NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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HPDT NO	**1371/Nur23/580D**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act
BETWEEN	**DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994
	Applicant
AND	**WILLIAM MCPHAIL of Dunedin, retired registered nurse**
	Practitioner

HEARING	**Held at Dunedin 18 to 22 September 2023**
TRIBUNAL	Ms T Baker (Chair) Dr B McCulloch, Ms C Neilson-Hornblow, Ms S Matthews, Ms J Byford-Jones Ms G Fraser and Ms L Cheetham (Executive Officers)
REPRESENTATION	Ms J Herschell and Ms C Billing for the Director of Proceedings Dr F McCrimmon for the practitioner

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TRIBUNAL DECISION

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[1] The Director of Proceedings laid a charge of professional misconduct against William McPhail (**the practitioner**) under section 91(1)(a) of the Health Practitioners Competence Assurance Act 2003 (**the Act**) alleging breaches of boundaries, including sexual intimacy with a patient or former patient [Ms N], whom he had cared for in his capacity as a mental health nurse, while employed at Southern District Health Board (**SDHB**).

[2] The period covered by the charge is [4 months] "[ ] January [ ] to about [ ] May [ ]". The allegations are grouped into three categories:

(a) Professional boundary breaches with [Ms N], including communication via cell phone, meeting her outside the professional context, giving gifts, money and food and sharing personal information;

(b) Failing to take appropriate steps when [Ms N] purchased [xx]; experienced episode(s) of dissociation while at [] (a motel) and alleged that she had had sexual relations with another staff member;

(c) Engaging in sexual and/or intimate contact with [Ms N].

[3] The Tribunal convened in Dunedin and heard evidence and submissions over 4½ days. They then retired to reach a decision on the factual allegations and the charge of professional misconduct. The Tribunal upheld the charge under section 100(1)(a) and (b) of the Act and issued a summary of findings on 2 October 2023. The parties then filed submissions on penalty, costs and name suppression and the Tribunal considered the written submissions.

[4] Under section 103 of the Act, any orders of the Tribunal must be in writing with reasons. This is the full reasoned decision on liability, penalty, costs and name suppression.

Summary of findings

[5] The Tribunal found the factual allegations of the charge were established with one small exception being whether Mr McPhail gave [Ms N] a bracelet and pendant.

[6] The Tribunal found the established conduct amounted to professional misconduct under section 100(1) of the Act.

[7] The Tribunal orders cancellation of Mr McPhail's registration under section 101(1)(a).

[8] Under section 102(1)(a) Mr McPhail is not permitted to reapply for registration before the expiry of 12 months from the date of this decision.

[9] Under section 102(1)(b), if Mr McPhail seeks re-registration he must first:

(a) Confirm in writing to the Nursing Council that he has completed, at his own cost, an appropriate course on ethics and boundaries approved by the Nursing Council;

(b) Undertake in writing to the Nursing Council that he will comply, at his own cost, with all directions, recommendations and requirements of the Nursing Council, including any requirement for proof of compliance with any conditions;

(c) Undertake in writing to the Nursing Council that for a period of three years after re-registration, he will have a chaperone present if attending to female patients;

(d) Undertake in writing to the Nursing Council that for a period of three years after re-registration, he will advise any future employers of the Tribunal's decisions and orders.

[10] Under section 101(1)(d) Mr McPhail is censured.

[11] Under section 101(1)(f), the Tribunal orders Mr McPhail to pay $70,006.28, being 35% of the Director of Proceedings' costs and 35% of the Tribunal's costs.

[12] Under section 95(2) the Tribunal orders permanent non-publication of the name and identifying details of the complainant, [Ms N].

[13] The Tribunal declines Mr McPhail's application for continued name suppression. The existing interim orders will continue for 21 days from the date of this decision, at which time they will lapse.

[14] There are orders under section 95(2) for suppression of details of the [circumstances] of Mr McPhail's wife and the current [circumstances] of Mr McPhail's son.

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

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

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

Standard of proof

[16] The burden of proof is on the Director of Proceedings. The standard of proof is on the balance of probabilities. That means that the Tribunal must be satisfied that an allegation is "more likely than not" to be true.

[17] In *Z v Dental Complaints Assessment Committee* [2008] NZSC 55 Elias CJ discussed the notion of "flexibility" of the standard of proof, concluding:[1]

> Proof is made out whenever a decision-maker is carried beyond indecision to the point of acceptance either that a fact is more probable than not…

[18] In the majority judgment in *Z,* the discussion continued:[2]

> … it is not the position that flexibility is "built into" the civil standard, thereby requiring greater satisfaction in some cases. Rather the quality of the evidence required to meet that fixed standard may differ in cogency, depending on what is at stake.

Evidence

[19] The Director of Proceedings called 7 witnesses:

(a) Clare Prendergast, the Deputy Registrar and Senior Legal Advisor of the Nursing Council. She gave evidence about receiving a notification from SDHB and referring it to the Health and Disability Commissioner, as required by section 64 of the Act.

(b) The complainant, [Ms N].

(c) Richard Mullen, consultant psychiatrist, who was [Ms N]'s psychiatrist from January [ ] until early [ ] [3 years].

[1] At [28]
[2] At [101]

(d) Charlotte Mentzel, consultant psychiatrist, currently reGsponsible for [Ms N]'s care.

(e) Cameron Hansen-Beadle, computer analyst who gave evidence about the authenticity of the content of some phone messages.

(f) Lesley Roberts, former Charge Nurse Manager at SDHB's Emergency Psychiatric Services.

(g) Heather Casey, former Director of Nursi ng for Mental Health, Addictions and Intellectual Disability Services at SDHB.

[20] The witnesses for the practitioner were:

(a) The practitioner himself.

(b) Harry McConnell, consultant neuropsychologist, called as an expert witness.

(c) Lena Svensk, former New Zealand Police officer who was a colleague of the practitioner through the emergency psychiatric services.

(d) Rita Banhalmi, a Medical Officer in Psychiatry.

(e) Kerry Cross, a registered nurse and colleague of the practitioner.

(f) Amy Porter, registered nurse and colleague who gave evidence of her observations of Mr McPhail's professional and diligent care.

(g) Abby McFadgen, Senior Emergency Department Nurse, whose affidavit was also in the nature of character evidence.

(h) [ ], the practitioner's wife.

Overview

[21] In January [ ] Mr McPhail was a [ ]-year-old registered nurse (**RN**) with 46 years' experience in mental health and psychiatric nursing. He had been employed by the SDHB (and its predecessors) in Dunedin since 1977, had worked for Emergency Psychiatric Services (**EPS**) team since 2010 and had previously worked as a registered nurse in an acute psychiatric

inpatient unit. The EPS is a mobile 24-hour, 7 days-a-week service providing emergency services to people with acute mental health needs.

[22] In late January [ ] [Ms N] had been admitted to hospital after [ ] . She was discharged but readmitted expressing [ ]. At this time, she was [ ] years old, had been using mental health services since she was a teenager and had presented to EPS previously. At this time she was living in assisted accommodation run by PACT[3] where staff support people with mental health and addictions issues to live independently.

[23] On [ ] January [ ] [Ms N] was referred to EPS, where she was assessed by Mr McPhail. [Ms N] was then admitted to the ward in the early hours of the morning.

[24] Mr McPhail finished his shift at 7.30am on Wednesday [ ] January [ ] and then had his usual rostered days off of Thursday and Friday followed by four weeks' prearranged leave commencing on Saturday [ ] February.

[25] The Director produced evidence of a text (SMS) conversation between 11.43 am and 3.10pm on [ ] January [ ] between [Ms N] and Mr McPhail.

[26] There is no dispute that following this exchange, the two met in person on several occasions, including at the car park overlooking the Taieri Plains, at the Spotlight store, and at a motel in [ ]. This was between [ ] January and [ ] March [ ], at which point [ ]. It is also agreed that between [ ] January and [ ] May [ ], the two had phone conversations, engaged in communication via Facebook's "secret chat" and had further conversations via Messenger and SMS.

[27] It is not disputed that Mr McPhail either lent or gave [Ms N] various items. Therefore the factual allegations of much of the charge are accepted. As outlined below, the nature and circumstances of the ongoing contact are in dispute. Whereas [Ms N] said that the couple engaged in sexual intimacy, Mr McPhail denied that there was any physical aspect to their encounters. His position is that he was being blackmailed and that he was trying to placate [Ms N] in order to stop her from making false accusations of sexual assault.

[3] PACT is a mental health and addictions services that supports people recovering from mental illness, with addiction problems or with intellectual and other disabilities

[28] In early May [ ] [Ms N] was admitted to Ward 9C. On [ ] May [ ] and [ ] May [ ] she disclosed to staff that she had been involved in a relationship with Mr McPhail. She was later interviewed by the Southern DHB.

[29] Mr McPhail was advised of the allegations on [ ] May and [ ] May [ ], when the DHB's proposed investigation process was explained to him. Mr McPhail took special leave until [ ] May [ ] when he returned to work on alternative duties that did not involve contact with patients.

[30] On [ ] May [ ] Mr McPhail informed the DHB that he would retire immediately from EPS as he no longer regarded his workplace as safe due to false claims that had been made and the manner in which the matter was being handled by the DHB. On [ ] May he emailed the DHB, confirming his retirement effective immediately.

[31] The DHB could not complete their investigation because Mr McPhail resigned. With support from her mental health team and advocacy services, [Ms N] decided to report the matter to the Health and Disability Commissioner.

Impact of mental health on veracity

[32] Determinations of fact require the Tribunal to make findings of credibility, which may be a combination of reliability of a witness's memory and also veracity, which is defined in section 37(5) of the Evidence Act 2006 (**EA**) as the disposition of a person to refrain from lying.

[33] Dr Richard Mullen gave evidence to the Tribunal. He was a consultant psychiatrist at the DHB from 1995 until October [ ]. He was [Ms N]'s psychiatrist from January [ ]until early[ ] [approximately 3 years] . He gave evidence about [Ms N]'s mental health, advising that [Ms N] had suffered from complex mental health difficulties since her early teens. During Dr Mullen's care, the working diagnoses were post-traumatic stress disorder (**PTSD**), borderline personality disorder (**BPD**), depression and opioid dependence. At times it was thought she also had a panic disorder. At the time of the hearing, [Ms N] was receiving treatment at [a Clinic].

[34] Dr Mullen said that the PTSD resulted from childhood trauma and the events were the subject of ongoing distress for her and probably contributed to her being distrustful and

feeling powerless and negative about herself. [Ms N]'s diagnosis of BPD refers to a pattern of [ ]. She had a history of [ ] with multiple brief hospital admissions when [ ].

[35] Dr Mullen advised that individuals with a BPD diagnosis are not always accurate in their account of events, sometimes giving exaggerated or otherwise misleading accounts and often being very inconsistent. In May [ ] [Ms N] indicated to him that she had had some inappropriate intimate contact with a staff member, short of sexual intercourse. Dr Mullen did not press her for details. He did not consider her account to be dramatic, overstated or intended to be misleading.

[36] Dr Charlotte Mentzel also gave evidence for the Director of Proceedings. She is a vocationally trained psychiatrist, currently working as a Senior Medical Officer at [a Clinic]. At the time of the hearing, [Ms N] had been receiving treatment there since December [ ] and Dr Mentzel was the psychiatrist responsible for her care.

[37] Dr Mentzel described the two manuals that code psychiatric diagnoses, the Diagnostic and Statistical Manual of Mental Disorders (**DSM-5**) created by the American Psychiatric Association, and the International Classification of Disease (**ICD-11**) created by the World Health Organisation. There is considerable overlap, but there is also variation. BPD is a subtype of a personality disorder found in the DSM-5 which defines a personality disorder as "an enduring and inflexible pattern of long duration leading to significant distress or impairment and is not due to use of substances or another medical condition. BPD is present if at least 5 of 9 criteria are met. Dr Mentzel set out the 3 criteria that have been observed in [Ms N] during her treatment and concluded that as she did not display at least 5 criteria, [Ms N] did not meet the requirements for a BPD diagnosis.

[38] Dr Mentzel said that she and the Multi-disciplinary team agree that [Ms N]'s symptoms are best explained by the diagnosis of complex post-traumatic stress disorder (**c-PTSD**), which is found in the ICD-11 but not the DSM-5.

[39] Having set out the basis for this diagnosis, Dr Mentzel noted that one criterion of complex PTSD is "Persistent perceptions of heightened current threat". She said this means that [Ms N] can interpret other people's behaviour as more threatening than they intend it to be and she can remember experiences as more dangerous than someone without c-PTSD

would remember them. In cases discussed in therapy, [Ms N] has never been unclear on the facts or events that happened, just on the intent of the person associated with those events. At no point has the team had any doubts about [Ms N]'s ability to correctly recall or relay information. There have been limited periods of dissociation which mean that [Ms N] can have gaps in her memory or find recalling things difficult. They have not involved the creation of new memories or the insertion of new material in existing memories.

