NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1236/Phar21/514D**
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	**FERAS DAWOOD**, a registered pharmacist
	Practitioner

HEARING held via audio visual link on 6 December 2021

TRIBUNAL	Ms T Baker (Chair) Ms J Dawson, Ms D Vicary, Dr B Lu, Mr S Hanrahan (Members) Ms D Gainey (Executive Officer)
APPEARANCES	Ms C McCulloch and Ms D Roche Mr D Dickinson

DECISION OF THE TRIBUNAL

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Introduction

[1] A panel of the Tribunal convened on 6 December 2021 to hear a charge of professional misconduct laid by the Acting Director of Proceedings (**the Director**) against the practitioner, Feras Dawood. The parties had agreed the facts and Mr Dawood accepted that his conduct amounted to professional misconduct.

[2] The Tribunal considered an Agreed Summary of Facts signed by the parties, an Agreed Bundle of Documents and submissions from counsel.

The Charge

[3] The charge concerns Mr Dawood's role as the checking pharmacist in a dispensing error in May 2019 and his attempts to cover up his error and attribute blame to another staff member. The particulars of the charge are:

(1) On an unknown date between 7 and 13 May 2019, when you checked a technician's dispensing of the antibiotic medication rifaximin 550mg for [Ms B], you failed to detect that the anticoagulant medication rivaroxaban 20mg had been dispensed incorrectly instead of rifaximin 550mg.

AND / OR

(2) Between 27 May 2019 and 4 July 2019, when you knew that you were the pharmacist who had checked the dispensing of rifaximin 550mg for [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead), you acted dishonestly when you:

(a) Disposed of the original certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

and/or

(b) created a new certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

and/or

(c) signed pharmacist, [Ms A]'s initials in the "checked by" box of the newly created certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

and/or

(d) told [Ms A] that she had been responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

and/or

(e) told pharmacist, [Mr N], that [Ms A] was responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

and/or

(f) told [Ms B] that another pharmacist was responsible for the dispensing error;

and/or

(g) told [Ms A] that you would notify the Pharmacy Council of New Zealand of her dispensing error;

and/or

(h) created and sent an Incident Notification Form to the Pharmacy Defence Association in which you stated that [Ms A] was responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

and/or

(i) advised the Pharmacy Defence Association that you intended to issue [Ms A] with a written warning in relation to her dispensing error.

Facts

[4] The Agreed Summary of Facts was supplemented by documents in the Agreed Bundle of Documents. The following summary is derived from those items.

Background

[5] Mr Dawood qualified as a pharmacist in 2002 and began practising in September 2004. In 2019 he was the managing director and majority pharmacist shareholder of the Unichem Waiuku Medical Pharmacy (**the Pharmacy**).

[6] At that time Mr Dawood had a condition on his practice (under section 43(1)(a)(ii) of the Health Practitioners Competence Assurance Act 2003) that he work in association with another pharmacist at all times when dispensing medicines and that he be under

the supervision of a Council-approved pharmacist. Ms A, a pharmacist employed by the Pharmacy, was appointed as Mr Dawood's supervising pharmacist.

[7] On 13 March 2019, Ms B presented to the Pharmacy as a new customer with a prescription for 13 medications, including Rifaximin[1] 550mg to be taken as one tablet, twice daily. Rifaximin is also sold under the brand name Xifaxan.

[8] Most of the medications were dispensed in blister packs, but some were dispensed in separate packages or bottles. On 3 May 2019, pharmacy technician, Ms C, processed future blister pack foils, dispensing labels and certified repeat copy (**CRC**) forms for Ms B. Some of the blister packs were filled using medication Ms B already had at home, and which she had brought into the Pharmacy. There was insufficient Rifaximin and so Ms C processed an order for these medications.

[9] A CRC is generated by a pharmacy's computing system when a repeat medication is processed for dispensing. It is then printed and used for packing and checking the repeat prescription. CRCs are signed or initialled by the pharmacist or technician when the medicine is packed, and checked, prior to being given to the patient.

[10] There was another medication, Clonazepam, that also needed to be ordered. It is agreed that the Rifaximin and the Clonazepam would have been on the same CRC, as they were processed at the same time.

[11] On 4 May 2019 the Rifaximin and Clonazepam arrived at the Pharmacy. Another staff member, Ms D received the order, unpacked it and put the medications on the shelf.

Dispensing and checking error

[12] On 9 May 2019, Ms C prepared Ms B's repeat medications. Ms C incorrectly dispensed Rivaroxaban[2] 20mg tablets (brand name Xarelto) instead of the prescribed Rifaximin. Ms C signed the "packed by" section of the CRC with her initials (CC).

[13] Ms C fixed a dispensary sticker labelled "60 RIFAXAMIN TAB[LETS] 550MG XIF ALF Take ONE tablet TWICE daily" on to the front of the Rivaroxaban box. The words Xarelto

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[1] An antibiotic used to treat diarrhoea, irritable bowel syndrome and hepatic encephalopathy

[2] An anticoagulant medication used to treat and prevent blood clots

20mg were still visible on the top of the box and Xarelto 20mg Rivaroxaban were still visible on the side of the box.

[14] On an unknown date between 10 and 13 May 2019, Mr Dawood checked the medication prepared for Ms B. He failed to detect the dispensing error. He signed the "Checked by" section of the CRC with his initials, "FD".

[15] On 16 May 2019 Ms B collected the medications prepared for her. She then became increasingly unwell, and early on the morning of 24 May 2019, Ms B woke with pain in her upper abdomen and began vomiting blood as well as passing pitch black bowel motions.

[16] Shortly before midday she activated her medical alarm and a 111 call was made. A St John Ambulance officer attended and found her alert and lying in bed. She was put on an IV line and administered fluids and antinausea medication and transported to Middlemore Hospital.

[17] At the emergency department she was noted to have mildly low blood pressure and a low haemoglobin. The admitting doctor diagnosed an upper gastrointestinal haemorrhage, an acute kidney injury and hypovolaemia, which is an abnormal decrease in the volume of circulating blood plasma. Ms B was admitted to hospital for treatment and remained there until discharge on 29 May 2019.

[18] On 27 May, the hospital pharmacist telephoned the Pharmacy and spoke first with Ms A and then to Mr Dawood. It was explained that Ms B had been admitted with multiple bruising, an acute kidney injury and hypovolaemia, as a result of having taken the incorrectly dispensed Rivaroxaban.

