NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE TE RŌPŪ WHAKATIKA KAIMHI HAUORA / HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1398/Nur23/579P**
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	**A PROFESSIONAL CONDUCT COMMITTEE appointed by the NURSING COUNCIL OF NEW ZEALAND** **Applicant**
AND	**Ms VICKIE WADE of Auckland, registered nurse** **Practitioner**

Hearing: Thursday 7 November 2023 in Auckland

TRIBUNAL	Mr W McCarthy (Chair) Mr C Nicol, Ms C Neilson-Hornblow, Ms J Molesworth, Ms S Matthews MNZM (Members) Ms G J Fraser, Executive Officer Ms K O'Brien, Stenographer
APPEARANCES	Mr M McClelland KC, Ms C Taylor and Ms L Misa for the Professional Conduct Committee (PCC) No appearance by or for the practitioner

Introduction

[1] In a Notice of Charges dated 23 February 2023, a Professional Conduct Committee (**PCC**) appointed by the Nursing Council of New Zealand (**the Council**) laid a disciplinary charge against Ms Vickie Wade (**the practitioner**) pursuant to ss 100(1)(a) and 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 (**the Act**).

[2] The charges relate to several incidents where the practitioner was working as a staff nurse in the Neonatal Intensive Care Unit (**NICU**) at Starship Child Health, Auckland District Health Board (**Starship**) between 19 November 2019 – 13 February 2020.

[3] A panel of the Tribunal convened on 7 November 2023 to hear the charge in Auckland. As the practitioner did not attend the hearing it proceeded by way of formal proof.

The Charges

[4] The charges laid by the PCC and their particulars are set out in full in Appendix A of this decision. In summary, the charges allege that the practitioner compromised the safety of infants in her care and interacted inappropriately with the parents of one of the infants.

[5] The particulars of the three charges are as follows:

> 1.0 On or about [ ] December 2019 she:
>
> 1.1 failed to respond to baby [A]'s acute apnoea monitor alarms while in her care which resulted in intervention from another staff member; and/or
>
> 1.2 was wearing headphones and/or was distracted by an electronic device; and/or
>
> 1.3 was hesitant to document and/or failed to document the apnoeic/"red writing" episode in accordance with NICU policy.
>
> 2.0 On or about [ ] February 2020:

2.1 Failed to respond appropriately to an infant's acute apnoea monitor alarms while in her care which resulted in intervention from another staff member; and/or

2.2 was wearing headphones and/or was distracted by an electronic device; and/or

2.3 failed to document the apnoeic/"red writing" episode in accordance with NICU policy.

3.0 On or about [ ] November 2019 was unprofessional and/or disrespectful in her interactions with the parents of baby [Y]. In particular:

3.1 When asked by Ms [AY], baby [Y]s' mother, to help get [Y] to her so she could hold him to enable skin to skin contact, Ms Wade sighed loudly and said she was too busy.

3.2 Ms Wade told Ms [AY] that she could get baby [Y] herself, but Ms [AY] could not stand due to the severe pain she was in following a difficult Caesarean delivery.

3.3 Ms Wade was indifferent to, unsupportive and judgemental of Ms [AY].

[6] Accordingly, it is charged that the alleged conduct separately and/or cumulatively amounts to professional misconduct pursuant to s 100(1)(a) and/or (b) of the Act.

Background and relevant facts

[7] The practitioner gained her registration as a nurse on 16 December 2002 after completing a Bachelor of Nursing at Unitec. She was first employed as a registered nurse in the NICU at Starship in 2012, and was working there at the time of the alleged incidents.

[8] It is helpful to provide a brief explanation of the way the NICU nursing team work together. The majority of infants in NICU are constantly monitored. Each infant has a bedspace with an individual monitor, and then each room in turn has a central monitoring screen that allows nurses to cover each other if an infant in any room requires assistance[1].

[1] Statement of Anneke de Bie, at [7].

[9] It is part of the NICU nurses' regular duties to check that alarms and limits are set correctly on the monitors for each infant, as some infants have different parameters. If correct alarm limits are set on the monitors, an orange bar will show on the screen while an audible alarm is going. The alarm will stop if the infant corrects itself. If the infant's condition does not improve, the alarm sound will change and the line will turn to red. An apnoeic episode will not alarm until an infant goes approximately 20 seconds without a breath. This will usually result in a 'high' red line alarm, as opposed to yellow/orange which is a 'medium' alarm[2].

[10] In December 2019, an issue was raised about the practitioner's care of an infant in the NICU (**the December incident**). A formal meeting was held with the practitioner to discuss this incident on 11 February 2020. On 13 February 2020, a further similar issue was raised about the practitioner's care of another infant in the NICU (**the February incident**).

[11] On 17 March 2020, a complaint was made about the practitioner's care of Ms [AY] that took place on [ ] November 2019.

[12] As a result of the seriousness of the issues raised, and as a precautionary measure to ensure patient safety, the practitioner was placed on paid leave in March 2020, and she subsequently resigned in June 2020. On 18 July 2020, the Nurse Director at Starship made a complaint to the Council about the conduct of the practitioner the subject of this charge.

