New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: 459/Nur 12/202P

IN THE MATTER of section 92 of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of disciplinary proceedings against **MR MICHAEL CHRISTOPHER ROBERTS** registered nurse formerly of Dunedin

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Ms K G Davenport (Deputy Chair)
Mr Q Hix, Ms T Campbell, Ms C Cooney, and Ms M Broodkoorn (Members)

Miss D Gainey (Executive Officer)
Ms K O'Brien (Stenographer)

HEARING: Held in Dunedin on Wednesday 15 May 2012

APPEARANCES: Mr M McClelland and Ms H de Montalk for the Professional Proceedings Committee

Ms A O'Brien and Ms K Rose for the practitioner

Introduction

1. Mr Roberts is a registered nurse. He was in practice in Dunedin at the time of the events which are the subject of the charge. He now works in the United Kingdom. He faces a charge arising out of his care of, and relationship with, Ms N in 2007 - 2010.

2. The charge is as follows:

> "***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 s.80(3)(b) of the Act, that the complaint about the conduct of Michael Roberts, 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 s100 of the Act.*
>
> ***Particulars of Charge***
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> *1.0 That during the period on or about December 2007 to 10 November 2010, while employed as a registered nurse in Ward 5B of Dunedin Hospital, it is alleged that Mr Roberts entered into an inappropriate and/or sexual relationship with Ms N, a patient in his care and/or formerly in his care. In particular:*
>
> *1.1 While Ms N was an inpatient in Ward 5B where Mr Roberts was employed, he gave Ms N his cell phone number;*
> *1.2 While Ms N was an inpatient in Ward 5B where Mr Roberts was employed, Mr Roberts sent Ms N a number of text messages;*
> *1.3 On 26 December 2007, Mr Roberts commenced an inappropriate and/or sexual relationship with Ms N.*
>
> *2.0 On 10 November 2010 it is alleged that Mr Roberts misappropriated a credit card belonging to Ms N, and using this credit card, withdrew $1000 from Ms N's account without her consent.*

3.0 On 10 November 2010 it is alleged that Mr Roberts misappropriated personal items belonging to Ms N, including tramping gear.

The conduct alleged in Charges 1.0, 2.0 and 3.0 amounts to professional misconduct pursuant to section 100(1)(a) or (b) of the Act and particulars 1.1, 1.2 and 1.3 either separately or cumulatively, are particulars of that professional misconduct."

3. Agreed amendments were made to the charge and it is the amended charge that is set out above.

4. The PCC and Mr Roberts agreed a Summary of Facts set out below.

"1. In October 2007 Ms N was admitted as an in-patient to Ward 5B in Dunedin Hospital. She had been diagnosed with [ ]. Her symptoms included double vision, ptosis (droopy eye), facial paralysis, slurred speech, difficulty swallowing, inability to hold her head up if she leant forward and inability to hold her arms up. She had been admitted for a trial of intravenous immunoglobulin to see whether that would alleviate some of her symptoms.

2. Ms N was again admitted to hospital on 4 December 2007, for further investigations and treatment of her rapidly progressing [ ] (the December admission). At that time Ms N had been separated from her husband for about 12 months. She had lost a considerable amount of weight at the time of her admission and weighed only 46 kilograms. She thought she looked horrendous and that no-one would ever want to be in a relationship with someone who was so sick. Ms N describes herself as being extremely vulnerable at that time.

3. Mr Michael Roberts ("Mr Roberts") was working as a registered nurse in Ward 5B on a fixed-term contract from 30 July 2007 until 3 February 2008. On 6 June 2008 Mr Roberts was offered a full time permanent position in Ward 5B. He left his employment on 9 November 2010.