[19] Mr Dawood looked for the CRC form generated for the dispensed medications and subsequently told the other pharmacy staff that he could not find it.

[20] On 28 May 2019 at 6:53 a.m., Mr Dawood entered the Pharmacy through the back door. He then disposed of the CRC for Rifaximin and Clonazepam that had been created by Ms C on 3 May 2019. He created and printed two new CRCs, both of which he dated 3 May 2019. One was for the repeat dispensing of Clonazepam in which he signed Ms C's initials in the "Packed by" section and his own initials in the "Checked by" section. The other CRC was for the repeat dispensing of Rifaximin. On that CRC

Mr Dawood signed Ms C's initials in the "Packed by" section and Ms A's initials in the "Checked by" section.

[21] Mr Dawood then placed the two newly created CRCs in amongst a batch of other CRCs that had already been processed. He left the Pharmacy through the back door at 7:58 a.m.

[22] At 8:36 a.m, Mr Dawood entered the Pharmacy again, but through the front door as he usually did.

[23] During the morning Mr Dawood "found" the missing CRC for Rifaximin, that he had created earlier that morning. He informed Ms A that he had found it and showed her the false CRC on which he had recorded that she was the pharmacist who had checked the incorrectly dispensed medication. Ms A told him that the CRC did not reflect her usual checking process, as it did not have any of the usual markings she made on CRCs when she checked prescriptions (such as circling the dose and strength on the CRC, and ticking and underlining important information on the form).

[24] Mr Dawood told Ms A that they needed to move forward from this error, that he knew she was very particular and careful when checking, but that mistakes happen.

[25] Later that day Ms C found the fake CRC for the repeat Clonazepam which showed Ms C's initials in the "Packed by" field and Mr Dawood's initials in the "Checked by" field.

[26] At 5:27 p.m. Mr Dawood emailed Ms B's GP to advise that Ms B had been incorrectly dispensed Rivaroxaban instead of the Rifaximin that had been prescribed. He also advised Green Cross Health.

29 May 2019

[27] On 29 May 2019, Mr Dawood and Ms A had a conversation about the dispensing error. She maintained that she did not make the error as she had not checked the incorrectly dispensed medication. Mr Dawood replied that she was responsible for the error and that he would notify the Pharmacy Council of New Zealand (**the Pharmacy Council**) of her error as it was serious and she was not accepting responsibility for it. Ms A was given extended stress leave from work.

[28] At 9:38am Mr Dawood completed an incident notification form and sent it to the Pharmacy Defence Association. He specified that the pharmacist involved was Ms A and

the technician was Ms C. He wrote that the medication had been dispensed by Ms C and checked by Ms A. He wrote:

> Correct dispensing process was not followed. I have discussed with [sic] incident with [Ms A] and [Ms C], both could not remember checking repeat but they said that they will ensured me [sic] such error would not happen again. I am very upset by this incident, written warnings will be issued to staff involved and ongoing support.

Subsequent events

[29] Following this, Mr Dawood had a private meeting with another pharmacist, expressing his disappointment with Ms A and her refusal to accept that she had checked the incorrectly dispensed medication. On 30 May he held a meeting with pharmacy staff about the dispensing error and asked staff to read the standard operating procedures about dispensing medicines.

[30] On 30 May 2019 Mr Dawood wrote to Ms B apologising for the error and saying that a thorough investigation was being conducted.

[31] On the same day Ms A made a complaint to the Pharmacy Council regarding the dispensing error and Mr Dawood's subsequent actions.

[32] Mr Dawood continued to communicate with Ms B, explaining that a female pharmacist had been responsible for checking the incorrectly dispensed medication.

[33] On 4 July 2019 the Green Cross pharmacist sent a second notification form to the Pharmacy Defence Association advising that there was a disagreement between the pharmacists as to who had incorrectly dispensed the Rivaroxaban instead of Rifaximin.

[34] In response to Ms A's complaint to the Pharmacy Council[3] Mr Dawood admitted that he was the pharmacist who had checked the prescription for Rifaximin where Rivaroxaban was dispensed instead. He acknowledged that his actions following the dispensing error had hurt both Ms A and Ms B.

[35] Mr Dawood admitted during the investigation by the Health and Disability Commissioner that the notification he sent to the Pharmacy Defence Association was incorrect.

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[3] Referred to above at paragraph 31

[36] On 5 July 2019 Mr Dawood volunteered to suspend his annual practising certificate effective from that date and has not practised as a pharmacist since.

[37] On 19 July 2019 Mr Dawood resigned as the managing director of the Pharmacy and sold his interest as the majority pharmacist shareholder.

Findings

[38] It is an agreed fact that Mr Dawood was the pharmacist who checked the dispensing of rivaroxaban 20mg which had been dispensed incorrectly instead of rifaximin 550mg. Particular 1 of the charge is therefore established.

[39] The second particular of the charge concerns Mr Dawood's actions following the discovery of the error. It is alleged that he acted dishonestly, as further specified in the sub-particulars. Each of the allegations in those particulars is proved by the agreed facts. The Tribunal also finds that Mr Dawood's actions amount to dishonest conduct. Particular 2 is therefore established.

Professional misconduct

[40] Having found the factual allegations in the charge are established, the Tribunal must consider whether the conduct amounts to malpractice or negligence under section 100(1)(a) of the Health Practitioners Competence Assurance Act 2003 (**the Act**) and/or has brought or is likely to bring discredit to the medical profession under section 100(1)(b) of the Act.

[41] Section 100 of the Act provides:

> **100 Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—
>
> (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or

…

[42] The Tribunal and the Courts have considered the term "professional misconduct" under section 100 (1)(a) of the HPCA Act on many occasions. In *Collie v Nursing Council*, Gendall J said: [4]

> Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[43] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct".[5]

[44] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:[6]

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

[45] Determining professional misconduct is approached in two steps. This has been expressed:

(a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession.

(b) The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction. In *F v Medical Practitioners Disciplinary Tribunal*[7] the Court of

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

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

6 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28]

7 Noted at 2005 3 NZLR 774 at [80]

Appeal, in considering the disciplinary threshold under the Medical Practitioners Act 1995 said:

> In cases of both professional misconduct and conduct unbecoming it will be necessary to decide if there has been a departure from acceptable standards, and then to decide whether the departure is significant enough to warrant sanction.