Relevant standards

[13] Counsel for the PCC referred the Tribunal to several principles contained within the Nursing Council's Code of Conduct (**the Code**) which are relevant to the practitioner's conduct, including:

> Principle 1. Respect the dignity and individuality of health consumers.

[2] Statement of Anneke de Bie, at [8] – [10].

- 1.4. Work in partnership with the family/whānau of the health consumer where appropriate and be respectful of their role in the care of the health consumer.
- 1.6. Practise in a way that respects difference and does not discriminate against those in your care on the basis of ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age.
- 1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers.

Principle 3. Work in partnership with health consumers to promote and protect their well-being.

- 3.8 Use your expertise and influence to promote the health and well-being of vulnerable health consumers, communities and population groups.

Principle 4. Maintain health consumer trust by providing safe and competent care

- 4.2 Be readily accessible to health consumers and colleagues when you are on duty.
- 4.8 Keep clear and accurate records.

Evidence

[14] The practitioner did not file any evidence. The PCC's evidence consisted of the PCC's bundle of documents, which included:

(a) the complaint to the Council dated 18 July 2020 (including documents relating to the Auckland District Health Board's investigation of several incidents and clinical notes);

(b) the Code; and

(c) 11 witness' statements from:

i. Dale Garton, the Nurse Unit Manager at the NICU;

ii. Claire Anna van Roekel, a registered nurse in the NICU who was working in an adjacent room to the practitioner on [ ] December 2019 and witnessed the December incident;

iii. Ashleigh O'Grady, a registered nurse in the NICU who was working on [ ] December 2019;

iv. Amy Louise Van Der Loos, a registered nurse in the NICU who was working on [ ] December 2019;

v. Anneke de Bie, a registered nurse who was Coordinating NICU on [ ] December 2019 and received notification of the December incident from Ms van Roekel;

vi. Elizabeth Lorna Haugh, a registered nurse at the NICU, who was working on [ ] December 2019, prior to the December incident;

vii. Susan Gail McKnight, a Clinical Charge Nurse in the NICU who came onto shift after the December incident and was told about it by Ms de Bie;

viii. Hannah Ashley, a registered nurse in the NICU who was working on [ ] February 2020 and witnessed the February incident;

ix. Ms [AY], a [position] in Auckland who complained about the practitioner's conduct towards her and her newborn infant;

x. Tamara Nickerson, a Nurse Specialist, Family Liaison at the NICU who supported Ms [AY] following her interactions with the practitioner on [ ] November 2019; and

xi. Ms Maureen Earls, a registered nurse at the NICU who also spoke with Ms [AY] about the practitioner's conduct on [ ] November 2019.

Relevant law on liability

[15] The practitioner is charged with professional misconduct under s 100(1)(a) and/or s 100(1)(b) of the Act which provide:

> **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;
>
> (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 is likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred;

[16] The Tribunal and Courts have considered the term professional misconduct numerous times. In *Collie v Nursing Council,* Gendall J said:[3]

> 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

[3] *Collie v Nursing Council of New Zealand*, [2001] NZAR 74 at [21].

that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.

[17] At paragraph [23], Justice Gendall further states:

> Clearly it envisages conduct in the performance of the nurse's usual professional duties if it amounts to "malpractice or negligence". That requires, in line with authorities and the accepted view, that the negligence or malpractice be of a serious degree and such as to be substantially below the standards expected of a nurse."

[18] The Tribunal has also consistently adopted common usage definitions of "malpractice" as being:

> the immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct[4]; and
>
> Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer… a criminal or illegal action: common misconduct."[5]

[19] It is for the Tribunal to determine whether the conduct has or is likely to bring discredit on the medical profession under s 100(1)(b) of the Act. In *Collie* at [28], Gendall J discussed the meaning of this provision, under the previous legislation, and stated:

> To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with the knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned.

[4] Collins English Dictionary, 2nd Edition.
[5] The New Shorter Oxford Dictionary, 1993 Edition.

[20] There is a well-established two stage test for determining professional misconduct set out in previous decisions of both this Tribunal and its predecessor.[6] The two key steps involved in assessing what constitutes professional misconduct are:

(a) first, an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice, negligence or otherwise bringing or likely to bring discredit on the profession; and

(b) second, the Tribunal must be satisfied that the practitioner's acts or omissions require a disciplinary sanction for the purposes of protection of the public or maintaining professional standards or punishing the practitioner.

[21] The burden of proof in the present case is on the PCC. This means that it is for the PCC to establish that the practitioner is guilty of professional misconduct. This remains so even where the practitioner does not participate.

[22] The standard of proof is the civil standard of proof, that is proof which satisfies the Tribunal that on the balance of probabilities the particulars of the charge are more likely than not.

[23] The Tribunal is also required to consider each particular independently and then cumulatively, in the context of determining whether the overall charge is established.[7]

Case law

[24] The Tribunal was referred to a number of cases by Counsel for the PCC.