4. For the December admission Mr Roberts completed Ms N's daily care plan, admission assessment and risk screen, falls risk assessment and pressure area risk assessment (pages 13-21 of clinical notes bundle). These forms were completed at the time of Ms N's admission to Ward 5B. Mr Roberts made another 3 entries in Ms N's notes on this admission (progress notes 5/12/2007 page 30, Internal Referral Forms dated 4/12/2007 and 5/12/2007 pages 77 and 78 of the Clinical Records bundle).

5. On one occasion during the December admission while Ms N was in Ward 5B as an in-patient Mr Roberts brought her a piece of paper

with his name and mobile phone number written on it (attached as "A"). He gave it to her saying "This is highly unprofessional" before leaving the room. Ms N then sent Mr Roberts a text message and from that point on they exchanged text messages. Mr Roberts does not recall this.

6. Ms N had enjoyed Mr Roberts' company during her December 2007 admission. He would often spend time speaking to her when he was on duty and had been her nurse on a number of occasions. She had just been diagnosed with an extremely debilitating disease and did not think anyone would love or care for her, but then along came a nurse who showed an interest in her and did not seem to worry about the "horrible" shunt in her arm. She was not aware that there was anything wrong with a nurse having a relationship with a patient they had looked after.

7. Ms N was discharged from hospital on 24 December 2007. As arranged on 26 December 2007 Mr Roberts visited Ms N at her home at [ ]. Sexual intercourse took place. This was the beginning of their sexual relationship.

9. The intimate relationship between Ms N and Mr Roberts continued from 26 December 2007. In December 2009 Mr Roberts moved into Ms N's home. In February 2010 Mr Roberts moved with Ms N to a house she had purchased at [ ], where he continued to live until he left Ms N in November 2010.

10. While their relationship continued Mr Roberts continued to nurse Ms N when she was admitted to Dunedin Hospital. Ms N was admitted to hospital on 8 September 2008 for plasmaphoresis. Mr Roberts completed her admission assessment and risk screen (page 194), patient care plan (page 196), pressure area risk assessment (page 197), falls risk assessment (page 198) and made one entry in her progress notes (9/9/2008 page 189 of the Clinical Records bundle).

11. On 30 August 2010, Ms N was again admitted to hospital for a patch angioplasty on her AV fistula left arm to repair a fistula stenosis. Mr Roberts is listed on her admission front sheet as an alternative contact and his address is the same as Ms N's. Mr Roberts did not nurse Ms N on this occasion.

12. On 10 November 2010 (the day after Mr Roberts sat the final exam for the Critical Care course he was doing at Dunedin Hospital) Ms N returned home from work and found a letter from Mr Roberts telling her that he was leaving and would not be coming back.

13. Ms N then discovered that Mr Roberts had used her credit card and had withdrawn $1,000 from her account without her permission. He had also taken all her near-new tramping gear. Later that day Mr Roberts returned the money by depositing $1,000 into Ms N's credit card account.

14. Ms N contacted the Police who traced Mr Roberts to the Wellington address of a friend, Mr Regan Spillane on 12 November 2012. Mr Roberts advised the Police that he had repaid the money to Ms N and that he did not have her tramping gear. Ms N acknowledged that the money had been deposited to her account with the notation "sorry" but told the Police she wanted Mr Roberts charged.

15 The Police phoned Mr Roberts and told him he would be arrested and charged. Mr Roberts told Police he had found Ms N's camping equipment amongst his belongings and took it to the Wellington Police Station for return to Ms N.

16 Mr Roberts was charged and on 15 November 2010 he appeared in Court where he pleaded guilty and was granted a discharge without conviction. Mr Roberts then left New Zealand.

17. On 27 November 2010, Ms N spoke briefly with Ms Carolyn Preston ("Ms Preston"), Charge Nurse Manager of Ward 5B (who she had met quite by chance) and told her that she had been in a relationship with Mr Roberts. Until this time Ms Preston had no idea that Mr Roberts was in a relationship with Ms N and had been for close to three years.