[46] The High Court endorsed the earlier statement of Elias J in *B v Medical Council* [2005] 3 NZLR 810 that "the threshold is inevitably one of degree". This was further discussed in *Martin, HRE v Director of Proceedings* where the High Court said:[8]

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

[47] This two-step test has been adopted by this Tribunal since its first decision, *Nuttall* 8/Med04/03P issued in 2005.

Director's Submissions

[48] For the Director of Proceedings, it was submitted that Mr Dawood's error in failing to detect that rivaroxaban had been dispensed instead of rifaximin was made despite the fact the words 'Xarelto 20mg rivaroxaban' were printed on the box and on the trays of tablets inside the box, and that this did not correspond with the pharmacy label fixed onto the box or the prescription.

[49] In making this error, Mr Dawood failed to follow Waiuku Pharmacy's Standard Operating Procedure C06 'Dispensing and Checking a Prescription', Domain O3 of the Pharmacy Council's Competency Standards for the Pharmacy Profession, and its Code of Ethics, particularly Principles 1 and 6, as well as Standard 5.2 of the Health and Disability Services Pharmacy Services Standards NZS81434.7:2020.

[50] The relevant standards were set out in the Agreed Summary of Facts:

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

[51] The Waiuku Pharmacy's standard operating procedure ("Dispensing and checking a prescription") include the following for checking a prescription:

- Check that each medicine dispensed is correct against the medicine prescribed on the prescription. This includes checking the generated dispensary label and dispensed medicine(s) against the original prescription for the:

- Correct customer's name; correct instructions for use; correct formulation, strength and quality of medicine;

- …

- Sign their initial on the third part of the dispensary label for each medicine to confirm that each medicine has been fully checked as per the process above.

- …

- After reviewing all the medicines on the prescription and receipt, initial in the CHECKED box on the dispensary stamp to indicate that the entire prescription has been checked and that the dispensing is complete and accurate.

[52] Domain 03 of the Pharmacy Council's Competency Standards for the Pharmacy Profession says:

Competency 03.2 Dispense Medicines

Behaviours

03.2.1 Maintains a logical, safe and disciplined dispensing procedure

03.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them

…

03.2.5 Accurately records details of medication incidents and actions taken, including clinical and professional interventions, to minimise their impact and prevent recurrence

[53] Domain M1 of the Pharmacy Council Competency Standards for the Pharmacy Profession concerns professionalism in pharmacy, and in particular sets out the expectation

pharmacists are to demonstrate compassion, integrity and respect for others as well as accountability to patients, society and the profession.

[54] Competency M1.1 is headed "Demonstrate personal and professional integrity".

[55] The behaviours are expected are:

> M1.1.2 Demonstrates awareness of position of trust in which the profession is held and practises in a manner that upholds that trust
>
> M1.1.3 Accepts responsibility and accountability for membership in the profession
>
> …
>
> M1.1.7 Accepts responsibility for own actions and performance

[56] Competency M1.2 is headed "Comply with ethical and legal requirements"

> Behaviours:
>
> …
>
> M1.2.3 Demonstrates sound knowledge and understanding of ethical principles and values that underpin the profession
>
> M1.2.4 Complies with the obligations created by the Code of Ethics

[57] The Code of Ethics 2018 embodies three principles: care, integrity and competence. Principle 4 requires pharmacists to act with honesty and integrity and maintain public trust and confidence in the profession.

[58] It was submitted that since September 2013, Mr Dawood had been on notice that the Pharmacy Council had concerns relating to his competence to practise. One of the areas of concern related to his dispensing and checking practices.[9] Mr Dawood was therefore particularly aware of the need to take care when checking medications dispensed by others, and this need had been brought to his attention on multiple occasions during competency assessments and reviews.

[59] Further, Mr Dawood was the author of Waiuku Pharmacy's Standard Operating Procedures, which set out the procedures to be followed when checking prescriptions (as

[9] This was evident in the Competency Review documents contained in the Agreed Bundle.

well as when a dispensing error was discovered). Mr Dawood should be held to a high standard, and expected to follow his own procedural policies.

[60] The Director submitted that the subsequent conduct could not be characterised as an oversight, an unintentional error, or even a momentary lapse of judgment. Rather, his conduct was deliberate, calculated, and sustained. Mr Dawood made a deliberate decision to cover-up his involvement in the dispensing error, and then to blame a junior pharmacist in his employment for his error. He destroyed original documents, created false documents, forged the pharmacy technician's and Ms A's initials onto the false documents, submitted a false report to the Pharmacy Defence Association, repeatedly told Ms A the error was her fault, and threatened to report her to the Pharmacy Council when she refused to take responsibility for it, and told another staff member Ms A was responsible but would not accept this.

[61] The Director referred to two Tribunal decisions involving dishonesty:

(a) In PCC v Ms E 972/Phar17/400P, a registered pharmacist created and presented two false prescriptions at two pharmacies. The Tribunal commented:

> This dishonest conduct must inevitably be seen as a serious departure from the ethical and lawful conduct expected of a practitioner. A pharmacist must be keenly aware of the obligation to act at all times with the highest degree of ethical and lawful conduct when dealing with prescriptions and medicines.[10]

(b) In *PCC v Dr N* 812Med/15/335P, the Tribunal said of a doctor who made fraudulent entries into the controlled drug register and patient case notes, forged the signatures of his colleagues and self-prescribed drugs of dependence:

> Practitioners are entitled to rely on their colleagues not to involve them in any way in any activity which impacts upon their reputation or practice. Certainly that is the case with any fraudulent activity. For Dr N to have forged the signatures of his colleagues … is to have breached the trust that those practitioners placed in him not to use their name or signature for any fraudulent or selfish purpose.[11]

[62] Mr Dawood accepted his conduct amounted to professional misconduct.

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[10] At [41]
[11] At [30]

Discussion

[63] It is clear that a dispensing or checking error amounts to negligence. Even in the absence of documented competency standards and standard operating procedure, a dispensing error is a departure from the standards expected of a pharmacist, whose daily practice involves the dispensing and checking of prescriptions. The first particular of the charge therefore meets the first part of the test for professional misconduct because it amounts to negligence under section 100(1)(a).

[64] The consequences for the patient of Mr Dawood's error were significant. The Tribunal acknowledges that Mr Dawood was on notice of the importance of careful checking, but in fact any pharmacist must exercise a very high level of diligence when checking prescriptions. It does not matter what the medication is that is being checked: any error can have severe effects on the patient.