[25] In *Pillay*[8]*,* Registered Nurse Pillay deliberately slept during a night shift which put the safety of her patients at risk. There were also issues with the way the practitioner had completed her notes for a resident who had fallen while the practitioner was asleep.

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[6] *McKenzie v MPDT* [2004] NZAR 47 at [71] and *PCC v Nuttall* (8/Med04/03P).
[7] *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513.
[8] *Pillay* 1258/Nur21/524P (2022).

Initially she had not recorded the fall, however when she did complete the patient's notes she wrote that nothing had happened. The Tribunal held that this conduct met the threshold for malpractice. The practitioner was censured, ordered to undertake monthly supervision for 12 months and ordered to pay 30% costs.

[26] In *E*[9]*,* the Tribunal found the following particulars established:

(a) particular 1: failed to give 1 to 2 hourly spacers of Salbutamol to a 13-year-old patient with asthma, and documented that observations were completed and spacers were administered when they were not.

(b) particular 3: failed to carry out observations and/or administer antibiotics medication and/or documented four hourly observations and administration of oral antibiotics medication to a one-year-old child with pneumonia when she had not;

(c) particular 4: acted in an inappropriate/unprofessional manner by refusing or failing to take two booked adolescent patients assigned to her for that shift.

(d) particular 6 and 8: failed to carry out observations, administer medications and documented observations and medications for an 11-month-old child when they were not completed. Countersigned the administration of intravenous antibiotics by using the signature of another registered nurse when this had not occurred.

[27] Particulars 1, 3, 6 and 8 separately and cumulatively amounted to professional misconduct. When considering whether cancellation was warranted, the Tribunal noted that "*the established conduct goes to the heart of the Practitioner's role to provide safe and competent care and maintain honest and accurate patient records*". Ms E was censured, had her registration cancelled and she was not permitted to reapply for registration for a period of three years.

[9] 1121/Nur18/429P (2020).

[28] In *Ha'unga*[10]*,* the practitioner was a Public Health Nurse within the Early Childhood Health Team at Starship Community who was contracted to provide services to the highest risk and vulnerable children under the age of five years. There were two charges laid against the practitioner. The first had 36 particulars, with 23 being established, and 13 separately amounting to negligence. These included:

(a) failure to undertake a core visit in accordance with the Well Child Schedule;

(b) aspects of the practitioner's clinical care to carry out the Well Care assessment e.g. failure to weigh the child, complete a PEDS assessment;

(c) documentation e.g. failure to fully document a health assessment; and

(d) case management, failure to formally refer to Plunket.

[29] The Tribunal also established a second charge of the practitioner practising when she knew or ought to have known that her annual practising certificate was suspended. The Tribunal imposed cancellation and censure as penalties, but acknowledged that the first charge could have been dealt with by suspension, coupled with conditions, if it was considered separately.

[30] In *Goff*[11]*,* a midwife practitioner was charged in relation to alleged failures following a patient's blood pressure readings and signs of pre-eclampsia, as well as failures to discuss and recommend consultation with a specialist. The charge was established and found to be malpractice and negligence on the practitioner's part, as well as conduct bringing discredit to the midwifery profession. The Tribunal noted that this may have been a case calling for suspension but given the practitioner had already been suspended following a competence review, the Tribunal ordered a censure and conditions to her practice.

[10] 1278/Nur21/526P (2022).
[11] *Goff* 890/Mid16/373D (2017).

Consideration of charges 1 and 2

[31] Due to factual similarities in charges 1 and 2, they are discussed together below.

PCC evidence relevant to Charge 1

[32] Ms Claire van Roekel was working the same shift as the practitioner in the NICU on [ ] December 2019. She was stationed in an adjacent room to the practitioner which she could partially see into.

[33] Ms van Roekel heard an alarm from the practitioner's room and could see that an infant's monitor in that room was flashing red and said "*apnoea*". She could also see the heart rate levels and oxygen levels decreasing. She thought that the practitioner would tend to the infant but after ten seconds the alarm continued to sound. When Ms van Roekel entered the room the infant's oxygen levels were at 20% (critically low) and heart rate was 99 (below normal range). The infant was blue, not breathing and was having an apnoeic event. Ms van Roekel's evidence was the practitioner was sitting in a Lay-Z-Boy chair in the corner of the room, with her laptop on her knees and her headphones in.

[34] While Ms van Roekel was providing care to the baby, the practitioner came over to ask what had happened. Ms van Roekel explained, including the apnoeic event and oxygen levels, and asked the practitioner to record these matters in red writing. Red writing is used to signify that intervention was required. Ms van Roekel was of the view that the practitioner was reluctant to use red writing, but eventually acquiesced. When Ms van Roekel later reviewed the notes of the night there was no record of any respiratory support, nor did it refer to the apnoeic event, which she would have expected.