18. Shortly afterwards, Ms N met with Ms Preston and Ms Sharon Jones, Nurse Director for Surgical Services at Dunedin Hospital and told them the details of her relationship with Mr Roberts including the theft of money from her account and her tramping gear. Ms N told them that at the time she had met Mr Roberts on Ward 5B her self-esteem was very low due to her illness.

19. Ms Preston encouraged Ms N to write a letter to the Nursing Council which Ms N did on 20 February 2011 (attached as "B")."

5. Mr Roberts is now practising in England and has obtained registration as a nurse there. He is currently working in an outpatients clinic. He returned to New Zealand to answer the charges. He told the Tribunal that he accepted that charge 1 and that particulars 1.1 to 1.3 amounted to professional misconduct but did not accept that charges 2 and 3 were professional misconduct. On his behalf Ms O'Brien submitted that these charges related to the end of his relationship with Ms N and that they were domestically related and not professional misconduct.

6. The Tribunal told the parties that it would consider whether or not it felt that professional misconduct had been made out on the facts at the end of the hearing

and asked both counsel to make submissions on penalty. Mr Roberts elected to give evidence.

7. Mr Roberts told the Tribunal that he had initially worked as a hospital aide in the mental health area before coming to New Zealand and enrolling in a Bachelor of Nursing degree. He graduated in 2005 and was registered in 2006. He said he resigned his post in November 2010 and returned to England where he is now registered as a nurse. He said he now accepted that his relationship with Ms N involved a breach of professional boundaries. He apologised to Ms N. He told the Tribunal that he had searched for some training on the area of professional boundaries so that he would not make the same mistake(s) again. He found the Clinic for Boundaries Studies in the UK. After making enquiries he had had a two hour consultation on the telephone and a one hour session with the psychologist. He has been recommended for acceptance in their three day programme. He told the Tribunal that he will attend the next course whenever that is run, probably in June 2012. He has had some counselling with the Royal College of Nursing in England and he said he planned to follow up with this.

8. He told the Tribunal that he had advised the Nursing and Midwifery Council of the United Kingdom about this complaint. He said (exhibit 8):

> *"The person I left was a patient on the ward I was working, but never a patient of mine. Dunedin being a small place this person (Ms N) came into a café I was having coffee in and we started talking to which she explained she was once a patient and I recognised her from being on the ward. We met a few times more to which the relationship began. We continued this and we moved into a house together once I had left my wife and lived together for 12 months.*
>
> *I felt this was not going anywhere and we had always talked about leaving if any one of us was not happy. This I did.*
>
> *Ms N has made an allegation to New Zealand Nursing Council explaining I had a relationship with her while she was under my care, well that's what I*

understand of the letter of complaint from Ms N. There are also other allegations of owing her money and taking money out of her account. Over the period of time I had paid into her account over 10,000.00 nz dollars and any money owing should have been paid back. We also always used each others cards to pay for stuff (shopping, bills) so we new each others pass numbers. As well we were also saving for holidays."

9. As Mr McClelland put to Mr Roberts in cross examination these statements were not accurate. Mr Roberts acknowledged that he did not meet Ms N in the way that he had set out and in fact nursed her on two additional dates after her departure from hospital in 2007, namely 2008 and 2009. The agreed statement of facts was amended to incorporate the 2009 date.

10. He also told Mr McClelland that he had told his current employer of this complaint before he started work but acknowledged after a letter was put to him from the Director of Nursing of his current employer that this was not the situation.

11. Before considering this matter, the Tribunal must consider the law under which it must make its decision and impose a penalty.

The Law

12. A practitioner may be disciplined if the conduct complained of falls within one of the categories set out in s.100. The sections which are relevant to this case are s.100 (1) (a) and s.100 (1) (b). They are set out below.