[40] [Ms N] told the Tribunal that at the time the BPD diagnosis was made she was under a lot of stress, having been in a toxic abusive relationship, dealing with past traumas and trying to withdraw from opiates. [Ms N] described her experiences of dissociation and flashbacks, adding that she is very good at reality checking and knowing which is past and which is present and she knows very well what is real and what is a trick of the mind.

[41] Under cross-examination [Ms N] was referred to an entry in her notes from [ ] April [ ] and agreed that she had reported a difficulty distinguishing dream from reality. She responded:

> At the time it was difficult because I was under a lot of stress, but I still know, ah, what happened. Like, it's very clear to me and real.

[42] [Ms N] said that because of her mental health issues, she finds it hard to make friends and maintain healthy relationships. She said that she has been drawn to older men who she thought could protect and look after her and she has often been taken advantage of. When feeling particularly distressed and [ ], she has had thoughts of wanting to seek revenge against men who have abused her in the past and paedophiles.

[43] The practitioner called Professor Harry McConnell, a Consultant Neuropsychiatrist[4] from Robina in Queensland, Australia, to give his opinion on the credibility of the accounts of both [Ms N] and Mr McPhail. On a pre-hearing application, parts of Professor McConnell's evidence were excluded for the reasons outlined in a ruling dated 8 September 2023.

[44] Evidence relevant to the credibility of a complainant was considered in the decision of *Aryan v R*[5] where it was said:

> …What matters is that in New Zealand:

[4] A psychiatrist who has also trained in neurology.
[5] *Aryan v R* [2020] NZCA at [26]

> (a) Expert evidence may not be admitted unless it is reasonably required in order to educate a jury in relation to particular issues which they have to consider; and
>
> (b) Care must be taken to make clear to the jury that the evidence is by way of general background education and says nothing about the credibility of the particular complainant.

[45] In an affirmation made on 25 August 2023, Professor McConnell summarised the following training, as recorded in his CV:

(a) Psychology (BSc with Great Distinction, McGill)

(b) Psychiatry (5 years, Otago)

(c) Neurology (7 years, Otago, Medical College of Pennsylvania, Kings College London).

[46] Professor McConnell frequently assesses the risk of violence, aggression and/or stalking behaviours in patients, and most of the patients he sees have a history of violence and a history of drug abuse/misuse or addiction. There is no separate medical specialty or subspecialty under Psychiatry specifically for "violence", "personality" "personality disorders" or PTSD. Professor McConnell has over 30 years' experience seeing patients with prescription and recreational drug abuse/misuse/addiction as well as significant personality factors and violence, stalking-related behaviour and aggression. He also has approximately 15 years' experience as an independent expert medical examiner in a variety of medicolegal cases related to Psychiatry and is a member of the Notification Committee/Immediate Action Committee for AHPRA/Queensland Medical Board.

[47] As noted in the interlocutory ruling, Professor McConnell has the relevant specialised knowledge and skill based on his study and experience to offer an opinion on aspects of the clinical diagnoses, symptoms and presentations outlined above and the standards expected of medical practitioners practising in those fields.

[48] Professor McConnell had been asked to provide expert evidence on "some of the psychiatric reasons that a patient might put in a false accusation to a regulatory body about their therapist/mental health professional". Professor McConnell referred to a Masters Paper

by a C Rizk, which describes 3 major categories of stalking and cited a 2006 article[6] about assessing and managing risks with stalkers.

[49] Professor McConnell also referred to an article by Whyte et al. which describes 14 possible pathways to false allegations. He said it is clear that most of these could pertain to the complainant.

[50] Professor McConnell said that false allegations of sexual impropriety are very common and mental health professionals are at particularly high risk of being subject to such false accusations and that patients with c-PTSD and borderline personality disorder are particularly more likely to make such false accusations.

[51] Professor McConnell referred to an article by Huntingtin et al: 'False accusations of sexual assault: Prevalence, misperceptions, and implications for prevention work with men and boys' was misleading.[7] Dr McConnell accepted that the estimates were higher than actual false allegations. As Ms Herschell said in closing, that the study reviewed the literature on false accusations and the article's stated purpose was to correct the widespread misinformation and over-estimations among men and boys about the prevalence and nature of false accusations of sexual violence.

[52] In closing submissions, Ms Herschell noted that Professor McConnell is not a forensic psychiatrist and he acknowledged that epilepsy, intellectual disability, autism, and brain injury are his areas of specialty and interest. In fact, the 2006 article by Mullen et al. outlined a psychiatric and psychological evaluation process to be performed on stalkers. Professor McConnell acknowledged that he did not conduct a structured or standardised stalking risk on [Ms N]. He has not met her.

[53] The Tribunal accepts Ms Herschell's submission that many of the articles Professor McConnell relied on were not directly relevant, out of date or not peer-reviewed by independent reviewers. Ms Herschell noted that the paper by C. Rizk is a thesis submitted by

[6] Mullen, P. et al, "Assessing and Managing the Risks in the Stalking Situation", J Am Acad Psychiatry Law 34: 439 – 50, 2006.
[7] https://www.researchgate.net/publication/359479608 False accusations of sexual assault Prevalence misperceptions and implications for prevention work with men and boys

a Master of Arts student for a Forensic Psychology paper. Another article[8] focusses on false sexual harassment allegations in the workplace. A 1990 article by Lee Coleman assessed the methods for interviewing children who make allegations of sexual abuse from 1970-1990.[9] The 2011 report by a "John Doe" is a perspective piece based on the anecdotal experience of a physician who was the subject of a complaint by a nine-year-old child.[10] Another report was published in 2009 based on qualitative data from June-October 2002.[11] The Tribunal accepts the Director's submission that Professor McConnell did not provide a cogent and substantive analysis of relevant literature. Rather, he selected articles with suggestive titles and tailored them to suit his narrative.

[54] Ultimately, there was nothing in the evidence of Professor McConnell which was relevant to the Tribunal's assessment of [Ms N]'s "disposition … to refrain from lying."[12]

[55] A diagnosis of BPD, even if accurate, does not mean that a person tells lies. All that can be said is that people with this diagnosis are sometimes prone to exaggerating or misleading. Such a diagnosis does not lead to an automatic conclusion that the witness tells lies or that the testimony must be discounted. As with any witness, the Tribunal must assess all the evidence and consider whether [Ms N]'s statement is more likely than not to be true.

[56] *Rabih v Professional Conduct Committee of the Dental Council*[13] is the leading authority for the test for credibility. The High Court said "no issue could be taken" with the following principles applied by the Tribunal, adopting a passage from an earlier Tribunal decision,[14] where it was said:

> 26. The test for "credibility" was stated by a Canadian appellate court (in *Faryna v Chorny* [1952] 2 DLR 354 (BCCA)) as being that the real test of the truth of the story of a witness must be at harmony with the preponderance of the probabilities which

[8] Bales, A and Spar, J. *The Psychodynamics of Factitious Sexual Harassment Claims*. Professor McConnell's citation for this was American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington.

[9] Coleman, L. *False Accusations of Sexual Abuse: Psychiatry's Latest Reign of Terror*. Journal of Mind and Behaviour, vol 11 (3-4), 545-556

[10] Doe, John, *Occupational Hazard: The Experience of a False Patient Accusation.* Academic Psychiatry. 35:4, 2011

[11] Gale, C. The 12-month prevalence of patient-initiated aggression against psychiatrists: a New Zealand national survey. Int J Psychiatry Med, vol 39(1) 79-87, 2009

[12] Evidence Act 2006, section 37(5)

[13] [2015] NZHC 1110

[14] Referred to as *Mr Y*, 197/Phar08/99P. Name suppression was lifted in the penalty decision, *May 222/Phar08/99P*

are practical, and which an informed person would readily recognise as reasonable in that place and in those conditions.

27. Accordingly, the Tribunal, where relevant, must consider such factors as:

(a) The manner and demeanour of the witness when giving evidence.

(b) Issues of potential bias, that is, to what extent was evidence given from a position of self-interest.

(c) Internal consistency or, in other words, whether the evidence of the witness was consistent throughout, either during the hearing itself, or with regard to previous statements.

(d) External consistency or, in other words, was the evidence of the witness consistent with that given by other witnesses.

(e) Whether non-advantageous concessions were freely tendered.

28. Essentially, what is involved is an analysis of all the evidence, rather than merely asserting that one party rather than another is to be believed.

[57] The Tribunal has applied these principles to the evidence when assessing the credibility of the witnesses, including Mr McPhail.

Patient/former patient

[58] The Tribunal found that during the time covered by the charge, [Ms N] was Mr McPhail's patient. [Ms N] had a long-term history of using mental health services provided by SDHB and continued to use those services throughout the period covered by the charge. Mr McPhail had assessed [Ms N] as a member of that mental health team. It would be artificial to characterise her has a former patient, given her frequent presentations to the service at that time, but even if she was a "former patient", the nexus between her presentation to EPS on the night of [ ] and [ ] January [ ], and the text communications on [ ] January [ ], coupled with her significant vulnerability, mean the standards expected of Mr McPhail apply no matter whether she is characterised as a patient or former patient.

[Ms N]

[59] [Ms N]'s evidence was that before the assessment at EPS on [ ] January [ ], she had met Mr McPhail before through EPS. This was in the cells at the Police Station. She said that on [ ] January she gave Mr McPhail her number to update EPS's system and told him that he could call her any time. She said that because she was going to be admitted to the ward, he offered to take her cannabis to give back to her when she was discharged. He also told her that he

remembered her, that he found her attractive, and that he gave her his mobile phone number and said that she could contact him any time.

[60] On [ ] January [ ] at 11.41, [Ms N] sent Mr McPhail two text message which read:

> Hello is this Bill?
>
> It's the young lady you met last night here. Are you keen to meet somewhere?

[61] Starting at 1.59pm, the following exchange ensued. The circumstances surrounding this exchange are in dispute and are discussed further below.

> WM: Apologies for the delay in replying. I have been moving stuff for a friend. Happy to meet were would suit
>
> [MS N] Somewhere quiet for a coffee? If you know of any good places let's go there. I'll get back to you with a time when I know no ones gonna be watching me ok 😊
>
> WM: Are you still on the ward?
>
> [MS N] Yeah but not for long. Will get out today or tomorrow. They just wanna monitor blood pressure I can leave as I like though.
>
> WM: I have more heavy lifting today and for bits of tomorrow. I am going to sound like a wuss but do have to be careful about our being seen together. Can you move to the garden away form people and I will ring you.
>
> Ready?
>
> [MS N] Yep can do in a tick
>
> Might have to chat later I need a lie down. You not keen to catch up today? We don't even have to go to a shop we could meet somewhere more secluded.
>
> WM: Not that I am not keen but today and tomorrow busy helping and I really do want to talk this through but as I said I do need to be careful. I will explain either on phone or in person.
>
> Lie down and rest now – that is what is important
>
> [MS N] Can I call u noe (*sic*)
>
> WM: Yes absolutely
>
> [MS N] I'm out for a walk

[62] On [ ] January [ ] [Ms N] was discharged from the ward. Mr McPhail collected her from outside her supported accommodation and she suggested that they go to a café but she said

that Mr McPhail did not want anyone to find out that he was breaking boundaries by meeting up with her and so he drove her to the Taieri Plains lookout, which is about halfway up Three-Mile Hill. [Ms N] said that from the lookout they walked through the Three-Mile bush track and found a clearing, where they sat down and kissed while he touched her. [Ms N] said that Mr McPhail had scratched his leg from branches on the walk and the blood got on her jeans when she was on top of him while he was lying on the ground. Some people came by and it was awkward and so they left.

[63] [Ms N] also said that Mr McPhail took her for several drives around Dunedin in his car to isolated places such as three Mile Hill, Halfway Bush, Signal Hill, Mt Cargill and around the harbour. She said that they would park up where there were no people and they met up once or twice a week, usually during the day. Mr McPhail did not deny this but denied that he drove [Ms N] to secluded places.

[64] [Ms N] said that on these outings they would talk. Sometimes Mr McPhail would kiss her or touch her on her breasts and genitals, sometimes over her clothes and sometimes inside her underpants. Mr McPhail told her about his prostate cancer and that he had had surgery for it and that they had had to remove bits at a time. He talked about his wife and that she worked at [ ]. He said they had not had sex for years and that she was the first intimacy he had had in a long time. Mr McPhail also told her that he had a daughter who lived with them and was a bit older than her. He said that he lived in Mornington or Māori Hill or something like that.