[35] After checking that the practitioner was okay and did not need a break, Ms van Roekel asked the practitioner to concentrate on her babies. About five minutes later, Ms van Roekel walked through the practitioner's room and again saw the practitioner on

the Lay-Z-Boy chair with a laptop in front of her with her headphones in. At that point she reported the incident to the coordinating registered nurse, Ms Anneke de Bie.

[36] Ms de Bie's evidence detailed what Ms van Roekel told her about the December incident when their shift was concluding. She also gave evidence about the infant the practitioner was caring for. The infant was 25 weeks old and likely to develop chronic lung disease. She noted that the infant had also previously had multiple self-correcting desaturations on the shift immediately prior to the December incident, which was recorded by Registered Nurse Elizabeth Haugh. In Ms de Bie's view, the desaturation that occurred was significant, and a nurse in that position should be at the bed space watching closely, if not intervening. She could not think of a reason why a nurse would not intervene earlier if oxygen levels had dropped to 20% and heart rate was less than 120.

[37] Ms Ashleigh O'Grady and Ms Amy Van Der Loos were on the same shift as Ms van Roekel and were working in another adjacent room. Ms O'Grady recalled a laptop in the room when she was assisting the practitioner with a separate matter. She did not recall the practitioner having headphones in on that occasion.

[38] Ms Van Der Loos' evidence corroborated aspects of Ms van Roekel's evidence. She said that the alarm was going off for 10-20 seconds before she saw Ms van Roekel go into the room. She also saw the practitioner sitting in the Lay-Z-Boy chair. However, she thought the practitioner was on an iPad and could not remember seeing earphones, although did recall Ms van Roekel saying the practitioner had earphones in. Both Ms O'Grady and Ms Van Der Loos were of the view that the practitioner was known for using a laptop/iPad on shift.

[39] Ms Susan (Sue) McKnight, the Clinical Charge Nurse who came on shift after the December incident, was told about it by Ms de Bie, and Ms van Roekel also reported the incident to her via email on [ ] December 2019. Ms McKnight had dealt with a similar issue in May 2019, where a complaint was made about the practitioner's phone use, computer use and a phone call from a friend asking for a recipe. The practitioner had agreed at that time to keep her phone and computer in her bag.

[40] Ms McKnight in turn reported the incident to Ms Garton, the Nurse Unit Manager of the NICU. After speaking with Ms McKnight and Ms van Roekel, Ms Garton reported the matter to human resources.

[41] Ms Garton conducted a disciplinary meeting with the practitioner on 11 February 2020. She described the practitioner as confused during their meeting, and that she lacked insight into her actions and the significance of these to the baby. The practitioner offered differing explanations that were difficult to understand, varied and contradictory. For example, the practitioner explained that the leads attached to the baby were not working properly and that she didn't jump up immediately when Ms van Roekel entered the room as it was not unusual. However, later in the interview she states that she stood as soon as Ms van Roekel entered. The practitioner denied she was looking at her device or wearing headphones instead explaining she was completing professional development on her laptop.

[42] Ms Garton noted that this was not the first complaint she had received regarding the practitioner's use of devices and headphones. Two Clinical Charge Nurses had spoken to the practitioner about this previously, with the practitioner promising not to do it again. When questioned by the Tribunal, Ms Garton noted that completing professional development in the context of a night shift would be acceptable, however the use of headphones in this context would be unacceptable. Ms Garton also referred to Starship professional practice that nurses do not use social media in clinical spaces.

PCC evidence relevant to Charge 2

[43] Ms Hannah Ashley was working a night shift on [ ] February 2020 alongside the practitioner in an adjacent room. During the shift, Ms Ashley heard an initial alarm from the practitioner's room, looked over to the monitor and saw an infant's heartrate was in the 90s. At this time the infant was 31-weeks-old. Ms Ashley continued conducting a tube feed to an infant she was tending to as she thought the practitioner would deal with it.

[44] A second higher alarm sounded and when Ms Ashley looked at the monitor in the adjacent room she saw that the heart rate and oxygen levels had continued to go down. At this point, Ms Ashley paused the tube feed she was doing as she could still not see the practitioner attending to the baby. Just as she stopped, she saw the practitioner get up from an armchair recliner and turn off the alarm. She did not see the practitioner look at the monitor or address the dropping heartrate or oxygen levels. She then returned to her chair.

[45] Due to her concerns, Ms Ashley entered the room and checked on the infant. The baby was dusky, pale and greyish with an oxygen level in the 30-40s and heartrate in the 50-60s. Ms Ashley stimulated the infant and was at the point of getting a Neopuff when the infant started to recover. She then left the room.

[46] Ms Ashley returned a few minutes later to see whether the apnoea event had been charted. There was no red writing on the chart to signify this, so Ms Ashley entered the event. When going through the chart, Ms Ashely noted that the practitioner had not noted any self-correcting desaturation she had witnessed, so Ms Ashely ticked the appropriate boxes.

