health unit for a period of two months whilst employed as a registered nurse with the Department of Corrections. No sexual relationship actually occurred although they communicated in a sexually implicit way and became deeply emotionally involved with each other. The Tribunal determined that Nurse O's name should be removed from the Register of Nurses.

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48 *Professional Conduct Committee v Gray* MPDT 411/DH11/190P, 22 November 2001.
49 *Professional Conduct Committee v Patel* HPDT 59/Med06/36D, 19 September 2006.
50 *Professional Conduct Committee v O* HPDT 47/Nur05/25P, 6 July 2006.

(6) *Professional Conduct Committee v Gulliver*.[51]

In this case a nurse entered into an inappropriate sexual relationship with a patient under his care. This was held to be fundamentally inappropriate. Mr Gulliver's registration was cancelled. He was also censured and fined $500 and ordered to pay 50 per cent of the costs of the hearing and prosecution.

(7) *Professional Conduct Committee v Chand*.[52]

This case involved a nurse who was found guilty of inappropriately touching a colleague and telephoning a patient at home and hugging another patient. His registration was cancelled.

(8) *Professional Conduct Committee v Rosie*.[53]

In this case the registration of a nurse was suspended for three months for engaging in a sexual relationship with a patient. The patient was suicidal and had a disability and was at high risk of self-harm. At the time the relationship was formed the patient was a committed patient. She was extremely vulnerable.

[64] As the summary of these cases shows, the Tribunal and its predecessors have imposed a range of penalties on health professionals who engage in sexual relationships with patients or former patients. The range of penalties that has been imposed demonstrates that the Tribunal and its predecessors have tailored penalties to the facts and merits of each case. However, it is notable that no other health professional appears to have been suspended for the maximum term for offending of this kind. This is a feature of this case that has caused me considerable concern, even though there are certain cases in which the more serious penalty of cancellation has been imposed where health professionals have formed a sexual relationship with a patient or former patient.

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51 *Professional Conduct Committee v Gulliver* HPDT 61/Nur06/35P, 19 September 2006.
52 *Professional Conduct Committee v Chand* HPDT 109/Nur06/49P, 14 June 2007.
53 *Professional Conduct Committee v Rosie* HPDT 294/Nur09/141P, 13 April 2010.

Overall assessment

[65] In assessing whether or not the Tribunal's decision was "plainly wrong" I have endeavoured to make an overall assessment focusing upon the following factors:

(1) Ms N was a vulnerable patient. Her health and personal circumstances meant that she was very susceptible to the attention that Ms Roberts gave her when she was in hospital. She also appears to have been unaware of the inappropriateness of Mr Roberts engaging with her. Mr Roberts on the other hand appreciated from the outset that what he was doing was "unprofessional".

(2) The nature of the professional relationship between Mr Roberts and Ms N was not particularly extensive. I reach this conclusion because it is clear:

(a) Mr Roberts was one of several nurses working on the ward;

(b) Mr Roberts does not appear to have played any significant role in Ms N's care and management.

The therapeutic relationship between Ms N and Mrs Roberts was quite different from the highly intense and dependent relationship seen in cases such as *Professional Conduct Committee v O* and *Professional Conduct Committee v Patel*.

(3) The relationship that developed between Mr Roberts and Ms N appears to have been a genuine and loving relationship. It lasted close to three years. This does not appear to have been a case of predatory behaviour, although it is a matter of concern that sexual intercourse occurred two days after Ms N was discharged from hospital on 24 December 2007.

(4) Mr Roberts did admit his guilt, albeit at a late juncture. He should not be punished because of the lateness of his admission of his wrongdoing. At the same time, it is difficult to give him credit because his plea occurred so late in the disciplinary process.

[66] Like the Tribunal, I am concerned about Mr Roberts' attempts to mislead the Nursing and Midwifery Council of the United Kingdom and his employer in the United Kingdom. However, I do not believe it is appropriate to conclude that these attempts constitute evidence of a failure on his part to appreciate the impact of his relationship upon Ms N and the inappropriateness of his relationship. It is highly likely that Mr Roberts attempted to mislead the authorities in the United Kingdom and his current employer because he wanted to gain employment, not because of any lack of insight on his part into the nature of his offending. Nevertheless, Mr Roberts' attempts to mislead authorities in the United Kingdom is an aggravating factor.

[67] When these factors are taken into account and assessed in conjunction with my concern that the Tribunal did not properly consider Mr Roberts' rehabilitation or impose a suspension penalty that was reasonably comparable to other instances in which health professionals have been suspended for offending of the kind in question, then I am left with the conclusion that the Tribunal did err in a significant way. Accordingly, I will allow the appeal.

The appropriate penalty

[68] In my assessment, the appropriate penalty is one of suspension for a period of 18 months. In reaching this conclusion, I have reasoned that it is difficult to conclude why longer time would be required for Mr Roberts to complete appropriate training programmes in the United Kingdom that are designed to ensure he fully understands professional boundaries and the need to avoid engaging in any form of personal relationship with patients.

[69] I have given careful consideration as to whether or not it is possible and/or appropriate to impose other conditions. Because Mr Roberts is living in the United

Kingdom, it is very difficult to impose conditions for Mr Roberts to satisfy in the United Kingdom that could be monitored by the Nursing Council of New Zealand.

[70] There is also a real issue as to whether or not conditions can be imposed concurrently with a period of suspension. Section 101(1)(c) of the Act states:

> **101 Penalties**
>
> (1) In any case to which section 100 applies, the Tribunal may—
>
> ...
>
> (c) order that the health practitioner may, after commencing practice following the date of the order, for a period not exceeding 3 years, practise his or her profession only in accordance with any conditions as to employment, supervision, or otherwise that are specified in the order:
>
> ...

The language of s 101(1)(c) suggests to me that conditions can only be imposed after a practitioner is reinstated and not as a pre-condition to reinstatement following cancellation or suspension of a practitioner's practising certificate.

[71] In my assessment it is necessary and appropriate for the Nursing Council of New Zealand to monitor Mr Roberts if he resumes practice in New Zealand. To achieve this I direct that Mr Roberts must, within six months of resuming practice in New Zealand complete to the satisfaction of the Nursing Council of New Zealand any courses on ethics and professional boundaries that the Nursing Council direct he undertakes. This order is similar to the order which the Tribunal made on 15 May 2012 pursuant to s 101(1)(c) of the Act but which, for some reason was not mentioned in the Tribunal's written decision.

[72] All other penalties imposed by the Tribunal remain in force.

Cross-appeal

[73] It will be appreciated that the cross-appeal must be dismissed. Even if I had not allowed the appeal, I would have concluded that the PCC had not discharged the

onus upon it to allow the cross-appeal in terms of the principles set out in *May v May*.

Conclusions

[74] The appeal against the length of suspension imposed by the Tribunal is allowed. Mr Roberts' registration as a nurse is suspended for a period of 18 months from 15 May 2012.

[75] The order made by the Tribunal on 15 May 2012 pursuant to s 101(1)(c) of the Act is quashed and substituted with the order set out in [71].

[76] All other orders of the Tribunal remain.

[77] The cross-appeal is dismissed.

[78] I am minded not to order costs. If counsel oppose this course they should file submissions by 1 February 2013.

D B Collins J

Solicitors:
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