[65] [Ms N] said that in early February she went to Spotlight and bought [ ]. She said that Mr McPhail collected her from Spotlight and they went for a drive and he dropped her back at her accommodation with the [ ]. When asked what she was going to do with the [ ], she told him that she wanted to use it [ ]. She said that he seemed concerned but told her it was her choice, that he was not going to take that from her. [Ms N] was feeling ambivalent. She also told him that she was going to [ ]reminder of her lost baby. [Ms N] said that she told Mr McPhail that she had a [ ]the night before. Later that evening she [ ] She phoned EPS and was later admitted to the ward.

[66] [Ms N] produced a copy of a text exchange which she says happened while she was on the ward. The date on the screenshot is Thursday [ ] February:

WM: ?

[Ms N]: What's the question?

How are you doing

WM: I am worried about you [Ms N] but couldn't get through on messenger[15]

Yes I am ok it is you that I am worried about

[Ms N]: I'm spending a little bit of time in 9C.

WM: Good [Ms N] I am pleased to hear it. Recover well.

[Ms N]: Thanks, I can't find any nice red heels I've been looking around a bit and most of them just look tacky. I bought some other things you might b *(sic)* interested in though 😊

[67] [Ms N] explained that Mr McPhail had told her to buy some red high-heel shoes as he wanted to take what he called "sensual" photos of her wearing them. He also suggested that she could use the photos to make a modelling portfolio. [Ms N] said that Mr McPhail also gave her about $200 or $300 in cash. They talked about buying sex toys and a "strap-on" for him to wear as he could not perform sexually, but she only bought lingerie.

[68] [Ms N] said that Mr McPhail also gave her some books to read. They had titles that she felt were manipulative: "Out of Bounds" by Val McDermid, "Need You Dead" by Peter James, "Tell No-one" by Harlan Coben, and "The Runaway Jury" by John Grisham. He also gave her a blank Valentine's card.

[69] [Ms N] said that in February [ ] they decided that she would stay in a motel for couple of days so that they could meet there. [Ms N] stayed at the [ ] in [ ] for two nights from [ ] to [ ] February [ ].

[70] [Ms N] said she told Mr McPhail that she had a relationship with a Pact staff member, but this had nothing to do with the decision to stay at the motel.

[71] [Ms N] said that she booked and paid for the motel with her credit card and Mr McPhail gave her cash so that there was no paper trail for him. He also bought her some granola, Caramilk chocolate and cigarettes. She said that Mr McPhail told her that his daughter liked Caramilk.

[15] Messenger is an app connected to Facebook. Messages can be sent using a wifi internet connection, rather than using the data on a simcard

[72] [Ms N]'s evidence was that on the second day of her stay at the motel, Mr McPhail visited her and she dressed up in lingerie that Mr McPhail had given her money to buy. She said that they took turns performing oral sex on each other. She said that they did not have "actual sex" because he had had a lot of operations for his prostate cancer. She said they were "experimenting to see if it would work but not much was happening."

[73] [Ms N] said that these events then triggered flashbacks for her past trauma and she froze in fear and dissociated. It was hard for her to move and communicate. Mr McPhail helped her to come back to the present and they talked.

[74] [Ms N] did not accept Mr McPhail's statement made to the Health and Disability Commissioner that he visited her because she called him needing help with a dissociative episode. She confirmed that the episode was as a result of what they were doing in the motel.

[75] [Ms N] clarified that her flashbacks are not the same as what is happening in real life; she can tell the difference.

[76] [Ms N] said that during their relationship, Mr McPhail gave her a digital camera, which she still has. She denied that it was a loan, saying that Mr McPhail gave her the camera so that he could teach her about photography and he also said he used photography as a cover story for his wife, to explain why he was going out. [Ms N] said that Mr McPhail also talked about taking photographs of her, but she did not want him to.

[77] [Ms N] said that Mr McPhail also gave her a bracelet and a kiwi pendant in a little red Cartier pouch. He said that he was clearing out his basement.

[78] [Ms N] said that the last time they met up was in March while she was an inpatient on Ward 9. They met in his car at the back of the ward. She had asked him to get her some codeine. He gave her some of his own.

[79] [Ms N] said that in around April [ ] she was feeling as though Mr McPhail had taken advantage and done wrong by her. She felt that he had power and authority over her and she did not like the position she was in. She told her partner about what was happening and he helped her to see how wrong it all was. She confronted Mr McPhail about this.

[80] [Ms N] produced a copy of screenshots of messages in April [ ]. It shows a record of a video chat for 15 minutes and 45 seconds on [ ] April [ ] followed by a message on [ ] April [ ] at 19.45 from Mr McPhail saying:

> Not sure if you got my reply to yesterday's messages on SC. Basically saying that I have felt crushed by the condemnation that came my way. None the less happy to help if I can.

[81] When [Ms N] messaged asking what he meant, Mr McPhail sent two messages:

> I was referring to your remarks made about 3 days ago about how you were disappointed with my actions, or to that effect.
>
> In effect I am trying to say that I acknowledge your anger and criticism and apologise for all offence given. I feel that you would prefer a cessation of contact which is totally ok if that is what you want, but if you ever need me I would always be happy to help.

[82] Mr McPhail sent a third message explaining that he was heading off to the hospital to work and that he would be happy to talk more.

[83] On [ ] April [ ] [Ms N] messaged Mr McPhail saying:

> Hey I'm gonna stop communication with you OK. I don't want to continue doing what we have been doing.

[84] Mr McPhail replied with, "Ok I understand and wish you well".

[85] The screenshots show that on [ ] April [ ] [Ms N] made contact with Mr McPhail, who said, "What can I do for you, [Ms N]?" The following exchange ensued:

> [MS N] I've been thinking about our time together. I was wondering what made you decide to call me?
>
> WM: I didn't, I replied to your text checked my *(sic)* it was me and introducing yourself again. I now wonder if this was all a plan to take me down
>
> [MS N] I can't remember getting your number. I thought I said call me any time and then you did. I dunno I'm just trying to figure out what the hell went on. I can see it from so many different points but I'm not sure which one is the real one. I'm sorry that things were a bit messy but no I don't want to take u down I just want to feel fuckn safe! Apparently that's not possible though
>
> U still have ur job right?

> WM: Is that what this is about – checking to see if the stuff [ ] wrote on my Facebook page got me fired?

[86] This last comment was in reference to matters that [Ms N]'s partner had posted on Mr McPhail's Facebook page. [Ms N] expressed shock, saying she would make him take it down. She apologised and said that she would try to sort it out.

[87] Mr McPhail said:

> [Ms N] I have tried to be there for you, even offered to come to the police to support you if you wanted to complain about the event in the – what I get back now is awful.

[88] [Ms N] replied:

> You were supportive and did all the right things. Except for when u picked me up with the [ ]. You were gonna let me [ ]. and oh boo hoo it's another young addict with a bpd. Now I realise no one in the mental health field actually cares. Your all robots being puppeteers.

[89] To this, Mr McPhail replied:

> Woah [Ms N] with regard to the [ ] – you promised it was to [ ]s to mark a very sad anniversary. I even agree to take you to Henly to [ ]. When you got in contact and admitted that you had [ ] I was the one to stress that you get help. …
>
> …Christ that is Rich I busted my hump to try and help you only to be threatened.
>
> "I have a sample of your blood" "get me opioids or else" "get me the names of paedophiles" – remember these threats [Ms N]?

[90] [Ms N] replied:

> Oh well looks like I just caused another drama trusting the wrong people. I didn't threaten and I didn't want him to either. Thank you for ur support I really mean that.
>
> Yeah I remember me getting confused about who u are and what you wanted. But I always come around when my moods switch or whatever the hell goes on. Dissociate I dunno. That was uncool but I have been pretty open and honest. I let you see who I was man. U tell me if I'm a bad person ur the best judge of character I know.

[91] [Ms N] then agreed not to contact Mr McPhail again and observed that he would not contact her again. She added that she respected his wishes and that she liked talking with him. She said, "That's what I liked most of all". Mr McPhail replied that her team and EPS should be able to support her, adding that if at any time that wasn't the case, then "of course" he would respond with advice. [Ms N] replied, "I won't bother you, I understand".

[92] On [ ] May [ ] Mr McPhail messaged [Ms N] asking her if the high-heel shoes he had ordered from Wish had arrived. He had been contacted by the supplier and he thought had prompted them to check. He added, “I hope you are well and happy but can (sic) do miss our chats”. [Ms N] replied, “Nothing has arrived, cancel the order if you want”. Mr McPhail replied, "The shoes aren’t important, I just wanted to say hello and see how you are”.

[93] [Ms N] said that later the shoes did arrive, but they were black, not red as she had wanted.

[94] Soon after this conversation, [Ms N] was admitted to ward 9C where she spoke with a nurse about her relationship with Mr McPhail. She told the Tribunal she had been trying to work out what had happened and if the relationship was appropriate. She felt guilty and conflicted as she had consented to it. She was concerned about ruining Mr McPhail’s life and he had said to her that he would take poison if his wife found out. Mr McPhail had been supportive and she enjoyed talking with him. She went from trusting him to not trusting him and feeling taken advantage of as he was much older than her and he had a wife and a daughter older than [Ms N].

[95] [Ms N] acknowledged that she had threatened Mr McPhail that she would tell people what was going on. She denied that she had threatened to accuse Mr McPhail of sexual assault.

[96] [Ms N] also said that early on she asked Mr McPhail for codeine as she had long-term addiction issues. She denied that she threatened him if he did not bring her codeine. She also asked Mr McPhail for the names of repeat sex offenders and talked to him about wanting to expose or kill paedophiles. [Ms N]’s evidence was that it is well-known to her mental health team that she has had fantasies where she seeks revenge on the men who have abused her in the past or on paedophiles. She said she is not proud of this and explained that she was very unwell.

[97] [Ms N] also acknowledged that during the course of the Health and Disability Commissioner’s investigation she expressed frustration to her health team that nothing seemed to be happening with her complaint and she might have to sort it herself. This led to the Police speaking with her about making threats.

[98] [Ms N] said that she had thought that she would [ ] and not have to face the consequences of her relationship with Mr McPhail. She feels embarrassed and disgusted by her choices and she would not have made them if she had not been unwell at the time. She feels she should have been safe with Mr McPhail but she was not. She feels that he took advantage of her mental state and vulnerability.

Heather Casey

[99] Heather Casey is a retired registered nurse. In [ ] she was the Director of Nursing for Mental Health, Addictions and Intellectual Disability Service (**MHAIDS**) for the DHB. In that capacity she had notified the Nursing Council following [Ms N]'s disclosures to two registered nurses on [ ] and [ ] May [ ]. The nurses had written accounts of the disclosures which Ms Casey had produced along with copies of correspondence.

[100] In a prehearing ruling dated 25 August 2023, Ms Casey's evidence was admitted by affidavit without the need for her to appear. This was on the basis that she was unavailable as a witness.

[101] At the hearing of the charge, Dr McCrimmon submitted that little weight can be placed on Ms Casey's evidence.

[102] Ms Casey's evidence covered the background to her notification to the Nursing Council. She produced copies of a letter dated 2 June [ ] from her to the Nursing Council and to Mr McPhail, a record of a meeting that had been undertaken with [Ms N] on 28 May [ ] and the SDHB's Code of Conduct and Integrity. Dr McCrimmon did not challenge the authenticity of this or any of the correspondence between Mr McPhail and his former employer. Essentially the purpose of Ms Casey's evidence was to produce documents that would often be included in an agreed bundle of documents.

[103] The attachments that are hearsay are a record dated 11 May [ ] of a meeting with [Ms N] and the Charge Nurse Manager, an email of the same date to the Charge Nurse Manager from a staff member to the Charge Nurse Manager, and a record dated 10 May [ ] of a registered nurse following a conversation she had had with [Ms N] on the ward. These three attachments were sent to the Nursing Council.

[104] Although the staff who had interviewed [Ms N] did not give evidence, [Ms N] was available to answer questions about this document, which was essentially a prior statement.

[105] At the hearing of a charge, the Director of Proceedings must produce the evidence to support the allegations. The key witness in this case is [Ms N], who gave evidence and was available to answer questions, including any inconsistencies with prior statements. In those circumstances it is appropriate that the Tribunal examines those documents in light of Dr McCrimmon's questions. That is relevant to our assessment of the evidence. It was not clear from Dr McCrimmon's submissions which aspects of Ms Casey's evidence should have little weight attached to them.