PCC submissions on charges 1 and 2

[47] The PCC submits that there is similarity between *Pillay* and the particulars of charges 1 and 2. Like *Pillay,* the practitioner's conduct was intentional. She was witnessed sitting with headphones in and on her device, and in relation to the second charge she went as far as standing up, silencing the alarm and sitting back down without tending to the infant she was charged with.

[48] Counsel for the PCC also submitted that the practitioner was hesitant and/or failed to make accurate notes of the evidence, which was an intentional effort to cover up the deficits in her care. Further, those taking over care may not be able to provide the best possible care given the inaccurate records provided.

[49] A key difference noted by Counsel for the PCC is the relative seniority of the practitioners when considering an appropriate outcome. *Pillay* was a junior practitioner, whereas the practitioner in this instance had been registered and began working at Starship in 2012.

[50] The PCC also draws parallels between the practitioner's conduct and that of *E,* in that both practitioners were charged with providing care for highly vulnerable patients. The PCC submits that while there is no allegation that the practitioner's conduct caused harm in either case, this is not mitigatory. *E* establishes that the Tribunal must focus on the risk of harm. Given the practitioner was working in the NICU, the PCC submits the risk of harm was greater than that of *Pillay, E,* or *Ha'unga*.

[51] Counsel for the PCC also submits that there is a degree of similarity with *Goff,* in that the practitioner's conduct represents a sustained pattern of behaviour as opposed to having a momentary lapse.

[52] In relation to the relevant standards, the PCC puts particular emphasis on standard 4.2 (that nurses are required to be readily accessible to health consumers and colleagues when they are on duty) and standard 4.8 (the requirement to keep clear and accurate records).

Tribunal findings on charges 1 and 2

[53] The Tribunal found Ms van Roekel's evidence to be credible and broadly consistent with her earlier statements and the evidence given by Ms Ashleigh O'Grady and Ms Amy Van Der Loos who worked the same shift. While the practitioner did not attend the hearing, her explanations noted in the PCC evidence were not internally consistent, were not substantially corroborated by any witness, nor did they make sense logically.

[54] The Tribunal has no issue in finding particulars 1.1 and 1.2 established. The practitioner clearly failed to respond to baby [A]'s alarms and the Tribunal finds that she was wearing headphones and distracted by an electronic device. The Tribunal is doubtful that the practitioner was completing professional development as she contended at one

stage, but even if this was the case, doing so with headphones in and allowing an electronic device to distract her from her primary duty is unacceptable. In relation to particular 1.3, the Tribunal finds that the practitioner was hesitant to document the apnoeic/"red writing" episode, and that it was poorly recorded.

[55] In relation to charge 2, the Tribunal is similarly satisfied that particulars 2.1 and 2.2 are sufficiently supported by the evidence heard and are established. The Tribunal found Ms Ashley's account to be credible. Although the Tribunal did not hear corroborating evidence from other colleagues on the shift, and her account of the evidence is consistent with the practitioner's previous behaviour contained within the PCC evidence.

[56] After examining clinical notes, the Tribunal does not consider that particular 2.3 is established. However, the Tribunal finds that the overall charge is established.

[57] Having established the charges, the Tribunal must consider whether each charge amounts to professional misconduct. In regard to charge 1, the Tribunal had no difficulty finding that the conduct amounts to negligence. In addition, there is an element of intentionality involved, as the practitioner was using electronic devices when she was charged with caring for vulnerable infants. The Tribunal also considers that the practitioner's hesitancy to record the incident appropriately was intentional and professionally inappropriate. As such, the Tribunal is of the view that the particulars of charge 1 amount to malpractice and negligence.

[58] The Tribunal is also clear that the particulars bring disrepute to the profession. A reasonable member of the public expects that nurses would attend to vulnerable children in their care, that they would not inappropriately be distracted by electronic devices and would accurately record incidents when they occur.

[59] When considering whether the conduct warrants disciplinary sanction, the Tribunal finds that the particulars of charge 1 warrant discipline on a cumulative basis. While the charge has three particulars, in reality, it refers to one very serious incident. The Tribunal is mindful that the practitioner's behaviour is not consistent with principles

4.2 (that nurses are readily accessible when on duty) and 4.8 (requirement to keep clear and accurate records) of the Code. The Tribunal agrees with Ms de Bie's evidence that, in a NICU context, "*to walk into a room and see the nurse of that room doing nothing is unacceptable*".[12] The conduct thus represents a sufficiently serious departure from acceptable standards and warrants a penalty to protect the public and also to set appropriate standards.

[60] The facts established under charge 2 are almost identical to charge 1. While particular 2.3 relating to record keeping was not established, overall, the analysis from charge 1 applies. As such, the Tribunal finds that particulars 2.1 and 2.2 amount to malpractice and negligence, and also bring disrepute to the profession. Similarly, for the same reasons considered above, the Tribunal considers that particulars 2.1 and 2.2 warrant discipline on a cumulative basis.

Consideration of charge 3

PCC evidence relevant to charge 3

[61] Ms [AY] gave evidence about her interactions with the practitioner. Her son was born in November 2019 during level 3 lockdown and was in the NICU for 76 days. Ms [AY] had a caesarean section and was in hospital for two weeks after the birth. She could not walk for a week following the operation and struggled to stand.