"<u>Section 100: Grounds on which a practitioner may be disciplined</u>

1. The Tribunal may make 1 or more of the orders authorised by Section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that –

> *(a) The practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or*
>
> *(b) The practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred or …"*

13. As set out above, a health professional is guilty of professional misconduct in terms of section 100(1) if the conduct:

(a) Amounts to malpractice or negligence in the way that they discharge their professional responsibilities; or

(b) The acts or omissions will or are likely to bring discredit to the practitioner's profession regardless of whether or not they occur within a practitioner's scope of practice.

14. Negligence, in the professional disciplinary context, does not require the prosecution to prove that there has been a breach of a duty of care and damage arising out of this as would be required in a civil claim. Rather, it requires an analysis as to whether the conduct complained of amounts to a breach of duty in a professional setting by the practitioner. The test is whether or not the acts or omissions complained of fall short of the conduct to be expected of a nurse in the same circumstances as Mr Roberts. This is a question of analysis of an objective standard measured against the standards of the responsible body of a practitioner's peers.

15. As Justice Elias said in *B v The Medical Council*[1]:

> *"The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, whilst significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards".*

16. Section 100(1)(b) requires the Tribunal to determine whether or not the act or omission has brought or is likely to bring discredit to the profession. The Nurses Act 1977 contained a similar clause and this was considered by the Gendall J in *Collie v Nursing Council of New Zealand*[2]. He said:

> *"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 whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standard of the nursing profession was lowered by the behaviour of the nurse concerned."*

17. The provisions contained in s.100 sit within the body of earlier well established case law on professional discipline. The statements made by Judges such as Gendall J in *Collie (supra)* and those set out below, still apply when considering the definition of malpractice and negligence.

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[1] (HC, Auckland, HC 11/96, 8 July 1996, Elias J)
[2] [2001] NZAR 74

18. Justice Jeffries described professional misconduct in *Ongley v The Medical Practitioners Disciplinary Tribunal*[3] as the answer to the following question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting medical misconduct? With proper diffidence, it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency…"*

19. Justice Venning in *McKenzie v The MPDT*[4] described the test of professional misconduct as follows:

(Paragraph 71)

> *"In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards, and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in the consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."*

20. Decisions such as these and other cases under the Medical Practitioners Act 1995 and its predecessor the Medical Practitioners Act 1968 established a 2 stage test for determining professional misconduct. The test provides:

(a) Was the conduct complained of such that a nurse, in the same vocational area as the nurse charged, think that the conduct fell (significantly) short

[3] [1984] 4 NZAR 369 at 374
[4] (HC Auckland, CIV 2002-404-153-02;12/06/03)

of the conduct that was to be expected of a reasonably competent nurse? and;

(b) If the answer to 1. is "yes"; then did this finding warrant the imposition of a disciplinary sanction for the purpose of protecting the public and or maintaining standards and or punishing the nurse?

21. A commentary on the second part of this test can be found at paragraph 68 and 70 of this Tribunal's decision in *Nuttall*[5] and in cases such as *Pillai v Messiter*[6].

22. Applying these tests to the agreed statement of facts and the charges the Tribunal consider that charge 1 amounts to professional misconduct under s.100(1)(a) and (b). Forming a sexual relationship with a patient is regarded with the strongest condemnation by all health professionals.

Discussion and reasons

23. The Tribunal announced its decision orally and the transcript of that oral decision is annexed to this decision.

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

[5] PCC v Nuttal [decision 8/Med04/03P]
[6] (1989) 16 NSWLR 197

25. With charges 2 and 3 the Tribunal accepts that in the circumstances of this case (and the discharge without conviction) they were unwise acts taken at the end of a three year relationship. Mr Roberts repaid the $1,000 the day after he removed it and returned the tramping gear as soon as he found it. The Tribunal therefore does not find that charges 2 and 3 are professional misconduct.

26. Mr Roberts therefore must have a penalty imposed upon him for the serious misconduct in charge 1.

27. The principles of sentencing are:

Principles of Sentencing

28. A penalty must fulfill the following functions. They are:

a) **Protecting the public**.