[65] However, we do not find that the second part of the test for professional misconduct is met. In the course of a busy practice, dispensing and checking errors do occasionally occur. These can have catastrophic consequences, but the error is the same. Without belittling the experience of Ms B, or in any way condoning or dismissing such an error, the Tribunal is reluctant to find that a dispensing or checking error on its own is sufficiently serious to warrant a disciplinary sanction. It is the practitioner's response, or lack of response, on being informed of an error that may take the conduct over the threshold to warrant disciplinary sanction.

[66] In the present case, Mr Dawood appropriately contacted the patient but then lied about his own involvement and falsely blamed someone else.

[67] Mr Dawood's contrivance not only in attempting to avoid responsibility, but also in setting up a colleague and employee to take the blame is highly unethical and can be described as despicable. He has breached his obligations to the public and to the profession. Such conduct tends to lower the reputation of the Pharmacy profession. The Tribunal is in no doubt that the conduct in Particular 2 amounts to malpractice and conduct that is likely to bring discredit to the profession. This conduct clearly reaches the disciplinary threshold and warrants a disciplinary sanction for the purposes of protecting the public and maintaining standards for the profession. Particular 1 and 2 cumulatively meet that threshold.

Penalty

[68] Having found the charge is established, the Tribunal may now consider whether the conduct requires a disciplinary sanction for the purposes of protecting the public and maintaining professional standards. Section 101 provides for the following penalties:

(a) Cancellation of registration.

(b) Suspension of registration for a period not exceeding three years.

(c) Conditions imposed on practising certificate.

(d) Censure.

(e) Payment of costs of the Tribunal and/or PCC.

[69] In *Roberts v Professional Conduct Committee,*[12] His Honour Justice Collins discussed eight relevant factors in determining an appropriate penalty in this jurisdiction. These factors have been summarised in the decision of *Katamat v Professional Conduct Committee* [2012] NZHC 1633:

1. Most appropriately protects the public and deters others;
2. Facilitates the Tribunal's "important" role in setting professional standards;
3. Punishes the practitioner;
4. Allows for the rehabilitation of the health practitioner;
5. Promotes consistency with penalties in similar cases;
6. Reflects the seriousness of the misconduct;
7. Is the least restrictive penalty appropriate in the circumstances; and
8. Looked at overall, is a penalty which is "fair, reasonable and proportionate in the circumstances".

Director submissions

[70] The Director submitted that cancellation was the appropriate penalty, along with conditions to be met before Mr Dawood can apply for re-registration, including:

[12] [2012] NZHC 3354 at [44] to [51]

(a) That he must have undertaken at his expense and established to the satisfaction of the Pharmacy Council that he has completed further education in ethics and professional responsibilities as is directed and approved by the Pharmacy Council; and

(b) That he will have provided an undertaking to the Pharmacy Council that he will comply with all conditions as imposed by the Pharmacy Council on his future practice as a pharmacist.

[71] The Director also asked for a fine to be imposed.

[72] If cancellation was not to be imposed, the Director sought further specified conditions on Mr Dawood's practice.

[73] The Director referred to the following aggravating features:

(a) The concepts of acting with integrity and honesty, accepting responsibility for one's own actions, and upholding the trust and confidence of one's colleagues are fundamental to every medical profession and are concepts that every pharmacist is expected to understand and adhere to. Mr Dawood's actions showed a lack of understanding of these important core concepts.

(b) Mr Dawood sought to exploit a significant power imbalance. While the initial dispensing error can be characterised as an unintentional error, his subsequent actions cannot. Rather, he deliberately went to elaborate lengths to cover up his dispensing error by taking a number of separate steps to point the blame away from himself and onto someone else. At any point, Mr Dawood could have stopped his deceit and admitted the true nature of the error. He did not.

(c) Mr Dawood was not only senior to Ms A as a pharmacist, he was also her day-to-day manager and a director of the company that employed her. It certainly caused her significant distress at the time; she took a period of stress leave and shortly afterwards, obtained new employment elsewhere.

(d) This was not the first time that Mr Dawood had interfered with and retrospectively amended dispensing documentation. In July 2013, an

unannounced inspection audit by a Medicines Control advisor revealed discrepancies in Mr Dawood's methadone dispensing records such as retrospective annotations and entries to the Controlled Drugs Register, the Toniq dispensing record, the methadone dispensing recording sheets and patient methadone prescriptions. This was outlined in a letter dated 13 August 2013, from the Ministry of Health to Mr Dawood and included in the Agreed Bundle of Documents.

(e) This was also not the first time that Mr Dawood had been dishonest with relevant authorities. During the July 2013 inspection audit by a Medicines Control advisor, Mr Dawood wilfully obstructed, hindered and deceived the advisor by claiming he had signed and initialled each entry in the Controlled Drugs Register and dispensed prescription forms when, in fact, the initials and signatures had been entered by the technician.

(f) And during the course of Mr Dawood's Pharmacy Council competence re-assessment in September 2016, Mr Dawood's peers told the assessor that Mr Dawood had a tendency to blame others for problems at the Pharmacy.

(g) Mr Dawood has previously been subjected to professional conditions as a way of managing competency issues and concerns. Despite such conditions, he has continued to conduct himself in an inappropriate manner. This significantly reduces the likely effectiveness of imposing further conditions on his practice as a penalty.

(h) Had it not been for Ms A's strong conviction that she was not responsible for the error and subsequent complaint to the Council about Mr Dawood's conduct, it is unlikely that Mr Dawood's conduct would have been discovered and Ms A would have been incorrectly and unfairly held accountable.

[74] The Director acknowledged in mitigation:

(a) Mr Dawood has accepted the charge against him. He also accepts that his conduct amounts to professional misconduct warranting disciplinary sanction.

(b) Mr Dawood has provided Ms B with a written apology, in accordance with the recommendations of the Health and Disability Commissioner.

[75] The Director cited some comparable cases to assist us with determining penalty.[13]

[76] On the question of rehabilitation, the Director referred to further documents in the agreed bundle and noted that following a Pharmacy Council competence assessment in November 2013, Mr Dawood was ordered to undertake a competence programme which required him to meet fortnightly with a Council-approved counsellor for at least six months, have weekly consultations with his business partner, and undergo a competence reassessment.

[77] Following a competency re-assessment in September 2016, Mr Dawood was found to have not met the requirements of the competence programme and was subjected to further conditions on his practice including that he:

(a) work in association with another pharmacist at all times when dispensing medicines;

(b) work under supervision of a Council-approved pharmacist;

(c) initiate and maintain documented fortnightly meetings with his business partner; and

(d) have a mentor to help establish a best practice dispensing procedure.