[62] On [ ] November 2019, while in this condition, Ms [AY] asked the practitioner to help her get her son out of the incubator. It had been impressed upon her that skin-to-skin contact was very important. However, the practitioner refused to help Ms [AY] saying she was too busy and that Ms [AY] should get him. This was the only day where Ms [AY] did not have skin-to-skin contact with her son. After this, Ms [AY]'s husband took time off work so he did not have to leave her alone on the ward and so he could support her in caring for their son.

[12] Statement of Evidence of Anneke de Bie at [30]

[63] Ms [AY] also gave evidence that the practitioner treated her differently than her husband who was of European descent.

[64] Ms [AY] told Ms Tamara Nickerson and Ms Maureen Earls, NICU staff, about her experience with the practitioner at the time of the incident. Both witnesses gave evidence during the hearing that Ms [AY] was upset about her interactions with the practitioner. Ms Earls spoke with the practitioner who appeared receptive to the feedback.

[65] On 17 March 2020, Ms [AY] made a complaint about the practitioner's conduct to Ms Garton. The complaint outlined what had happened, and said that afterwards the practitioner was incredibly cold and made Ms [AY] feel unwelcome in the room.

[66] When Ms Garton put the complaint to the practitioner, the practitioner explained that the infant had just had a clinical procedure and that she did not think it appropriate for the infant to be held due to stress levels. Ms Garton's evidence was that there was no reason why skin-to-skin contact could not have occurred, although she noted it would not be unusual for a mother and nurse to negotiate skin-to-skin contact in some instances. Ms Nickerson also gave evidence about the importance of skin-to-skin contact and the fact that, unless the infant was medically unstable, there should have been no reason Ms [AY] could not have held him.

[67] In response to Ms [AY]'s concern that this was the one day that her infant had not had skin-to-skin contact, Ms Garton noted the clinical records showed it appeared the father had held the baby that day. However, this had not been documented in the observation chart which is the usual practice. She also said that she would not describe the practitioner as cold.

PCC submissions on charge 3

[68] The PCC submits that Ms [AY] was clearly vulnerable and was reportedly experiencing high anxiety. The practitioner's conduct contributed to increasing Ms [AY]'s feelings of vulnerability.

[69] The PCC further submits that the practitioner failed to treat Ms [AY] with appropriate respect, empathy, and sensitivity. She did not consider the emotional impact her failure to assist had on Ms [AY]. Counsel submits that this impact was evidenced by Ms [AY] raising her concerns with Ms Earls and Ms Nickerson at the time and making a complaint to Ms Garton some months later.

[70] The PCC submits that the practitioner's conduct towards Ms [AY] was a clear breach of the Code, particularly principles 1,2, 3, and 4.

Tribunal findings on charge 3

[71] The Tribunal finds that charge 3 and its particulars are sufficiently supported by the evidence heard and are established. The Tribunal found Ms [AY] to be a credible witness. The account she gave in the hearing of her interactions with the practitioner was consistent with prior accounts she had made closer to the time of the alleged incident. In relation to particular 3.3, the Tribunal had particular regard to the evidence of Ms Garton and Ms Nickerson who gave evidence that there was no reason why skin-to-skin contact could not have occurred.

[72] The Tribunal considers that particulars 3.1 - 3.3 amount to negligence. Each particular demonstrates that the practitioner did not carry out her duties in a professional way. The Tribunal also considers that the practitioner not carrying out her role in a professional way brings discredit to the nursing profession.

[73] The Tribunal considers that the particulars of charge 3 warrant discipline on a cumulative basis. The public expects a degree of professionalism from all nurses. This expectation is heightened when the patient is vulnerable. The Tribunal is also mindful of Principles 1 and 3 of the Code. The patient did not respect the dignity of the patient and her conduct did not promote the health of the vulnerable patient and her infant. As such, the Tribunal considers the established conduct to be a significant departure from acceptable standards, and therefore warrants discipline.

Penalty

[74] Having been satisfied the charges, save particular 2.3, are established, the Tribunal must go on to consider whether it is appropriate to order any penalty under s 101 of the Act.

Relevant law

[75] Under s 101(1) of the Act, penalties may include:

(a) cancellation of the practitioner's registration as a health practitioner;

(b) suspension of the practitioner's registration for a period of up to 3 years;

(c) an order that the practitioner may only practise in accordance with any conditions as to employment, supervision or otherwise, such conditions not to be imposed for more than 3 years;

(d) an order that the practitioner is censured;

(e) subject to subsections (2) and (3), order that the health practitioner pay a fine not exceeding $30,000; and

(f) an order that the practitioner pay part or all of the costs of the Tribunal and/or the PCC.

[76] The appropriate sentencing principles are those contained in *Roberts v Professional Conduct Committee*[13], where Collins J identified the following eight factors as relevant whenever this Tribunal is determining an appropriate penalty. In particular, the Tribunal is bound to consider what penalty:

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

[13] *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2012] NZHC 2254 at [44] – [51].