S.3 of the Health Practitioners Competence Assurance Act sets out the purposes of the legislation. 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."

b) **Maintenance of professional standards**.

This was emphasised in *Taylor v The General Medical Council*[7] and *Dentice v The Valuers Registration Board*[8].

c) **Punishment.**

While most cases stress that a penalty in a professional discipline case is about the maintenance of standards and protection of the public there is also an element of punishment – such as in the imposition of a fine. see s.101 (1)(e) or censure. See for example the discussion by Dowsett J in *Clyne v NSW Bar Association*[9] and Lang J in *Patel v Complaints Assessment Committee*[10]).

d) Where appropriate, rehabilitation of the practitioner must be considered – see *B v B*[11].

29. The comments of Justice Gendall in *PCC v Martin*[12] are helpful in considering penalty. He said at paragraphs 24 and 26:

> *[24] Removal from the Register or striking-off may have the consequences of a punishment but as has been made clear in many cases the order is not made by way of punishment but because the person was not a proper and fit person to remain registered as a professional person. If the conviction and the actions of the practitioner lead to the conclusion that he/she is not fit to be registered as a nurse, or to practise in a particular profession, then de-registration or suspension is <u>inevitable.</u>*

[7] [1990] 2 All ER 263
[8] [1992] 1 NZLR 720
[9] (1960) 104 CLR 186 at 201-202
[10] (HC Auckland CIV 2007-404-1818; Lang J; 13/8/07)
[11] (HC Auckland HC 4/92 6/4/93; [1993] BCL 1093)
[12] (HC Wellington CIV 2006-485-1461; Gendall J; 27/2/07)

> …
>
> *[26] The appropriate starting point seems to me to ask: "What orders will protect the public, through advancing the proper responsible standards and practice of nursing?" rather than to ask: "Should the professional be punished again?".*

30. Also relevant are the comments of Randerson J in *Patel v Dentists Disciplinary Tribunal*[13]. Randerson J stressed that the Tribunal had to consider the

> "*alternative available to it short of removal and to explain why the lesser options have not been adopted in the circumstances of the case*".

31. The Tribunal has examined each of these principles with care. It considers the maintenance of professional standards and protection of the public require a response from the Tribunal in this case and at the more serious end of the penalty scale.

Discussion of appropriate penalty

32. Both counsel recognise in their submissions that the appropriate penalty for Mr Roberts was either a period of suspension or cancellation of Mr Roberts' registration as the charge represents a significant breach of his professional obligations. He also failed to recognise that he was in breach of professional boundaries right up until his guilty plea. Mr McClelland submitted to the Tribunal that Mr Roberts' registration should be cancelled.

[13] at para 30 from *Patel v Dentists Disciplinary Tribunal* [HC Auckland AP 77/02; 8/10/02 Randerson J]

33. Ms O'Brien on the other hand submitted that the Tribunal should recognise that Mr Roberts appreciated he had committed a breach of boundaries, had come back to New Zealand to answer the charges and had taken significant steps to evaluate for himself, why he had fallen into the error that he did.

34. The Tribunal very carefully considered all of the submissions of counsel and the law. The Tribunal must impose upon Mr Roberts the least punitive penalty which also maintains standards and protects the public. Clearly, therefore, given the seriousness of the sexual and boundary offences, counsel were correct to focus attention on either cancellation or suspension. It was a very close decision for the Tribunal as to whether cancellation or suspension for a period of years was the most appropriate penalty. In the event, after consideration of previous cases and the law, the Tribunal concluded that given Mr Roberts has now (albeit only recently) recognised his breach of boundaries, he ought to be rehabilitated if at all possible back into the profession.