William McPhail

[106] As noted above, Mr McPhail accepted that he had contact with [Ms N] via text, phone, secret chat and in person. Mr McPhail denied any sexual relationship with [Ms N] and he denied some details of their contact, including certain gifts. Mr McPhail said that [Ms N] was making up some aspects and in particular [Ms N]'s mental health diagnoses meant that she was prone to fabrication.

[107] A summary of Mr McPhail's explanation for his admitted conduct between [ ] January and [ ] May [ ] was:

(a) [Ms N] blackmailed him saying that she would allege that he had sexually assaulted her if he did not provide her with opiates and/or the names of paedophiles or if he told any of her carers about their contact.

(b) Mr McPhail did not accept responsibility for all the messages that the Director said he had sent to [Ms N], saying that [Ms N] told him that she had cloned his phone.

(c) Mr McPhail did not tell management about what was going on because of a difficult relationship with management.

[108] Mr McPhail said that before [Ms N] sent him the message at 11.41am on [ ] January [ ], she had phoned him on his cell phone and said that she wanted to talk to him about some things. He told her it was not appropriate and he hung up on her. Mr McPhail's evidence was

that [Ms N] then rang him on his landline at home and spoke aggressively, telling him that he should not hang up on her. She said that she had his blood on her jeans and that she could make it look like he tried to touch her. Mr McPhail said that [Ms N] said something like, "It could look like you've tried to sexually assault me. I'm going to ring you again and don't you hang up."

[109] Mr McPhail said that he panicked. The evening before his shift had started, he had scratched his arm on roses he was working on in the garden, and his arm was still bleeding and so he had dabbed it with tissues at work. He did not know how [Ms N] had got his phone number but on reflection thought it might be from an online antiques business he used to run.

[110] Mr McPhail said that he did not report this contact or discuss it with his senior colleagues because he had a difficult relationship with management. Mr McPhail described an incident at the very beginning of his nursing career in the late 1970's when he was working as a registered psychiatric nurse at the Acute Admission Unit at Wakari Hospital and a patient held a loaded gun to his forehead. After he had wrestled the gun from the man, Mr McPhail took that rifle to the Police Station. The ward manager was annoyed with him for doing this because it was the patient's property. Mr McPhail was offered no support, counselling or reassurance. He said he learned early in his career that the support one might expect from management was not forthcoming.

[111] In the 1980's a patient stabbed Mr McPhail in the groin with a sharpened stick. Mr McPhail's incident report was ignored. He was told it had been lost, as was a second report he filed. Following a third report, Mr McPhail was offered a new role, but again not provided with any support. Mr McPhail said that he came to distance himself from managers and administrators and instead focused on the provision of nursing care. He said that those early experiences taught him to be cautious in dealing with management. He felt that his opinion was not valued and that he was not listened to.

[112] Mr McPhail also gave evidence of his medical history and provided extracts and reports from his medical records to support his account. He explained that in 2014 he had a radical prostatectomy as a result of prostate cancer. Post-operative complications necessitated further procedures and he also underwent 32 sessions of radiotherapy which caused further

complications and three further major surgeries over the next three years. This has resulted in urinary incontinence which has not responded to other treatments which he also outlined.

[113] Mr McPhail also described mobility issues as a result of degeneration in his lower spine, a knee replacement which makes it difficult to kneel, high blood pressure, significant pain issues and interstitial lung disease which causes breathlessness.

[114] All of these health conditions mean that he cannot have an erection, he does not experience sexual urges, his genitalia are painful to touch, he wears incontinence pads and he has not engaged in any sexual activity since 2014.

[115] Mr McPhail decided to speak with a police colleague, Sergeant Martina Svensk about the threats from Ms [N]. He had a lot of contact with Dunedin Police because of his role with the EPS. He believes this conversation was before [ ].Mr McPhail's evidence was that he told her what was happening and why it would be difficult for him to go to DHB management. He recalls that she expressed her understanding of his thinking and that it would not be a good move and that she suggested waiting to see what was happening and if the threats escalated to demands for money.

Martina Svensk

[116] Martina Svensk was called to give evidence for Mr McPhail. She was in the New Zealand Police for 15 years and 7 months and that for the last 5 years she held the rank of sergeant. In that capacity, she worked on the Public Safety Team, Custody Team, and the Investigation Support Team. For the last 18 months she relieved as an acting Senior Sergeant in other teams.

[117] Ms Svensk confirmed that in late March [ ] when she was on duty as the Custody Sergeant, Mr McPhail came to the Dunedin Police Station and spoke to her in her office about his patient that had been threatening and blackmailing him. She recalled that he told her that the patient would make an allegation that he had sexually assaulted her in EPS unless he agreed to do things like pick her up and provide transport. He said that the patient had said that she had picked up a tissue with his blood on it and had rubbed it on her jeans. Ms Svensk also recalled that Mr McPhail said that [Ms N] had said that she had cloned his phone and that she would allege sexual assault if he told any of her carers.

[118] Ms Svensk did not understand the conversation to be a formal complaint and she recalls that they thought they would adopt a "wait and see" approach. Her recollection is that she advised Mr McPhail to make a formal complaint to the Police.

Kerry Cross

[119] At the time of these events Mr McPhail was not engaged in any formal supervision. The DHB's Clinical Supervision Guidelines said that all registered health professionals of the MHAIDS were expected to undertake clinical supervision on a regular basis at a minimum of once a month.

[120] Mr McPhail said that when a colleague of his, registered nurse Kerry Cross, became a clinical supervisor, she agreed to supervise him, but they had not signed off each time they met. He had thought that he was receiving formal clinical supervision from her.

[121] Kerry Cross gave evidence. She said that she had first worked with Mr McPhail on the ward in 2010 and later at EPS during periods between 2013 and 2019. She spoke highly of Mr McPhail, saying that she had never witnessed him treat a female in a disrespectful or inappropriate way, that his work was thorough and completed to a high standard, and he was always very safety conscious and adhered to work protocols. They would often sit in on each other's assessments.

[122] Ms Cross said that she completed the clinical supervision course in June 2018 and that she did not provide formal clinical supervision to Mr McPhail. She said that they would occasionally meet outside of work on an informal basis and often ended up discussing work issues; this was not a formalised process. She said at the DHB there is a form that you fill out and sign and date it. She said she was not his supervisor.

[123] In relation to the present events, Ms Cross said that she and Mr McPhail met once for coffee, and he told her that a client that they both knew was attempting to blackmail him for medications and the names of sex offenders. He told her that his phone had been cloned and Ms Cross attempted to explain to him how to take a screenshot of the messages that he said she had sent him. Ms Cross could not recall if Mr McPhail showed her any of the messages. She believed he had spoken to, or was going to speak to, a police colleague.

Rita Banhalmi

[124] Rita Banhalmi also gave evidence of her observations of Mr McPhail's relationship with management. Dr Banhalmi is a Medical Officer in Psychiatry. In [ ] she was a Senior Psychiatric Registrar at Dunedin Hospital, having qualified as a medical practitioner in 2004. She worked with Mr McPhail for over 8 years in EPS. On one occasion[16] when she was at EPS, Mr McPhail was visibly distressed. She observed Mr McPhail trying to approach Ms Lesley Roberts (formerly Mooney), the Charge Nurse Manager for EPS on at least 3 occasions over a period of about 15 to 20 minutes. Ms Mooney would not look at him or make eye contact and was very dismissive.

[125] Dr Banhalmi acknowledged in cross-examination that when she first saw this interaction, she was not aware that a formal investigation (into [Ms N]'s allegations) had begun, but she did hear Ms Roberts say that an investigation was going to start. Dr Banhalmi did not know that Ms Roberts had already advised Mr McPhail it was not appropriate for her to discuss the case with him when an independent panel had been set up to investigate the matter.

[Mr McPhail's wife]

[126] Mr McPhail's wife, also gave evidence, largely of a corroborative nature. In particular, she said that it seemed to her that the relationship that he had with management was toxic and deteriorating. She recalled that in late February [ ] Mr McPhail told her he was being blackmailed by a patient. He did not provide detail and they did not discuss how he would deal with it; rather he was simply letting her know. It was later, probably when the complaint had been made, that Mr McPhail told her that [Ms N] had told him that she had his blood on her jeans and would use that to claim that he had sexually assaulted her.

[127] In cross-examination, Mrs McPhail said that she was not aware that Mr McPhail had given [Ms N] money, had taken her for drives, had visited her at a motel, given her a camera, or bought her high heels.

[16] Although Dr Banhalmi did not say when this occurred, in cross-examination of Ms Roberts, it was said that a witness would give evidence of observations on 20 May.

Particular 1: failure to set and/or maintain appropriate professional boundaries

[128] In the first particular of the charge, the Director of Proceedings alleged that Mr McPhail failed to set and/or maintain appropriate professional boundaries with his patient and/or former patient in the manner set out in the sub-particulars.

[129] The Tribunal found that during the time covered by the charge, [Ms N] was Mr McPhail's patient. [Ms N] had a long-term history of using mental health services provided by SDHB and continued to use those services throughout the period covered by the charge. Mr McPhail had assessed [Ms N] as a member of that mental health team. It would be artificial to characterise her has a former patient, given her frequent presentations to the service at that time, but even if she was a "former patient", the nexus between her presentation to EPS on the night of [ ] and [ ] January [ ], and the text communications on [ ] January [ ] coupled with her significant vulnerability, mean the standards expected of Mr McPhail apply no matter whether she is characterised as a patient or former patient.

Did [Ms N] threaten to allege sexual assault?

[130] Mr McPhail said that the reason he engaged with [Ms N] outside the patient relationship was she threatened to accuse him of sexual assault if he did not provide her with opioids and provide the names of paedophiles.

[131] [Ms N] accepts that she threatened to expose the relationship, but not that she threatened sexual assault. She accepts that she asked for codeine but not that she made threats in order to obtain it. She maintained this position under cross-examination, acknowledging that she had made good on her threat to expose the "sexual relationship".

[132] In the message exchange on [] April [ ]Mr McPhail said to [Ms N] (referring to threats she had made to him):

> "I have a sample of your blood" "get me opioids or else" "get me the names of paedophiles" – remember these threats

[133] In her response message to this, [Ms N] did not deny that she had said these things but it is not clear what exactly it was that [Ms N] had threatened to do.

[134] The only evidence of Mr McPhail acquiescing with the request to provide medication is in March. [Ms N] says that he gave her some of his own codeine. He denies this, saying that he had not taken codeine in years because of the side effects, which his wife confirmed in her evidence. There was no other evidence before the Tribunal that Mr McPhail complied with [Ms N]'s requests for opiates or for the names of paedophiles. There is therefore a lack of logic in Mr McPhail's argument that he was being blackmailed over a period of three months before [Ms N] disclosed that she had been in an inappropriate relationship with him.

[135] There is no evidence before the Tribunal that [Ms N] has ever alleged that she was sexually assaulted by Mr McPhail. Nor is there any suggestion in the evidence or submissions of counsel that her disclosure of the relationship was as a result of Mr McPhail declining a request of hers for anything. There was no evidence that [Ms N] continued to contact Mr McPhail after their exchange on [ ] April [ ] when she agreed not to. Her disclosure of a sexual relationship occurred a few days after Mr McPhail had contacted her about the high heeled shoes. Her response to him had simply been that they had not arrived and he could cancel the order. Mr McPhail then said that he missed their chats. There was no evidence that [Ms N] replied to this communication.

[136] It is also notable that this exchange on [ ] April [ ] started with [Ms N] saying that she had been thinking about their time together. She asked what had made him decide to call her. Mr McPhail said that he had replied to her text. Mr McPhail did not say that [Ms N] had phoned him.

[137] The Tribunal also found that the start of that initial conversation on [ ] January [ ] was not consistent with [Ms N] having just rung Mr McPhail. She says:

> Hello is this Bill?
>
> It's the young lady you met last night here. Are you keen to meet somewhere?

[138] It seems unlikely that [Ms N] would have introduced herself that way if they had just been talking on the phone and had threatened him with an allegation of sexual assault.

[139] The Tribunal accepts that over the next two to three months, [Ms N] threatened to expose the relationship that had commenced, but not that she made threats right at the start before they ever met up or that she threatened to allege sexual assault. The Tribunal does not

find that Mr McPhail continued his contact with [Ms N] simply because he was being blackmailed to do so. There is nothing in the correspondence between them which indicates any reluctance on his part and in fact the last communication was instigated by Mr McPhail, telling [Ms N] that he missed their chats.