(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 the penalty which is "fair, reasonable and proportionate in the circumstances".

[77] The objective when determining penalty is described in *Young v Professional Conduct Committee*:[14]

> The protection and maintenance of professional standards is an important part of the protection of the public. It is through the maintenance of high professional standards that the public is protected. Deterrence is in the same category. This is intended to discourage others from acting the same way reflected in the severity of the punishment imposed.

[78] The Tribunal was also referred to *Katamat v Professional Conduct Committe*e where Williams J gave guidance on the process by which the Tribunal should determine an appropriate penalty:

> In summary, the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect

[14] *Young v Professional Conduct Committee* HC Wellington CIV 2006-485-1002 1 June 2007.

> the public and to maintain professional standards, are more intuitive in their application. Others, such as the seriousness of the offending and consistency with past cases, are more concrete and capable of precise evaluation. Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct. The need to punish the practitioner can be considered, but is of secondary importance. The objective seriousness of the misconduct, the need for consistency with past cases, the likelihood of rehabilitation and the need to impose the least restrictive penalty that is appropriate will all be relevant to the inquiry. It bears repeating however, that the overall decision is ultimately one involving an exercise of discretion.

[79] Overall, the Tribunal's role is to determine the appropriate penalty considering the nature and seriousness of the conduct and the purposes of the Act to protect the public interest and the integrity of the profession.

PCC submissions on penalty

[80] In relation to charges 1 and 2, Counsel for the PCC submits that in determining the appropriate penalty, the following aggravating factors are relevant:

(a) the children the practitioner was caring for were part of one of, if not the most, vulnerable groups of patients a registered nurse can care for;

(b) there were two reported incidences of the practitioner failing to attend to infants, and further evidence of her phone use while on duty. This demonstrates a pattern of unsafe practice whereby her patients were put at risk and their health and safety were compromised;

(c) if not for the practitioner's colleagues, the infants would not have been attended to. Ms van Roekel gave evidence that she was not comfortable going on regular breaks due to a lack of confidence in the practitioner. The practitioner's failure to provide safe and competent care not only put the patients she was caring for at risk, but adversely impacted her colleagues in that they were picking up her work; and

(d) the practitioner was physically present in the room on both occasions. There is no suggestion that there was anything more urgent requiring her attention at the time. There is no justification for her failure to provide care, and this must be attributed to laziness and/or indifference.

[81] In respect of Charge 3, Counsel for the PCC submits the following aggravating factors are relevant:

(a) at the time of this incident, Ms [AY] was recovering from a caesarean section, her son was in the NICU, and Auckland was in a level 3 lockdown. The practitioner should have been aware of Ms [AY]'s increased vulnerability and provided her with appropriate reassurance and assistance. The practitioner did the opposite by behaving indifferently towards her, and failing to help with a very reasonable request that had been recommended as part of the infant's care; and

(b) based on the evidence of the other nurses, getting the infant up would not have been difficult, and the infant's medical procedure should not have prevented this.

[82] Given the practitioner's failure to engage in the disciplinary process, Counsel for the PCC submits there are no mitigating factors.

[83] Counsel for the PCC relies on the cases referred to in its liability submissions (and recorded from paragraph [25] above) as comparative cases for penalty. Counsel also drew the Tribunal's attention to *Schlee*[15] to make the submission that cancellation is appropriate to set standards and protect the public. Any lesser penalty would not adequately reflect the seriousness of the practitioner's misconduct.

[15] Schlee (843/Nur15/328P).

Tribunal consideration of penalty

[84] The Tribunal has considered the principles enunciated in *Roberts* and accepts the aggravating factors identified by Counsel for the PCC. While the Tribunal sought to consider any mitigating points, it does not consider there are any in this matter.

[85] The vulnerability of the infants the practitioner was caring for, and the fact that there were two very similar incidents of the practitioner failing to attend to infants within a short space of time, are the factors which weigh most significantly in the Tribunal's decision.

[86] The established conduct is objectively very serious. As Counsel for the PCC notes, infants within the NICU are amongst the most vulnerable groups a registered nurse can care for. While there is no evidence of harm arising to the infants, this was due to the care provided by other nurses who had their own responsibilities, and in spite of the practitioner's repeated indifference to her professional duties. The care she provided to Ms [AY], although occurring in a different context, demonstrates this indifference was present across her practise.

[87] Even if the practitioner had attended the hearing and demonstrated a degree of insight, the seriousness of the conduct means the Tribunal would have been very slow to consider any penalty short of cancellation. Given the practitioner's non-attendance, there is no evidence of the practitioner's insight into her actions which makes cancellation inevitable in this circumstance.

[88] The Tribunal considers that the imposition of cancellation would also be consistent with the comparator cases provided by the PCC. The Tribunal is of the view that the established conduct here is more serious than in those cases and has reached the view of the *E* Tribunal (which imposed cancellation) that the established conduct "*goes to the heart of the Practitioner's role to provide safe and competent care and maintain honest and accurate patient records*".