[78] These conditions were in place when the events to which this charge relates occurred.

Practitioner submissions

[79] For the practitioner, Mr Dickinson submitted that the Director's alternative penalty should be imposed.

[80] In a statement made in support of name suppression, Mr Dawood says that he now realises in retrospect that he was not up to the task of managing the pharmacy,

[13] *Director of Proceedings v Zelcer* 877/Phar16/366D; *PCC v Wong* 974/Phar17/409P; *PCC v Taylor* 932/Phar17/388P; *PCC v Gilgen* 149/Med07/60 & 07/61P; *PCC v Dr N* 812/Med15/335P.

running the company and being an effective pharmacist under the competency programme. He did not respond well to his peer reviews. He has since sold the pharmacy and feels an enormous weight off his shoulders.

[81] In the Director's submission, but for the employee's strong belief in her innocence, Mr Dawood's subterfuge would have prevailed is insufficiently articulated. It is submitted that it is an equally available inference that Mr Dawood's efforts lacked real guile and were doomed to failure.

[82] Mr Dickinson also submitted that the case of *Zelcer* was distinguishable in that the patient in that case was vulnerable in the extreme. That no real harm came to him was a matter of extraordinary, almost unbelievable luck. Mr Zelcer was fortunate himself that the patient was alert to the fact that the incorrectly dispensed medication looked different. Furthermore, Mr Zelcer lied to the patient and his employer (by omission and direct representation) multiple times. It is suggested Mr Zelcer benefited from a generous interpretation of the competing inferences in relation to an alleged "cover up" and of his representation that he always intended on bringing the matter to the attention of his employer. Mr Dawood, by contrast, does not rely on a "past future" intention about owning up to his behaviour but rather did so. Although not done early, it is submitted, such issues are not easy ones to work through. Five weeks later he accepted the conduct.

[83] Mr Dickinson disputed that rehabilitation would be wasted. Mr Dawood devoted the first half of his adult working life to pharmacy. He intends to do so again should it be possible. He made himself available to the Pharmacy Council on multiple occasions and although he was not able to come out from under the competency programme he continued to work hard while performing multiple roles in his pharmacy.

[84] Unlike the case of *Chum* 1033Phys18/420D, an order for suspension would be far from "meaningless". Mr Dawood has not practiced for two years. Furthermore, *Chum* involved a physiotherapist making sexual advances on a highly vulnerable patient. The practitioner did not attend the Tribunal and was uncertain about whether he would seek to return to practice. Mr Dawood is not uncertain in that regard.

Discussion

[85] In the present case, the dispensing error itself does not warrant cancellation. The previous conduct referred to by the Director along with several acts of dishonesty, however, makes arguments for a rehabilitative penalty less compelling. And when considering penalty for both of the particulars, in light of Mr Dawood's past conduct, the protective purpose of disciplinary proceedings is high in the Tribunal's mind.

[86] Included in the Agreed Bundle of Documents was a series of letters from the Ministry of Health and the Pharmacy Council regarding Mr Dawood's practice. From these, the following undisputed information is derived.

[87] Following a dispensing error in 2013 an unannounced audit was performed by the Medicines Control Unit of the Ministry of Health. This and a subsequent audit revealed the following issues which were referred to the Pharmacy Council of New Zealand on 13 August 2013:

(a) Multiple discrepancies in the maintenance of documentation relating to methadone.

(b) Non-compliance with Ministry of Health Practice Guidelines for Opioid Substitution Treatment in New Zealand

(c) Dispensing against prescriptions that were no longer valid and non-compliance with prescriber's instructions

(d) Non-compliance with Controlled Drug Register requirements

(e) Obstruction of officers by attempting to wilfully deceive an officer.

(f) Inability to demonstrate direct supervision of a pharmacy technician in the dispensing of methadone.

[88] The Council decided to review Mr Dawood's competence and the reviewers attended his practice on 27 and 28 November 2013. The terms of reference included Competence Standard 6, the dispensing of medicines.

[89] Although there were positive aspects to Mr Dawood's practice, it was the conclusion of the reviewers that Mr Dawood did not meet the following Competence Standards:

Competence Standard 1: Practise Pharmacy in a Professional Manner

- Activity 1.1.1 Behaves in a professional manner
- Activity 1.1.2 Maintains a consistent standard of work
- Activity 1.1.3 Accepts responsibility for own work tasks and performance
- Activity 1.1.5 Works accurately

Competence Standard 4 Apply Management and Organisation Skills

- Activity 4.2.1 Works with documented procedures and systems

Competence Standard 6 Dispense Medicines

- Activity 6.1.3 Annotates prescriptions
- Activity 6.6.2 Maintains a logical, safe and disciplined dispensing procedure
- Activity 6.7.2 Produces comprehensive and complete labels for medicine
- Activity 6.9.2 Acts to minimise the effects of his dispensing errors.

[90] The basis for these findings was detailed in the reviewers' report and a Competence Programme was recommended.

[91] In a letter dated 10 March 2014, the Council advised Mr Dawood that it had decided a Competence Programme[14] was required to address the following deficiencies:

- Suitable and consistent processes that allow for an accurate and consistent dispensing including checking
- Near-miss recording so that insight into problem areas and ways for improvement are not inhibited
- Following of Standard Operating Procedures
- Leadership and implementation of change
- Management of staffing levels

[92] The Council recorded, "You did not demonstrate competency in your dispensing process with regard to: consistent checking of staff dispensing; the reading of labels; recording of near misses and using this information to improve practices."

[14] Under section 38(1)(a) of the Act

[93] In a letter dated 26 November 2014, the Council expressed its disappointment at the lack of progress made in the Competence Programme, which was expected to have concluded within 6 months.

[94] A reassessment of Mr Dawood's practice took place between July and September 2016. The assessor found that last two competence standards, 6.7.2 and 6.9.2 had been met, but no others. The assessor recorded that Mr Dawood did not follow Standard Operating Procedures that he had approved and his staff followed. In particular he did not record annotations in dispensing. His dispensing procedure was observed to be inconsistent when he got busy or pressured.