[140] Despite Mr McPhail's evidence that the first instance of blackmail was in a phone call made before the text communication began, he did not report the alleged blackmail to anyone until late March when he told Ms Svensk and also Ms Cross. The Tribunal does not find Mr McPhail's explanation credible. The Tribunal does not accept that [Ms N] phoned Mr McPhail before the first text communication on [ ] January [ ] or that [Ms N] threatened to allege that he had sexually assaulted her.

Mr McPhail not reporting threat

[141] Mr McPhail's reasons for not reporting [Ms N]'s threats to management are outlined above at paragraphs 110 and 111.

[142] The Tribunal did not find these explanations plausible. The issues Mr McPhail outlined had occurred 30 to 40 years before the events with [Ms N]. There was no evidence of a difficult relationship with Ms Roberts prior to the complaint from [Ms N]. Ms Banhalmi's observations of Ms Roberts being dismissive of Mr McPhail were in the context of an employment investigation when Ms Roberts did not want to discuss matters with him outside the formal process.

[143] Dr McCrimmon referred to events when Mr McPhail returned to work during the investigation, noting that he was not permitted to undertake his non-patient duties in the shared working area with his colleagues despite the fact, as confirmed under cross-examination, that patients were not present in that area. The Tribunal was asked to conclude that Mr McPhail's reluctance to bring his concerns about blackmail by the complainant to management due to his expectation of the unfair hearing the matter would receive, were proved to be well founded concerns based on the way he was actually treated when the complaint was made.

[144] The Tribunal did not consider that the evidence showed an unfair hearing. The working arrangements were no doubt very uncomfortable and stressful for Mr McPhail, but that is not

evidence of inappropriate or unfair treatment. The investigation had only just commenced. Mr McPhail retired before the process was completed.

1(a): Private communications

[145] The Director of Proceedings alleged that Mr McPhail communicated privately with [Ms N] outside the parameters of the professional relationship multiple times via telephone and/or Facebook messenger messages and/or text messages.

[146] Mr McPhail accepted that there was some phone communication with [Ms N]. The evidence of the Facebook messenger and text messages was produced as screenshots and transcripts. The screenshots showed text conversations on [ ] February, [ ] April, [ ] April, [ ] April [ ] and evidence of a 15-minute videochat on [ ] April [ ]. Both parties agreed that they also engaged in communications on "secret chat". There is no dispute that these were private communications outside the parameters of the professional relationship.

[147] Mr McPhail accepts that he sent some of the messages, but not all of them. His evidence was that after he and [Ms N] had met in person in early February, [Ms N] rang him on his landline at home the next day and told him that she had his cell phone and she had cloned his phone. He did not know what that meant. She said that she could see all his emails and that she could send messages and pretend to be Mr McPhail. She said something like, "I can make things bad for you". He did not have any password or PIN on the phone to lock it.

[148] Mr McPhail was not clear which texts he accepted he had sent. Under cross-examination it was put to him that during an interview during the HDC investigation, he had denied sending the texts on [ ] January [ ], but now seemed to accept them. At the hearing, he told the Tribunal that he was still unsure.

[149] [Ms N] denied cloning Mr McPhail's phone.

Did Mr McPhail send all the communications produced?

[150] The Director called a Computer Analyst, Cameron Hansen-Beadle, to give his opinion on the possibility that Mr McPhail's phone had been cloned. Mr Hansen-Beadle has been active in digital forensics for over 15 years, working first with Computer Forensics New Zealand Ltd and now with Datalab Limited. He has undertaken hundreds of investigations including assisting NZ Police E Crime labs in collation of evidence from electronic devices; providing

expert witness assistance to the Courts; assisting in evidence preparation for high level government staff in high profile cases; assisting various government agencies to interpret and present data from various hardware including cell phones, hard drives and cloud storage; assisting in cases of fraud or suspected fraud to mine and present records of access, system misuse or data manipulation; recovery and analysis of physically damaged CCTV systems to extract and present footage assisting both prosecution and defence; cybercrime attack response to assist with malicious lockdown of systems managing the interaction with online cyber criminals and blockchain payment.

[151] Mr Cameron-Beadle's expertise and methodology was not challenged and the Tribunal accepts that he has the necessary expertise and experience to provide the evidence sought.

[152] The Director of Proceedings had asked Mr Cameron-Beadle to locate and parse direct from source hardware and accounts, messages between the phone numbers and accounts of [Ms N] and Mr McPhail, in order to determine the authenticity of content. He was also asked to comment on the process for cloning a phone.

[153] Mr Cameron-Beadle received [Ms N]'s phone. Mr McPhail's was not available. He said that he no longer had that phone. Mr Cameron-Beadle isolated all evidence on [Ms N]'s phone which related to Mr McPhail's cell phone number.

[154] In Mr Cameron-Beadle's opinion, a high to very high level of technical expertise is required to create a functional "clone" of any cellular hardware that would in turn operate on the cellular or data networks in New Zealand. Facebook employs the "data" network, whereas SMS messages use the "cell" network. If a SIM card is removed and put in another phone, the original phone will not operate on the cellular network. A cloned phone cannot access the cellular network without the original SIM card.

[155] The action of cloning a SIM card is possible with specialist tools and software, but not the use of the SIM to access the cellular network. Mr Cameron-Beadle has attempted to do this in his labs using Cellebrite tools to clone a blank SIM card and then deployed both, simultaneously, on their test phones. The cloned SIM was blocked from making calls or sending SMS messages by the cell network, with the phone displaying the message, "Not Registered on Any Network".

[156] An unlocked phone may allow the user to access permanently logged in applications such as Facebook, Snapchat or WhatsApp via data networks if the phone is connected to known or unlocked Wi-Fi. However, the passwords remain encrypted and so the user cannot access the login simply by copying or accessing parts of the operating system of any given cell phone.

[157] Mr Cameron-Beadle acknowledged that backing up a phone using the provider-based data transfer method such as iCloud or iTunes for Apple, or any of the Android softwares would transfer application login tokens. Tokens are records of the exchange of user credentials stored in a device that allow the device to remain logged into applications when the application is closed or the phone turned off. Mr Cameron-Beadle said that in theory the tokens could provide access to cloud-based communication platforms, but in his experience, the device needs to be unlocked. He clarified in cross-examination that depending on the device, tokens may provisionally give access to certain things. But with two-factor authentication in most modern third-party communication applications, it is unlikely that the other person would hold a fully functioning iteration of the device.

[158] Mr McPhail produced a copy of an article he had found online, called “How to tell if your phone has been cloned”. This article talks about copying SIM card data and International Mobile Equipment Identity) information to duplicate a smartphone on to another device. It says that they can make calls and send messages.

[159] Mr Cameron-Beadle’s view was that the article was not well-founded in science.

[160] Based on the screenshots presented to the Tribunal, it appeared that Mr McPhail sent the texts and messages as alleged by the Director. [Ms N] denied cloning the phone. If Mr McPhail seeks a finding that they are as a result of cloning his phone, the onus of proof shifts to him. Mr McPhail produced only an article he found online through the Google search engine. The credentials of the author of that article are unknown and the author has not been available for cross-examination. On the basis of Mr Cameron-Beadle’s evidence the Tribunal finds that it is not possible to clone a SIM card so that two people have simultaneous access to the cellular network from the same phone number. The Tribunal also finds it is very unlikely that [Ms N] had the capability to undertake such a task.

[161] In addition, Mr McPhail has been inconsistent in his evidence about the texts. Mr McPhail's evidence was that he engaged in the text communication on [ ] January [ ] as reproduced above. Then in cross-examination, he acknowledged that he had previously denied sending these texts. His evidence to the Tribunal was that he was not sure if he had sent these texts.

[162] The Tribunal is satisfied that all of the communication that has been reproduced as copies of screenshots is authentic and did take place between Mr McPhail and [Ms N]. Mr McPhail accepts that the pair communicated by phone, text (SMS) and Messenger, including "Secret Chat". Particular 1 a) is established.

1(b) Private meetings

[163] In particular 1(b), the Director alleged that Mr McPhail met privately with his patient or former patient and/or former patient outside the parameters of the professional relationship several times when he took her for drives in his private vehicle and/or visited her at a motel.

[164] Mr McPhail agreed that he collected [Ms N] and took her to the parking area overlooking the Taieri Plain but thought that it was early February. He also agreed that she asked him to take her for coffee, but he was not comfortable with that and considered the parking area was a public area.

[165] There is no dispute that on or about [ ] February [ ] Mr McPhail collected [Ms N] from outside her supported accommodation and took her to a motel, that he visited her there the next day, and that on [ ] February [ ], he transported her back to her supported accommodation. The circumstances and nature of the contact during that motel stay is discussed above in paragraphs 69 to 74.

[166] It was also common ground that there was a meeting that involved the store Spotlight. [Ms N] says that this was early February, whereas Mr McPhail said that it was [ ] March.

[167] [Ms N] produced a printout of a screenshot of text messages which Mr Hanson-Beadle showed in his analysis commenced on[ ] February [ ] at 11.24am with question-mark from Mr McPhail.

[168] In his evidence Mr McPhail prefaced his evidence of his parts to this exchange with "I understand that I sent …" When it was put to Mr McPhail in cross-examination that he had started this exchange with a question mark, he said, "I'm told I did but I actually can't understand that I would do that. That's not my normal communication." He agreed that the remainder sounded more like his language. Mr McPhail denied collecting [Ms N] from Spotlight in early February [ ].

[169] [Ms N] produced a copy of a bank statement showing that she made a purchase from Spotlight on [ ] February [ ], but none on or around [ ] March [ ].

[170] Based on the bank records and the coincidence of the incident with the [ ] with the anniversary of the loss of [Ms N]'s baby, the Tribunal finds it is more likely it was on or about [ ] February [ ] that Mr McPhail collected [Ms N] from Spotlight.

[171] The conduct alleged in particular 1(b) is admitted and so particular 1(b) is established.

1(c): Tried to keep private contact secret

[172] The Director alleged that Mr McPhail tried to keep his private contact with [Ms N] a secret. Ms Herschell pointed to [Ms N]'s evidence that the pair communicated mostly through secret chat on Facebook.

[173] Mr Hanson-Beadle confirmed that secret chat messages are hidden from servers and storage and interception and that if he had not seen any when he investigated, it is because they either never existed, or the entire thread has been deleted. He said that if the parties say they used secret chat, but it can no longer be detected, then in theory both parties have deleted the secret chat threads from their devices.

[174] Mr McPhail had been asked to provide his phone to Mr Hanson-Beadle but had declined to and he said that phone had died. He said that a new SIM had been printed for the new phone. He had declined Mr Hanson-Beadle access to his Facebook account because he and his wife had felt that would be a step too far.

[175] [Ms N] said that Mr McPhail did not want his colleagues to find out about their contact and he suggested that if they were seen together, they would say they met through his online

antiques business. She said that Mr McPhail used his photography hobby as cover to explain to his wife why he was going out.

[176] The Director also submitted that Mr McPhail's proposal for parking in an area overlooking Taieri Plain for their first outing, rather than a café as suggested by [Ms N] was evidence of Mr McPhail wanting to keep the meeting secret. [Ms N]'s evidence was also that the purpose of staying at the motel was so that they could keep their contact secret.

[177] This sub-particular was not specifically addressed in closing submissions for the practitioner.

[178] The Tribunal found there was nothing transparent about Mr McPhail's relationship with [Ms N]. He did not tell his clinical nurse manager or other senior colleagues about his communication and contact with [Ms N]. He did not tell his wife of the blackmail until late February. In cross-examination, his wife said that she was not aware that Mr McPhail had given [Ms N] money, had taken her for drives, had visited her at a motel, given her a camera, or bought her high heels. In late March, he spoke Ms Svensk and Ms Cross. That was two months since he had first started having personal contact with [Ms N].

[179] The Tribunal found that by taking [Ms N] to the Taieri Plains lookout, rather than to a café for their first meeting, by using "secret chat" for personal communication and not disclosing his contact with [Ms N] to his wife or colleagues, Mr McPhail tried to keep this private contact a secret. Particular 1(c) is established.

1(d): Divulged personal information

[180] The Director alleged that Mr McPhail divulged personal information about his family and/or his personal medical issues to [Ms N].

[181] [Ms N] said that Mr McPhail told her about his prostate cancer, the surgery he had for it, and that he had trouble with incontinence and wore incontinence pads. He also talked about his wife, that she worked at []. He told [Ms N] he had not had sex with his wife for years. He told her he had a daughter who lived at home with them, who was a bit older than [Ms N] and who liked Caramilk chocolate. He told her he lived somewhere like Mornington or Māori Hill (she cannot recall which now) and that he had a sister who lived in [ ].

[182] Mr McPhail acknowledged that he told [Ms N] that he could not have sex because of his surgery. He said that he possibly told her that his wife worked at [].