[89] Finally, given the seriousness of the conduct and the imposition of cancellation, the Tribunal also considers a censure is appropriate to impose.

Costs

[90] In relation to costs, the Tribunal records that it has used a starting point that a health practitioner will generally be expected to contribute 50% of the actual and reasonable costs of the Tribunal and PCC.

[91] Counsel for the PCC submits that the appropriate level of costs is a matter for the Tribunal taking into account the practitioner's particular financial circumstances. However, it is submitted that although the practitioner did not appear before the Tribunal, the PCC nonetheless had to call witnesses to give evidence, a process which caused the witnesses some inconvenience and stress and added to the cost of the hearing.

[92] Following the conclusion of the hearing, the practitioner was given an opportunity to make submissions on costs before the Tribunal considered its costs award. The practitioner did not avail themselves of this opportunity.

[93] Given the lack of submissions, the Tribunal has no evidence before it as to the practitioner's financial situation. Given this, and the practitioner's overall failure to engage with the disciplinary process, the Tribunal's considers that a 45% costs contribution is appropriate.

Name Suppression

[94] The practitioner did not apply for interim or permanent name suppression. There are no orders suppressing the name of the practitioner.

[95] At the hearing, an oral application was made for the permanent suppression of the names of Ms [AY], Baby [Y] and Ms [AY's] husband [LH]. A further order was sought for permanent suppression of the names of those babies the subject of charges 2 and 3.

Ms [AY]

Baby [Y]

Mr [LH]

Those babies the subject of charges 2 and 3.

Orders of the Tribunal

[96] Accordingly, the Tribunal makes the following penalty orders:

(a) the practitioner's registration is cancelled pursuant to s 101(1)(a) of the Act;

(b) the practitioner is censured pursuant to s 101(1)(d) of the Act; and

(c) the practitioner is to pay a 45% contribution of costs to both the PCC and the Tribunal pursuant to s 101(f) of the Act. The practitioner is therefore ordered to pay $18,550.59 to the Tribunal costs and $15,178.07 contribution to the PCC's costs.

[97] Permanent orders are made suppressing the name and any identifying details of Ms [AY], Baby [Y], Ms [AY]'s husband Mr [LH] and the names of those babies the subject of charges 2 and 3.

[98] Pursuant to s 157 of the Act, the Tribunal directs the Executive Officer to:

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

(b) 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.

DATED at HASTINGS this 30th day of May 2024

Winston McCarthy
Deputy Chairperson
Health Practitioners Disciplinary Tribunal

Appendix A

TAKE NOTICE that a Professional Conduct Committee appointed by the Nursing Council of New Zealand pursuant to section 71 of the Health Practitioners Competence Assurance Act 2003 ("the Act") has determined, in accordance with section 80(3)(b) of the Act, that the complaint about the conduct of Vickie Wade ("Ms Wade") referred to the Committee pursuant to section 68(1) of the Act, should be considered by the Health Practitioners Disciplinary Tribunal.

The Professional Conduct Committee has reason to believe that grounds exist entitling the Tribunal to exercise its powers under section 100 of the Act.

Charges

The PCC charges that when working as a staff nurse in the Neonatal Intensive Care Unit at Starship Hospital ("NICU") in the period November 2019 to February 2020 Ms Vickie Wade, registered nurse of Auckland compromised the health and safety of babies in her care. In particular:

1.0 On or about [ ] December 2019 she:

- **1.1** failed to respond to baby [A]'s acute apnoea monitor alarms while in her care which resulted in intervention from another staff member; and/or
- **1.2** was wearing headphones and/or was distracted by an electronic device; and/or
- **1.3** was hesitant to document and/or failed to document the apnoeic/"*red writing"* episode in accordance with NICU policy.

2.0 On or about [ ] February 2020:

- **2.1** Failed to respond appropriately to an infant's acute apnoea monitor alarms while in her care which resulted in intervention from another staff member; and/or
- **2.2** was wearing headphones and/or was distracted by an electronic device; and/or

2.3 failed to document the apnoeic/"*red writing"* episode in accordance with NICU policy.

3.0 On or about [ ] November 2019 was unprofessional and/or disrespectful in her interactions with the parents of baby [Y]. In particular:

3.1 When asked by Ms [AY], baby [Y]'s mother, to help get [Y] to her so she could hold him to enable skin to skin contact, Ms Wade sighed loudly and said she was too busy.

3.2 Ms Wade told Ms [A] that she could get baby [Y] herself, but Ms [AY] could not stand due to the severe pain she was in following a difficult Caesarean delivery.

3.3 Ms Wade was indifferent to, unsupportive and judgemental of Ms [AY].

The conduct alleged in charges 1,2 and 3, and particulars 1.1 – 1.3, 2.1 – 2.3 and 3.1 – 3.3 separately and/or cumulatively amount to professional misconduct pursuant to section 100(1)(a) and/or (b) of the Act.