35. The Tribunal however was not impressed that Mr Roberts was not truthful with the Nursing and Midwifery Council of the United Kingdom in his report to them and in the evidence that he gave to the Tribunal. It illustrated how far he has to go in recognition of the impact of the relationship on Ms N and his responsibility for this. It is clearly a significant breach of his nursing obligations to form a relationship with a patient whilst she was an inpatient in the ward where he worked and to form a sexual relationship with her such a short time after she left hospital after a lengthy period of being an inpatient. Mr Roberts then nursed her on two separate occasions when she was readmitted, without informing anyone of their relationship. It seems to have taken Mr Roberts some

significant amount of time to recognise that this behaviour is a breach of his professional obligations as well as his moral obligation.

36. Taking into account the Tribunal's obligation to rehabilitate him and the steps that he seems to have taken to rehabilitate himself thus far, the Tribunal considers that a period of lengthy suspension is the most appropriate. The Tribunal considers that because it has taken some time for Mr Roberts to recognise that his behaviour is a breach of his professional obligations, the length of suspension will enable him to take every opportunity to rehabilitate himself and to learn more about boundaries in nursing.

37. Accordingly the Tribunal orders that:

(a) Mr Roberts' registration is suspended pursuant to s101(1)(b) for a period of three years from the date of the Tribunal's order.

(b) Mr Roberts is censured.

(c) Mr Robert's pay $10,000 of the costs of and incidental to the investigation, prosecution and Tribunal costs (s101(f)).

38. Mr Roberts did not seek name suppression and the Tribunal directs the Executive Officer publish a copy of this decision and a summary on the Tribunal's website. The Tribunal also directs the Executive Officer to publish a notice stating the effect of the Tribunal's decision in Kai Tiaki Nursing New Zealand and the Nursing Council Newsletter (Section 157 HPCA Act 2003).

39. The Tribunal further directs that a copy of its decision be provided to the Nursing and Midwifery Council of the United Kingdom.

DATED at Auckland this 12th day of June 2012

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K G Davenport
Deputy Chair
Health Practitioners Disciplinary Tribunal

Appendix 1

Oral decision of the Tribunal on penalty:

"The Tribunal have carefully considered the submissions of counsel and the law, the amended charge, the agreed statement of facts. We consider that Mr Roberts is guilty of professional misconduct under charge 1. In the circumstances of this case we do not consider that charges 2 and 3 reach the threshold on their own for professional misconduct. We'll expand upon that in our written decision.

We have taken into account in imposing a penalty on Mr Roberts our obligations to impose the least punitive penalty on him which also maintains standards in the nursing profession and protects the public. We will expand upon our reasons when we give our written decision.

In this case in imposing our decision we have deliberated for some time about whether or not Mr Roberts' registration ought to be cancelled. And the factors which we took into account in reaching our ultimate decision is the fact that Mr Roberts has only recently, and we think this is after the date on which he saw his affidavit in March of this year, recognised that there has been a breach of boundaries; and the fact that he was not completely truthful when giving evidence to us today, and in his disclosure to the Nursing Council of the UK.

However, the cases have urged upon us the need to consider rehabilitation of Mr Roberts and in this case we were finely balanced between the need to cancel Mr Roberts' registration and imposing a period of suspension upon him.

We have considered that in this case the appropriate penalty is a period of suspension on Mr Roberts pursuant to Section 101(1)(b) but we suspend him for the maximum of three years from the date of this order.

We also consider that it's important that pursuant to Section 101(1)(c) Mr Roberts undertake an appropriate course to be approved by the Nursing Council of New Zealand in professional ethics and boundaries. We order that a copy of our decision be sent to the Nursing and Midwifery Council of the United Kingdom.

We censure Mr Roberts. We do not impose a fine upon him but we order that he pay $10,000 as a contribution to the cost of the investigation by the PCC, the hearing of this charge and the prosecution by the Professional Conduct Committee and make these orders under Section 101(1)(f) of the Health Practitioners Competence Assurance Act 2003.

We order that there be publication of Mr Roberts' name on the Health Practitioners Disciplinary Tribunal website and in such publications as are subscribed to by the Nursing Council and which we will specify in our written decision."