[183] Mr McPhail did not accept that he told [Ms N] that he and his wife had not had sex in years or that his daughter liked Caramilk chocolate and told the Tribunal that in fact that she hates Caramilk chocolate.

[184] [Ms N] may have been mistaken about Mr McPhail's daughter's taste in chocolate, but such an error does not erode the fact that [Ms N] clearly had knowledge of a number of Mr McPhail's personal matters, consistent with the acknowledged ongoing contact that the two had. The Tribunal accepts [Ms N]'s evidence that Mr McPhail shared this information with her. It is difficult to understand how she would otherwise be aware of it. Mr McPhail himself admits that he told her that he could not engage in sexual intercourse.

[185] Particular 1(d) is established.

1(e) Gave your patient and/or former patient money;

[186] In particular 1(e), the Director alleged that Mr McPhail gave [Ms N] money.

[187] [Ms N] said that Mr McPhail gave her approximately $200 or $300 in cash to buy lingerie, and cash to pay for the motel.

[188] Mr McPhail said that he gave [Ms N] $180 for dental treatment. He said it was an act of charity and it is not uncommon practice for him to help people out.

[189] Ms Roberts also gave evidence that on [ ] May [ ] Mr McPhail said he had lent [Ms N] $200 for dental work.

[190] [Ms N] said that her mother paid for her dental treatment.

[191] There was no evidence that [Ms N] had ever returned any money given to her.

[192] The Tribunal found that Mr McPhail gave [Ms N] at least $200. It is possible that he gave her more than that, but based on his own admission that he lent her $180, his statement to Ms Roberts that he lent her $200, and in the absence of any evidence that [Ms N] returned it at any time, the Tribunal is satisfied that Mr McPhail gave [Ms N] $200. Particular 1(e) is established.

1(f): Bought food for your patient and/or former patient

[193] Particuar 1(f) alleged that Mr McPhail bought food for [Ms N].

[194] Mr McPhail accepted that on the way to the motel on [ ] February [ ], he bought [Ms N] some bread, spread, milk, cereal and chocolate for her. Particular 1(f) is established.

1(g): Gave your patient and/or former patient personal items, including a camera and/or a bracelet and/or a pendant;

[195] Mr McPhail accepted that he "lent" [Ms N] a camera. However, she still has the camera. There is no evidence that he asked for it to be returned, including at the time of the text exchange on [ ] April [ ] when it was agreed that they would have no further contact. The Tribunal finds that Mr McPhail gave her a camera. The Tribunal accepted Mr McPhail's evidence that its value would be no more than $50.

[196] Mr McPhail denied giving [Ms N] a bracelet, noting that he would not have had the money for a genuine Cartier bracelet and he would not have bought a fake one.

[197] The Tribunal were divided on the question of a bracelet and pendant, with the majority not satisfied on the balance of probabilities that part of the particular was established. Particular 1(g) is established to the extent that the Tribunal found that Mr McPhail gave [Ms N] a camera.

1(h) Ordered high-heel shoes for your patient and/or former patient

[198] Mr McPhail accepts that he ordered high-heel shoes from Wish for [Ms N]. Particular 1 (h) is established.

Particular 2: failure to take appropriate action

[199] Particular 2 concerns the steps the Director said Mr McPhail should have taken as a registered nurse when faced with certain events. It is alleged that he failed to take appropriate action and/or document in the clinical notes in the following circumstances.

[200] In establishing what "appropriate action" would have been, the Director referred to the following principles in the Nursing Council of New Zealand (**NCNZ**) Code of Conduct (June 2012).

[201] In the introduction to the Code it is noted that while mandatory language is limited in the Code, it is important for nurses to understand there is an expectation that they will adhere to these standards. Principle 1 is that the nurse will "Respect the dignity and individuality of health consumers." Underneath that are 10 standards. The Director referred to Standard 1.10 which reads:

> Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers.

[202] Principle 4 is "Maintain health consumer trust by providing safe and competent care". The Director relied on Standards 4.1 and 4.8:

> Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> Keep clear and accurate records.

[203] Principle 7 is "Act with integrity to justify health consumers' trust". The Director referred to Standards 7.2 and 7.3:

> Protect vulnerable health consumers from exploitation and harm.
>
> …
>
> Act promptly if a health consumer's safety is compromised.

[204] There is final section to the Code entitled "Guidance: Escalating concerns" which includes:

- You have an ethical obligation to raise concerns about issues, wrongdoings or risks you may have witnessed, observed or been made aware of within the practice setting that could endanger health consumers or others. Put the interests of health consumers first.
- If you are unsure, seek advice from a senior colleague or professional organisation.
- Raise your concerns with colleagues or other members of the team if they are contributing to your concerns.

[205] The 'Competencies for Registered Nurses' (Amended September 2016) describe the skills and activities of registered nurses:

> Competency 1.4 Promotes an environment that enables health consumer safety, independence, quality of life, and health. *Indicator:* Identifies and reports situations that affect health consumers' or staff members' health or safety. *Indicator:* Recognises and manages risks to provide care that best meets the needs and interests of health consumers and the public.

[206] The Tribunal considered each of the sub-particulars of this charge as follows.

2(a): Disclosure of sexual relations with a staff member of supported accommodation

[207] [Ms N] told Mr McPhail that she had had sexual relations with a staff member at her supported accommodation. She said Mr McPhail did not have much of a response, he did not seem to care about it. He did not say anything about telling anyone.

[208] [Ms N] understood that the staff member lost his job but not because of this relationship. She said she did not tell staff at the accommodation because she did not want him to get into trouble.

[209] Mr McPhail accepted that he was aware of this relationship and that he did not make a record or inform management at her supported accommodation or anyone at EPS or in her community mental health team. He said that he discussed with her about reporting that to her community psychiatric district nurse to get appropriate assistance.

[210] The Tribunal finds it unlikely that he made such recommendation to [Ms N], given he himself was inappropriately embroiled with [Ms N] at that time. Mr McPhail did not discuss this with any of her mental health team or document this is in the notes.

[211] As a registered nurse working in EPS, Mr McPhail should have been aware of the risk of compromise to [Ms N]'s mental health arising from a relationship with a staff member of her supported accommodation. This was information that needed to be passed on to the mental health team caring for her. This could have been done by recording it in the notes or informing one of the team members. He therefore failed to take appropriate action. Particular 2(a) is established.

2(b): Dissociative episode

[212] It is an agreed fact that [Ms N] underwent a dissociative episode at the motel in late February [ ].

[213] Although Mr McPhail was on annual leave during this period, he remained a mental health nurse and member of the team who was treating [Ms N]. Mr McPhail failed to alert anyone in the mental health service of these matters or ensure there was a record in [Ms N]'s progress notes. Particular 2 b) is established.

2(c): [ ]

[214] The third circumstance in which the Director of Proceedings says that Mr McPhail failed to take appropriate action was when he knew that [Ms N] had purchased from Spotlight a [ ] on or about [ ] February [ ], given her history of [ ]presentation.

[215] In answer to questions from Ms Herschell, Mr McPhail agreed that on [ ] January [ ] he had assessed [Ms N] as a [ ]. He was aware that [ ]. Mr McPhail said that he was uncomfortable with [Ms N] having the [ ] but denied that she had expressed any intention to use it. Mr McPhail acknowledged that in the course of the HDC investigation, he had said that [Ms N] had told him that her [ ] were fairly constant.

[216] Mr McPhail said that [Ms N] had promised she would hand the [ ]in to staff at her supported accommodation and let them keep it overnight. Mr McPhail said that he had attempted to minimise the risk of harm by discussing it with [Ms N] and getting that undertaking. If people choose to say one thing and do another, there is a certain amount of self-will in that.

[217] The fact that [Ms N] had purchased a [ ] was information that was highly relevant to any risk assessment and care of [Ms N]. As a registered nurse working for EPS, he needed to alert the team caring for her, by escalating to her responsible clinician or key worker, and/or by recording it in her notes. The Tribunal found that Mr McPhail failed to take appropriate action and particular 2(c) is established.

Particular 3: Sexual/intimate activities

[218] In the third particular of the charge, the Director alleged that Mr McPhail had engaged in sexual and/or intimate activities with his patient or former patient.

[219] As set out above at paragraph 62 to 64, [Ms N]'s evidence was that on [ ] January, when Mr McPhail drove them up to the Taieri Plains lookout, they walked through the bush track and then sat down and kissed, he touched her and she was on top of him. She listed other locations and said that sometimes Mr McPhail would kiss her or touch her on her breasts and genitals, sometimes over her clothes and sometimes inside her underpants. [Ms N] said that on her second day at the motel they attempted oral sex on each other.

[220] Mr McPhail's evidence was that in early February, at [Ms N]'s request, Mr McPhail collected [Ms N] from outside her supported accommodation. In the car she asked him if he was interested in having sex with her and he said it was not an option, that he was married, and it was not something he could do anyway. This last comment was reference to the impact of surgery for prostate cancer.

[221] Mr McPhail said that [Ms N] made repeated threats that she would tell people he raped her. He could not remember if she first threatened him at that meeting, but subsequently she did and she started demanding opiates and also the names of paedophiles.

[222] Mr McPhail said that the next day, [Ms N] rang him on his landline at home and told him that she had his cell phone and she had cloned his phone. He did not know what that meant. She said that she could see all his emails and that she could send messages and pretend to be Mr McPhail. She said something like, "I can make things bad for you".

[223] Dr McCrimmon referred to [Ms N]'s stated concern about distinguishing dream from reality. Under cross-examination, [Ms N] said she knew what had happened and it was very clear to her and real.

[224] Dr Mentzel said in cross-examination:

> [Ms N] at times expresses some concern that she might be confused, and she has in [ ] as well. It is never a break from reality, it is her checking reality. So, she worries about being confused more than she is actually confused, at least in [ ] - in [ ] she does.

[225] Having heard from [Ms N] and two of her treating psychiatrists, the Tribunal did not believe that [Ms N] was delusional or that her mental health issues meant that her evidence was inherently unreliable.

[226] Dr McCrimmon pointed to “inconsistencies” in [Ms N]’s evidence about her assessment on the evening of [ ] January: that [Ms N] did not remember that she had been admitted for a[ ] but could remember that they exchanged phone numbers and she had asked Mr McPhail to phone her and that he had told her that he found her attractive.

[227] Dr McCrimmon also referred to [Ms N]’s different descriptions of sexual activity. In her evidence [Ms N] said that Mr McPhail could not perform sexually and that they took turns performing oral sex on each other. It was put to [Ms N] that on [ ] May she had said that they had met up and “had sex”. She replied, “I think I would have meant, like we’d been engaging in sexual activity. That’s what I meant”.

[228] At the interview on [ ] May [ ], [Ms N] clarified that at the motel “was more sexual, not intercourse”.

[229] The Tribunal did not find [Ms N]’s inability to remember the circumstances of the EPS assessment remarkable, given her multiple encounters with EPS and the mental health services for similar presentations. Similarly, it was not significant that in the first two disclosures on [ ] and [ ] May, there is no mention of cannabis, but that was mentioned later when she was interviewed. It is not unusual for further detail to be added once interviewed for an investigation. Dr McCrimmon referred to other details that emerged in subsequent interviews. That is different from recording a spontaneous disclosure in the course of a therapeutic interaction. The same applies to the reference to “had sex” rather than specifying oral sex.

[230] In previous conversations with [Ms N], there is no mention of Mr McPhail’s incontinence pad. The first time she mentioned it was when asked during evidence-in-chief, presumably in response to evidence disclosed in Mrs McPhail’s statement. [Ms N] said that she was aware of it in the motel before the two engaged in oral sex. The Tribunal is being asked to infer that [Ms N] did not mention it earlier because she did not know about it. However, that is not the only logical conclusion to reach. It is equally plausible that it was not a detail that warranted mentioning. The Tribunal does not agree with Dr McCrimmon’s submission that this was despite [Ms N] saying it was disgusting. [Ms N]’s response to a statement that people need to wear incontinence pads when they have difficulties following surgeries was, “I don’t mean that part, I mean the other part”, which was clearly in reference to the oral sex.

[231] The Tribunal found that [Ms N] was consistent in her evidence. She was reasonable and moderate both in her manner and the factual allegations. She did not allege that Mr McPhail had assaulted or coerced her in any way.

[232] [Ms N] made non-advantageous concessions. She accepted that she had revenge fantasies about past abusers. She did not describe Mr McPhail as an abuser. [Ms N] did not dispute that she had asked Mr McPhail if he wanted to engage in sexual activity. [Ms N] agreed that she had wanted Mr McPhail to give her the names of repeat sex offenders and give her drugs and that she had threatened to expose their relationship.