[95] In light of this and following a meeting with Mr Dawood on 22 November 2016, the Council found that Mr Dawood had not satisfied the requirements of the Competence Programme. After allowing Mr Dawood an opportunity to be heard on its proposed action, on 30 January 2017, the Council imposed the following order under section 43(1)(a)(ii):

(a) Work in association with another pharmacist at all times when dispensing medicines;

(b) Work under the supervision of a Council-approved pharmacist;

(c) Initiate and maintain documented fortnightly meetings with his business partner, Green Cross Health; and

(d) Have a mentor to help him establish a best practice dispensing procedure.

[96] It is not the role of this Tribunal to impose a penalty for the matters that led to the order imposed under section 43(1)(a). The Council has dealt with that. But it is relevant to deciding what penalty best addresses the penalty principles outlined in *Roberts*.

[97] The conduct covered in the charge of professional misconduct occurred in May 2019 against a background of poor practice, Council review of practice and professional support. Despite mentoring and supervision, the checking error occurred, but worse, Mr Dawood attempted to cover it up, blame his employee/supervisor and he lied to the patient, another colleague and the Pharmacy Defence Association when he told them that Ms A was responsible. He went so far as to fabricate CRCs. Although Mr Dawood's

deceit was not sophisticated, it was pre-meditated and he persisted with his lies for 5 weeks.

[98] There are a number of High Court decisions[15] from which the principles relating to cancellation may be derived:

(a) An order for cancellation or suspension is not to punish, but to protect the public because the person is not a fit and proper person to remain registered as a professional person.

(b) Cancellation is more punitive than suspension (albeit the purpose of neither is to punish).

(c) The choice between the two turns on proportionality, and therefore the decision to suspend implies that cancellation would have been disproportionate.

(d) Suspension is more appropriate where there is a "condition affecting a practitioner's fitness to practice that may or may not be amenable to a cure".

(e) Suspension should not be imposed simply to punish.

[99] Where the case involves a significant failure by a practitioner together with a lack of insight, the Tribunal often considers cancellation is appropriate.

[100] Cases where the Tribunal has cancelled a pharmacist's registration include:

(a) *Katamat* Phar10/162P where the pharmacist had been found guilty of a wide range of misconduct regarding the management of medicines at his pharmacies and breaching several undertakings he had given while investigations were ongoing. Medicines Control had suspended the Pharmacies' licences to operate following audits which found multiple and serious breaches of the Medicines Regulations, including selling prescription only medicines without a prescription.

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[15] *PCC v Martin* High Court Wellington (CIV2006-485-1461), 27 February 2007, Gendall J; *A v PCC* HC Auckland [2008] NZHC 1387 [81]

(b) *Amarsee* Phar14/292P also involved a wide range of misconduct including significant breaches of the Misuse of Drugs Regulations and Medicines Regulations and the supply of controlled drugs and other pharmacy management issues; false applications for funding and practicing while suspended.

(c) The pharmacist in *Price* Phar09/134P was suspended from practice, again for a range of charges. In that case it was decided that a rehabilitative approach was appropriate.

(d) *Musuku* Phar16/374P involved a breach of a condition on the Pharmacy's licence as well as other grounds for misconduct. In that case the Tribunal decided that the interests of public safety could be served without cancellation or suspension. The pharmacist was censured with conditions placed on his practice.

(e) In *Osborne* Phar12/214P, the Pharmacist was suspended for three months and had conditions imposed along with a fine and censure for a range of professional misconduct including mismanagement of his pharmacy, storage and labelling of medicines.

[101] Turning to the cases cited by the PCC, no cancellation was imposed in *PCC v Zelcer* 877/Phar16/366D, where a pharmacist lied on discovering a dispensing error. The pharmacist told the patient that the medication had been discontinued and he should stop taking it, but he failed to tell the patient that he had been given the incorrect medication or ascertain how much of the medication had been ingested. He also failed to advise the patient's GP or his own manager. The Tribunal considers Mr Dawood's dishonesty is worse. The patient knew that she had received the wrong medication because she had been admitted to hospital and it was discovered there. The dispensing error was therefore already known before Mr Dawood set upon his path of deception, a course he maintained for 5 weeks.

[102] Cancellation was imposed in *PCC v Wong* Phar17/409P, but we view Mr Dawood's conduct in a different category. Mr Wong was disciplined as a result of four convictions under the Crimes Act 1961 and the Medicines Act 1984. The police charged him

following the execution of a search warrant issued in the course of a joint investigation by the Police and Medsafe into the supply and prescription of restricted medicines. He knowingly dispensed medication without a valid prescription. On hearing of the ill-effects of the medication on a patient, he then attempted to cover up his wrong-doing by modifying the invalid prescription and forging the signature of a doctor. He also supplied excessive amounts of restricted medicines containing codeine to the same customer; large amounts of Nurofen Plus to another customer whose dependency on the medication led to her admission to hospital with life-threatening health conditions; and supply to a third customer of large amounts of Nurofen on a no questions asked basis. Aside from the elements of dishonesty in the *Wong* case, the aggravating features were that Mr Wong's conduct inevitably contributed to the harm caused to one patient who died and another who was hospitalised; he continued his offending even after learning about the first patient's death due to an overdose; Mr Wong also took steps to cover up his offending by creating false prescriptions upon learning of the patient death; and the lengthy period of the offending for more than 18 months, and in obvious breach of his professional obligations.

[103] There was no cancellation imposed on the pharmacist in *Taylor*, whose wrongdoing included falsifying entries on the controlled drug register. The pharmacist had encountered difficulties obtaining employment and in his first position, had followed his employer's lead and been complicit in the employing pharmacist's misconduct. It was felt that there was scope for rehabilitation.

[104] The other two cases the Director cited involved doctors. In *PCC v Gilgen* 149/Med07/60 & 07/61P who, while his practicing certificate was suspended, forged the signature of his colleague on three standard prescription forms which he then attempted to collect from a pharmacy. Another aspect of the charge related to Dr Gilgen ordering prescription androgens and anabolic steroids from Singapore whilst his practicing certificate was suspended. At penalty stage, the Tribunal considered that an aggravating factor was that "Dr Gilgen had demonstrated in the present case outright dishonesty in the way in which he continued to try and obtain medications, and then denied he had done so." It also took Dr Gilgen's previous disciplinary offences into account, which included a prior deregistration relating to a prescription infringement

which was described at the time as being “a flagrant example of excessive and reckless prescribing” and displaying elements of dishonesty and deceit. In cancelling Dr Gilgen’s registration, the Tribunal noted that previous conditions imposed did not appear to have produced a satisfactory outcome.