[233] [Ms N] was clear in cross-examination that her wish for revenge was against past abusers. In her text communication in April [ ], it was evident that [Ms N] was reflecting on their relationship, but she did not at any point make any accusations of assault or abuse either in that communication or since.

[234] The Tribunal did not find Mr McPhail's explanations plausible. For the reasons outlined above, the Tribunal did not accept that [Ms N] threatened to allege sexual assault and did not accept Mr McPhail's explanation for not reporting anything to management (or anyone else) immediately. Even when the contact had ended, Mr McPhail reached out to [Ms N] again on [ ] May [ ], saying that he missed their chats, and the shoes were not important, he just wanted to see how she was.

[235] Mr McPhail's previous surgeries are not an impediment to engaging in sexual or intimate activity. Mr McPhail said that he had not sexual urges and produced a letter from a urologist. Ms Herschell noted that this specialist said he "cannot comment on [Mr McPhail's] ongoing libido as it is a multi-factorial desire that can change due to your social situation and mental state." The Tribunal accepts the submission that interacting with an interested younger woman, years after his surgery, may have affected Mr McPhail's levels of desire.

[236] The evidence of Mr McPhail's good character does not assist the Tribunal in determining credibility. As noted by Ms Herschell, the Tribunal has previously found that it is possible for a practitioner to act in the way they did with those witnesses, whilst also behaving the way they did with the complainant.[17]

[17] Joseph 1143/Psy20/469P (25 March 2021) at [126].

[237] In cross-examination, RN Kerry Cross acknowledged she was unaware of a previous incident in [ ] where Mr McPhail was warned not to contact an EPS patient outside of work hours, after ringing a patient at home and sending a message request on Instagram and emailing her. In that email he had said to the patient that he wanted to reassure her that she was welcome to present at EPS any time that she felt she needed to. He gave her his personal email address and said, "I would prefer if you didn't mention that I have offered you this email however as it could be misinterpreted". Ms Cross confirmed that she herself would not contact vulnerable EPS patients from her private email address and ask the patient not to tell anyone, and that it was inappropriate for nurses to do that. Ms Cross was unaware Mr McPhail had given [Ms N] money, taken her for drives, spent time with her at a motel, bought her high heel shoes and given her a camera.

[238] Similarly, Dr Banhalmi had no knowledge of the prior EPS complaint against Mr McPhail. She confirmed that it was "absolutely not appropriate" for male staff to drive alone with female patients.

[239] The Tribunal found it was more likely that Mr McPhail responded to [Ms N]'s attention and breached boundaries before she made threats to expose their relationship if he did not acquiesce to her requests.

[240] The Tribunal found that between [ ] January and [ ] May [ ] Mr McPhail engaged in sexual and intimate activity as outlined by [Ms N]. Particular 3 is established.

Professional misconduct

[241] Having found that the facts of the charges are proved, the Tribunal must now consider whether the established conduct either separately or cumulatively amounts to professional misconduct under section 100(1)(a) and/or (b) of the Act:

> **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;

[242] 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: [18]

> 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.

[243] A finding of negligence requires the Tribunal to determine:[19]

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

[244] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct".[20]

[245] 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:[21]

> … 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.

[246] 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

[18] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [21]
[19] *Cole v Professional Conduct Committee* [2017] NZHC at [41]
[20] *Collins English Dictionary* 2nd Edition. Definition accepted in many cases, including *Leach* 389/ Nur11/179P and *Rodrigues* 384/Ost11/173P.
[21] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28]

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*[22] the Court of 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.

[247] 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:[23]

> … 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.

[248] This two-step test has been adopted by this Tribunal since its first decision, *Nuttall* 8/Med04/03P issued in 2005 and endorsed by the High Court in many decisions.[24] The second step is a "threshold" rather than a "substantive hurdle".[25]

NCNZ Standards

[249] Standard 7.13 of the NCNZ Code of Conduct requires nurses to:

> Maintain a professional boundary between yourself and the health consumer and their partner and family…

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[22] Noted at 2005 3 NZLR 774

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

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

[25] *PCC v R* [2018] NZHC 2531

[250] Standard 7.14 says:

> Do not engage in sexual or intimate behaviour or relationships with health consumers in your care or with those close to them.

[251] Further guidance to Standard 7.13 is found on page 5 of the Nursing Council document "Guidance: Professional Boundaries".

> Professional relationships are therapeutic relationships that focus on meeting the health or care needs of the health consumer. Nurses must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers and those close to them when receiving care. The health consumer does not have access to the same degree of information about the nurse as the nurse does about the health consumer thereby increasing the power imbalance. The nurse may also have a professional relationship with the health consumer's family and others close to that person that may increase the health consumer's vulnerability.

[252] The Guidance contains a further section on maintaining the professional boundaries at page 15. It reads:

> This section focuses on boundary issues that arise when a nurse becomes over involved with a health consumer or family/family member. The nurse may believe she/he is helping the health consumer (or family member) by developing a friendship or close relationship. However these boundary crossings have the potential to harm the health consumer by changing the focus from the therapeutic needs of the health consumer to meeting the nurse's own needs e.g. to be "special" or helpful or needed, or to be close to someone or to have other personal, financial or sexual needs met. They have the potential to harm the health consumer by increasing their vulnerability or dependence in the relationship with the nurse and could be detrimental to their health outcomes by compromising the nurse's objectivity and professional judgment. The harmful consequences may not be recognised or experienced until much later.

Director's submissions

[253] The Director's position was that Mr McPhail had failed to comply with his professional and ethical obligations as a registered nurse and departed from standards of expected care. It was submitted that his breaches of standards are significant enough to warrant a disciplinary sanction on the following grounds:

(a) When vulnerable consumers seek treatment they have a reasonable expectation that nurses will act in their best interests, and not engage in sexually inappropriate behaviour.

(b) As noted in the NCNZ Guidelines, a breach of boundaries is a fundamental breach of trust which can result in physical and/or emotional harm to a patient. [Ms N] was a young, fragile mental health consumer who was particularly vulnerable to misunderstanding the nurse-patient relationship and to the risk of exploitation from others. Mr McPhail was a much older man with extensive psychiatric nursing experience. The inherent power imbalance should not be underestimated. The relationship developed at a time when [Ms N] was very unwell with long-standing complex mental health issues and had had several admissions to an acute in-patient unit.

(c) A finding of professional misconduct is consistent with other decisions of the Tribunal, including *Kurth*[26]where a nurse breached professional boundaries with his 25-year-old former mental health inpatient (whose history included BPD, ADHD, suicidality, and substance abuse). The Tribunal found Mr Kurth formed a personal relationship with her (including text messaging, meeting socially - including at a motel - going camping overnight, cuddling and hugging) and that the boundary breach/personal relationship compromised Mr Kurth's objectivity and professional judgement. On receipt of text messages from the consumer indicating her distress and likelihood of self-harm, it was his professional obligation as a nurse to take steps to obtain appropriate assistance for her or to ensure her safety. He failed to take any action, he did not call emergency services or advise any nurse on duty at the mental health unit.

[254] The Director noted that in *Kurth*, the Tribunal considered that an intimate personal relationship with a vulnerable patient "creates a materially similar breach of professional boundaries" as a sexual relationship.[27] "The same elements of an abuse of trust and an abuse of the power imbalance that exists between nurse and patient exist. In addition, the same risk to patient safety exists – when the patient is in a personal relationship with a nurse, this compromises the professional judgment of the nurse - as it did in this case." The Tribunal

[26] 651/Nur14/285D (10 September 2014).
[27] Above, at [53]

noted that the boundaries of professional conduct are put in place to avoid exactly the situation that arose in that case.[28]

[255] Ms Herschell also submitted that the previous incident in [ ] about which Ms Roberts had given evidence[29] and the fact that Mr McPhail had been warned about it was an aggravating feature which also meant that the present conduct warranted disciplinary sanction. Ms Roberts had contacted Mr McPhail by telephone to ask him to cease any further contact with the client concerned. She then met with Mr McPhail to discuss the matter. Mr McPhail acknowledged to Ms Roberts that it was inappropriate to contact the client by email and that it was a breach of professional boundaries. Ms Herschell submitted that Mr McPhail was on notice not to contact EPS patients outside his EPS hours. It suggests that either he has a significant lack of insight or that it was predatory grooming conduct.

Practitioner

[256] For the practitioner it was submitted that:

(a) if members of the pubic were indeed properly informed and did indeed have knowledge of all of the factual circumstances in which Mr McPhail found himself, it would not be considered that the reputation or good standing of the profession was lowered by the behaviour of the nurse.

(b) No disciplinary sanction is required for the purposes of the protection of the public as Mr McPhail retired as a result of this complaint being made after insistent requests from his manager that he do so when this complaint was made. There is no public interest to protect.

(c) Mr McPhail has spent his entire career maintaining professional standards and working exceedingly hard to be the best mental health nurse that he could possibly be. This was not a situation in which he failed to maintain professional standards but rather a perfect storm of events in which he floundered and struggled and the action he took faced with threats and blackmail, was to discuss matters with the police. This is not a situation in which a health practitioner has

[28] Above, note 27 at [58]
[29] Outlined above at paragraph [237]

been sloppy about professional standards but rather one in which a health practitioner has struggled to get his feet back on the ground when being manipulated and blackmailed.

(d) Mr McPhail has had "a hellish time" at the hands of the complainant and management such that he felt he had no choice but to resign when the complaint was made, and therefore lost the last years of his working life, lost his reputation amongst his peers and lost any and all of his much-needed retirement savings struggling to get out from under this false accusation.

Discussion

[257] For the practitioner it was also submitted that *Kurth*[30] and *Director of Proceedings v McMillan 634/Nur14/274D* could be distinguished because in those cases the practitioner admitted the facts. However, in the present case, the Tribunal has now made findings of fact based on the evidence and so that submission is rejected.

[258] Second, it was argued that in *Kurth* there was no evidence of threats or manipulation. The Tribunal finds in the present case that any threats made to Mr McPhail were after the boundaries had already been breached. [Ms N] simply threatened to tell people what was going on between them. The Tribunal has not found that [Ms N] threatened to allege sexual assault.

[259] The third ground for distinguishing from *Kurth* was that in that case the patient had sent a text message that she was[ ]. The Tribunal finds that although the [ ] in that case was more imminent than in the present case, the distinction is a fine one. Mr McPhail knew that for [Ms N], [ ] were "fairly constant".

[260] Particular 1 of the charge concerns the failure to set and maintain professional boundaries in ways that do not include sexual misconduct. The Tribunal found that Mr McPhail's private communication with [Ms N] outside the parameters of the professional relationship, as set out in particular 1a) was a significant departure from accepted standards and amounts to negligence. The degree and nature of the communications also amount to malpractice, and this conduct is of a sufficient severity to warrant a finding of professional

[30] Above note 27

misconduct. The same conclusion is reached in relation to the meetings covered by particular 1b).

[261] The Tribunal found that each of the remaining particulars 1 c) to 1 h) amounts to negligence because they are a departure from accepted standards. Individually each would not reach the disciplinary threshold. Particular 1 c) is related to particulars 1 a) and 1 b) and so cannot stand on its own. The totality of the conduct established in particular 1 is sufficiently serious to warrant a disciplinary sanction and amounts to professional misconduct.

[262] The Tribunal found that Mr McPhail failed to take appropriate action or document in the clinical notes when [Ms N] alleged that she had had sexual relations with a staff member at her supported accommodation, experienced episodes of dissociation at [ ] on or about [ ] to [ ] February and purchased a [ ]. Although Mr McPhail was on annual leave during this period, he remained a mental health nurse and member of the team who was treating [Ms N]. Mr McPhail failed to alert anyone in the mental health service of these matters or ensure there was a record in [Ms N]'s progress notes. The Tribunal finds that this was negligent. It was also a neglect of his professional duty and in that sense, it amounts to malpractice. The Tribunal considers his failure to report significant matters that had an impact on her wellbeing against her history of [ ] was akin to a nurse failing to render assistance to a person experiencing a suspected heart attack. It was a breach of Mr McPhail's fundamental duty of care as a nurse. The conduct in particular 2 is sufficiently serious to warrant a disciplinary finding and amounts to professional misconduct.

[263] The Tribunal has also found that Mr McPhail engaged in sexual and intimate activities with [Ms N] and that this conduct amounts to negligence, malpractice and conduct likely to bring discredit to the nursing profession. It is a very significant breach of standards irrespective of [Ms N]'s vulnerability and is sufficiently serious to warrant a disciplinary finding and amounts to professional misconduct. The fact that she was a mental health consumer with a history of presentations and admissions to the mental health services is an aggravating feature that is discussed further under Penalty.

Penalty

[264] Having found the charge of professional misconduct 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 the Director of Proceedings.

[265] In *Roberts v Professional Conduct Committee,*[31] 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:

(a) Most appropriately protects the public and deters others;

(b) Facilitates the Tribunal's "important" role in setting professional standards;

(c) Punishes the practitioner;

(d) Allows for the rehabilitation of the health practitioner;

(e) Promotes consistency with penalties in similar cases;

(f) Reflects the seriousness of the misconduct;

(g) Is the least restrictive penalty appropriate in the circumstances; and

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

[266] The Director sought the following penalty:

(a) Cancellation;

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[31] [2012] NZHC 3354 at [44] to [51]

(b) Specification of a minimum period before Mr McPhail may apply for re-registration;

(c) Certain conditions to be met before he returns to practice;

(d) Censure;

(e) Fine.

[267] The Director outlined a number of similar cases[32] in which cancellation had been imposed where a practitioner had engaged in sexual conduct with a health consumer.

[268] For the practitioner a penalty of cancellation and censure was accepted. No submissions were made on the question of conditions, but it was submitted that the cancellation of Mr McPhail's registration already means his career of more than 50 years is now over and he has no future as a nurse. The principles of sentencing as enunciated are more than sufficiently addressed by the cancellation of Mr McPhail's registration and any further punishment by the imposition of a fine is unwarranted. There was an objection to the imposition of a fine.

[269] Dr McCrimmon listed the following matters to take into account. The practitioner is aged and retired in May [ ]. He is now a pensioner and his only income is his New Zealand superannuation, although the Tribunal notes from Mr McPhail's affidavit of financial means, he does have some income from his antiques business. Mr McPhail has modest Kiwisaver retirement savings, has no disposable income or significant assets. He and his wife live in a very modest home which is much in need of basic repairs due to significant deferred maintenance.

[32] *RN Kurth* 651/Nur14/285D (10 September 2014); *RN Sheela* 1164/Nur20/491P (28 June 2021); *RN Gulliver* 61/Nur06/35P (19 September 2006); *RN Mete* 191/Nur08/104D (26 November 2008); *RN N* 211/Nur08/112D (17 March 2009); *Dr Nuttall* 8/MED/04/03P (18 April 2005); *Dr Maharajh* 581/Med13/243D (12 November 2013); *Dr Patel* 59/Med06/36D (19 September 2006); *RN O* 47/Nur05/25P (6 July 2006); *Mrs O* 104/Psy07/58D (21 May 2007); *Dr Drew* 1034/Med19/441P (1 August 2019);*Dr K* 349/Med10/157P (17 January 2011)

[270] Although fines have been ordered at the same time as cancellation in some of the cases referred to above, the Tribunal has taken into account Mr McPhail's age and earning ability and decided that a fine is not appropriate in this instance. The penalty of cancellation, conditions and censure, is sufficient for the maintenance of standards and deterrence of others.

[271] In light of the practitioner's age, circumstances and acceptance of a penalty of cancellation, the Tribunal orders cancellation of his registration under section 101(1)(a). This is consistent with other cases cited by the Director, is the least restrictive in the circumstances and is fair, reasonable and proportionate to the established misconduct.

[272] The Tribunal also makes the orders sought by the Director under section 102(1) of the Act.

[273] Under section 102(1)(a) Mr McPhail is not permitted to reapply for registration before the expiry of 12 months from the date of this decision.

[274] Under section 102(1)(b), if Mr McPhail seeks re-registration he must first:

(a) Confirm in writing to the Nursing Council that he has completed, at his own cost, an appropriate course on ethics and boundaries approved by the Nursing Council;

(b) Undertake in writing to the Nursing Council that he will comply, at his own cost, with all directions, recommendations and requirements of the Nursing Council, including any requirement for proof of compliance with any conditions;

(c) Undertake in writing to the Nursing Council that for a period of three years after re-registration, he will have a chaperone present if attending to female patients;

(d) Undertake in writing to the Nursing Council that for a period of three years after re-registration, he will advise any future employers of the Tribunal's decisions and orders.

[275] Under section 101(1)(d) Mr McPhail is censured.

Costs

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

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

(a) The fact that professional groups ought not to be expected to fund all the costs of a disciplinary regime; and members of the profession who come before disciplinary bodies must be expected to make a proper contribution towards the costs of the inquiry and hearing.[33]

(b) Costs are not in the nature of a penalty or to punish.[34]

(c) Means, if known, are to be taken into account.[35]

(d) A practitioner has a right to defend himself or herself.[36]

(e) The level of costs should not deter other practitioners from defending a charge.[37]

[278] The Director seeks a contribution of 50%. The total of the Director's investigation and prosecution costs came to $110,804.80. The Tribunal costs were estimated at $89,213.13. That makes a total of $200,017.93.

[279] The starting point in considering costs was confirmed in by the High Court in *Vatsyayann v Professional Conduct Committee of the New Zealand*[38] as being 50% of total reasonable costs with discretion to increase or decrease that mount based on the particular circumstances of the case.

[33] *G v New Zealand Psychologists Board* (Gendall J, 5 April 2004, HC Wellington, CIV-2003-485-2175) and *Vasan v Medical Council of New Zealand* (18 December 1991, AP43/91 at page 15)
[34] *Gurusinghe* v Medical Council of New Zealand [1989] 1 NZLR 139 at 195
[35] *Kaye v Auckland District Law Society* [1988] 1 NZLR 151
[36] *Vasan*, above note 34
[37] *Gurusinghe*, above, note 35
[38] [2012] NZHC 1138 at [34]

[280] Mr McPhail provided an affidavit of means, showing that he and his wife receive the New Zealand superannuation, and have limited assets, with a modest balance of his Kiwisaver. The Tribunal did not receive evidence of his wife's Kiwisaver balance or other investments. Although Mr McPhail said that their home is owned by a trust and of which he is neither trustee nor beneficiary, in his affidavit of means, he referred to required maintenance and outgoings such as rates and insurance. The Director advised that in fact the couple had gifted their home to a trust for no consideration in February 2023 just before the Director laid the disciplinary charge against Mr McPhail.

[281] The Tribunal considers the Director's costs are not unreasonable for a 4 ½ day hearing and that in a hearing of this length, with a number of witnesses, it was appropriate to have a second (junior) counsel.

[282] The Tribunal accepts that Mr McPhail has no significant assets and has therefore made some reduction to the quantum ordered. However, the Tribunal is satisfied that he will be able to make arrangements to pay some contribution towards the costs and a contribution of 35% of the Tribunal's and the Director's costs is appropriate in the circumstances of this case. It takes into account the fact that the Director has been put to the cost of proving the charge and arguing that the established conduct amounts to professional misconduct. Accordingly under section 101(1)(f), Mr McPhail is ordered to contribute $38,781.68 to the Director's costs and $31,224.60 to the Tribunal's costs.

Name suppression

[283] The Director seeks permanent name suppression for the complainant, which is not opposed by the practitioner.

[284] The Director opposes Mr McPhail's application for permanent name suppression.

Legal principles

[285] Section 95(1) of the Act provides that all Tribunal hearings are to be in public.[39] 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

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

> 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.

[286] Therefore, in considering the application prohibiting publication, the Tribunal must consider the interests of the practitioner 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.

[287] The Tribunal has frequently summarised public interest factors as:[40]

(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.

[288] This is consistent with what the Supreme Court[41] has since said about open justice in a civil case between private entities:

> [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.

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

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

> [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.

[289] And in legal commentary, the principal 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.[42]

[290] The public interest in knowing the identity of a practitioner charged with a disciplinary offence includes the right to know about proceedings affecting a practitioner, but also the protection of the public and their right to make an informed choice.[43]

[291] In disciplinary proceedings in this jurisdiction the public interest may also include a public protection factor. Section 3(1) of the Act provides 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.

[292] This recognises the special position that health practitioners hold. The unique privileged position and relationship of trust and confidence between them and their patients (and clients) is characterised by factors such as the patient sharing intimate information, disrobing for the purpose of diagnosis or treatment, allowing touching of the body including invasive procedures, surgical incisions and pharmaceutical interventions, all on the basis of an assumption that the practitioner is knowledgeable, competent and trustworthy because their professional body has deemed them fit to practise. Patients expose themselves to the risk of harm if that is not the case. This distinguishes the disciplinary tribunal's protective function from that of the criminal jurisdiction, which concerns protecting the public from the wrongdoing of other members of the public, not from people who have been certified as fit

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

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

to practise their profession. The protection afforded by the regulatory regime is to the public who are consumers of the health services provided by the registered health practitioner.

[293] In *Johns v Director of Proceedings* Moore J said:[44]

> … the test under s 95 invokes a considerably lower threshold than the usual civil test. It does not require exceptionality nor even something out of the ordinary. And while it is a concept not readily amenable to precise definition it does require evaluating the competing considerations of the interests of any person and the public interest. Attempts to refine the definition further are fraught because the analysis will always be case dependent.

[294] The High Court has said the statutory test for what is desirable is flexible:[45]

> 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 incline 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 professional misconduct has been established.

[295] The more serious the offending, the greater the stress to the practitioner and their family, but at the same time, the public interest factors may also have greater weight. Where the established conduct has an unethical and/or sexual component there is an added embarrassment and humiliation for a practitioner's family if their name is associated with it, and yet there may be strong public interest factors in publication. That includes "flushing out" any unknown similar complaints.

The application

[296] Mr McPhail's application is based on the risk of adverse impact of publication of his name on his wife and on his son. The Tribunal considered Dr McCrimmon's submissions and affidavits from Mr McPhail and his daughter, Siubhan McPhail.

[44] *Johns v Director of Proceedings* [2017] NZHC 2843 at[166]. This is consistent with many dicta of the High Court, including *ANG v Professional Conduct Committee* [2016] NZHC 2949

[45] *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*)

[297] Mr McPhail described his wife's [circumstances] and her [circumstances] as a result of these proceedings and the likely impact of publication on her [circumstances]. Siubhan McPhail confirmed that proceedings have caused a strain on her mother.

[298] Mr McPhail expressed concern that his son's [circumstances] would be adversely affected by lifting of interim name suppression. He explained that his son is [circumstances].

[299] For the Director, Ms Herschell referred to the public interest factors, and argued that there was no evidence to support Mr McPhail's "tenuous assertion" that his wife's [circumstances] will be impacted adversely by publication. Mrs McPhail was not a party to the misconduct and accordingly, there is no question of fault being attributed to her through association with her husband. Her long and well-respected history of [work] will speak for itself.

[300] Similarly, it was submitted that there is no evidence from Mr McPhail's son about the likelihood of his [circumstances] being jeopardised by publication of his father's name.

[301] Mrs McPhail's interests must be balanced against the public interest factors outlined above. Mr McPhail has been found guilty of professional misconduct, including sexual conduct with a vulnerable consumer of mental health services. This is a serious matter.

[302] We acknowledge the stress caused by disciplinary proceedings can adversely affect the [circumstances] of a practitioner and/or family members. Some embarrassment or discomfort is inevitable, and the Tribunal accepts that such is likely in the present case. However, if that were a ground for name suppression, sufficient to displace the presumption in favour of publication and enough to outweigh the public interest factors, then permanent orders for non-publication would be made in most, if not all, cases. Where the wellbeing of a family member has been a ground for name suppression, there is usually independent, clinical evidence of the likely impact of publication on that person's physical or mental wellbeing. In the case of *Mr R 1353Phar22/548P*, the Tribunal expressed reservations about the persuasiveness of the clinical opinion, but ultimately an order for non-publication was made by consent. The matters outlined by Mr McPhail do not outweigh the public interest and the Tribunal does not consider it is desirable to order name suppression on those grounds.

[303] Similarly, the Tribunal accepts the Director's submission that there is no clear evidence that Mr McPhail's son's [circumstances] will be compromised by publication of his father's name. It is possible that there will be some embarrassment for him, but the evidence before the Tribunal does not specify how his [circumstances] will be affected. Any possible adverse impact on him is not outweighed by the public interest publication of Mr McPhail's name and so the application is declined.

[304] The evidence in support of Mr McPhail's application for name suppression was not given in public but considered on the papers. The Tribunal has treated the hearing of the name suppression application as a hearing in private. There is no public interest in publishing the grounds which were relied on. Details of the son's [circumstances] and Mrs McPhail's circumstances do not need to be published and there are orders under section 95(2) for suppression of those details.

DATED at Feilding this 1st day of March 2024

Chair
Health Practitioners Disciplinary Tribunal