[105] The Tribunal acknowledges that Mr Dawood’s conduct is not as serious as that in *Wong* or *Gilgen*. The cases where pharmacists have been struck off have tended to cover a range of misconduct. Some of the cases cited at first seem more serious than the present case.

[106] However, there are two reasons the Tribunal has decided that cancellation is the appropriate penalty for Mr Dawood. First is the significant lengths and degree of dishonesty Mr Dawood engaged in, not only to protect himself but to frame his colleague, who was his employee and his supervisor. He maligned her by telling the Pharmacy Association, another pharmacy colleague and the patient. Such action was likely to undermine the support mechanisms put in place by the Council to safeguard the public from harm and had the potential to sabotage the career of Ms A. His actions also erode the confidence that Ms B, a reliant on frequent dispensing of her regular medications should be able to have in the pharmacy profession. As noted by the Director of Proceedings, this is not the first instance of Mr Dawood attempting to cover up for his short-comings. The Medicines Control audit that led to the referral to the Pharmacy Council revealed discrepancies in Mr Dawood’s methadone dispensing records such as retrospective annotations and entries to the Controlled Drugs Register, the Toniq dispensing record, the methadone dispensing recording sheets and patient methadone prescriptions.

[107] The second reason for cancellation is that the Tribunal cannot expect the profession or the public to feel protected or reassured by a further attempt at rehabilitation. The Council has engaged in rehabilitative measures over a period of 4 to 5 years with little or no improvement demonstrated in Mr Dawood’s dispensing practices. The Competence Review and reassessment revealed that he continued not to follow his own Standard Operating Procedures, despite the fact that his staff did. Mr Dawood then comes before us on matter involving dispensing. Patient safety has not been protected.

[108] Rehabilitation has not been effective. The practitioner was under the review of the Council for the better part of 6 years. The profession's obligations under the Act do not require indefinite supervision or mentoring of a colleague whose practices pose a risk of harm to the public. A penalty of cancellation under section 101(1)(a) is fair and proportionate in the circumstances.

[109] Under section 102(1)(a) Mr Dawood may not apply for re-registration for three years from the date of this decision and under section 102(1)(b) before applying for re-re-registration:

(a) he must have completed to the satisfaction of the Pharmacy Council further education in ethics and professional responsibilities as is directed and approved by the Pharmacy Council; and

(b) he will have provided an undertaking to the Pharmacy Council that he will comply with all conditions as are imposed by the Pharmacy Council on his future practice as a pharmacist.

[110] We also mark the disapproval of the public and profession in censuring Mr Dawood under section 101(1)(d), and impose a fine of $5,000 under section 101(1)(e).

Costs

[111] The starting point for costs should be 50%.[16] Where there has been a guilty plea and co-operation with a disciplinary prosecution, some reduction is usually made.

[112] The Director acknowledged Mr Dawood's acceptance of the charge against him, his willingness to agree a summary of facts and to attend the hearing by AVL, which the Director acknowledges was not Mr Dawood's initial preference, and submitted that a 30% contribution to costs would be appropriate. A costs schedule totalling $20,160.00 was provided.

[113] The Tribunal's costs totalled $12,392.

[114] No statement of financial means was provided for Mr Dawood. There is no evidence that he is unable to meet an order for costs. We considered that 35% is a

[16] *Cooray v Preliminary Proceedings Committee* (unreported, AP 23/94, Wellington Registry, 14 September 1995)

reasonable amount for Mr Dawood to contribute to the total costs of under section 101(1)(f). A further small reduction was made and total of $10,500 is ordered.

Suppression of Name

[115] The practitioner applied for suppression of his name on the basis of adverse impacts on his family member that would be caused by publication.

[116] The Director opposed it.

Principles

[117] Section 95(1) of the Act provides that all Tribunal hearings are to be in public.[17] Section 95(2) provides:

> (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.

[118] Therefore, in considering and application prohibiting publication, the Tribunal must consider the interests of the practitioner, his family, and the public interest. If we think it is desirable to make an order for non-publication, we may then exercise our discretion to make such an order.

[119] The public interest factors have been established:[18]

(a) Openness and transparency of disciplinary proceedings;

(b) Accountability of the disciplinary process;

(c) The public interest in knowing the identity of a health practitioner charged with a disciplinary offence;

(d) Importance of free speech (enshrined in section 14 of the New Zealand Bill of Rights 1990); and

(e) The risk of unfairly impugning other practitioners.

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[17] This is subject to section 97 which provides for special protection for certain witnesses

[18] As set out in *Nuttall 8Med04/03P* and subsequent Tribunal decisions

[120] There has been much discussion of the principle of open justice in the Courts and legal commentary. The principle of open justice has been described as a fundamental principle of common law and is manifested in three ways:

> [F]irst, proceedings are conducted in 'open court'; second, information and evidence presented in court is communicated publicly to those present in the court; and, third, nothing is to be done to discourage the making of fair and accurate reports of judicial proceedings conducted in open court, including by the media. This includes reporting the names of the parties as well as the evidence given during the course of proceedings.[19]

[121] In *Erceg v Erceg*[20] the Supreme Court said:

> [2] The principle of open justice is fundamental to the common law system of civil and criminal justice. It is a principle of constitutional importance, and has been described as "an almost priceless inheritance". The principle's underlying rationale is that transparency of court proceedings maintains public confidence in the administration of justice by guarding against arbitrariness or partiality, and suspicion of arbitrariness or partiality, on the part of courts. Open justice "imposes a certain self-discipline on all who are engaged in the adjudicatory process – parties, witnesses, counsel, Court officers and Judges". The principle means not only that judicial proceedings should be held in open court, accessible by the public, but also that media representatives should be free to provide fair and accurate reports of what occurs in court. Given the reality that few members of the public will be able to attend particular hearings, the media carry an important responsibility in this respect. The courts have confirmed these propositions on many occasions, often in stirring language.
>
> [3] However it is well established that there are circumstances in which the interests of justice require that the general rule of open justice be departed from, but only to the extent necessary to serve the ends of justice.

[122] The disciplinary process needs to be accountable so that members of the public and profession can have confidence in its processes.[21]

[123] The public interest in knowing the identity of a practitioner charged with a disciplinary offence includes the right to know about proceedings affecting a

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19 Jason Bosland and Ashleigh Bagnall, 'An Empirical Analysis of Suppression Orders in the Victorian Courts: 2008-12 (2013) 35 *Sydney Law Review* 674.

20 *Erceg v Erceg* [2016] NZSC 135.

21 *Nuttall* 8Med04/03P para [26], referring to *Director of Proceedings v Nursing Council* [1999] 3NZLR 360*; Beer v A Professional Conduct Committee* [2020] NZHC 2828 at [40]

practitioner, but also the protection of the public and their right to make an informed choice.[22]

[124] The High Court has said the statutory test for what is desirable is flexible:[23]

> Once an adverse finding has been made, the probability must be that public interest considerations will require that the name of the practitioner be published in the preponderance of cases. Thus, the statutory test of what is "desirable" is necessarily flexible. Prior to the substantive hearing of the charges the balance in terms of what is desirable may include in favour of the private interests of the practitioner. After the hearing, by which time the evidence is out and findings have been made, what is desirable may well be different, the more so where the professional misconduct has been established.

Practitioner submissions

[125] In support of his application for suppression of his name, Mr Dawood presented and affidavit from himself and one from his [family member], [Ms O]. The Tribunal also received a statement signed by his family. Mr Dawood seeks name suppression because of the negative effects publication could have on his parents and [ ].

[126] In her affidavit, [Ms O] told the Tribunal that she was concerned that publication of her [family member]'s name could have "extremely negative consequences" on her career and professional reputation in the healthcare industry, where she works as an [ ] in [another country]. She grew up in New Zealand, was educated here, owns a house here and considers New Zealand home. She said that her field is a niche area comprising only a small pool of dedicated people. She described her role and said it requires having a rapport and reputation with health providers across [ ] to [ ]. Negotiation and co-ordination across a range of health disciplines is required. [Ms O] is very worried about the possible negative impact on her career in [ ] and also should she return to New Zealand, and that it negatively affect her employer's reputation.

[127] In support of the application, Mr Dickinson referred to a Court of Appeal decision *B v R* [2011] NZCA 331 where the Court recognised that "publication of Mr B's name would plainly cause incalculable hurt to individual family members and the extended family as a group". Mr Dickinson submitted the anxieties Mr Dawood's [family member]

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22 *Nuttall* 8Med04/03 para [27], [28], referring to *Director of Proceedings v Nursing Council* [1999] 3NZLR 360

23 *A v Director of Proceedings* CIV-2005-409-2244, Christchurch 21 February 2006 at [42] (also known as *T v Director of Proceedings* and *Tonga v Director of Proceedings*)

expresses about her reputation and career progression are far from notional. The downstream consequences of publication in a competitive working environment are difficult to predict much less actually uncover if any “labelling” or “branding” is going on. The risk alone, it is submitted, would cause incalculable hurt.

Director’s submissions

[128] In opposing name suppression, the Director of Proceedings submits that [Ms O]’s concerns are speculative. The Human Rights Review Tribunal decision of Director of Proceedings v Brooks (Application for Final Non-Publication Orders) [2019] NZHRRT 33 was offered for assistance because of its discussion of impact of publication on family members. Reference was made to expert evidence provided to the HRRT. was that:

[129] The Director submitted that *B v R* could be distinguished because:

(a) In that case naming the defendant would “undoubtedly compromise” the ability of his wife and daughter to execute the functions of their jobs. Here, [Ms O] does not claim that she would be unable to do her job, but rather, that she fears some harm to her reputation, or possible career progression.

(b) Secondly name suppression was also considered necessary because it would cause distress to the defendant’s school-aged child and grandchild, and had the potential to seriously disrupt their development.

(c) Further, the family all lived and worked in the local area, and were known within that area.

Discussion

[130] In the *Brooks* decision the evidence of Ms Kelly summarised by the Director appears to be evidence of her experience rather than an “expert” opinion. We are wary of it having general application. Nor is it apparent that the HRRT relied on it in its conclusion.

[131] The Tribunal accepts the Director’s submission that the present case is not in the same category as *B v R*, where The Court recorded that Mr B’s surname was unusual, that it was well known in the rural district where he and the family members live. Mr B's former wife held senior positions in two District Courts in the area and in her capacity as a court official she had frequent dealings with members of the public who

relied on her integrity and honesty. His elder daughter who also worked for the courts and a younger daughter employed by the Investigation Section of the Inland Revenue Department. That position was said to carry with it an expectation of integrity and honesty which was likely to be adversely affected were the father's name to be published. The Court found:

> Publication of Mr B's name would plainly cause incalculable hurt to individual family members and the extended family as a group. Apart from the acute embarrassment it would cause on a personal level, it would undoubtedly compromise the ability of Mrs B and her two daughters to do their jobs. It will inevitably cause distress to the children involved and has the potential to seriously disrupt their development.

[132] This Tribunal has considered [Ms O's] evidence and is not persuaded that her [family member]'s disciplinary findings in New Zealand will compromise her ability to work as an [ ] in [another country] to such a degree that it outweighs the various public interest factors outlined above. There is no further evidence to substantiate her fears. On the information before us, it is difficult to understand that this case will be widely known in [another country] health circles, that a link would be made between this decision and [Ms O], that her credibility or ability to negotiate for her clients would be undermined, her employer's reputation eroded, or her employment prospects compromised either in New Zealand or [ ].

[133] These disciplinary proceedings have no doubt caused stress and anxiety to Mr Dawood's family members, but the Tribunal is not persuaded that [Ms O]'s work, career opportunities or her employer's reputation would be so adversely affected, if at all, as to outweigh the public interest factors in publication of Mr Dawood's name.

[134] The name of Mr Dawood's [family member] and the name or identifying details of her occupation as an [ ] are suppressed. She may be referred to as a family member. But for the application for name suppression, that information would not have been before the Tribunal. Reference to "[ ]" will also be replaced with "another country".

[135] The interim order for suppression of Mr Dawood's name lapses.

Results and Orders

[136] A finding of professional misconduct has been made.

[137] The practitioner's registration is cancelled under section 102(1)(a).

[138] The practitioner is censured under section 102(1)(d)

[139] The practitioner is fined $5,000 under section 101(1)(e).

[140] The practitioner is ordered to pay costs of $10,500 under section 101(1)(f).

[141] There is no order of non-publication of the practitioner's name, but certain details as outlined in paragraph 134 are to be suppressed under sections 95 of

[142] Under section 157 of the Act the Tribunal directs the Executive Officer:

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

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

DATED at Wellington this 6th day of May 2022

....

T Baker
Chair
Health Practitioners Disciplinary Tribunal